MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, January 10, 2013
9:39 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
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AGENDA PAGE

P R O C E E D I N G S [9:39 a.m.]

MR. HACKBARTH: Welcome to everyone in the audience. Today and tomorrow we will be voting on our final recommendations for payment updates for inclusion in our March 15th report to Congress.

We went through, as I think most of you know, an extensive discussion of draft recommendations for those update factors in our December meeting, an extensive review of the relevant data in what we refer to as our payment adequacy framework. Today we will have somewhat more truncated presentations, won't retrace all of the ground that we reviewed in December.

At the end, we will have our final votes on those.

The one provider group that is not on our agenda today that was on our agenda in December is still nursing facilities. It is not on our agenda today because what we discussed in December and what we plan to do there is rerun our prior recommendation for rebasing the rates for skilled nursing facilities. Therefore, there's no new recommendation on which to vote.

In addition to that, there were no new issues, questions raised by Commissioners that we need to follow up

on at today's meeting. So given the absence of a vote, and no new issues to discuss, we decided not to have a separate discussion on SNF at this meeting.

Since our December meeting, Congress has passed the American Taxpayer Relief Act of 2012, the so-called Fiscal Cliff Legislation, which as people know included a number of Medicare provisions. One, deferring the cut in physician payment rates scheduled under SGR for another year; and then a series of other extenders on the work GPCI floor and physician and health professionals payment system, extenders on outpatient therapy, ambulance add-on payments, various hospital special payments.

Then those extenders, which generally speaking were scored by CBO as costing money for the Medicare program, those new costs were offset with much of the offset in Medicare costs coming from changes in the hospital payment, payment for dialysis service, and a reduction in payment for outpatient therapy and MA plans. There were some other smaller items, but those were the largest one.

So this continues a pattern whereby Congress has deferred an SGR cut at a substantial cost to the Medicare program, about $25 billion over 10 years is the CBO score,

and then offset those costs through cuts to other Medicare providers. In effect, using 10 years of savings from the new cuts to buy a one-year extension of the SGR.

As we proceed through our recommendations for each of the provider sectors, we will talk specifically about the implications of the Taxpayer Relief Act for our recommendations.

Just as a reminder to the audience, our charge from the Congress is to each year make recommendations on how much the Medicare payment rates should change and our target, our beacon, in that analysis is that Congress has asked us to recommend payment rates that are consistent with the efficient provision of services to Medicare beneficiaries.

For those who have followed our work for a period of time, it's clear -- we go through our payment adequacy analysis that includes access to care, access to capital for providers, financial margins where those data are available, quality of care, and the like. Those analyses don't produce a single right update. There is no one right answer to the question we've been asked by Congress, but rather a reasonable range.

It's been our practice, and continues to be our practice, that given the reality that there's a range of reasonableness, that we tend to -- after weighing all of the various factors -- to apply consistent pressure on payment rates for providers with an eye towards matching payment rates to the efficient delivery of services and encouraging future improvements in the efficient delivery of services.

So that's the context for our work over the next couple days. After all my focus on the update process, in fact, our first session is on the Medicare Advantage program and special needs plans where there is no update given how the payment system works. But each year, as we've been asked by Congress, we provide a status report on the Medicare Advantage program in our March report.

And then we also have, this year, recommendations on special needs plans.

So we're off on Medicare Advantage. Scott, are you leading the way?

DR. HARRISON: Good morning. Carlos and I are here to report on the current status of the Medicare Advantage, or MA, program. Like in fee-for-service sectors, we look at access, cost, and quality indicators for the

plans. Our March chapter is a view of the landscape of the program and contains no formal recommendations.

After we present the landscape, Carlos and Christine will present recommendations on special needs plans that will appear in a separate chapter of the report. But first we would like to thank Lauren Metayer and Katelyn Smalley for their assistance with this work.

We will move through the material very quickly as time is tight, but feel free to ask us for clarifications on both the material here and the more extensive material in the draft chapter in your packets.

I know we have some Commissioners who have not yet seen an overview of the MA program, so let me begin by briefly describing the program and payment system.

The MA program allows beneficiaries to receive their Medicare Parts A and B benefits through a private plan rather than through the traditional fee-for-service Medicare program. A beneficiary who enrolls in a plan pays the usual Part B premium and any additional premium that the plan may charge. Medicare pays the MA plan a capitated amount, adjusted for the health risk of the individual beneficiary. And the plan provides coverage for Parts A and B and usually

provides coverage for Part D drugs and additional benefits. As of November, 27 percent of Medicare beneficiaries were enrolled in MA plans.

In some of the analyses, I will try to differentiate by plan types and other plan characteristics, and I want to define some of them here.

Coordinated care plans, or CCPs, are either HMOs or PPOs. Under the MA program, there are local PPOs and regional PPOs. The difference is that local PPOs can serve individual counties, while regional PPOs are required to serve entire regions, which are made up of one or more complete states.

The program also includes private fee-for-service plans which historically had no provider networks and paid providers Medicare fee-for-service rates. However, recent legislation increased the plan requirements.

We sometimes make other distinctions. Special needs plans, or SNPs, limit their enrollment to either Medicare/Medicaid dual eligibles or to those beneficiaries who have certain chronic or disabling conditions or require institutionalization. Carlos and Christina will discuss them in more detail.

And there are plans that are not available to individual beneficiaries but only to employer or union groups. Our availability numbers do not include these so-called employer plans or SNPs because they are not available to all beneficiaries. But our enrollment and payment numbers generally include them.

So let's look at access to plans or plan availability.

Medicare beneficiaries have a large number of plans from which to choose. MA plans are available to almost all beneficiaries. Less than half a percent of beneficiaries do not have a plan available.

Looking at the second line, in 2013, 95 percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, up from 93 percent in 2012.

Regional PPOs are available to 71 percent of beneficiaries in 2013, down from 76 percent in 2012, due to the withdrawal of the regional PPOs in Nevada and the seven-state Great Plains region for 2013.

In many counties, a large number of MA plans are available to beneficiaries. For example, beneficiaries in

Miami, New York City, and a few other areas can choose from more than 40 plans. On average, 12 plans, including nine coordinated care plans, are offered in each county in 2013.

And in 2013, 86 percent of Medicare beneficiaries have access to at least one MA plan that includes Part D drug coverage and charges no premium beyond the Medicare Part B premium.

MA enrollment continues to grow. From 2011 to 2012, enrollment grew by about 10 percent up to 13.3 million beneficiaries. Again, in 2012, about 27 percent of Medicare beneficiaries were enrolled in MA plans.

Among plan types, HMOs at 8.8 million continued to enroll the most beneficiaries, with 17 percent of all Medicare beneficiaries in MA HMOs. Local PPOs exhibited continued rapid growth, with enrollment increasing about 30 percent.

Going forward, plan bids project overall enrollment growth in the 8- to 10-percent range for 2013 with most of the projected growth in HMOs.

Enrollment patterns differ in urban and rural areas. About 29 percent of urban Medicare beneficiaries are enrolled in MA compared with about 16 percent of

beneficiaries in rural counties. However, rural enrollment has been growing at a faster rate than urban enrollment.

Now I want to summarize MA payment policy.

Plans submit bids each year for the amount they think it will cost them to provide Parts A and B benefits; there is a separate bid for part D drugs, but the MA plans just get paid for D as if they were stand-alone Part D plans.

Each plan's bid is compared to a "benchmark," which is a dollar amount set for each county. Under PPACA counties are ranked by average fee-for-service spending, and the highest spending quartile of counties would have benchmarks set at 95 percent of local fee-for-service spending, and the lowest spending quartile would get 115 percent of local fee-for-service. There is a transition from old benchmarks that will be complete by 2017. A plan's benchmark is based on the benchmarks of the counties it serves and on the plan's quality rating. Plans that reach certain quality levels can have their benchmarks raised by up to 10 percent. Carlos will discuss the plan quality ratings shortly.

If a plan bids above the benchmark, Medicare pays

the benchmark and beneficiaries make up the difference with a premium.

If a plan bids below the benchmark, Medicare pays the bid plus a rebate, calculated as a percentage of the difference between the bid and the benchmark. For 2013 the rebate percentage ranges between 58 percent and 72 percent, where plans with higher quality ratings are awarded higher rebate percentages. The rebate must then be used by the plan to provide extra benefits to the beneficiaries. These extra benefits can take the form of reduced cost sharing for A/B services; additional non-Medicare benefits such as dental, vision, or gym memberships; or they could also take the form of improved Part D benefits, including lower Part D premiums.

We use the plans' bid projections to compare projected MA spending with projected fee-for-service spending on similar beneficiaries.

Looking at the top row, we estimate that, on average, 2013 MA benchmarks including the quality bonuses, and their bids and payments will be 110 percent, 96 percent, and 104 percent of fee-for-service spending, respectively.

PPACA reduced benchmarks which resulted in zero

average growth in benchmarks for 2013. The lack of growth in the benchmarks may have encouraged plans to tighten costs and lower their bids. The average bid is now 96 percent of the projected fee-for-service spending for similar beneficiaries, and HMO bids average 92 percent of fee-for-service

However, due to the high benchmarks, we are still spending more for MA enrollees than we are for beneficiaries in traditional fee-for-service Medicare. Though we are paying closer to FFS than in a long time, we are still paying more than fee-for-service on average.

We note here that the 104 percent of the fee-for-service payment figure assumes that the risk-adjustment system and the CMS' coding adjustment properly correct for all of the health risk differences between the FFS and MA populations. Several studies suggest that MA plans may be enjoying some favorable selection that the current risk-adjustment model is not capturing. In that case, the 104-percent figure might understate the additional payments made for plan enrollees. On the other hand, payments do include quality bonuses worth about 3 percent of payments. So if there were no quality bonuses or favorable selection, plan

enrollees in 2013 would receive about 101 percent of the funding that Medicare spends on similar fee-for-service Medicare beneficiaries.

MR. ZARABOZO: Moving to the discussion of the quality of care in MA plans, as Scott mentioned, beginning with the year 2012, MA plans were eligible for quality bonus payments. Plans are awarded a star rating, up to a maximum of five stars, based on their performance on clinical process and outcome measures, patient experience measures, and contract performance measures.

Under the statute, plans with four stars or higher are entitled to a bonus. But under a CMS demonstration, plans at three and three and a half stars also receive bonuses.

The quality bonus program, as a pay-for-performance system, has resulted in changes in plan behavior. Plan star ratings went up between 2012 and 2013. Looking at the distribution of enrollment as of November 2012, the new 2013 star ratings will have the effect of including a greater proportion of the enrollment in higher rated plans. The most dramatic increase in star ratings was among local PPOs. Under the 2012 star ratings, 13 percent

of local PPO enrollees were in plans rated at four stars or higher. With the new 2013 star ratings, 35 percent of local PPO enrollees are in plans at four stars or higher.

Looking at the specific quality measures by which we judge plans, we see that the measures that have improved are the process measures and intermediate outcome measures that plans report to CMS. There was little change in the measures that are the patient experience measures collected via beneficiary surveys, where beneficiaries rate their access to care and satisfaction with the plan and its providers. We also did not see much movement in the survey results that track whether beneficiaries' health improved over a two-year period in MA plans.

Although about one-third of the process and intermediate outcome measures showed improved results between 2012 and 2013, it is hard to say how much of the improvement in the numbers reflects improved quality between 2011 and 2012 in MA. There are two things that the numbers reflect: better quality of care among providers in the plans, and better documentation and coding at the provider level and at the plan level. It is hard to disaggregate the two.

What seems clear from the numbers is that documentation and coding are major factors in the increase in star ratings among local PPOs because of the change in reporting rules for PPO plans as of 2010, as discussed in the mailing material.

To summarize the current status of the MA program, we are seeing continued growth in the program and lower bids in relation to FFS under a payment system that sets MA rates closer to fee-for-service levels. As the quality bonus program goes into its second year, we see plan quality potentially improving.

The Commission has stressed the concept of imposing fiscal pressure on providers to reduce Medicare program costs. For MA the Commission recommended that payments be brought down from previous high levels and should be set so that the payment system is neutral and does not favor either MA or the traditional fee-for-service program. Recent legislation has taken the program closer to this point of equity between MA and fee-for-service. As benchmarks have come down, plans have responded to the financial pressure by lowering their bids.

The Commission has also recommended that pay-for-

performance programs should be instituted in Medicare to promote quality, with the expected added benefit of reducing program costs by reducing unnecessary care. For MA, initial results indicate that plans are changing their behavior in response to potential bonuses by paying closer attention to the quality measures with improved documentation and coding as a contributing factor for many plans. Although CMS has implemented the quality bonus program in a flawed manner at very high program costs not contemplated in the statute that originally authorized the program, the Commission does support the concept of a quality bonus program, combined with continuing fiscal pressure, so that a strong MA program will do its part in ensuring the continued financial viability of the Medicare program.

Before moving to the discussion of special needs plans, we would like to answer some questions that Commissioners raised in past meetings related to plan quality. Herb and George asked whether there were differences in MA quality measures based on age and whether there were racial disparities.

We looked at several screening and testing process measures and the intermediate outcome measure of tracking

blood pressure control across all MA plans. In terms of age differences, we are finding that younger Medicare beneficiaries tend to have lower rates on screening and testing measures, a difference that persists until reaching the age category of 85 or over. However, we did not find differences by age in the blood pressure control measure, though that measure is only tracked up to age 85. In terms of racial disparities, we found that for screenings and tests, the rates among African Americans were similar to the rates among whites, but for the control of blood pressure measure, rates among African Americans were significantly lower than among whites. These numbers are very preliminary, and we are continuing to examine the numbers in our ongoing work looking at disparities.

Bill Hall, you also asked two questions at the last meeting. One was about the composition of the future Medicare population. This particular issue is dealt with in the context chapter that will appear in the upcoming March report, and Kahlie has provided information from that chapter for you. We will return to a different question that you asked when we talk about chronic care special needs plans.

Here is a road map for the SNP analysis. We will give an overview of the SNP program, review our findings on each type of SNP as discussed at the October and November meetings, and then review the draft recommendations.

We have been examining special needs plans at this time because the statutory authority that enables these plans to enroll only certain categories of Medicare beneficiaries was going to expire at the end of 2013. Recently, however, Congress extended all SNPs through 2014 under the American Taxpayer Relief Act of 2012.

On January 1, 2015, SNPs will not be terminated, but they will have to operate as regular MA plans in which all types of beneficiaries are eligible to enroll, not just beneficiaries with special needs.

There are three kinds of special needs plans. Dual-eligible SNPs, or D-SNPs, enroll beneficiaries who are dually eligible for Medicare and Medicaid. The largest share of SNP enrollment is in D-SNPs. These plans enroll almost 1.3 million beneficiaries, or about 10 percent of all MA enrollment. The two other types of SNPs enroll far fewer enrollees. The two other types area chronic condition SNPs, or C-SNPs, which enroll beneficiaries with certain specified

chronic or disabling conditions; and institutional SNPs, or I-SNPs, which provide care to people in institutions or who reside in the community but need an institutional level of care.

The main difference between SNPs and MA plans is that SNPs can design benefit packages that are tailored to the special needs beneficiaries they enroll -- for example, by varying cost sharing based on a person's disease. SNPs also have to report more data to CMS than regular MA plans and have to meet model-of-care requirements as specialized plans.

Compared to regular MA plans, the main difference to be aware of in enrollment rules is that a C-SNP can enroll someone mid-year if the person has one of the conditions covered by the plan, but this is a one-time opportunity given to each beneficiary. Regular MA plans, other than five-star plans, can only enroll beneficiaries during the October-December coordinated open enrollment period.

In evaluating whether SNPs should be reauthorized, we considered how SNP reauthorization would affect Medicare program spending, the quality of care for beneficiaries, and

whether SNPs encourage a more integrated delivery system.

With respect to spending implications, SNP authority will expire under current law at the end of 2014, and the financial implications of this are already included in the baseline. A likely assumption is that a small number of beneficiaries currently enrolled in SNPs will go to fee-for-service once SNP authority expires. If SNPs are reauthorized and those beneficiaries remain enrolled in SNPs, Medicare spending will increase relative to baseline spending. This is because spending on beneficiaries enrolled in MA plans, including SNPs, is generally higher than fee-for-service spending.

We will now look at each SNP type in turn, briefly summarizing the findings discussed in your mailing material and at the October and November meetings.

With regard to I-SNPs, they perform better than other SNPs and regular MA plans on a number of quality measures -- measures such as monitoring patients on persistent medications, doing pain screenings and medication review. I-SNP also perform better than other SNPs and regular MA plans on risk-adjusted rates of hospital readmissions.

I-SNPs' performance on the hospital readmission rates is an important measure of whether they are providing a more integrated delivery system. They attempt to reduce hospital and emergency department utilization through care management and by emphasizing the provision of primary care.

The draft recommendation for I-SNPs states that: The Congress should permanently reauthorize institutional special needs plans.

In terms of the impact, as we've mentioned, this continues a SNP option and therefore results in a small increase in program costs. The draft recommendation would allow current beneficiaries can remain in their plans, and plans no longer have uncertainty about the future of the program.

Moving on now to a summary of findings on C-SNPs, these plans tend to perform no better than, and often worse, than other SNPs and no better than regular MA plans on most quality measures. Within C-SNPs, regional PPO plans tend to perform more poorly than HMO C-SNPs. Regional C-SNPs also have higher than expected rates of hospital readmissions, but HMO C-SNPs have lower than expected hospital readmission rates compared to the all-HMO average.

Returning to Bill Hall's question in relation to C-SNPs, he asked whether there were any "home runs" -- that is, very high performing plans -- among the C-SNPs. We can use the star ratings to answer this question. The C-SNPs that are highly specialized do not have star ratings because of their small enrollment. However, 95 percent of C-SNP enrollment is in plans with star ratings. For plans with star ratings, none of the plans that are primarily C-SNPs have a star rating above three and a half stars. That is, they are average in their performance.

However, organizations that have only a small share of their enrollment in C-SNPs have higher ratings, including some at four and a half and five stars in 2013. These higher-rated organizations function primarily as general MA plans with C-SNP options. In other words, it appears that it is the organization that is high-performing and not necessarily the C-SNP model that explains the better star ratings. In light of this, an aspect of the draft recommendation for C-SNPs, which we talk about in the next slide, is to facilitate the offering of C-SNP models of care within regular MA plans, potentially enabling more higher-performing plans to offer tailored services for the

chronically ill.

Importing the C-SNP model of care into regular MA plans would move MA plans in the direction of providing a more integrated delivery system and would benefit people with chronic conditions who are in regular MA plans. In order to import the C-SNP model of care, MA plans would need to be given flexibility to offer benefit packages that differed based on individual's medical condition, something that is not possible under current rules.

We also recognize that some of the C-SNP conditions dominate an individual's health and that there may be a rationale for maintaining separate plans for them while innovations in the care delivery for these populations are still being made. These conditions include end-stage regnal disease, HIV/AIDS, and chronic and disabling mental health conditions. However, the ability of MA plans to adequately care for beneficiaries with these conditions should be revisited in the future.

This brings us to the second draft recommendation which reads: The Congress should:

Allow the authority for chronic care SNPs to expire, with the exception of C-SNPs for a small number of

conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions;

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. Except for the conditions noted above, impose a moratorium for all other C-SNPs as of January 1, 2014.

The draft recommendation imports the C-SNP model of care into regular MA plans. C-SNP authority would expire for the majority of conditions that are currently eligible for C-SNPs. But MA plans would be given the flexibility to offer specialized benefit packages. We anticipate that MA plans would be held to some or all of the existing C-SNP model-of-care requirements. The Secretary would have three years to develop the needed regulations. Our intention is for the benefit design flexibility to be fully implemented and the transition period to end no later than December 31, 2016. During the transition periods, current C-SNPs would continue operating, but no new C-SNPs would be permitted to

enter the program for the conditions with expiring authority.

Note that this draft recommendation would impose a moratorium on new C-SNPs in 2014. This would be a change from current law because all C-SNPs were just extended through the end of 2014.

The draft recommendation permits C-SNPs' authority to continue for a small number of conditions. And note also that the wording of the first bullet is changed slightly from what you saw in your mailing material to better convey what is intended.

This draft recommendation would result in an initial small savings followed by an increase in cost of less than $1 billion over five years. It would increase spending because current C-SNPs would be permitted to continue through the three-year transition period.

For the beneficiary impacts, access and quality may improve to the extent that more tailored benefit packages are available to chronically ill beneficiaries. Plans can continue to serve chronically ill beneficiaries through the new flexible benefit designs. C-SNPs for beneficiaries with certain conditions would also be able to

continue.

Christine will now discuss our findings and recommendations on D-SNPs.

MS. AGUIAR: With respect to quality, D-SNPs tend to have average or below-average performance compare to other SNPs and regular MA plans. However, some of the D-SNPs that are the most highly integrated with Medicaid perform well on the star ratings.

Moving on to integration, we define integration as plans assuming clinical and financial responsibility for Medicare benefits and some or all Medicaid long-term care services and supports, or LTSS, and/or behavioral health. However, most D-SNPs are not integrated. This may be due to legislation in some States that prohibits managed care for LTSS or behavioral health or lack of State resources to develop contracts with D-SNPs.

As you recall from previous meetings, we observed two scenarios where D-SNPs have the incentive to be integrated. For the first scenario, one plan, the D-SNP, covers some or all Medicaid LTSS and/or behavioral health through its contract with the State. Under the second scenario, one managed care organization has both a D-SNP and

a Medicaid plan that furnishes some or all LTSS and/or behavioral health. The same dual eligibles are enrolled in both plans and the integration occurs at the level of the managed care organization across the two plans. The D-SNP in this scenario does not need to have a State contract to furnish Medicaid benefits because its companion Medicaid plan has the contract for these services. Only about a quarter of current D-SNP enrollment is in one of these types of integrated D-SNPs.

This brings us to the 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.

The intention of this recommendation is to move D-SNPs towards integration and to make integrated D-SNPs permanent.

There is no effect on spending in 2014 because D-SNPs have been reauthorized for that year. We expect a small increase in spending over five years that is at the lower range of the estimate on the slide.

We do not expect beneficiaries or plans to be

adversely affected by this recommendation. Non-integrated D-SNPs have the option to convert to regular MA plans or work with States in the future to become integrated.

In November, we discussed two misalignments that were barriers to integration. These were separate Medicare and Medicaid appeals and grievances processes and restrictions that prohibit D-SNPs from marketing Medicare and Medicaid benefits they furnish in the same place on marketing materials.

I would like to draw your attention to two additional barriers. One is that dual eligibles can be given multiple enrollment cards to access their Medicare and Medicaid benefits even if they are enrolled in one plan or within one organization that covers both sets of benefits.

The last barrier relates to a limitation that I discussed earlier, which is that some States may lack the resources and expertise to develop contracts with D-SNPs.

This brings us to the fourth draft recommendation. It reads: For D-SNPs that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes;

direct the Secretary to allow these D-SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package; direct the Secretary to allow these D-SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits; and direct the Secretary to develop a model D-SNP contract.

This recommendation would alleviate the misalignments that I discussed on the previous slide.

We do not expect this recommendation to affect program spending.

We expect this recommendation will increase integration for beneficiaries and will reduce the burden on plans.

This slide presents a summary of the draft recommendations.

This concludes our presentation, and we are happy to answer your questions.

MR. HACKBARTH: Okay. Thank you. Good job.

So we have two pieces of business to accomplish here. One, of course, is to do our votes on the SNP recommendations. The other is to talk about the broader context of the Medicare Advantage program. We have about 50

minutes for this conversation, so once we get to the clarifying questions and then the second round, I want people to, in particular, pay attention to the SNP recommendations on which we need to vote. So put that at the top of your comment list.

Before we turn to the clarifying questions and comments, I have a few things I want to say about the broader context of the Medicare Advantage program for the new Commissioners as well as people in the audience who have not followed our work over the years.

MedPAC has always strongly supported giving Medicare beneficiaries the option to enroll in private health plans or, if they choose to remain in traditional Medicare, the government-run insurance program. We believe that choice is important because we think the private plans have the potential to do things for Medicare beneficiaries that traditional Medicare finds difficult to do, including develop arrangements for better coordination of care. Private plans have assets, opportunities, that traditional Medicare does not have. On the other hand, traditional Medicare has some strengths that private plans don't have, and so giving beneficiaries a choice between the two paths

makes sense to us.

Among the potential benefits of private plans is greater flexibility in payment methods and how they contract with individual providers. We spend much of our time at MedPAC working on new payment methods, and as people well know, it is a long and laborious process to change Medicare payment methods. Private plans unencumbered by the legislative and rulemaking processes can often make changes, innovative and desirable changes in payment policy, much more quickly than traditional Medicare can.

In addition to that, private plans have the opportunity to identify particularly efficient high-quality providers, and through a variety of methods, steer Medicare beneficiaries to those select providers. That is very difficult for traditional Medicare to even contemplate doing, and by virtue of the very first section of the Medicare law, would require an Act of Congress for Medicare to begin actively steering beneficiaries towards plans.

So those are distinct advantages for private plans.

On the other hand, traditional Medicare has substantial pricing power and lower administrative costs,

which provide it an advantage.

Again, one is not better than the other. We think beneficiaries should have an opportunity to choose the model that they think best meets their personal needs.

We do believe, and this is MedPAC policy going back a decade or more, that the choice offered to Medicare beneficiaries should be financially neutral. There should be a level playing field, if you will, between the two choices. And that has not been the case in Medicare Advantage for a number of years now. Medicare has, or the government has systematically paid more to private plans than it would have cost if the same beneficiaries had remained in traditional Medicare. And we have urged Congress to change that. In PPACA, they took some steps in that direction, towards a neutral playing field, but still, as was described in the presentation, even after PPACA is fully implemented, they will not be all of the way there.

In effect, Congress has elected to pursue other goals. Our focus has been on creating a system where beneficiaries are rewarded for going into the most efficient, highest quality performing system that is consistent with their personal needs. Medicare Advantage

over the years has incorporated goals beyond encouragement of efficiency and value to, for example, addressing perceived regional inequities in payment and trying to develop a payment system that promotes more benefits for Medicare beneficiaries in certain parts of the country. We think that is an inappropriate focus and that, instead, the focus should be on rewarding enrollment in efficient systems.

When I read the popular press, and sometimes even the health press, on Medicare Advantage, I find that there is confusion on a very basic point. Do private plans have the potential to save money relative to traditional Medicare versus whether the Medicare Advantage program is currently structured -- costs or saves money. Those are two very different questions.

I'd ask Scott to put up, I think it's Slide 7. The root of the confusion is here. Our best estimate of the cost of private plans in providing care to Medicare beneficiaries is their bids that they submit as part of the process. As you can see from the middle column, at least some of the private plans bid at a cost lower than traditional Medicare for the basic Part A and B benefit

package. And in some parts of the country, as you can see from your paper, the private plan bids are dramatically lower than traditional Medicare, while in other parts of the country they tend to be higher, and these numbers in the middle column reflect the national averages based on enrollment, weighted by enrollment.

It is a different question whether Medicare Advantage costs money, and the third column shows that, in fact, the program as it currently functions, we spend more than we would have had the beneficiaries remained in traditional Medicare, and that's because of how the Medicare Advantage payment system is structured, in particular, the use of these benchmarks which are not market prices in any sense. These are legislatively determined benchmarks. And the interaction between the bids and the benchmarks is what produces Medicare payments that are above -- Medicare payments to private health plans that are above what it would have cost Medicare, traditional Medicare, to care for the same patients.

So, yes, at least some private plans have demonstrated that they can provide the care for less -- not all, some -- but the way the program is structured, it

actually continues to cost more than if everybody had stayed in traditional Medicare. Those are two very different questions.

One last point, and then we'll get to the clarifying questions. There's also been some confusion recently about our stance on the quality demonstration that CMS established for Medicare Advantage plans. So as, I think it was part of Carlos's description, Congress in PPACA linked payment to quality as measured through the star system and said, if you have a certain number of stars and certain conditions, you ought to get bonus payments for your quality. So Congress passed that law in 2010 and said, this is the link between payment and quality.

In short order after that, CMS came along and created what it characterized as a demonstration, using the Secretary's demonstration authority, which greatly extended the quality bonus payments beyond what was envisioned in PPACA, to the tune of billions and billions of dollars over ten years.

We took the position that that was an inappropriate use of the Secretary's demonstration authority in that it was -- there was no testable hypothesis other

than that people responded to money, and we knew that before we started the project, and that -- so we took the stance that this was an inappropriate use of the Secretary's demonstration authority, particularly since, in effect, it overrode the judgment that the Congress had made the preceding year about the appropriate link between payment and quality for Medicare Advantage plans.

That is not to say that we are opposed to pay-for-performance for Medicare Advantage plans. That is not to say that we don't think that plans will respond to incentives to improve quality. Indeed, back in the early 2000s, the very first provider group that we recommended go to pay-for-performance was Medicare Advantage plans because we thought, in fact, plans should be rewarded for quality and would respond to the incentives. But that is a separate question from whether this is an appropriate use of the Secretary's demonstration authority. You can believe plans respond to incentives and this was not an appropriate thing for the Secretary to do. Those are not mutually inconsistent.

So that's a little background for our new Commissioners, but the journey, Medicare Advantage journey

that the Commission has been on for a while now.

Herb, do you want to lead off with clarifying questions.

MR. KUHN: Thanks, Glenn. That was a wonderful overview. I appreciate that.

A couple questions here dealing with kind of enrollment. Now that we're at 27 percent, what's the current projection for enrollments in the future years, whether it's a CMS actuary or others? Where do we think the trajectory is going to continue to take us?

DR. HARRISON: We think for 2013, we're going to see more growth. CBO and the actuaries had forecast a downturn in enrollment. That has not come true yet. I know CBO has pushed out their downward point at least a couple years. I'm not quite sure where they have it coming down. Personally, I think a lot of the payment reductions have already happened and so I don't know that we're going to see a decline.

MR. KUHN: And in terms of enrollment, obviously, it's spotty across the country. We have some areas that are outliers, like Puerto Rico. But are we seeing, really, in some communities around the country where we are

approaching, say, 50 percent, 40 percent, or whatever enrollment, I mean, much greater enrollment, and what's kind of going on in those communities that's driving that higher enrollment numbers.

DR. HARRISON: I mean, I'd have to say that I think the benefit packages are attractive to beneficiaries. You have a lot of beneficiaries who are aging into the program just now who have had managed care for their whole -- most of their working life, and so I don't think it's a strange product for them anymore.

MR. KUHN: Okay. And then, finally, on the enrollment, it was at least three, four, five years ago that we were seeing large numbers of enrollees into MA plans basically -- not those that were dual eligibles, because they had coverage elsewhere. And then those that had fee-for-service had their Medigap plans, seemed to be kind of satisfied with that. A higher proportion of enrollees were those that kind of fell in between there and were kind of using the MA opportunity as kind of a bridge, you know, to get better benefits and a more comprehensive package. As a result of that, we were seeing higher enrollments in terms of minority populations into the MA plans than traditional

fee-for-service. Is that still the case with the higher enrollments now, or are we starting to see MAs start to look more like traditional fee-for-service Medicare in terms of the proportion of enrollments?

MR. ZARABOZO: In terms of the minorities, the situation is still that it's about -- the proportion of blacks, for example, in MA is similar to the general population. Hispanics are more likely to be enrolling in MA. That has not changed. This is based on our look at the 2011 data.

MR. KUHN: Okay. And then one final question on the coding intensity adjustment. As we've noted, there are higher risk scores in MA plans versus similar beneficiaries in fee-for-service and the coding is much more accurate in the MA plans. CMS has done a 3.41 percent adjustment already. But in the Taxpayer Relief Act, there is additional coding adjustment authority.

I saw it in terms of an absolute dollar figure, but do we know what the kind of percentage would be? So if you take the 3.41 that has already occurred, how much more would this be in terms of coding that we might see?

DR. HARRISON: Okay. So the 3.4 goes up to 3.6,

but PPACA already had an upward trend in it and I believe it was going to go up by a quarter-point a year for a few years, and I believe that is still -- so it's going to start from a higher base and then continue its upward climb at a quarter-point a year. I think it settles at 5.9 percent.

MR. KUHN: Okay.

MR. HACKBARTH: My recollection is that those are minimum required adjustments, correct --

DR. HARRISON: That's correct. CMS --

MR. HACKBARTH: -- as opposed to the authority for the Secretary --

DR. HARRISON: Right.

MR. HACKBARTH: -- it's a minimum required --

DR. HARRISON: CMS has discretion to go higher, if they wish.

MR. HACKBARTH: Right.

MR. KUHN: And under the Taxpayer Relief Act, the additional -- is there a particular time period that needs to be captured by, that additional coding?

DR. HARRISON: In a sense, it's really a permanent 0.2 percent upward adjustment.

MR. KUHN: Okay. Thank you.

DR. MARK MILLER: Another thing I was going to ask Carlos, when you responded on the demographics, I also thought part of the Hispanic story was the markets were -- can you finish that --

MR. ZARABOZO: Right, that the highly-penetrated markets, you have more Hispanics in the highly-penetrated MA markets. Now, the situation also with the blacks is that under 65, you have a higher proportion of blacks under 65 disabled. In general, under 65 tend not to enroll, I mean, compared to the proportion in the general population.

MR. GEORGE MILLER: Yeah. Great chapter. I appreciate the report and particularly the answers to the questions concerning the minority populations.

For a technical question, I would like to go to Slide Number 4, please, and a question concerning the zero premium plan with drugs. In 2011, it was about 90 percent and it's dropped down to 2013. Do we have an understanding why that has decreased over that time frame and what may be driving that decrease? And is there a goal --

DR. HARRISON: Yeah. I mean, this gets -- you have sort of quantum leaps if you have a very large plan that provides such a benefit, you know, over a wide range of

the country and then drops. So there were some private fee-for-service zero premium with drug plans and they may have dialed back a bit. We know, in general, that private fee-for-service has dialed back and I think some of the loss may be due to that. But, you know, the year before that, it was 85, so it could have been one plan that affected this.

MR. GEORGE MILLER: Okay. Thank you.

DR. NAYLOR: Terrific report. Table 8 in the report on the Medicare Advantage talked about hospital readmission rates for MA being relatively stable, and I'm wondering if you could help, or do we know the comparison in hospital readmission rates for MA versus fee-for-service.

MR. ZARABOZO: The short answer is no, because the HEDIS measure has specific specifications as to how it's measured. You know, a number that the industry uses is 20 percent from the Jenks article. I'm looking maybe at the hospital people. It's probably not 20 percent currently. I don't know if they have, like, a rough estimate. This is the 30-day all cause readmission, and we don't actually have a comparable number --

DR. NAYLOR: A comparable --

MR. ZARABOZO: -- that I'm aware of.

DR. NAYLOR: Great.

MR. ZARABOZO: So I'm still looking at the hospital people and they're just nodding, so --

DR. NAYLOR: Great.

[Laughter.]

DR. NAYLOR: Two other brief questions. Slide 7 gets back to the payment for fee-for-service. You mentioned three percent of this is accounted for in the quality bonus payment, and so that -- just from -- does that mean that under the current circumstances where payments for 56 percent who get three stars versus 36 percent who get four stars -- so if you were to take out those in the demo, then you'd have probably -- would it be closer to 102? I'm just trying to say, a year from now --

DR. HARRISON: Yeah --

DR. NAYLOR: -- does that -- if the demo is expected to end, does that mean that the -- would we consider the payments getting closer as a result of reduction --

DR. HARRISON: I think about two-thirds of the quality difference, I think, is due to the demo.

DR. NAYLOR: Is due to the demo. So people in the

-- the 56 percent in the three-star rating, right?

DR. HARRISON: Right.

DR. NAYLOR: Okay. And the last thing is, just for clarification on a recommendation, Slide 22, and this is to do with the C-SNP recommendation. You're talking about all MA plans in three years being able to have the capacity to implement a benefit redesign that could accommodate and have the flexibility to accommodate, and in the three intervening years just continuing with the existing current C-SNPs in their current form to make that transition, is that right?

MS. AGUIAR: Exactly. That's right. And the moratorium would only apply to new C-SNPs during that three-year transition except for the ones for ESRD, HIV/AIDS, and for the chronic and disabling mental health conditions.

DR. NAYLOR: Thank you.

MS. UCCELLO: Both of these chapters, I thought, were really great.

Following up on Scott's answer to Herb on some of the enrollment trends, I think that we still kind of want -- there's still potential for kind of a leveling off or decline in that I think in the short term, at least, some of

the quality bonuses maybe have offset some of the other payment reductions, so there are still some things there.

So on Slide 7, the local PPO bids are just so much higher than the regional PPO, and I'm wondering if any of this is due to having a higher share of employer group coverage in that or is it reflecting other things, as well?

DR. HARRISON: It could be do to some of the employer. Now, the regional PPOs, their benchmarks are lower because of the way their benchmarks are structured --

MS. UCCELLO: But even beyond --

DR. HARRISON: And so it could be some pressure to lower the bids if they want rebates. But it could also be that the local PPOs have a lot of employers in this.

MS. UCCELLO: -- pushes it up. And then on Slide 8, I really want to commend the quality write-up. I remember last year, there was just so much information in there, and I think it did a really good job this year of sorting through that.

MR. ZARABOZO: Yeah. You didn't see the first draft --

[Laughter.]

DR. MARK MILLER: For the record, thank you for

saying that, Cori.

MS. UCCELLO: But this issue of the quality increases based on enrollment, how much of that is due to people switching to higher-rated plans and how much is due to plans increasing their quality rating?

MR. ZARABOZO: Well, the comparison that was done was just saying, we're looking at a fixed enrollment number here in these plans. Those are the two tables that were in the mailing material. And there, you saw that the plan itself, the star rating changed and, therefore, the proportions of people in those plans increased in the four-star rating. Holding everything constant other than the star rating of that particular plan at that time, it was just a comparison between the 2012 star rating for the same people in the same plan, and then it went up because -- the other thing that's happening is the five-star plans do have this year-round open enrollment option, and it looks like, just looking at the comparison of the growth rates during the off period outside of the open enrollment, that there is some additional enrollment happening into the five-star plans during that period.

MR. HACKBARTH: Scott, could you put up 7 again?

So if you look at the benchmark column, I just want to be clear for the new Commissioners that the variation there is not attributable to there being different benchmarks by plan type. It is, rather, a function of where plans choose to operate, get their beneficiaries. The variation in benchmark is geographic, not by plan type. So the local PPOs have chosen to operate in areas where the benchmarks are higher relative to fee-for-service, and that's what causes that variation. I just wanted to make sure people understood that.

DR. HALL: Herb mentioned and Cori also mentioned trying to understand the dynamics of why MA plans seem to have greater penetrance is one geographic area versus another. I think Glenn's point is very important, that when there are high benchmarks for fee-for-service, that's going to influence enrollment to some extent.

I guess the extension of that question is -- maybe you know this, but I think for the future, are there some pretty predictable things that would say higher penetrance of MA in one geographic area than another? I think you mentioned to some extent ethnicity.

For example, if I'm a physician working in a area

that's offering 60 MA plans, it's highly unlikely that I'm going to want to enroll in all 60 of those with different forms, different pharmacy formularies. And so I'm going to be influenced by other factors. I'm not sure what they are, but one of them may be the attractiveness of the plan to the physicians, the kind of advice that physicians or medical practices give to their patients.

Conversely, if there's only one in the area, well, that means there's going to be -- it's probably going to have higher penetrance because that particular carrier, insurance carrier, may wish to influence -- exercise a lot of influence on physicians. But I think this is important in the future as we go forward that the dynamics that the reason that some plans are more popular is that Medicare recipients laboriously go over the star system and say, well, this is five and that's one four, I'm going to pick five. I think that's somewhat overstated. I'd be very, very surprised if that were the case. So that's more of an observation for the future.

The other is, if we're using the star system to rate your report, I wouldn't give it a five. I'd give it an eight or a nine. It's really good.

[Laughter.]

DR. DEAN: Yeah, it did clarify a lot of things. I second what Bill said.

Just one question, and you probably have already answered this, but the whole issue of the quality ratings and the effect on the benchmark, you know, the benchmark is basically set based on geographic issues, but then the quality impact on that is that so we basically end up with a different benchmark for each plan? Is that what you're saying? And they know that in advance, so they have that information when they actually submit their bids? Is that correct?

MR. ZARABOZO: That's correct, yes.

DR. DEAN: Okay.

DR. CHERNEW: So I have a loose question about Slide 4, which is the MA plan availability slide. I just want to make sure. You mean plans, not contracts or firms? When you say this is the number of choices, for example, that's the number of choices of plans?

DR. HARRISON: The 12 you mean?

DR. CHERNEW: Yeah.

DR. HARRISON: Yeah. That is the number -- you're

a beneficiary sitting down, you have 12 choices.

DR. CHERNEW: Right, but five of them might be Aetna or something like that.

DR. HARRISON: They could be. There was an effort to cut them down to, say, three of each, but yes, it could be like that.

DR. CHERNEW: And in this slide, you've taken out the employer plan portion, so these are not the employer --

DR. HARRISON: Correct.

DR. CHERNEW: All the other slides have employers in them, like the enrollment slide and stuff? You said that, right?

DR. HARRISON: Right.

DR. CHERNEW: But these ones don't. These are just the non --

DR. HARRISON: Correct. And these don't have SNPs either.

DR. CHERNEW: Right. And so my other question is: Have you seen a change in what employers are doing? One of the things that I think we don't spend enough attention on is what the employers are doing in general for this and how it interacts with some of the other questions about

enrollment in MA and other things. Have you seen changes in what the employers are doing?

DR. HARRISON: Well, first of all, employers cannot offer private fee-for-service anymore.

DR. CHERNEW: Right.

DR. HARRISON: That ended two years ago, I believe. So that's done. There was some movement into regional PPOs. I just checked and Cori's right. About half of the -- roughly half of the enrollment in local PPOs is employer based. So they do seem to be going fairly heavily into the local PPOs.

DR. CHERNEW: But what I was concerned about, you don't see employers dropping a lot of MA plans, for example, or adding a lot of MA plans or moving in or out of...

DR. HARRISON: Yeah, I mean, their enrollment is still growing at about the same rate as general enrollment.

DR. CHERNEW: Okay.

MR. BUTLER: Two quick questions. Let's see. SNP enrollment is 11 percent or something of all MA enrollment and growing -- it's not in the tab, but I think I've asked this before. It's growing at about the same pace as the non-SNP. Is that right?

MR. ZARABOZO: Looking at SNP overall, yes.

MR. BUTLER: Yeah. And so do you have a sense of, you know, the healthy 65-year-old that you force to walk up to the second floor to enroll, that kind of -- SNP is a different enrollment marketing kind of process. I'm just a little curious about the most likely marketing methodology for the SNP population to get into the plans.

MR. ZARABOZO: Well, the C-SNPs, the chronic care SNPs, are a special case because they can market year-round essentially, because if you have the condition, you can enroll in June. So they have a different marketing strategy than a regular MA plan, which emphasizes the open enrollment period, and tend to use brokers. Some of the C-SNPs, for example, have employed marketing staff. So that's a different dynamic there.

MS. AGUIAR: I would just add, I mean, we've heard from our conversation with the industry that the I-SNPs have a very different population that is somewhat captured in the nursing home. And so they have told us that they are somewhat limited in how they are able to market just because some of the restrictions, like, for example, some of the nursing home staff can't directly refer a potential patient

to them. So they're sort of trying, you know, to get the beneficiaries that are in the nursing home itself. We've heard from the C-SNPs, as Carlos said, that they tend to work with brokers, with third-party entities in their marketing. They also -- at least some of the C-SNPs tend to be strategic about which markets they go into so that they think that they'll have, like, for example, a high -- sort of a concentration of potential diabetics and things like that that then they could use with their third-party brokers to approach those people to enter into the C-SNP.

You know, the D-SNPs, again, it's a separate population, the dual eligibles, and we've also heard that they work through brokers as well.

Again, the institutionalized beneficiaries as well as the dual eligibles are able to enroll monthly into those plans, and so that does help them, I believe, with their ability to market and to find those beneficiaries because they're not confined to enroll them only during the open enrollment period.

MR. ZARABOZO: And that was one of the attractive aspects of D-SNPs, is also the year-round marketing. A low-income person can enroll and disenroll on a monthly basis.

DR. NERENZ: Just a couple things. Slide 7 does a wonderful job of illustrating the interplay between the benchmarks and the bids and payments, and, Glenn, you walked us through that very nicely.

A basic background question. The benchmarks clearly have ripple effects through the rest of the two columns. Why are they set as high as they are set? I understand these are legislative things, they're regionally based. Why not 105? Why not 100? Why not some other number?

DR. MARK MILLER: Okay. So probably the quickest way to talk about this story is if you think about taking counties in the United States and organizing them from low to high, you'll have sort of a, you know, 45-degree angle, low cost/high cost. And what that means when I say low cost/high cost is really probably low utilization and high utilization. Okay? And when you think about it, managed care plans can probably enter the market and do the best in the areas where fee-for-service is high, because you can enter, undercut it, and then with the difference offer a package and invite people in. And there was some sense of that going on.

As you can imagine, some people would look at that situation and say, Why doesn't everybody have the opportunity to get a plan and extra benefits? And so that set off a process where people said, well, the benchmark should be higher in the low-cost -- or low-utilization areas -- I'm trying to keep my vocabulary straight -- in order to attract plans to that area. But they would only go if they could get higher payments. And that's why through a process of years -- and behavior like that, this ended up costing higher than fee-for-service because you weren't getting this -- okay.

MR. HACKBARTH: And the history, Dave, is one of a series of adjustments occurring over several different pieces of legislation resulting in higher benchmarks. It's not like there was an analytic approach to saying, well, it should be, you know, 115 percent versus 113 percent.

And then when PPACA came along, what they did was sort of clean up that and develop a simpler approach, and I think it was driven in part by trying to balance these regional considerations on the one hand versus their objective of hitting a savings target from MA to achieve their larger policy goals in PPACA. And they came up with

the existing set of benchmarks that way.

DR. MARK MILLER: And just one more sentence. So now what you have is benchmarks above fee-for-service in the low-utilization areas, a little closer to fee-for-service, a little closer; and then in the high-utilization areas, benchmarks below fee-for-service.

MR. HACKBARTH: And, you know, in the extreme, you can end up in a situation where, if you have really high benchmarks in the low Medicare use areas, you encourage plans to rush into areas where they really have difficulty beating traditional Medicare on cost. And if you lower the benchmarks below fee-for-service in the high areas, you deter the participation of plans where they can do the most good. And, you know, you can really end up with sort of the opposite of what product may dictate.

DR. NERENZ: A second question, just about the D-SNPs. Do you see an influence now of some of these state-level demos coming about integration of care for the duals that are going to change the environment markedly for D-SNPs? And should we be thinking about that in any specific way?

MS. AGUIAR: Yes, and we have gotten a lot of

questions about that from our conversations with the industry about how we sort of see the two -- you know, the demonstrations and our recommendation on the D-SNPs to be integrated, how they'll interact.

The way that we think about it is that our recommendation would redefine a D-SNP as an integrated product. It's not a very strict definition of an integrated product since it's some or all Medicaid, LTSS, or behavioral health. So it's not as restrictive as some of the definitions that CMS has adopted on what's an integrated D-SNP. And so what's happening now is, you know, I think there were about 25, 26 states that were originally interested in the demonstrations. A few of those have gone as far as signing memorandums of understanding with CMS. However, there are a few others that have actually pulled out of the demonstration, and we are hearing -- you know, the way that we think this may interact is if those states have gone, made some progress on being able to move some of their -- or at least are amenable to moving some of their Medicaid, LTSS, or behavioral health into managed care, and if they're willing to still work toward integration, they could still use the D-SNP as we're defining as an integrated

product to that end.

So we think there's an opportunity still for the D-SNP to be able to serve, either parallel or particularly, to sort of serve as a back-up plan for the states that were pursuing the demos and then decided not to.

MR. HACKBARTH: Rita, clarifying questions?

DR. REDBERG: Yes. First I want to compliment you. They were both excellent chapters and really helpful.

My questions are related to the quality and trying to better understand the star measurements and quality, because I think at the end of the day that's what is really important to beneficiaries. So I'm interested -- I understand there are three, four, and five stars, and lower, but I don't understand exactly how you get five stars. Like I can see what the measures are, but, for example, how do I have to do on all-cause readmissions and do I have to do really well on all 50 to get five stars? And do the beneficiaries have access to that level of data or just the star ratings?

MR. ZARABOZO: Unaccustomed as I am to doing so, I'll try to be brief.

[Laughter.]

MR. ZARABOZO: The measures -- what happened is there are the 15 measures, and for a given measure, let's say, what they do is they set a threshold based on historical results for the four stars, and then the distribution of results determines who's above four stars and who's below four stars. So they've been going along, here's where the four-star level is, if you on the control of blood pressure measure reach this -- this is known in advance -- here's the four-star level. And so the distribution determines outside of that particular who's above and who's below. So it's essentially a relative ranking by plans on their performance, except that there's a predetermined here's what gets you a four-star.

MR. HACKBARTH: It is a threshold of X percentile of historical results.

MR. ZARABOZO: Right, yeah.

DR. REDBERG: But, I mean, it did look -- if that's a curve, it's a very generous curve, because there's almost no one below average.

MR. ZARABOZO: Again, it goes star by star, so the curving is done at that star. So you can be bad at some things and very good at other things and result in an

overall rating over these 50 measures of --

DR. REDBERG: Okay, I'll move on.

MR. ZARABOZO: Okay. We can talk more later.

DR. REDBERG: I'll come back to that later, yeah.

My other question is again on the stars. Do we have any data on how the star ratings relate to outcomes like mortality?

MR. ZARABOZO: Not on mortality specifically, but some of the star ratings are outcomes. You know, the one that's supposed to measure the two-year change in outcomes, better health, poorer health, the problem there is that everybody is about average.

DR. REDBERG: Right. Wasn't that self-rating?

MR. ZARABOZO: That is self-rating, yes.

DR. REDBERG: We'll come back to that. Thank you.

MR. HACKBARTH: Rita, as you well know, this is a broader issue in the pay-for-performance realm. Are we rewarding things that actually are linked to improved outcomes that patients care about?

DR. REDBERG: Absolutely. Particularly when we're giving out billions of dollars, it is nice to know it's for something that's actually good for beneficiaries.

MR. HACKBARTH: Right.

DR. BAICKER: Just a quick clarifying question about the incorporation of C-SNPs within MA plans. My understanding was that there were two different types of things that differentiated them now. One was that the benefits were catered to the people with those particular conditions. That's what enabled that enrollment. And also the enrollment procedure was endless open enrollment window, and presumably the bids can be -- are different. You know, the plan is bidding just for that group.

Once you embed the C-SNPs in the MA plans, it sounds like we're preserving what I thought of as the key differential, which is the benefits can still be tailored to the particular condition of the person. We're recommending the flexibility to be able to do that. This would then eliminate -- this would constrain the enrollment period, though, back to the standard open enrollment, and there would still just be one bid and one premium for the whole group. So those features would then -- that ability to differentiate on those dimensions is gone, but you can still differentiate on benefit provisions.

MR. ZARABOZO: Right, and as we mentioned, the

model of care, that if they're going to specialize, they need to have the kind of care needed for specialization. It is a problem for bidding, meaning -- that's why we have the three-year transition, which is you need to work out how is this going to work in a bidding process, for example.

DR. BAICKER: But the end result after the transition would be there'd be one bid.

MR. ZARABOZO: There would be one bid, yes.

MS. AGUIAR: Yeah, one bid that could cover multiple benefit packages, the multiple benefit packages tailored to the chronically ill beneficiaries.

DR. COOMBS: One question that came up. How does for-profit industry impact the benchmarks, and also plans that have larger market share in geographic regions? Was that something that we could get our arms around?

DR. HARRISON: We haven't gone into it well enough to find patterns. We've stayed on the surface sometimes and haven't seen a lot.

I think I'll leave it at that.

DR. MARK MILLER: I just want to make sure that I follow. Your question is whether the bids break down differently if a plan is for-profit or not-for-profit? Is

that the question?

DR. COOMBS: Well, specifically as it applies to maybe large market share areas, what's the influence of that over the establishment of the benchmark?

DR. MARK MILLER: The benchmark is not determined by the bid at all. That's an administrative -- I knew there was a thing in there that you said that I was trying to catch.

DR. CHERNEW: In Part B, though, I believe it is. In Part D the benchmarks do reflect the bids. But in Part A/B here, it doesn't.

DR. COOMBS: Okay.

DR. HARRISON: The regional PPOs, it does.

DR. COOMBS: Okay. And then the other question I had, if we were to go with the recommendation for the C-SNPs, approximately how many, in terms of numbers, would be left out of the 233 that's on Slide 14?

MR. ZARABOZO: It would be a very, very small number. Of the currently specialized plans, maybe three -- maybe 4,000 or so, something like that. A very small number.

DR. COOMBS: Okay. Thank you.

MR. GRADISON: You commented awhile ago about the breakdown of participants in the MA plans by race and ethnicity. How about by income?

MR. ZARABOZO: Lower-income people are more likely to enroll, and not Medicaid, but lower-income and not on Medicaid.

MR. GRADISON: That seems consistent with my understanding in the past that that was true as well in the non-Medicare markets of HMOs, that they tended to have a significantly lower income. I'm going to return to that in the next round, but thank you.

MR. HACKBARTH: Bill, on the income point, in the past the position that we've taken is that if the policy goal is to expand benefits for low-income Medicare beneficiaries, the appropriate tools already exist through, you know, the qualified individual program and the various programs under which Medicare helps pay with states part of the premiums for Part B, fill in deductibles and coinsurance, et cetera. So that's the vehicle for dealing with income-related issues. To pay higher payments to all Medicare plans across the country for all income levels is a very inefficient way to deal with a perceived problem of

low-income people.

MR. GRADISON: Let me then pursue this just a minute to indicate that's not really where I'm coming from. The question in my mind is: What will be the experience during their working lifetime of people who age into Medicare in the foreseeable future? Part of this, I would assume, has to do with their income levels, and I think there's some real question in my mind as to whether the people -- whether there will be a significant increase or decrease in the number of people when they reach age 65, you know, where their income is relative to those differentials today.

There are reasons to think that people aging into Medicare in the future may on average have lower incomes. The apparent increase in the number of people who can stay in the workforce I think is an indication. The extremely low interest rates, the clobbering the economy has taken, the increased number of people working part-time, there's a lot of things going on there.

And so what I relate this to is trying to understand what is likely to happen in the private non-Medicare market in the next few years as compared within the

past.

Now, the big differences I see is the exchanges, and I don't know exactly what that is going to mean in terms of participation as it relates to income levels, although I could see some reason to think that the exchanges might be dealing with a lower average income.

So I'm merely looking ahead a few years, and I recognize it's way premature probably even to ask this question or raise this question, but I think it's going to be very important for us to be monitoring what is going on in the choices that are being made in the exchanges in order to see whether people who make choices -- what will be available at age 65 through Medicare as it relates to the choices people make in the exchanges, so that to the extent it's possible they can make a smooth transition, as apparently many HMO participants are making today and it's something they're quite comfortable with. That's really why I raise this.

Thank you.

MS. AGUIAR: And I would just add to that, in addition the exchanges, there is also the interaction of the Medicaid expansion, which may be occurring in some or all

states. And so, again, that would be a population that has traditionally higher income than the traditional Medicaid population, and they would be aging in as dual eligibles. And so that is something that we are tracking on.

DR. HOADLEY: Yeah, again, thanks. These are really great chapters, and it's always good to have this background.

On Slide 25, on the D-SNPs, you showed about 5 percent plus 19 percent that are in plans with some kind of integration today. Does that then really become the baseline that we'd expect in terms of the recommendation that, if nothing else changed, it would be about a quarter of the enrollment that would survive into our new kinds of D-SNPs?

MS. AGUIAR: Yes. However, we make the note that the recommendation does not preclude other D-SNPs from working with states to become integrated, to meet our definition of integration. So if no other D-SNPs worked with states to become integrated, then, yes, it would be that number. However, we do expect, particularly as we were talking about before, this interaction with the demonstrations, that maybe this would be a vehicle that will

be used by more states, and so you could then end up with an increase in D-SNPs that are beyond what we have there.

DR. HOADLEY: Right, okay. That makes total sense.

On the performance improvement, have we picked up -- and maybe this is a suggestion for the future, but have we picked up any sort of qualitative evidence of what plans are really doing when they're reaching out and trying to respond to these incentives? I mean, I see a lot of statements, and I've made them myself, that we assume and we even have anecdotal evidence of some of these things. But I wonder if there's any way to get a little more systematic, albeit qualitative perhaps, sense of what plans are doing to really up the ante and do better?

MR. ZARABOZO: Well, somewhat related to Rita's question, we could look at the individual measures to see what in particular, by plan type or, you know, individual plans -- like some plans, for example, went from three and a half to four and a half stars. Something must have happened there. So there are ways of looking at this from that data.

DR. HOADLEY: It seems like that might be something that would be helpful down the road.

And I guess the other thing that comes out is something in the chapter and from last year's, the whole issue of the reporting unit issue that you raised last year. And I guess I'm really -- I'm glad you're putting it in again because it does seem to be an issue. In fact, the discussion of SNPs says that we can't really say in some cases whether the SNPs are doing well because they're so entwined in the reporting unit.

Is there any sense from CMS of any kind of response to having put this out there last year?

MR. ZARABOZO: I have not heard from them on that particular point, but they usually say, you know, it's a small numbers issue and it's a little bit cumbersome to be doing this in other than the manner that we're doing it. But when you look at the makeup of the contracts, there is an issue there.

DR. HOADLEY: Because I've had the same dialogue with them about the Part D stuff, and it's the same issue, obviously.

DR. SAMITT: Thanks very much for the report. I have a much clearer understanding of Medicare Advantage now.

I think I have a question for each of you. If we

can go back to Slide 7? I still have a hard time getting my head around mostly the differences between the payments for fee-for-service column versus bids for fee-for-service, and maybe further analysis in the future will help clarify.

So for the HMO line, for example, I can sort of understand the 103 percent. I would imagine that what's included in that would be sort of the cost of supplemental benefits because of the rebate, plus the quality bonus, the other things that you've identified. But the line I cannot understand is, for example, local PPO because if on average these bids are over benchmark, then there isn't going to be a rebate of as much for those. So I don't understand why local PPO fares so well in terms of payments for fee-for-service unless the higher quality plans tend to be in these local PPOs. I don't quite understand what the driver is of the payments to fee-for-service ratio in each of these categories.

DR. HARRISON: So the benchmarks are up at 110, 111 percent of fee-for-service.

DR. SAMITT: Yeah.

DR. HARRISON: And part of the problem is that a lot of the plans are bidding actually above the benchmark

because they are employer plans. We talked about that before, but we can talk more if you need to.

DR. SAMITT: So they're still below the benchmarks, but --

DR. HARRISON: Generally they are below the benchmarks, and so there's not a lot of room. So if they're bidding 107, they're not getting a lot of rebates and they're only getting paid 108. So generally speaking, these are not going to be particularly -- they're not offering a lot of extra benefits to beneficiaries typically, again probably because a lot of them are employer plans.

DR. SAMITT: So my second question pertains to the average HMO benchmark of bids per fee-for-service of 92 percent, for example. And it's about correlation.

Have we been able to do a correlation between bid rates and things like star quality? I'd be interested in the relation ship between those two, between bid rates and competition of plans.

So I'm curious to know how do bids correlate with quality? And how do bids relate to plan competitiveness and whether we can get that in the future?

DR. HARRISON: The one solid finding we've had

before is that the bids tend to be much more correlated with the benchmarks than they are with fee-for-service costs. So whether plans are shadow pricing the benchmark or -- and the other part of this may be that their costs may -- their production function doesn't look a lot like fee-for-service does, and so their costs don't go up as fast as fee-for-service costs do.

So in low fee-for-service cost areas, their bids are going to be higher relative to fee-for-service. And in the high fee-for-service cost areas their bids are going to be relatively lower. And so there's a lot of that going on.

We haven't found anything as far as competition.

What was the other piece?

DR. SAMITT: Quality.

DR. HARRISON: I did do a cross-tab of quality and it seemed like the higher quality plans tended to bid a little higher. Now, they could have done that because the benchmarks are higher for them.

DR. SAMITT: So they shadow the benchmarks.

DR. HARRISON: It could be.

DR. SAMITT: Third quick question. I'm curious, I feel an air of sort of assuming that MA plans would, in

general, attract a higher adverse selection or would even have a lower quality. So I'm curious to understand the comparison of quality between MA plans and traditional fee-for-service. When will we -- I come from a world of a staff model HMO where the presumption was that the quality of care in a staff model HMO is worse than a more traditional commercial setting.

And I wonder whether the same, incorrect assumption applies to MA plans and whether we've got a good comparison between MA quality versus fee-for-service quality.

MR. ZARABOZO: A couple of years ago we had a report on how you would compare fee-for-service to MA and we made a number of recommendations. We're still not at the point of having good ways of comparing the two.

If we get the encounter data, it would be useful. It's one of the bases that we can compare MA to fee-for-service.

DR. SAMITT: And then finally, Christine, on slide 28, will the fourth recommendation sort of address and resolve the industry concerns about state restrictions to integration? So will this -- I think we've got some

supplemental information about industry reaction as it pertains to D-SNPs and achieving integration.

Will this resolve this? Will this resolve their concerns?

MS. AGUIAR: Not all of them. The last one, to direct the Secretary to develop the model D-SNP contract, that does address a concern that we've heard from plans, from D-SNPs that work with states, that some of the states just don't have the technical resources or assistance to really know how to develop the D-SNP contract. So that one is intended to address that.

The other limitations that were -- you know, some states just have legislation that prohibits them from moving LTSS or behavioral health into managed care. That's not an issue that our Commission could make a recommendation about.

Another one is that some states just may have an adversity to managed care. So those two limitations are not addressed by this recommendation but the technical assistance piece is.

DR. SAMITT: Great. Thank you all for your answers.

MR. HACKBARTH: Okay, so we're behind by a lot.

Just keep that in mind as we go through our second round. In particular, I ask people to focus in on the recommendations on which we will vote at the end of this round. We will have other opportunities to come back and talk more broadly about Medicare Advantage and perhaps future recommendations at some point. Right now I'd like to really focus in on the SNP recommendations.

So Herb, set a good example for us here.

MR. KUHN: I support all four recommendations.

MR. HACKBARTH: That's a sterling example.

[Laughter.]

MR. HACKBARTH: The kind of leadership I like to see.

MR. GEORGE MILLER: I support all four recommendations.

MR. HACKBARTH: And....

MR. GEORGE MILLER: And, I would like to visit in the future, and we won't take time to do it now, the relationship of choice, level playing field, and typing closer MA with fee-for-service and having some type of direction to get there.

DR. NAYLOR: I support all four recommendations.

This was an outstanding report. And I love the evolution of the recommendations in response to everybody's feedback over time.

If I had one minor tweak, it would be in the chapter to really highlight when this demo ends, what implications it might have on payment so people could see what the possibilities are.

Thank you.

MS. UCCELLO: I support the recommendations and I want to specifically support the modifications of the C-SNP recommendation that includes the exception for those certain categories. I think those make sense and I don't think we necessarily need to worry about this becoming a big slippery slope. So I'm happy with the way that's done.

And I also especially like the C-SNP recommendation that kind of moves MA plans, gives them more flexibility so you can do more VBID within a plan, as opposed to separating out the beneficiaries into different categories.

DR. HALL: I also support the recommendations, and just two very quick points.

The integration of C-SNPs into overall MA plan is

a resounding endorsement of the growing concept that if you want to improve quality in health care you improve the entire system of care, rather than looking at isolated examples. This is so true of chronic illness today.

And if we look at the growing population, it's not the 65-year-old, but it's the 75 and above that we're going to be dealing with in the next 10 years. This makes eminently good sense.

The other point is, in terms of the D-SNPs, the amount of time that is spent trying to piece together and cobble together Medicare and Medicaid at the practical level of health care delivery is just monumental. This will save enormous amounts of money, time, and is a real benefit I think to our dually eligible population.

DR. DEAN: Yeah, I too, support the recommendations.

Again, it's beyond what we want to do right now but call attention to how important the whole star system and how difficult it is to structure it in a way that really does what we want it to do. I think we need to one -- I think the question came up a bit about how do beneficiaries look at this? My experience is that I doubt they pay much

attention to it. Or at least in some of the other context it hasn't been useful.

And not so much the star system here, but I've had some experience in the star system in Nursing Home Compare. That one jumps all over the place and has been very misleading in a number of settings.

So the simplicity is appealing but I think we really need to try to be sure that it's based on a solid foundation and we're not seduced by the attractiveness of the simplicity.

DR. CHERNEW: I support the recommendations.

MR. BUTLER: I will support the recommendations.

DR. NERENZ: I will also support them.

I just want to echo Bill's comments about the -- I like the emphasis in the D-SNP recommendations about the Medicare/Medicaid integration. I think it's very important.

DR. REDBERG: I support the recommendations and I will just state the audience that now MA is 27 percent of Medicare beneficiaries so I wish we could get more data on what's really going on inside those plans besides how many are enrolled.

DR. BAICKER: I support the recommendations and,

in the absence of that data, it seems especially important to understand how the risk adjustment is going to play out for C-SNP beneficiaries newly embedded in MA plans, given the one bid, one premium rule. I'd love to have a better understanding of whether there will be a disincentive to enroll them that wasn't present in the existing system?

That said, the existing system was not working the way we hoped it would, so I support the folding it into the existing structure.

DR. COOMBS: I support the recommendation and I would encourage us to actually look at some of the implementation projects that are out there, especially Massachusetts who is doing a great job of cost saving and delivering good quality on both sides, Medicare and Medicaid, and doing some innovative things clinically which I think will make a big difference going forward with the beneficiaries.

MR. GRADISON: I support them, as well.

DR. HOADLEY: I support the recommendations and would just say, like a couple of other people have said, some of the refinement of some of the details we have put in here I think should be really useful. And the flexibility

for the C-SNP enrollees inside the MA plans will be, I think, important to monitor because there are potential for problems in it. But there should be some real potential for some good things.

DR. SAMITT: I support all four and I would underscore Rita's comments about data, as you'd expect I would. I know she did, it's the problem of being last.

But I think that the data will, among other things, provide us a wealth of potentially new opportunities to think about to further improve fee-for-service Medicare. And without understanding how the MA plans are doing it, we may not be able to see what we want to see.

DR. MARK MILLER: Okay, I didn't want to break your flow because you guys are doing such a good job. On the risk-adjustment, we did make some remedial changes and are continuing to look at it and made -- if you recall that chapter. And we have made recent inquiries and hopefully we're trying to figure out what the status is.

MR. HACKBARTH: Okay, so draft recommendation one is up. All in favor of one, please raise your hand.

[Show of hands.]

MR. HACKBARTH: We'll get Rita when she comes

back.

Opposed to recommendation one?

[No response]

MR. HACKBARTH: Abstentions.

[No response]

MR. HACKBARTH: Recommendation No. 2, put that up.

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

[Show of hands]

MR. HACKBARTH: Opposed

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Okay, recommendation 3. All in favor of recommendation number 3?

[Show of hands.]

MR. HACKBARTH: Opposed.

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Recommendation 4. All in favor of number 4, please raise your hand?

[Show of hands.]

MR. HACKBARTH: Opposed.

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Thank you very much. Well done.

[Pause.]

MR. HACKBARTH: So now we switch gears and turn to payment updates, beginning with hospital inpatient and outpatient services.

MR. LISK: All right. Good morning. This session will address issues regarding Medicare payments to hospitals.

This is the first of several payment adequacy discussions you will hear today. In each case analysts will present you with information on payment adequacy indicators and the draft update recommendation that was developed based on your discussion in December. You will then vote on update recommendations.

To evaluate the adequacy of Medicare payments, we use a common framework across all sectors, shown on the slide. When data are available, we examine provider

capacity, service volume, quality of care, access to capital, as well as providers' costs and payments for Medicare services. Also, when we discuss profit margins, we will present Medicare margins for the average provider and for relatively efficient providers when we are able.

As we mentioned in December, most payment adequacy indicators are positive.

First, in looking at beneficiary access to care, we find the supply of hospitals and beds continues to be relatively steady. Occupancy has fallen slightly over the past couple of years, suggesting there is not a need for additional capacity in most markets. Alice had asked, however, about variation in bed capacity in markets and if we look at occupancy rates as an indicator of supply, and, yes, we do find variation across the country. Rochester, New York, for example, with four hospitals, has very tight supply -- three hospitals with over 90 percent occupancy and one with over 80 percent. In contrast, Charleston, South Carolina, with five hospitals, has just one hospital with over 80 percent occupancy, two with over 60 percent occupancy, and two others with occupancy rates below 50 percent. So we do see variation across the country there.

Second, we see breadth of hospital services continues to expand.

Third, hospitals' access to capital appears to be adequate, with interest rates at historically low levels.

Fourth, most quality-of-care measures are improving.

Turning to spending, in 2011, Medicare spent $117 billion on inpatient services and $41 billion on outpatient services. On a per capita basis, inpatient spending declined approximately 1 percent and outpatient spending increased approximately 9 percent. At the last meeting, Alice had asked about the impact of observation visits on the decline in inpatient discharges. We're unable to directly answer that question, but believe that up to a third of the decline in inpatient stays per capita may be attributable to increases in number of observation stays.

Next, if we turn to Medicare margins, we found that the aggregate overall Medicare margin in 2011 was minus 5.8 percent. Remember the overall Medicare margin measures Medicare costs and Medicare payments for most lines of services in the hospital, including inpatient, outpatient, all the lines of post-acute care services that hospital may

offer, and graduate medical education.

We expect that the Medicare overall margin will remain at roughly minus 6 percent in 2013, which is what we had told you in December. Although the American Taxpayer Relief Act of 2012 extended some expiring hospital payment provisions, providing additional revenues to many hospitals, we believe that the overall Medicare margin will still be roughly 6 percent. We did not make our estimates to a decimal point, so we're rounding to the nearest 6 percent, so to give you an idea there.

We expect payments to grow by roughly 4 percent, accounting for payment rate updates and payment policy changes like the new readmission payment penalty that took effect in 2013. We expect costs to grow faster than payment rate updates, rising roughly 5 to 6 percent from 2011 to 2013. However, this 1- to 2-percent difference between payments and cost growth should largely be offset by higher payments for health information technology. We estimate that health information technology payments in 2013 will likely be $2 to $2.5 billion higher than they were in 2011.

Jeff will now continue with our discussion.

DR. STENSLAND: So Craig discussed average

margins. However, we also present margins on relatively efficient providers as we discussed last December. We ended up with a group 297 hospitals that have historically been relatively efficient for three straight years prior to 2011. This group of hospitals represents about 14 percent of all IPPS hospitals that had usable data over those years.

If we look at the first column of numbers, we see that the historically efficient hospitals had about 13 percent lower mortality and 5 percent lower readmission rates, while keeping costs roughly 10 percent lower than the national median. Lower costs allow most of these hospitals to generate positive Medicare margins in 2011, with a median margin of 2 percent.

When we showed you this slide last December, several Commissioners raised some questions, so I will try to go through those questions next.

First, there was a question on occupancy. One factor behind the 10 percent lower inpatient costs in the efficient group is they have a 10 percent higher occupancy. The 63 percent occupancy on average of this group is about 10 percent higher than the 56 percent occupancy for the other group.

However, cost differences are not just occupancy. The efficient hospitals also tend to have higher outpatient margins. The median outpatient margin is negative 1 percent, suggesting that a significant share of these hospitals can at least break even on their Medicare outpatient services.

Kate and Alice both asked about what types of hospitals are in the efficient group. Between 9 and 21 percent of hospitals in each of the categories we typically discuss, such as rural, urban, teaching, non-teaching, are in the efficient group. The point here is that the efficient category is not limited to just one type of hospital.

There are some modest differences in propensities to be in the efficient group. Other teaching hospitals are more likely to be in the efficient group. These hospitals have residents, but not a lot of residents per bed. They tend to do well on the mortality and readmission metrics, and these higher quality scores get a larger share of these hospitals into the efficient category.

For-profit hospitals are slightly less likely to be in the efficient group, with 10 percent of for-profits

making it into the category. While most for-profit hospitals have below average costs, they are slightly less likely to do well on the mortality and readmission metrics. The result is that fewer of them make it into the efficient group, and this is just a reminder that efficiency is about more than just costs.

Last month, Scott had asked for a summary of the major payment policies that are going to be taking place over the next couple years, so this is just a quick review of some of the major ones.

First, as we discussed last month, payments for electronic health records are increasing as more hospitals qualify as meaningful users. On average, this will increase payments about 1 to 2 percent above where they were in 2011.

Second, there are several changes that will result in slight decreases in payments in 2013 and 2014. All five of these things I mention here were going to expire in 2013, but the MDH and low volume expirations were recently extended to 2014 as part of the American Taxpayer Relief Act of 2012.

Finally, the Taxpayer Relief Act also mandated that CMS recover $11 billion in overpayments that occurred

due to changes in documentation and coding. The Secretary of Health and Human services appears to have discretion over the timing of these recoveries, but they are required to reduce inpatient rates enough over 4 years to recover the full $11 billion. Because documentation and coding adjustments are a part of our recommendation and industry representatives have raised some concerns about these adjustments, I will discuss them in some detail.

For the past several years, the Commission has discussed how documentation and coding changes have increased payments and how those overpayments need to be recovered. I will quickly review why we need to make documentation and coding corrections.

In 2005 MedPAC conducted a congressionally mandated study of specialty hospitals. That report showed that specialty hospitals often took lower-severity cases that had lower costs and higher profits. To reduce the opportunities for specialty and other hospitals to profit from patient selection, MedPAC recommended that the DRG system be refined so that more costly cases receive higher payments.

In 2008 CMS implemented MS-DRGs to improve

severity adjustment. However, after MS-DRGs were introduced in 2008, hospitals had an incentive to improve documentation and coding. For example, payments would increase if physicians shifted from documenting unspecified heart failure to documenting diastolic or systolic heart failure. Changing to more detailed coding would result in higher payments overall than would have been paid under the old system. The trade press confirms that hospitals hired documentation specialists, trained doctors to code in a manner that was consistent with the MS-DRG system, and received higher payments. Now, there is nothing wrong with more detailed documentation, but to make the transition to MS-DRGs budget neutral, as is required by law, CMS needed to offset these payment increases associated with documentation and coding changes.

CMS and MedPAC had both suggested a prospective reduction to inpatient payment rates to offset anticipated changes in coding. The industry objected and Congress the mandated that CMS defer some of the proposed adjustments for documentation and coding until after data became available.

After the data became available, CMS and MedPAC both estimated the overpayments. CMS and MedPAC concluded

that two additional adjustments are needed at this point to make the transition to MS-DRGs budget neutral. One is an adjustment to prevent further overpayments of between 0.6 percent and 0.8 percent. The second is a recovery of over $11 billion in past overpayments that took place from 2010 to 2012.

The recently passed Taxpayer Relief Act also states that CMS is required to recover the $11 billion in overpayments. However, the MedPAC December recommendation differs from current law with respect to the timing of the recoveries, as we will discuss later.

Now, because some have raised concerns about whether the spike in case mix that we saw was caused by documentation and coding, I'll provide a simplified graphic to explain our methodology. CMS used a similar method. And if anybody wants the nitty-gritty details, it's all in our comment letter on the 2012 inpatient rule.

What we did in general was follow a two-step process. First, we examined the case-mix index and payment changes under the new MS-DRGs. As we see with the green line on this slide, the reported case mix spiked up in 2008 and 2009 as hospitals changed their documentation and coding

and reported more cases with complications or comorbidities. This case-mix growth was three times larger than any case-mix growth in the past decade.

Now, I also want to remind you of something from last month, because last month we noted that cost growth in 2009 and 2010 was the lowest in the last decade. So we have this odd phenomenon of somehow case mix grows faster than it has in a long time and cost growth grows lower than it has in a long time and why are these things different. And I think a large part of the explanation is that increase in case mix was due to coding and not actual increase in the expect costliness of the cases.

Second, we examined what the case mix and payments would have been under the old DRGs and weights. This is the bottom gold line. CMS also used this methodology. The general idea is simple. We asked what is the difference in case mix and payments between what was paid under the new system -- that's the green line -- and what would have been paid for those same claims under the old DRGs -- that's the gold line. Payments should be adjusted to close the gap between the gold and the green lines. In other words, payments should be adjusted so payments are equal under the

two systems.

CMS has already recovered overpayments that occurred in 2009 and has the authority to stop future overpayments of 0.6 to 0.8 percent. However, CMS originally did not have the authority to recover the overpayments from 2010 to 2013, and that's the authority they were granted under the new American Taxpayer Relief Act last week.

This brings us to the projected update under current law. Under current statute, both the inpatient and outpatient updates are set to equal the projected market basket minus two adjustments. One is the average multifactor productivity over the past ten years, and the other is a budgetary adjustment of 0.3 percent. Because the updates are effective at different times, the data used in the updates would vary slightly. This will be finalized this summer when the final market basket update data is available.

The projected inpatient update right now is 1.8 percent. In addition, the Secretary might start making an adjustment in 2014 to recover the $11 billion. This could be on the order of 2.4 percent.

In January, one year from now, the outpatient

adjustment will be updated. Under current law, the projected update is 2 percent.

Now that I have laid out current law, we will shift to the Commission's draft recommendation.

Given the data presented on payment adequacy and given inpatient and outpatient considerations that you all discussed in December, the Commission's draft recommendation reads the same as in December: The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Health and Human Services Secretary to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and recover past overpayments.

Now, this is the same 1 percent update recommendation we presented in December. However, the spending implications have changed substantially. That's because under the Taxpayer Relief Act that was passed last week, the $11 billion in documentation and coding recoveries would have to take place over four years, and that could result in a net decrease in payments in 2014. Now, the

Commission has also said that they will still recover the $11 billion in overpayment, but it will happen gradually over a long period of time. The net spending implication in the difference between current law, which is this 1.8 percent update plus this rapid recovery of the overpayments, versus the Commission's recommendation of a firm 1 percent update with a gradual recovery is that spending would increase in 2014 by between $750 million and $2 billion. And over the next five years, spending would increase by between $5 billion and $10 billion.

Now, over the longer period, say ten years, the spending implications of our recommendation would be more similar to the spending recommendations in current law, or the spending in current law.

Now, the rationale behind the update recommendation is outlined on this slide.

First, a 1 percent update would help maintain pressure on hospitals to constrain costs to a modest level.

Second, adjustments for documentation and coding are needed to recover all overpayments and restore budget neutrality, but they should not cause a financial shock to hospitals. Given the payment adequacy indicators, a 1

percent update is sufficient to preserve payment adequacy for reasonably efficient hospitals. The difference between current law and the 1 percent update should be applied to gradually recover all overpayments due to documentation and coding.

The 1 percent increase on the outpatient side is appropriate for two reasons:

First, we see outpatient volume growth.

Second, we are observing a site of service shift toward hospital outpatient departments from free-standing physician offices. A higher update would only exacerbate this problem.

This slide is simply a reminder of the problem of paying higher rates to hospitals than in physician offices that we discussed last December. The higher payment rates encourage a shift in the site of care to the higher cost site, even when the capabilities of the higher cost site are not needed for the care.

For example, we see E&M visits up 8 percent per capita in hospitals and echocardiograms up 18 percent in 2011. In contrast, the volume of these services actually fell in physician offices where the payment rates were

lower.

Now we'll open it up for discussion.

MR. HACKBARTH: Before we start this discussion, I just want to do one clarification. Rita, you actually left before we had a chance to formally vote on the SNP recommendations. During the comment, you said you supported all four recommendations. I just want to affirm that for the public record.

DR. REDBERG: Yes, I support all four recommendations.

MR. HACKBARTH: You said you would have voted yes on all four. Okay. Thank you.

Now, turning to the hospital update, just let me ask a clarifying question, Jeff. Under the Taxpayer Relief Act, the Secretary was given discretion on the recovery of the DCI overpayments, but she's to do it over the next four-year period. Let's assume for the sake of discussion that she elected to do it in roughly equal amounts over each of the four years, plug that into the formula, the net change in hospital payment rates would be what for fiscal 2014?

DR. STENSLAND: If she did that, there would be roughly a 2.4 percent decline in inpatient rates, so then

there would be -- it would be 1.8 minus 2.4 or a negative 0.6. So the differential on the inpatient side between us at 1 and current law roughly at negative 0.6, if things went as expected, and the outpatient side, the difference would be current law roughly at 2 and us at 1.

MR. HACKBARTH: Yes, okay. Thank you.

So, Craig, let me give you the first opportunity to ask clarifying questions.

DR. SAMITT: Sure. Can we go to Slide 4? I want to make sure I understand the driver of the spending growth changes. I see the inpatient has dropped by 1 percent, patient has grown by 9 percent. My first presumption was that that would be simply an offset of volume from higher-acuity setting to lower-acuity setting to provide services, but your last slide suggests that it's more than that, that it -- and I don't want to put words in your mouth, but it seems as if it's actually something different, which is a greater shift of services from lower-acuity settings into outpatient hospital. So I just wanted to clarify that my assumption is correct in that regard.

DR. STENSLAND: With respect to that outpatient 9 percent growth, I would divide that into three categories,

and about a quarter of it I think would be things going from lower-acuity settings, like the physician office, into the higher-acuity settings in the outpatient.

DR. SAMITT: Okay.

DR. STENSLAND: And some of it would also be due to some inpatient stuff going into outpatient, so this is kind of from a higher to a lower, and the other way it's just kind of organic growth in the outpatient.

DR. SAMITT: What percentage is the middle category inpatient to outpatient? You said about a quarter is --

DR. STENSLAND: I'm not sure what percentage that would be.

DR. SAMITT: Okay.

DR. STENSLAND: But we just looked at going from the physician office to the outpatient, that's about a quarter of the growth.

DR. SAMITT: Okay, great. Thank you.

DR. HOADLEY: Yeah, I want to go back to your response to Glenn and related to Slide 11 and just make sure I understand. The current law, where we were up until a couple weeks ago, a week ago, was the 1.8 that's on the line

there, and then you just said that there would -- if you did under Glenn's assumption that the recovery would be split across four years, that would be 2.4 off of that. Does the next line, the 0.6 to 0.8 for future overpayments, is that a further subtraction? Just help me put all those together.

DR. STENSLAND: That could be a further subtraction. The Secretary has authority to do that.

DR. HOADLEY: Has authority but not with discretion?

DR. STENSLAND: The way they've described it in the past is they have to do it -- they have discretion over when they're going to do it, and they've deferred this for quite a while. So there's two things they could do. They could say, okay, they have discretion over both of these two things, but if they took both of them at once, then you would be at something like a negative full -- let's see, 1.2 if they took both of them at once rather than just taking one of the two.

DR. HOADLEY: Okay. So if they just did the one the way you've previously described it, we'd be at something like a minus -- the new revised current law would be a minus 0.6. And we're saying instead it should be a plus 1.0 in

our draft recommendation.

DR. STENSLAND: Correct.

DR. HOADLEY: Thank you.

MR. GRADISON; I think you've covered this about three times, and I still can't get it through my head. I'm looking at 12, with regard to spending implications. What assumptions are you making about the time span over which the Secretary will exercise her discretion in coming up with this number?

DR. STENSLAND: This number is really coming from CBO, and when CBO did their budgetary estimates of what's going to happen under this Taxpayer Relief Act, they assumed roughly equal recoveries of the $11 billion. So they're basically assuming that in 2014 the Secretary would reduce payments by something on the order of $2 billion or more to take roughly a quarter of that needed recovery, and that's what's really driving this increase in spending, because they're saying current law is to drop that spending down by 2 percent, and we're saying no, don't drop it down by that much. So that's why we're spending more.

MR. GRADISON; I understand that, but in terms of the discretion which she has, she doesn't have to do it that

way. That's just a scoring convention, and it's necessary to have a scoring convention. I would just suggest that whatever language we use clarifies it -- if I got this right, that there is some uncertainty about this, depending upon the decisions that -- the Secretary could do it all the first year and it would give a very different -- that our comparison with the Secretary's action in year one would be quite different. That's all I was trying to raise.

MR. HACKBARTH: Going back to Bill's first point, in CBO's score, they've focused on the recovery of the past overpayments and said the Secretary is going to need to recover this in the next four years, and they assume she would do it equally over the four-year period. She could opt to do it differently, as Bill says.

On the issue of the future overpayments, what did CBO assume? Did they assume that she would do that beyond the initial five-year window and do it later?

DR. STENSLAND: There's nothing public in what's in their baseline over what that anticipation is, and it could be anywhere from assuming that they're not going to do it, they're just going to defer it, to assuming that they're going to take it all next year, to maybe something in

between.

MR. HACKBARTH: Okay. Alice, a clarifying question?

DR. COOMBS: Thank you so much for an excellent report. I'm a disproportionate share hospital. How do I integrate what has just happened here and this, and what's the net effect on me as a disproportionate share hospital in terms of the rebasing of the Medicaid disproportionate share? Because, you know, I was reading here, and it didn't seem that there's some exceptions for DSH hospitals, and I'm wondering how to reconcile that in terms of mapping out -- they're not going to be 0.6 percent, the bottom line, when you add the two things together. What's going to happen with it?

DR. STENSLAND: Well, in 2014 there will be two things that happen. The one is this is going to be a reduction in payment -- if the Secretary takes it, as CBO had projected, evenly, this would be a reduction for everybody. So this would be something on the order of a 2.4 percent reduction for everybody -- DSH and everybody else.

DR. COOMBS: Right.

DR. STENSLAND: The other thing that would happen

to the disproportionate share hospitals, as we've discussed, is that money that was going to be paid out as DSH is being shifted, and in a large part, a large part of that will be shifted paying for uncompensated care. So the total number of Medicare dollars that are going out now for DSH payments will be fairly similar to what goes out in 2014 for DSH and uncompensated care. Now, whether an individual hospital does better or worse will largely depend on how much uncompensated care they have. If they have a lot of uncompensated care but not a whole lot of DSH, they'll do better. If they have a whole lot of DSH but they don't have a lot of uncompensated care, then they'll probably do worse.

DR. COOMBS: Right, right. So you could estimate that it's a potential loss for the hospitals with large disproportionate share of upwards limits, maybe 1.5, 2 percent, with the combined. Could you project what the decrease might be?

DR. STENSLAND: I haven't done that, and I don't want to misspeak. So, you know, you could look at the figure that we've shown on what the total decline in DSH payments would be -- I think we discussed it last month -- I believe something on the order of $9 billion, which would

be, you know, something on the order of a 5 percent reduction in inpatient payments. So, you know, that's kind of the -- that's if you had no uncompensated care. But I really doubt that the hospitals that are serving a lot of poor or disproportionate share people also have no uncompensated care. That doesn't seem to make sense to me.

DR. COOMBS: Right.

DR. STENSLAND: So I wouldn't want to tell anybody that they're going to be losing that much money.

DR. COOMBS: Okay. Thank you very much.

DR. MARK MILLER: I just want to ask one thing. You were holding two pieces of paper and said reconcile this with that. The DSH you're referring to there is Medicaid, I believe, and so what we're talking about strictly here today and the exchange that you just had with Jeff has to do with Medicare payments and DSH. And I wasn't 100 percent sure, but when you waved the paper around, I was thinking you were waving around the Tax Relief Act. That's a Medicaid DSH provision.

DR. COOMBS: So right now we can assume that any of the provisions that we've just seen go through the American Taxpayer's Relief will not impact disproportionate

share hospitals.

DR. MARK MILLER: Just to be clear, the exchange you and Jeff just had is what's going on with Medicare DSH.

DR. COOMBS: Right.

DR. MARK MILLER: If that's what [off microphone].

DR. REDBERG: Thanks. On Slide 14, I'm just looking at the outpatient services and the shifts in physician office. What percentage -- and specifically cardiac imaging, where you have echo here -- what percentage of all echos are done now -- in 2011 were done in outpatient service and physician office?

DR. STENSLAND: For echos, that proportion done in the hospitals grew from 2010 to 2011 from, I think, about 25 percent to about 30 percent. So in a one-year time frame, there's about a five percent shift in market share.

DR. REDBERG: And even though there's now a one percent update, echo payments are 70 percent higher in hospital outpatient settings. So I expect that will continue to shift, and I assume that you've accounted for that. I mean, how does that impact sort of overall costs and also overall volume, because it looks to me like overall volume of cardiac imaging, which has been something MedPAC

has looked at for the last few years because of the rapid increase, is continuing to increase.

DR. STENSLAND: The incentive to shift that stuff to the hospital is still there, and that does increase spending because it's 70 percent higher, and that's an issue that we've discussed in other settings, and so I don't think that's completely off the table to discuss in the future, but it's not part of this recommendation.

DR. NERENZ: A couple questions, and I'll stay on Slide 14 for the first one. On this shift from physician office to hospital outpatient, when you look at it from the perspective of payment only, it seems fairly straightforward. The payment is higher in hospital outpatient than it is in the other and so you shift.

But when you look at margin, it raises a question to me. If hospital outpatient margins are negative, it would seem odd that if an entity can control this that you would shift from a setting in which maybe the margins are positive to a setting where the margins are negative. How does -- is there an answer to that?

DR. STENSLAND: Well --

DR. CHERNEW: [Off microphone.] I'm sorry --

DR. STENSLAND: Mark might follow up on this, but there's probably several answers. One of them is maybe they're buying this physician practice for reasons other than just the Medicare profit they're going to make on these types of services. There is some price discrimination, just like if the government workers go to a hotel on government business, they get a government rate, where the actual government rate might not actually cover the average cost of that person staying there, but they want that person to fill the empty room --

DR. NERENZ: Cover the marginal cost.

DR. STENSLAND: -- and so this idea, in this case, you're still probably covering the marginal costs of these hospitals.

The other thing that might happen is there's a lot of other reasons they might want to buy this physician practice, and a lot of people have said they want to buy physician practices because it helps maybe to integrate care, maybe because they want to have more inpatient business, and they not only want the inpatient business from Medicare, they want the inpatient business from the private payers, which they make more money on. So there's this big

picture of how much money you make by buying the physician practice is going to include more than just the profits on the Medicare patients that you convert to the outpatient department.

MR. HACKBARTH: Regardless of what the reason is, the impact is to increase Medicare payments for the same services and increase beneficiary cost sharing.

DR. CHERNEW: I was going to say, there's probably a distinction between what I would call the marginal margin and average margin, and so the margins that get reported here are an average margin with a lot of costs loaded in. But that doesn't tell you how profitable these things are at the margin when you're doing them.

MR. HACKBARTH: It can increase pricing power vis-a-vis private payers to have this consolidation and change the revenue flow on the private side, as well.

DR. NERENZ: Okay. Thank you. The --

DR. MARK MILLER: Well, no. No.

[Laughter.]

DR. MARK MILLER: You've got to be sure you want an answer.

DR. NERENZ: I do.

DR. MARK MILLER: The only other thing I'd say, in all of that, I would have said the other thing is, remember, we've also said probably the line-by-line margins, service line-by-service line margins, probably have some allocation issues in them, as well, and that's why we tend to focus on the overall. Very small, but I think this was the more important conversation.

DR. NERENZ: No, thank you. That's fully satisfactory.

The second thing, hopefully -- no, no, it was good. That's why I asked the question. Slide 11, we look at 2014. I'm a little surprised that there hasn't been a little more attention to the coverage expansion features of ACA that kick into effect in 2014, and it would seems to me that part of the reason for some of the cuts in the hospital sector that have come into place already this year and in 2014 perhaps could be phrased as negotiated offsets against the reduction of uncompensated burden. Is there anything at all that we should be thinking about for 2014 in that specific area, meaning the reduction in uncompensated care burden that we presume will be coming?

DR. STENSLAND: Well, I think that was part of the

original understanding, and that's kind of the way the law is shaped, is that there's a mandate that people get insurance, and to the extent they start getting insurance, there's fewer dollars coming out of Medicare to pay for uncompensated care. There's this basic trade-off that says, if the rate of uninsured doesn't go down, well, we'll keep all this Medicare money flowing in there and we'll pay for uncompensated care. But if the rate of uninsured does go down and the hospitals start getting insured people in those beds rather than uncompensated care, well, then Medicare payments will decline because we'll pay for less and less uncompensated care.

DR. NERENZ: And the DSH mechanism that's illustrated in the report is the main mechanism for accomplishing that?

DR. STENSLAND: Yes.

DR. NERENZ: Okay.

MR. BUTLER: So, I had three things I'm going to want to say, one round two, and I was cleverly going to start with questions on the other two to make them round one, but I won't try to be too clever.

Let me get to the DSH thing more directly. So if

you look at page four, I don't think this changes our recommendation, but I think it's important to understand. So we have $117 billion in inpatient care. The chapter says we have $11 billion in DSH payments. So to put that in perspective, you say there's seven percent of hospital funding is related to DSH. It's more like about ten percent of inpatient, because $11 billion of -- that's one way to put it in perspective. I'm getting to a question.

So in October 1 of this year, that gets reduced by 75 percent, for starters. So the hospitals on October 1 actually, on average -- on average -- if you were at ten percent, would have a 7.5 percent reduction to your DRG payments because DSH is added on to the DRG payments on October 1.

Now, offsetting that is that the 75 percent that is cut, half of that goes to, you know, is no longer paid for by Medicare, but the other half is saved for the uncompensated care that remains, that you can, in effect, earn back based on your own uncompensated care level. So far, I'm correct, right?

DR. STENSLAND: I think half of it goes away. How much goes away depends on how much uninsurance there is.

MR. BUTLER: Right. Yes. Yes.

DR. STENSLAND: So if uninsurance doesn't really change, then you'd really be getting about the same amount of money in aggregated dollars.

MR. BUTLER: So the tricky part about this, obviously, is, so, let's take my institution, $170 million in inpatient payments, $22 million, or in our case, like, 13 percent in DSH payments. All of that -- 75 percent of that $22 million goes away on October 1 and, hopefully, in our case, the expansion of Medicaid -- so some people that are coming in with no insurance now will be paying Medicaid and some will be signing up through the health exchange for mandatory insurance, and those things together, on balance in the whole system, will be paying for what's dropped from the 75 percent DSH cut.

Now, the tricky part is, and this is getting to the question, is, I think, on October 1, that automatically happens in your payment. So the average hospital would have a 7.5 percent reduction in their DRG payments on October 1 while they wait to hope the expansion occurs, in some States that may not even occur. I realize they might get some of the uncompensated, but we need to think through when they

get it and when it's reconciled, because if you have those kind of cuts and then you've got to wait a year or two to put your cost report in to see, there could be a real mismatch in terms of the reductions of the DSH payments and when the offsetting money may or may not come in.

This is a big deal, and it's not a realized related to our one percent recommendation. We shouldn't mix things up. But it's something that really -- a lot of money is going to move around in unintended ways and unintended times unless somebody is paying attention to the details.

Was that a question?

MR. HACKBARTH: So --

MR. BUTLER: Unless I'm understanding that somebody's got this figured out --

DR. MARK MILLER: [Off microphone.] Well, maybe you can say, "Right?" with a question mark at the end.

DR. STENSLAND: I think there's a couple things there. One, DSH payments right now are paid on an estimated basis and then it's reconciled later. And one thing that'll happen in 2014 is this expansion of Medicaid, so we expect the number of Medicaid people to go up. That actually increases your DSH payments because of the DSH formula. I

think we talked about last month we expected the DSH pool to go up from $11 billion to $13 billion.

MR. BUTLER: Right.

DR. STENSLAND: So this is kind of one thing that's increasing it.

And then you're going to have this, you know, about $3 billion of that carved out, still staying in DSH. And then you have about $10 billion that would be going into this pool, and maybe $7.5 billion or so of that would be going to uncompensated care. And a key question that will be coming up in rulemaking this summer will be how do you pay that uncompensated care --

MR. BUTLER: And when do you pay it.

DR. STENSLAND: -- and when do you pay it. You could do it in a couple of different ways. You could estimate it like you do DSH and say, okay, you know, because they do have uncompensated care data in the cost reports from the prior year, and we said, this is your prior year uncompensated care. We'll estimate what share of this pool you're going to get and pay it out over the year, just like you used to get DSH payments paid out of the year, and reconcile at the end. So you wouldn't necessarily have to

be out the money until all the data comes in.

MR. BUTLER: And further compensated, if you have six, seven, eight States who opt out of the expansion, it really screws up numerators and denominators big time. And so the real -- regardless, there will be some really big shifts among -- across hospitals, even if in the aggregate things -- okay. I'm sorry to take us off tangent. But this single issue, with $11 billion of the $117 billion all kind of moving around, is going to really create some chaos if somebody doesn't kind of pay attention to the rulemaking, as you said.

Okay. So I'll go to my second question, right?

DR. MARK MILLER: [Off microphone.]

MR. BUTLER: I'm not going to say in round two. Page seven. I'm just telling you, if people look at their -- I'm just, from a hospital perspective, looking at what's going to happen next year, this thing is way bigger than whether it's one percent or one-and-a-half. This is massive amounts of money moving around.

Okay. So I'm really appreciative that you looked at kind of outpatient margins, because I've been kind of saying, okay, these efficient provider -- I'm trying to find

somebody that can make money on outpatient. And you said -- you kind of said they can, yet you said the efficient ones are still negative one. Is that what this says?

DR. STENSLAND: At the median, it's negative one, so slightly less than half of them are making money and slightly more than half of them are losing money on outpatient.

MR. BUTLER: It would be good to learn more about this, because I'm a believer that, ultimately, we probably need to de-link the inpatient and outpatient updates. When I look at inpatient, you know, we bundle into a DRG. You have more variables to work with -- length of stay, supply chain, process improvement -- to kind of live within a rate. On the outpatient side, because the bundle, the APCs, are smaller, it's hard to kind of -- if you ask the typical operator, how do you get every year that kind of productivity gain when you don't have the utilization, you know, variable within the bundle to work with, it's a lot tougher. And I think we need -- with almost 30 percent or 35 percent in outpatient, we just need to understand it better. And it obviously is very complicated because things like the E&M codes is a totally different issue. But it's a

big part of the cost structure we need to understand better.

DR. DEAN: Again, on Slide 4, I was particularly interested in the CAH increase, obviously. Do you have a breakdown of that? Is that due to greater utilization? Certainly, I don't think there's been any increase in the number of hospitals. Is it cost per patient or is it more patients, or do you have a breakdown of where that -- because that's a pretty significant increase.

DR. STENSLAND: Yeah, I don't have the number off the top of my head, but the Critical Access Hospitals had a stronger cost growth than the PPS hospitals, and I think part of that might be just due to the incentive structure there. They're paid cost-based reimbursement rather than prospective. So that's part of the reason they're growing faster.

They also tend to have some growth. On average, it ticks up a little faster in your -- on the outpatient side and the post-acute swing bed side, and those are both areas where they get paid a lot more than a PPS hospital does and they're growing a little bit in their market share there. They don't really have a lot of growth on the inpatient side, but they don't really get paid much more on

the inpatient side than a PPS hospital.

DR. DEAN: How does this compare with previous years? I didn't remember that it was -- is this greater than previous years? I didn't remember it going up quite that fast, but --

DR. STENSLAND: Yes, it's always grown up around that way, about that level for the last several years, kind of this six, seven percent cost growth, you know, and some of this is input price inflation. Some of it is just Critical Access Hospitals just growing a little faster than PPS hospitals. And some of it is growth in some of these swing bed and outpatient.

DR. HALL: I'm okay.

DR. NAYLOR: Just on the higher characteristics of efficient providers, higher occupancy, bed occupancy, is there -- you mentioned the relationship between changes in bed occupancy and observation days. Is there a relationship between those that are more efficient in use of observation days versus those that are less efficient?

DR. STENSLAND: We haven't looked at it, but I wouldn't expect it to move the needle very much because the observation is really small relative to the inpatient. But

we could look at it if you want us to.

DR. NAYLOR: Now, I didn't -- I'm trying to figure out how hospitals with such excess bed capacity as you described in your examples function. So I'm trying to figure out, are they shifting services to -- in addition to outpatient, growing their observation days, et cetera. So I'm just trying to understand how they survive.

MR. LISK: Remember, the overall total -- I mean, the total all-payer margin is what really matters to the hospital in the bottom line, and those are -- those have been pretty high and there's not as big a difference between those hospitals and for the efficient and unefficient [sic] groups. I can't remember -- that was on the earlier slide, 2, I think.

MR. GEORGE MILLER: Thank you. I want to cover and illuminate on Peter's point about DSH payments. If you'd put up Slide 8. Why wasn't Medicare DSH listed on this slide? It would have the same type of impact.

DR. STENSLAND: Yeah, I think that probably would be a good addition to this slide. This slide is more about what's moving payments up and down and actually moving our margin. And I didn't put this on this slide -- though it

could have been on there, that's a good point -- because the DSH is really a reallocation of dollars away from -- the DSH money much more toward the uncompensated care. At least, that's what we expect to happen in 2014. Not so much a shrinking of the whole pie. So it's not really --

MR. GEORGE MILLER: But to Peter's point, 75 percent reduction is a reduction.

DR. MARK MILLER: I do want to clarify that, because I think Peter was making his -- and he's right here, so he can correct it -- but I think his most important point was, there's a timing and reconciliation issue --

MR. GEORGE MILLER: Yes.

DR. MARK MILLER: -- and what I wanted to recommend to all of the Commissioners and then to the public when it finally gets published is Jeff worked through this issue pretty carefully. It's in your material, and we went through it in public in December. And on net the dollars may move to different designations -- DSH, uncompensated care, whatever the case may be -- but they don't change a lot.

I think his bigger issue, but he can -- and he apparently is shifting into position -- but I think his

bigger issue is, but when will I see it and how will it be allocated, those types of issues. And I take that very seriously, and I think when we come to comment period, we'll be all over that.

But the reduction is not 75 percent on net, and that's the thought I wanted to dispel.

MR. GEORGE MILLER: Okay, I got that point. But the timing issue is critically important for those of us who deal with cash flow issues. So if you're talking about October 1 hit, the timing is a major issue, and you've already said, I think it should be included in this slide.

I'm from a State that the Governor, with her wisdom, one way or the other, decided that we would not opt in. So we've got a major problem. So that even exacerbates the cash flow from when the -- we're not expanding the -- I think it's about 250 Oklahomans will not be expanded into the Medicaid program. So that even, in my mind, exacerbates our situation.

The second technical question on Slide 5, you include the Health Information Technology payments, but have you done an analysis to see if those payments cover all of the technology costs? Is it what percentage of the total

cost, because we're wondering, one of the hospitals had meaningful use dollars, but it's purely for the technology. It doesn't add -- it doesn't cover the additional cost of staff that we have to put in place and the infrastructure upgrade that we need to put in place to be able to do that. So do you have an idea what the difference is for American hospitals that are paying for it out of their pocket?

DR. STENSLAND: We don't have any concrete data on that, and I don't know if anybody really does. What we hear is different things from different people.

MR. GEORGE MILLER: Yeah.

DR. STENSLAND: A lot of the nonprofit hospitals say, this is costing us more than we're getting.

MR. GEORGE MILLER: That -- I'm one of them.

DR. STENSLAND: And then the for-profit hospitals, when they're talking to their shareholders in their quarterly reports, say, we're getting more money from CMS than this is costing us to meet meaningful use. So we're not exactly clear what the dollar figure is. What we do know is that it's going to be a significant amount of money going out to the hospitals and that significant amount of money should basically allow the margins to stay relatively

where they are from 2011 to 2013.

MR. GEORGE MILLER: Okay. So you're just dealing with the margin, not the actual cost. Okay.

MR. LISK: I mean, you have to remember is our underlying costs are including the Medicare share of those costs already. So if you look at what happened in 2011, it's incorporating -- those costs are incorporating whatever they've started to invest in the technology and stuff, too, and --

MR. KUHN: Just, Jeff, one additional question on page eight, or Slide Number 8, and the array of payment changes that are coming into place. There's a couple additional ones, the productivity adjustment that was locked into the Affordable Care Act, as well as, then, also, the lock-in of just a kind of a permanent reduction to the marketbasket. Are those captured in this calculation, or is that --

DR. STENSLAND: Yeah --

MR. KUHN: -- would that be elsewhere in your estimates for margins?

DR. STENSLAND: Those are in the margin computations. I didn't put them in here because they were

also basically in policy in 2011, too. So there was -- since 2011 on, we've had the productivity adjustment and the budgetary adjustment in policy.

MR. KUHN: Thank you.

MR. HACKBARTH: Let's proceed to Round 2. Again, our ultimate mission here is to vote on the draft recommendation so I'd appreciate it if you'd focus your comments, in particular, on the recommendation.

Craig.

DR. SAMITT: I agree with the recommendation.

DR. HOADLEY: I agree with the recommendation and it's just important to emphasize what several of us have, is that this is in comparison or in substitute for some of these other policies that have been employed.

MR. GRADISON: I also support the recommendations.

DR. COOMBS: I support the recommendations.

DR. BAICKER: Likewise.

DR. REDBERG: I support the recommendations.

DR. NERENZ: I will also support. I just note the complexity, looking particularly at the year 2014, as Peter mentioned and others. There's so many moving parts that I think we just should watch this particularly closely as we

actually get into that time period to see how all the moving parts are coming together.

MR. BUTLER: So not to beat the dead horse, but Mark, you did accurately reflect what I was trying to say. And just for the record, the chapter does do a very good job of articulating, it really does do a good job of doing this.

My additional point, though, was that even in the aggregate that makes sense. I think, as you're just pointing out in your comments, the shifts could be in some very unintended ways. The safety net public hospitals that have a lot of uncompensated are sitting there saying great, now they'll have Medicaid. But guess what? Now they've got their Medicaid card, they're going to go somewhere else and I'm going to lose my DSH patients and my patients overall or they're going to get swept into a managed care plan, which is rapidly occurring.

So patients are going to shift, money is going to shift quite dramatically.

I definitely support the recommendation. I think it's very solid. I would just say one more time, it's irrespective of the fiscal cliff. It's irrespective of what the Secretary's authority is. And it's irrespective of what

might happen in sequestration.

We're saying that based on what the rates are today, we think they ought to go up 1 percent on October 1, 2013.

MR. HACKBARTH: That's correct and that does bear emphasis. So if you take the current prevailing base rate we're saying at the end of the day it ought to go up by 1 percent. And to the extent that any of these other events, sequestration, et cetera, reduce it below this year's base rate times 1.01, then it would be inconsistent with our recommendation.

Of course, that's Congress' prerogative, but there ought to be no mistake about what our position is.

DR. CHERNEW: I agree with the recommendation and, more importantly, support the exchange that you guys just had. I think that may be almost more important.

DR. DEAN: Yeah, I support the recommendation. I guess it's sobering and a little frightening, all the changes that Peter described so well. But I think we need to move ahead. We're obviously in a very unstable time and we're trying to shift to different structures and these are difficult things.

But I support the recommendation.

DR. HALL: I also support the recommendation.

MS. UCCELLO: I support the recommendation and I just wanted to have you reclarify something for me.

With the spending implication, I think you said that if this were done over 10 years that it would be a lot less different; right? It would not be as big of a cost?

DR. STENSLAND: Yes, and the reason for that is --

MS. UCCELLO: It's a timing issue rather than -- it seems like this is a place where we share the goals. We're just doing it in a different time frame. But then, in the long term, it's coming out at the same place.

DR. STENSLAND: Our recommendation really kind of has two effects going on. One is on the inpatient side, we're paying higher. Especially in the short-term, a lot higher. On the outpatient, we're paying less.

So you kind of think of over the next four years, when the Secretary has this temporary big reduction, we would be paying a lot more over those four years. But then on the outpatient side, we would be paying less over 10 years.

So you can kind of think of our outpatient savings

over 10 years kind of offsetting the extra inpatient spending we would have over the 10 years. Over the shorter time period, we're clearly spending more under our firm 1 percent recommendation.

MS. UCCELLO: Thank you for reclarifying that for me.

DR. NAYLOR: I support the recommendation.

MR. GEORGE MILLER: I support the recommendation and would reemphasize what Pete just said about the impact and your comments about supporting it no matter what.

MR. KUHN: I support the recommendation.

MR. HACKBARTH: Let me again emphasize for people in the audience that we are in accord with the objective of recovering the past overpayments due to DCI. When we take into account all of the considerations, not just DCI recovery but also the other elements of our payment adequacy framework, we conclude -- as we discussed in December -- that there should be a 1 percent increase in the current prevailing base rates.

And the context has changed since our December discussion. A proposal that would have saved money relative to the current law baseline in December now costs money

relative to the new baseline as amended by the Taxpayer Relief Act. The fact that the legislative context has changed does not alter our conclusion that the base rates should increase by 1 percent, regardless of the Taxpayer Relief Act, regardless of sequestration that may happen in the future. That is our recommendation to the Congress.

So thank you all. Oh, we have to do our vote. A little detail....

So the recommendation is up. All in favor of the draft recommendation, please raise your hands.

[Show of hands.]

MR. HACKBARTH: Opposed

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Okay, now thank you very much. Good work.

DR. MARK MILLER: And if I'll just make one commercial. I do appreciate the conversation on the DSH piece. I think you've made a really strong point and we will pay attention to it as the regulation comes out. So I appreciate you guys raising that.

MR. HACKBARTH: Okay, we'll now have our public comment period before we adjourn for lunch.

Let me just see if there's anyone else who plans on commenting so we can -- anybody else? Three. Okay.

So you know the ground rules here. Please begin by identifying yourself and your organization. As always, I will remind people that this isn't your only, or even your best, opportunity to provide comments on the Commission's work. The best opportunities are through work with our staff, letters to Commissioners, and also placing comments on our website.

You have two minutes, and when the red lights comes on, that signifies the end of your two minutes.

MS. MIHALICH-LEVIN: Great. Good morning.

My name is Lori Mihalich-Levin and I'm with the Association of American Medical Colleges. The AAMC appreciates the opportunity to present our views this morning on the hospital payment adequacy discussion that you just had.

First, the AAMC appreciates the Commission's recommendation that hospitals receive a positive update in fiscal year 2014. In this time of financial difficulty for

many hospitals, and with even more ACA cuts on the horizon, a positive update is absolutely essential to hospitals' financial stability.

Echoing the discussion that we just hear, the AAMC requests that as the Commission and the staff draft the March report chapter on this particular subject, that you be extremely clear in the written chapter about the language regarding the intent of your recommendation as it intersects with sequestration and the fiscal cliff legislation.

Second, we encourage the Commission to continue to monitor on a regular and ongoing basis the unintended consequences of funding changes on hospital financial stability. As history has shown us, dramatic cuts and changes to the DSH program, Medicare, and other mission-support related funding can lead to very serious patient access issues. So with ACA cuts and sequestration and all these DSH payments on the horizon, we really encourage you to keep patient access top of mind in your discussions.

Thank you for the opportunity to present our views. Thank you.

MR. LOHMEYER: Good morning. I'm Nathan Lohmeyer, director of integrated care with DaVita Village Health.

We just wanted to comment that we support your position and the recommendation to continue C-SNPs for ESRD patients. Furthermore, we greatly appreciate your recognition of the unique needs of ESRD patients.

So thank you.

MS. WORZALA: Good afternoon, Chantal Worzala with the American Hospital Association.

First of all, I really want to thank you for a very thoughtful conversation today. These are incredibly complex issues with so many moving parts. You do a great job of laying them out and helping people sort thorough them. We very much appreciate it.

Second, we really thank you for finalizing your draft recommendation from December, even though -- as you discussed -- it would go from saving money to costing money, given the recent provisions in the ATRA. As commented on previously, we would encourage you to make very clear that that 1 percent update is after sequestration, as well as the ATRA.

On the other side, I do want to acknowledge that the AHA does not believe that the scope of documentation and coding cuts in the ATRA are warranted, nor do we believe

that additional cuts are needed. We did outline our reasons for that position in a letter last week.

And finally, I definitely encourage further consideration of the timing of the DSH reductions and their impact on hospitals. And as Commissioners have noted over course of the last few months, really encourage MedPAC to think about the other ways that we can bring reductions in payments through real system transformation, as was envisioned in the health reform law. Really important to work toward the system transformation and real reform measures and not just looking at payment reductions.

So thank you very much.

MR. HACKBARTH: Okay, we are adjourned until 1:30 p.m.

[Whereupon, at 12:27 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:30 p.m.]

MR. HACKBARTH: It's time for us to begin the afternoon session. First up is payment adequacy for physician and other health professional services. Before we start with that, though, let me just make some broader comments for people in the audience who were not at this morning's session.

This afternoon, and continuing into tomorrow morning, the Commission will be voting on payment recommendations to be included in our March report to Congress. For those of you who were at the December meeting, we had, as you'll know, an extensive discussion of our payment adequacy framework for each of the relevant provider groups, relevant data on access to care, number of providers, access to capital for providers, financial margins where that data is available, quality of care, et cetera. We will not go through all of that in the same detail again at this meeting as we did in December. There will be more truncated presentations of the payment adequacy data preceding the votes.

We will not over the next two days have an additional discussion of skilled nursing facility payment,

and the reason for that is that, as we discussed at our December meeting, our plan is to rerun, without a separate vote, our prior recommendation for rebasing the skilled nursing facility payments as well as improving the payment system to more fairly allocate the dollars. And since at the December discussion of SNF services there were no questions asked by the Commissioners that were left unanswered, we don't have any of that ground to go back over, so we decided in the interest of time not to have a separate discussion of SNF policy at this meeting.

So I think those are the major points, and now we're ready to turn to physician and other health professional services. Kate?

MS. BLONIARZ: In today's presentation, we will review payment adequacy for physicians and other health professionals and answer a few questions you asked last month.

Kevin will go through the provision Congress just passed to repeal the SGR -- to extend the SGR override for one year --

[Laughter.]

MS. BLONIARZ: And then he will review the

Commission's position on repeal of the SGR. I'm sorry for the slip.

You saw this slide last month. It lays out some of the key facts of Medicare's payment to physicians and other health professionals. They include office visits, hospital visits, surgical and diagnostic procedures, and other services. Payments in 2011 were $68 billion, about 12 percent of total Medicare spending, and there are nearly a million clinicians billing Medicare.

Our payment adequacy framework assesses access to services, including our own MedPAC annual survey of beneficiaries and other national surveys and focus groups of patients and physicians; quality measures for ambulatory care; measures of financial performance; and growth in service use.

So to answer a few questions that you had asked at the last meeting: Bill Hall, you had asked about access to care for beneficiaries who have recently moved. I looked at the survey results for why people said they were looking for a doctor, and about 20 percent were looking because they had recently moved, and about 30 percent were looking because their doctor had either moved or stopped practicing. In

next year's survey, we could try to assess whether beneficiaries have more trouble when they are in certain circumstances, like when they're new to the area, but we'll have to be careful drawing conclusions because of the small sample size.

DR. MARK MILLER: Kate, can I stop you for one second? So this is of those looking.

MS. BLONIARZ: That's right.

DR. MARK MILLER: And I just want to drive this point home so that nobody misunderstands that. Thank you.

MS. BLONIARZ: That's right. It's of beneficiaries reporting they're looking for a primary care physician.

DR. MARK MILLER: You've got it there. I just want to make sure the public and the press doesn't miss what's being said here.

MS. BLONIARZ: Cori, you had asked whether the reason minority beneficiaries have trouble accessing specialty care is because they don't have a usual source of care. We looked at the share in the access survey reporting they had an ongoing relationship with a primary care provider and don't see a difference between racial and

minorities and whites. So the presence of a usual source of care doesn't seem to be driving the pattern we see where minority beneficiaries report more trouble accessing specialty services.

Mary, you had asked us to add information on the share of beneficiaries reporting that they see a nurse practitioner or physician assistant for their primary care. Consistent with findings from prior surveys, we see about 30 percent of Medicare beneficiaries reporting they use a NP or PA for some or all of their primary care. That's the 9 plus the 21 percent in the second column. The share in rural areas is, again, higher, with over 40 percent reporting that they use an NP or PA for some or all of their care. But, overall, the rates for Medicare beneficiaries are a little lower than that reported for the privately insured.

Alice, you had asked about whether we had information on how long beneficiaries were waiting to see their doctor. The Medicare Current Beneficiary Survey asks this question of current beneficiaries, both living in the community and also in institutions. Of those living in the community, over the past ten years, the share of beneficiaries reporting that when they needed to see a

doctor they could within three days was around 50 percent. Those reporting that they didn't have to wait at all rose between 2001 and 2010, the two data points on the slide, from about 15 percent to 22 percent. And I also want to note that in the intervening years we didn't see a big difference between these two years as well.

I'm going to turn it over to Kevin to talk to the rest of the payment adequacy measures and the SGR.

DR. HAYES: This slide reviews our analysis of changes in the volume of fee schedule services per beneficiary.

Across all services, volume grew from 2010 to 2011 by 1 percent. I won't go through the specifics for each type of service again, but will just highlight one, that the volume of evaluation and management services grew from 2010 to 2011 at a rate of 2 percent.

This growth rate was influenced by a number of factors such as hospital acquisition of physician practices and the PPACA's expansion of Medicare coverage to include annual wellness visits.

Two, the volume of imaging services decreased by 1 percent. Here, again, as discussed in December, there was a

shift in setting for services such as cardiac imaging. Some of the billing for these services remains under the physician fee schedule, but increasingly the billing is under the outpatient prospective payment system.

The equity of payments under the fee schedule was another issue considered at the December meeting. For example, data for 2010 show that compensation of non-surgical procedural physicians was more than double that of primary care physicians.

When considering this issue, the Commission has said that such disparities raise concerns about mispricing and the ability of some physicians to generate volume.

So, just to go summarize points we made today and at the December meeting:

On access, surveys show that access for Medicare beneficiaries is stable and their access is better than that of privately insured individuals. Surveys of physicians show that they are generally willing to accept new Medicare patients, and this has not changed much over time. Measures of ambulatory care quality are generally unchanged from last year. Measures of financial performance for this sector are generally neutral. For example, the ratio of private payer

fees to Medicare fees has been steady over the past decade. And there was a small increase in the volume of services from 2010 to 2011.

Moving on now to the payment update for this sector, on January 2nd, the President signed into law the American Taxpayer Relief Act of 2012. It included a number health provisions, including a provision on the fee schedule update, a provision that extended current payment rates through December of this year. This update overrides an update of minus 26.5 percent that would otherwise have occurred as required under the sustainable growth rate formula. The ten-year budget score for the update provision was $25.2 billion. Various offsets were included in the legislation. Such an override is not consistent with the Commission's position on the SGR.

As you know, the Commission's position is that the SGR should be repealed. The Commission laid out its findings and recommendations for moving forward from the SGR in its October 2011 letter to the Congress.

As discussed at the December meeting, deferral will not lead to better choices. There are concerns about access. The cost of repeal will only increase. The options

available are unlikely to change in the near term.

In the meantime, if Medicare savings are applied to deficit reduction, repeal of the SGR only becomes more difficult if the only offsets are Medicare offsets.

The Commission's principles for moving forward from the SGR are: one, preserve access; two, rebalance payments toward primary care; three, encourage movement toward new payment models and delivery systems; and, four, offset the cost of repeal.

If the Congress decides to finance repeal within Medicare only, the Commission gave assistance to the Congress in its October 2011 letter and outlined a package of offsets to constrain the cost of repeal. These consisted of: a freeze or reductions in the fee schedule's conversion factor; reductions for other providers; and increases in beneficiary cost sharing.

However, if the Congress decides that all of the cost will not be borne within Medicare, it could enact smaller conversion factor reductions, fewer reductions for other providers, and smaller increases in beneficiary cost sharing.

The Congress could also choose to phase in these

changes by, for example, ramping up conversion factor reductions over time to encourage movement of physicians and other health professionals into alternate models of payment and delivery of care.

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

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

At the risk of redundancy, I want to just underline a few things that Kate and Kevin said about the Commission's stance on SGR.

We, as people in audience know, produced a lengthy letter a year ago in October urging Congress to repeal SGR, and on the assumption that repeal needed to be fully offset from within Medicare, we outlined some options for them on how to do that.

Much of the ensuing discussion of our October 2011 letter focused on the schedule of conversion factor reductions that were included for specialty physicians. And I want to make sure that the public broadly and the Congress understand the most important principles in that document, and Kevin just alluded to them, but, again, I want to pound away and make sure they're understood.

Principle 1 is that we think that repeal of SGR is urgent. As Kevin indicated, the cost of this will only grow over time, and we fear that savings from within the Medicare program that could be used to offset repeal, at least in part, are being applied to other purposes, whether they were expansions of coverage in the Affordable Care Act or deficit reduction or short-term extensions of SGR itself. Once they're used for those purposes, they are no longer available for repeal of the SGR. And we think that, left as it is, SGR will only pose an increasing threat to access to care for Medicare beneficiaries.

Now, we're happy to report that at this point in time Medicare beneficiaries continue to have good access to physician services in a vast majority of the country, at least, access that compares favorably to people just under the Medicare eligibility age. That's good news. But I don't think that anyone should be lulled into a state of confidence that it will always stay that way. The balance between supply and demand for services in many markets is very tight. We have a large new cohort of people aging into the Medicare program now.

In addition to that, we have a large cohort of

physicians who provide care for Medicare beneficiaries nearing retirement, which could reduce the supply. And given the tight balance between supply and demand in many markets, relatively small shifts in the patient population or the supply of physicians and other health professionals could create rather quickly some significant problems of access for Medicare beneficiaries. So repeal now while the situation is relatively stable. There is a growing risk that it could destabilize if we continue down this path of just deferring a decision on SGR.

The second principle is that legislation repealing SGR will create an opportunity, and we think that that legislative opportunity ought to be used to do two things. One is to rebalance payments between primary care and specialty care. The second is to create a reason, an incentive, for physicians and other health professionals to provide a growing share of their care outside of fee-for-service Medicare and inside new payment models like ACOs. So there is actually an opportunity to advance the cause that certainly this Commission and many Members of Congress talk about the urgency, the importance of moving to new payment models. We actually see the SGR repeal legislation

as an opportunity to significantly advance that cause. And deferring coming to grips with this issue once and for all has the bad effect of not seizing that opportunity to reward movement to new payment models which so many of us seek.

So those are the three principles: repeal now, rebalance payments, and reward movement to new payment models. The other particulars of the October 2011 letter are driven in large part by the assumption that repeal has to be fully financed out of the Medicare program. Congress is the ultimate decision maker on whether it has to be fully financed, and if so, if it has to come out of Medicare, and their decisions on that will then drive what needs to be done with, say, the conversion factor. But we hope people will not lose sight of these three principles that I just described.

So, with that added preface, let me turn to -- oh, and just for the sake of clarity, we will not have a separate vote on an update recommendation. We are reiterating the principles that I just described. That is our approach to the physician update issue.

Tom, do you want to begin with clarifying questions or comments?

DR. DEAN: I really don't have any clarifying questions. I guess I would only say that I support as strongly as anyone can the position that you just outlined, and it is one of the most frustrating things that I think we have to deal with or have had to deal with that you have this arrangement which is clearly not working, which is clearly making things worse, and which clearly gets more -- well, gets worse, for lack of a better word, every year it goes on, and Congress refuses to fix it. And that just -- we've stated it I think as strongly as it can be stated. It has been stated repeatedly. And I guess our only option is just to continue to state it. But I think we've stated it about as strongly -- the urgency is huge.

MR. HACKBARTH: And let me make explicit what was probably implicit in how I phrased it to Tom. I think rather than go through two separate rounds this time, since we've been over this ground so frequently, I just plan to do one round of questions and/or comments.

DR. HALL: Can we also refer to the presentation?

MR. HACKBARTH: Absolutely.

DR. HALL: I would just second what Tom has said about the urgency of SGR reform. In fact, I think the

Commission's statement is one of the clearest and most rational that's out there, period, and I hope it gets the wide dissemination that it deserves even beyond congressional circles.

I had a question about Slide 3, about the physician and other health professional services in Medicare. Specifically, do we have some information on the trajectory of the ratio of physicians actively billing and then what's called other health professionals? My guess is that since the pool of physicians is not growing in any particular rapid phase, but the production of other health professionals is, are there trajectories -- will these two curve cross at some point in the not too distant future?

DR. HAYES: I have not seen any projections of that sort. There was in PPACA a call for further study of future workforce needs. Indeed, you know, that was one of the emphases. And so that would be a way to get the kinds of trajectories projections that you're talking about. But I have not seen any.

DR. HALL: If it looks like they're starting to become equal or of parity, it might be an opportunity really for such things as the medical home to have a lot more

traction among health care providers. It might be a good thing.

MR. HACKBARTH: Just a couple things on this important point. PPACA created a workforce commission to look at these issues. My recollection is that they created the commission but didn't appropriate funds for it to operate. Is that correct?

DR. HAYES: That sounds right.

MR. HACKBARTH: And that's still the situation now. So we have a concept in the law but not a real vehicle at this point.

Another development -- and I know you're aware of this, Bill -- is that a year or so ago the Institute of Medicine looked at some of these issues with particular emphasis on nursing and made some recommendations, one of which was that Medicare should pay nurses within the scope -- so long as they're practicing within the scope of their license at the State level, and at an appropriate point in the future, I'd like to come back to that issue as well, which I think is a significant one.

So just those two comments.

DR. MARK MILLER: And I just want to ask, I heard

your question also this way, and tell me if this is what you were thinking. Are we able with what we're counting to count the growth rates between these two different groups?

MS. BLONIARZ: Sure, and Kevin --

DR. MARK MILLER: Is that what you were asking?

DR. HALL: That was part of it, and also what are the pros and cons of that, and particularly in terms of the urgency of looking at alternate payment systems for health care delivery. I think this is an important factor.

DR. MARK MILLER: Right, because I wouldn't put these guys on the spot unless they happen to have it, but we can, I think, calculate, using our own data, the growth rates.

DR. HAYES: And we have. So if we were to look at Table 3 in the mailing materials, you would see that the number of primary care physicians billing Medicare, you know, as a ratio, stated as a ratio of physicians per beneficiary, has been pretty stable. This is looking at three years' worth of data, 2009 to 2011; 3.8 is the number. The number of specialist physicians outside of primary care, that, too, has been stable at 8.5 per thousand beneficiaries. But the number of advanced practice nurses

and physician assistants has gone up, you know, in relation to the beneficiary population, going from 2.4 per thousand in 2009 to 2.8 per thousand.

So there's still, you know, a pretty substantial gap in the numbers, but the one group, the advanced practice nurses and physician assistants, is growing at a faster rate.

DR. MARK MILLER: Another commercial, and again, I don't want to put you guys on the spot. We're going to be coming back to talk about some of the issues Craig raised on access and how Medicare deals with that, and I'm trying to remember, in that context, were we going to try and come back to this IOM question or were we going to do that somewhere else?

DR. HAYES: Yeah. That was -- what we had been talking about was dealing with the targeting issues, such as the HPSA bonus payment in March, and then the other issues that Glenn was alluding to having to do with the future of nursing, the IOM report, scope of practice, and so forth would be in April.

DR. MARK MILLER: Okay. So I wanted to make sure that there was -- thanks a lot.

MS. UCCELLO: So thank you for looking into my question, and I also want to say you've done a really great job expanding the SGR section of the chapter. I thought that was very well done. And I just want to echo what Glenn and Tom have said about the urgency about this, and I don't think we can overstate how deferring this is not going to make it easier, that as time goes on, the options are actually narrowed rather than broadened and we need to address this now.

DR. NAYLOR: I want to thank you for all the additional information. I want to echo my colleagues' comments about I do think that this is the number one issue, and as Glenn has said, opportunity which we cannot afford to squander. I think the Slide 11, where you describe the ten-year budget score for the update that has just occurred in the absence of repeal, and the costs that that has for us for the foreseeable future is just extraordinary. But on the issues of the key principles of preserving and rebalancing and assuring that all Americans, especially those that are entering Medicare, have access is critically important. So I can only reinforce all that you have.

I also want to make one other comment as we think

about the future. CMS has made a big investment in graduate nurse education to grow and significantly increase pretty quickly the number of advanced practice nurses for primary care. So I think that as we think about that future, we should include consideration of that effort, as well.

MR. GEORGE MILLER: Yeah. I also add my voice to the strong support, as my colleagues and Glenn laid out, and support the principles.

I've got one technical question on page eight and it -- Slide 8 -- and it may be what I heard, so I want to make sure I have this clarified. Did you say, Kevin, part of the growth of E&M services was because of the hospitals acquiring physicians? Did I hear that, practices? Did I hear that correctly?

DR. HAYES: Yes. Yes. Yes, I did.

MR. GEORGE MILLER: Okay. But this slide talks about fee schedule services for beneficiaries, not the actual dollars. So would that be accurate? Because a physician practice has been purchased by a hospital, they are going to go do more E&M services?

DR. HAYES: No. It's kind of a measurement issue where when we measure the volume of services, we use -- we

were intending to account for not just increases in the number of services, but also their intensity, okay, their complexity, the resource consumption that goes with them. And the way we do that is with the fee schedule's Relative Value Units, or RVUs.

MR. GEORGE MILLER: Okay.

DR. HAYES: And because the RVUs are lower -- become lower --

MR. GEORGE MILLER: And then go to -- I got it.

DR. HAYES: You've got it.

MR. GEORGE MILLER: Okay. All right. Okay. So I heard you correctly, but it's not what I thought.

DR. HAYES: Well, okay.

MR. GEORGE MILLER: All right. Okay. All right. Thank you.

MR. KUHN: Thank you, Glenn. A quick question and then a comment.

On the question, I'm curious, in the American Taxpayer Relief Act, there was a provision in there that changes the equipment utilization rate from 75 to 90 percent. So with the slide that's up here now, on the red line in imaging, any early projections, or does anybody have

any where we think the imaging might go as a result of that additional change on efficiency? I would assume it would go down, but I just am curious if we think the order of magnitude -- or do we think it will move it at all?

MR. HACKBARTH: Well, this is a volume measure as opposed to a dollar measure. So if it has an effect on volume, it would be sort of a second order effect.

MR. KUHN: Okay.

MR. HACKBARTH: To the extent that you reduce the price paid per unit of service, as this would do, you may make future investments in imaging equipment less attractive. The payback period is longer. And to the extent that that happens, that may slow volume growth in the future. In fact, I think, and correct me if I'm wrong about this, Kevin, that there are some people who think that the DRA, Deficit Reduction Act, provisions that said we won't pay more for imaging services under the Physician Fee Schedule than we do in outpatient departments had an effect on volume growth, even though it was a price reduction, perhaps because it discouraged investments in imaging equipment. Once the equipment is in place, the incentives to use it and pay it off are very powerful. And so any

price change that discourages investment in equipment can in the future potentially affect volume.

MR. KUHN: Thanks for that distinction, Glenn. That was helpful. And I'm just -- maybe, to maybe think it a little bit further, you're right. Once the capital investment is already made, the incentive to continue to use it. But, obviously, what was it, three years ago, we went from the 50 percent utilization to the now 75 percent and now up to 90, do we -- is there any evidence that when they moved from that 50 to 75, did that have any -- obviously, that had an impact on price, but did that impact volume at all?

DR. HAYES: As Glenn said, there were some who would interpret things that way, but it's hard to just kind of attribute a change in volume to any one thing. When we look at the reports on reasons why imaging has slowed down and why volume overall has slowed down, it's been partly the economy, but also specific to imaging, there's been increased concerns about exposure to radiation. So how you sort out the different factors that might be influencing changes in the volume of these services is kind of a tough call.

MR. KUHN: Okay. Thank you.

And now just a quick comment, and I'm going to, no surprise, join the chorus of everybody else about the need for the repeal of SGR. I think the additions to the paper that we have that will be the March 15 report, with headings of new categories that say repeal is urgent, is absolutely critical, and I thank the staff and everybody on the writing on that. I think they did a really good job.

To me, when I think about this, it's a little bit analogous to kind of what's going on right now, and as people rush to refinance their homes, they recognize that probably interest rates are the lowest they're ever going to be and people are taking full advantage of this. And I think by the continuing mountain of evidence that this is the cheapest it's ever going to be to refinance or finance an SGR repeal, we'll hope that folks will do what consumers are doing all across this country and say, yeah, let's take the deal. Let's refinance. Let's get rid of this thing now, because the evidence is here and I think the charts that are in this paper continue to show that every year we wait, it just gets more expensive. So let's refinance now.

DR. SAMITT: So I'll add my voice to the extreme

concerns about procrastination. I think that it was Lincoln that said, you can't escape the responsibility of tomorrow by evading it today, and I think that's apropos to the scenario here. You know, as, Glenn, you put it eloquently, the non-repeal of SGR has extreme destabilizing effects on the overall Medicare program and we don't have to look beyond just the price of the single-year fix for this year and the fact that that's coming out of reimbursements to other sectors other than physician payments.

And the second thing, from my point of view, and we've lived this within my own organization, is that we've got an extreme opportunity right now to incent physicians, many of whom around the country are very much on the fence about whether they should be moving to value over volume. Now is an opportunity to really incent the physician community to embrace alternative payments by linking an SGR repeal today with incentives to move in the direction of value-based care.

DR. HOADLEY: I don't know that I need to echo what's been said a lot. I really do think that the rewrite of the chapter does a nice job at really highlighting better. And I think the one point that appeals to me is the

notion that we keep talking about how we don't really see much in the way of access problems, but that notion that we can't be assured that that truth today projects to a similar truth if this issue isn't dealt with at some point in the future.

A couple quick points on much more down-in-the-weeds kinds of things. I like the fact that you added a little section on the HPSA and sort of anticipating the fact that you will be telling us more about that in a coming meeting. I think that's useful to go ahead and have in this chapter.

I was struck by the reading at this time in the chapter, you talk about the opt out physicians, and it always amazes me that we just can't have a real count of how many there are. We know it's small, but the sort of problems in counting them, I don't know if that's something to actually call attention to slightly more aggressively, that it would really be useful, because if that were to have a significant change, and I know there's some very marginal evidence from the IG of some increase in that, but when I looked back at that report, they're very tentative about making that statement. You know, it's something we ought to

be aware of, if it were to change.

And then, lastly, I had seen something in the news last week that was somebody projecting that physician participation in the PQRS might be quite low. I think this particular article said one out of five. I don't know if that's accurate or it's just somebody's guess or what kind of a study it was. It may have been a survey. But I don't know if that's something that you've tracked at all or have a sense. But, again, it's something that may be worth paying attention to, to see if that's the issue given that penalties will start to kick in, in what, a year or two.

MS. BLONIARZ: The measurement period is 2013 for penalties and 2015.

DR. HOADLEY: Okay.

MR. GRADISON: I, too, support the recommendation. I want to say, though, another word about it. This organization has been calling attention to the failure of the SGR since 2002 and not a whole lot has changed over that period. I think it's entirely appropriate that we focus in our public statements on trying to point out ways in which repeal could be paid for within the Medicare program. I think, however, the fact that it hasn't happened over such a

long period of time does suggest that maybe that isn't the likely resolution of the problem.

Now, the reason I say that is that I -- I served ten years on the House Budget Committee and long ago came to the conclusion that budget policy is health policy and health policy is budget policy. They're inextricably tied together, which suggests to me that those on the outside, not this Commission but those on the outside who agree with our conclusion that the SGR should go, unavoidably have to have an opinion on revenues and expenditures outside of the health care field. That's not a popular thing to do. I'm not advocating what that answer should be. But I think the failure to speak up on those subjects just kind of leaves us in a dead end, so to speak, arrangement, locked into some unfortunate but mistaken legislation that was passed a long time ago.

DR. COOMBS: So I don't think we can put up the Table 13, but thank you, Kate and Kevin. You guys did an awesome job. That Table 3 that was in the paper on page 22 actually does a great job of looking at the workforce and looking specifically at the workforce as it applies to the Medicare beneficiaries, the primary care, advance practice

nursing, and physician assistants. And I think that I agree with everything that's been said. It's not if, it's how, and the "how" part is the accumulated debt and how you go about trying to remedy the situation.

And so I have a problem just with the offset and how it happens and I liken it to someone having a heavy load and it just gets heavier every single year, and yet there -- it's going to be distributed over a smaller group of entities as we go on in terms of providers and it needs to be addressed in a short amount of time or a time that's much shorter than its existence. So that's one of my concerns.

Just to go back to the workforce, one of the issues, I think, as we look at workforce, we look at the distribution of non-physician providers, and what we've seen in some of the studies is that whereas physician assistants initially had a propensity to go into primary care, there's a direction into specialty pursuits for physician assistants. And the same thing is true of nurse practitioners.

And even more interesting is the maldistribution when it comes to geography, so that I think the AMA and several others have done studies to look at where advanced

nurse practitioners go and they want the same thing that physicians want in terms of the migration, the migration patterns. You can actually look at this in the literature. And I think it's important for us not to be fooled by the fact that we have a new group of providers coming into the arena that we may be still fraught with some of the same challenges as before, and I think that's significant.

I'm not sure we can say that the changing dynamics that occur in the workforce will necessarily result in decrease in imaging and decrease in some of the things that we think have been associated with a physician-dominant profession historically. And I work very closely with nurse practitioners and physician assistants and there's a piece of this that we don't have a lot of data on and I would say that we need to kind of proceed with caution in terms of whether or not you're going to see a large cost reduction, out of proportion with a more blended specialty in terms of disruptive innovation.

So I think that those are a couple of things that we make assumptions that we can get a less costly FTE, that we would have a better scenario in terms of cost and quality, but I'm being honest in that I can't necessarily

say that that is the case.

And so I'd like to echo that I support it. I have some concerns about the offset. I have concerns about how it occurs in the big picture and I think the workforce challenges are real, and they're real in terms of primary care. And I think primary care needs to have greater support and I think we have to change the paradigm in terms of what happens with patient care in the trenches, and that's where the rubber meets the road.

I will say that the Mass Medical Society did do a study on Medicaid acceptance rates -- and this is not Medicare, I understand -- but over the past five years, we've seen a significant number of doctors in various communities within Massachusetts whose, you know, I think it's 29 to 57 percent, somewhere in that vicinity, were physicians on survey, on telephone survey, who have said we are not accepting Medicaid patients. Now, they may accept Medicaid patients at a certain point and close their panels, but that's a very real concern in terms of being able to say going forward that the Medicare beneficiaries have the same kind of access that they have appreciated in the past.

DR. BAICKER: I think the way you've laid out the

challenges that the program faces is really helpful here, and we all have different analogies, but we're all getting at the same point. The problem gets worse every day that you don't address it.

The one caution that I'd urge in this subtle language of the chapter is I think it's great the way you've laid out the issue of how you're going to finance what is a growing burden from inside Medicare, not from inside Medicare, and that we've laid out some options for how to do it within Medicare. I think we want to avoid the implication, which is only there occasionally and subtly, that we recommended a specific package of offsets within Medicare. Rather, we've laid out some options that we haven't really fully debated or agreed on, but we wanted to at least give a helpful sense, and I think it is helpful, of the magnitude of offset that's available from some commonly discussed options and what the implications of those are. So I'd just like to see a few small tweaks to the language to make it clear that it's a potential menu, not if you're going to do it within Medicare, here's the way to do it.

DR. REDBERG: I thought it was an excellent chapter and I appreciated the new material and I certainly

support the continued recommendation for SGR repeal. I think SGR is clearly just not a functional system. I don't think it's good for patients. It's not good for physicians. It's not good for the Medicare program. It's never achieved its goals, clearly, and it never will. And just continuing to kick the can down the road just perpetuates this dysfunctional system. And I think the sooner -- it's very expensive. It's not achieving a good return on the investment, on what we're spending. It's an attempt to rein in costs by controlling physician payment, but there's nothing on volume, and you can see in Figure 5 that what it has led to is very high volume of services that we don't know are good for our beneficiaries and suspect in a lot of cases are not.

And so I echo Craig's suggestion that it's a good opportunity to look at value-based purchasing and do more with that and bundled payment, because it's not that we're not putting a lot of money into this system. We're just putting it in in a way that is not working well for the system and it's not working well for our beneficiaries. So I strongly support repeal of SGR and coming up with a new system.

And, lastly, I am a specialist and I agree with the rebalancing of the cost towards primary care and away from specialty because it's quite unbalanced in our current payment system.

DR. NERENZ: I just echo many of the earlier comments. I won't repeat them. But I think the one I would emphasize is to try ourselves, as well as with CMS, to move more aggressively to truly different payment models. It's probably good that that slide is up because it illustrates the increases in volume that we have in spite of the time period of SGR.

I also note that in a couple of the current demonstration projects, one in bundled payment and ACOs, what they really are is a shared savings model grafted into a continuation of fee-for-service payment. And although that is movement, probably in a direction we would support, it's not very aggressive or radical movement and there certainly must be opportunities to move more strongly, more quickly, and more clearly in the direction of alternative payments. So at least I'd encourage us to be thinking about that and being an impetus for that.

MR. BUTLER: So, I really like Bill's statement,

of course, his experience, too, in dealing with how Congress deals with these budgets. So I'm trying to get my arms around a simpler way to quantify the challenge of solving within Medicare. So tell me if these numbers are right.

First of all, we in our letter said, you know, if -- over a year ago, it was a $300 million number over ten years -- billion dollar number over ten years, and that we said $100 billion could be solved with the -- really reducing specialty fees over three years plus encouraging moving to payment reform. Those are the heart of the --

The next chunk were just simply taking recommendations we had previously made and implementing them, which was a, how much, 50?

DR. MARK MILLER: Fifty to 60.

MR. BUTLER: -- $60 billion. And then we left a menu that over-solved by $20 billion and we said, don't take all these too quickly because they need to be vetted, although since that time, we've taken a couple of those and made them into -- we put it in the upper bucket, whether it's the E&M codes or some of the others, right? Okay. I've got that landscaped correctly, I think, and that looked pretty challenging.

So now let me flip it a different way. In calendar year 2013, the Act that just passed said it solved really within Medicare, or almost, has $25 billion, which to me, on a $550 billion budget, which is roughly what Medicare is, is about 4.5 percent. So is another way of saying this, if you were to do roughly a 4.5 percent cut to Medicare across the board, you would solve for SGR, but that's all you would be doing, and then you'd have no -- you wouldn't be contributing, obviously, towards solving the Federal deficit at all, zero. So is that another way of just -- and then you could say, so sequestration, for example, so you could take 4.5 plus the two percent and that's a 6.5 percent -- that's another way of looking at it, and some would say the two percent is not the proportionate share that health care ought to contribute to solving the Federal deficit. I'm trying to get round numbers to what it would look like and how tough it is to solve within Medicare.

MR. HACKBARTH: Yes. I think the arithmetic, your arithmetic, is roughly correct. In order to offset the cost, it would be something like a 6.5 percent reduction, two percent for the sequester, then another four to five on top of that.

MR. BUTLER: I just took $25 billion, divided by $550 billion, which was the --

DR. MARK MILLER: That's -- and Kate -- I'm getting the look out of you that I think I'm getting, right? Keep in mind that the -- you, too, Kevin. But you always look that way, so I --

[Laughter.]

DR. MARK MILLER: -- can't always distinguish. You always look worried. Kate occasionally looks happy.

I want to just focus you on this $25 billion. This $25 billion is a one-year fix.

MR. BUTLER: Yeah, but if you did it year after year, it would be -- you'd have to do it year after year. I'm just saying --

DR. MARK MILLER: Okay.

MR. BUTLER: -- as a percentage of total spending this year, it's 4.5 percent. But you can't do it one year. You've got to do it ten years in a row.

DR. MARK MILLER: Right.

MS. BLONIARZ: And I would just make two points. That's kind of when you add it up over ten years, you're in the ballpark of $250 to $300 billion, the cost of repeal.

And the second is the payment cuts, you know, that you would be talking about to offset the SGR, those would compound year after year. The sequester doesn't compound. So you can't really net those two things together.

MR. HACKBARTH: Yeah, okay.

DR. MARK MILLER: But, notionally, I do now understand what you're saying.

MR. BUTLER: So I'm trying to translate it to a comment Mike made in Executive Session this morning, that health care has grown at GDP plus two percent, roughly, per year, right? Do you know?

DR. CHERNEW: [Off microphone.] Yeah.

MR. BUTLER: And so, trying to translate, if you were to take these things together, the SGR fix as well as the two percent, and then say you're really going to reform the system that much, that's a pretty tall order. It certainly runs counter to -- I mean, you're talking about not just tweaking payment rates. You've got to do something dramatically different.

DR. CHERNEW: So I have a few reactions. The first one is, we're a pretty friendly group and we often agree, but this is a new -- this like the SGR consensus,

which isn't just agreement. There's, like, passionate agreement, I think, in general, around the table. It's very easy to get a group of people to support the notion that SGR has to be repealed, and I certainly do.

I want to say a few things about it, though. The first one is, we talk a lot about the costs of SGR appeal, and that's an important one because it has a real budget cost. I think it's actually not a real cost in the following sense, or, I should say, in the real world, it's not like SGR is -- because you know you're eventually going to put the money back in anyway. So it's not like you're spending more money than you otherwise would have spent. You're just messing up the baseline because the baseline that you have with this 26 percent cut, in my view, is probably never really going to happen. So the cost of freezing it is really just an accounting cost of something you know you would have done. But I don't think you were really going to recognize that you were going to do that in the future.

But the reason why I think that matters, and you guys can correct me, is a lot of programs are judged versus the baseline. And so when the baseline is not right, so if

an ACO saves money, it has to save money relative to the current law baseline, it becomes very confusing, very distracting, and prevents us from moving forward in a bunch of other ways.

So where I think there is a genuine cost in a budget sense, I don't think that people really expect that the baseline that has been cut is going to go forward, so you really just recognize -- it's really a refusal to recognize that thing that we think we're going to do anyway as opposed to actually spending more.

MR. HACKBARTH: Yeah. I agree with that, Mike, but it does mean that the reported deficit is in reality larger than what all of the --

DR. CHERNEW: Right. I absolutely agree with that. But my point is, yes, the reported deficit is, in fact, larger than what's being reported, but we should just recognize that that --

MR. HACKBARTH: So they could just write it off and say, well, we were going to spend this money anyhow and so let's just do away with this mechanism because it's detached from reality. We were going to spend it anyhow. But what that does mean is that all of the projections about

the deficit have to go up by the $300 billion over ten years.

DR. CHERNEW: Absolutely. Absolutely. But let me -- the reason I agree with that -- that was what I was going to say -- and let me just add on to that, when we do our other things like we spoke of this morning and we're going to talk about later, we try and get the payment rates right by sector to the extent that we can get it right. Whatever you do with the SGR doesn't mean that the right payment rate in some other area changes. And so going back and just saying, oh, we needed this money for the SGR, therefore, we're going to pull money out of some other sector, what I think we will do going forward when we try and get the payment rates right is we would recommend the payment rate for hospitals and SNFs and home health to the ones that we think are right. Some of them, we think there's opportunities for savings. Some of them, we think less so. But I don't think we should view the notion of we could just pull money out of the other sectors as some basic fairness exercise. There's a bunch of other criteria that tell us what the payment rates we think should loosely be in the other sectors -- access to capital, access for

beneficiaries, those margins, those types of things.

And so I think we have to be careful that we don't, in our effort to get rid of the SGR, and I should say, I really strongly believe we should get rid of the SGR, that we don't think that we should just pull from other sectors because there's just money floating around there and we need it to make it balance. I think you have to think about what you're doing to those other sectors and try and run the program to maintain the fundamental criteria that we think the Medicare program should have with access and those types of things. And I think it's a big problem and I think it's just becoming an increasing problem. So I'm very supportive of the recommendations.

MR. HACKBARTH: So, you know, if I worked on Wall Street and made my living trying to predict future Federal interest rates and the role of the deficit in those, I wouldn't be looking at the CBO baseline that includes the SGR cut. I'd be looking at the so-called fiscal scenarios that assume that the SGR will -- we're going to spend the money anyhow. And so in that sense, I agree with you.

On the other hand, if you think about this in the current legislative context, the Congress and the President

labored mightily to produce a tax bill that would increase Federal revenues by $600 billion over ten years. The SGR is half of that. And that, I think, gives a sense of how large this looms legislatively, even if you are right on the economics of it.

DR. CHERNEW: No, but I agree with that completely.

MR. HACKBARTH: Yeah. Okay. So that completes our round on this. There's no separate vote on this recommendation, so thank you, Kevin and Kate. We are finished with physician and health professional services and now we'll move on to ambulatory surgical centers.

DR. ZABINSKI: Today, Ariel and I will discuss payment adequacy for ambulatory surgical centers and present a draft update recommendation.

As we described in our December presentation, important facts about ASCs in 2011 include that Medicare payments to ASCs were about $3.4 billion; the number of fee-for-service beneficiaries that were served in ASCs was about 3.4 million; and the number of Medicare-certified ASCs was 5,344.

Also, ASCs have benefits relative to hospital

outpatient departments including lower payment rates, which can lead to lower program spending; lower cost sharing for beneficiaries; and efficiencies for patients and physicians.

But 90 percent of ASCs have some degree of physician ownership, and these physician owners may furnish more surgical services in ASCs than they would if they had to perform those services in HOPDs. This may offset some of the gains in program spending and beneficiary cost sharing from having services provided in ASCs rather than HOPDs. Finally, the ASC payment rates received an update of 0.6 percent in 2013.

At the December meeting, we discussed measures of payment adequacy in detail, and we also provide detailed discussion in the Commissioner's meeting papers. So in the interest of time, today we'll cover measures of payment adequacy more briefly.

In particular, our measures of payment adequacy for ASCs were positive in 2011. Access to and supply of ASC services was adequate as the number of beneficiaries served, volume of services per fee-for-service beneficiary, and the number of ASCs all increased in 2011. Also, the increase in the number of ASCs indicates that access to capital was

adequate. Finally, Medicare payments per fee-for-service beneficiary increased in 2011.

However, we are unable to use margins or other cost-dependent measures because ASCs do not submit cost data to CMS, even though the Commission has recommended submitting cost data each year since 2009. In addition, we cannot assess quality of care because ASCs only began submitting quality measures in October of 2012.

In your meeting paper, we mention there is much variation across states in the number of ASCs per beneficiary. And at the December meeting, we were asked whether differences in certificate of need laws across states contribute to this variation. And it appears that it does.

Among the 12 states that have the lowest number of ASCs per beneficiary, all 12 have CON laws. In contrast, among the 12 states that have the highest number of ASCs per beneficiary, only four have CON laws and two of these states -- Maryland and Georgia -- have exceptions in their CON requirements that ease the establishment of new ASCs.

Now Ariel will discuss options for collecting cost data from ASCs and our draft update recommendation.

MR. WINTER: At our December meeting, Peter asked about the rationale for collecting cost data from ASCs, the type of information that would be reported, and how it would be collected.

The first reason to collect cost data is to identify or develop a more accurate input price index for ASCs than the price index that CMS currently uses to update ASC payments, and that's the Consumer Price Index for urban consumers.

The Commission, CMS, and the ASC industry have all expressed concerns about whether the CPI is an appropriate proxy for ASC input costs. CMS has said that it needs ASC cost data to determine whether there is a better alternative than the CPI to measure ASC's input costs. The Commission has also recommended that CMS collect data for this purpose. To examine this issue, CMS would need data on total ASC costs as well as the share of costs for specific categories, such as employee compensation, medical supplies, medical equipment, and building-related expenses.

The second reason to collect cost data is to enable the Commission to track changes in ASC costs over time and to examine Medicare payments relative to the costs

of efficient providers. This analysis would help inform annual update recommendations. To examine payments and costs, we would need data on ASCs' total costs, their total charges across all payers as well as for Medicare patients, and total Medicare payments.

Although ASCs have expressed concern that submitting cost data would be too burdensome, we think it is feasible for them to provide a limited amount of cost information.

To minimize their burden, CMS should create a streamlined process for ASCs to track and submit the kinds of cost data that we outlined on prior slide, and here are two options:

First is an annual survey of a random sample of ASCs with a mandatory response, and there are precedents for this approach. CMS conducted cost surveys of a sample of ASCs in 1986 and 1994, and GAO conducted a cost survey of a sample of ASCs in 2004.

The second option would be to require all ASCs to submit a streamlined cost report, and it is worth noting here that other small providers submit annual cost reports, such as dialysis facilities, hospices, and home health

agencies.

Some Commissioners asked us at the last meeting to reprint the recommendation that we made last year that the Congress should direct the Secretary to implement a value-based purchasing program for ASCs. So the recommendation that appears here on this slide will be printed in the chapter this year as well.

This takes us to the draft update recommendation. The Congress should eliminate the update to the payment rates for ASCs for calendar year 2014. The Congress should also require ASCs to submit cost data.

At the December meeting, you'll recall that the Chairman's draft recommendation was for a 0.5 percent update for 2014. But during the discussion at that meeting, several Commissioners said they favored a zero percent update, and, therefore, the draft recommendation was changed to reflect that, a zero percent update.

The rationale for this draft recommendation is the continued growth in the volume of ASC services, and the number of ASCs suggests that current payments are at least adequate. Second, it is important to keep financial pressure on providers to constrain costs. And, third, the

lack of cost and quality data make it difficult to justify a positive update.

And this slide shows the implications for this draft recommendation. In terms of the spending impacts, under current law, ASCs are projected to receive an update in 2014 of 1.5 percent. Relative to this statutory update, this draft recommendation would decrease spending by less than $50 million in the first year and less than $1 billion over five years. Because of growth in the number of ASCs and the volume of ASC services, we do not anticipate that this draft recommendation would diminish beneficiaries' access to ASC services or providers' willingness or ability to furnish care. And, finally, ASCs would incur some administrative costs to collect and submit cost data.

This concludes our presentation, and we'd be happy to take any questions.

MR. HACKBARTH: Thank you.

So let me just say a little bit more about the reason for the change in the recommendation. As Ariel reported, we had a draft recommendation in December providing for a 0.5 percent update, and that has been changed to zero.

In addition to the discussion that occurred at the December public meeting, I talked to each individual Commissioner about this, as well as all the other updates, and in the course of that, it became clear that, in fact, the consensus position among the Commissioners was for the lower update, namely, no update in the rates as opposed to 0.5.

In formulating the draft recommendation for the 0.5 update, I emphasized looking at the ASC issue through the lens of comparing what we pay for the same services provided in different locations -- ASCs versus hospital outpatient departments -- and as I explained in December, that way of thinking about the issue led me to think that we wanted to take care not to widen what is already a significant difference in payment between ASCs and hospital outpatient departments for the same services.

The hospital outpatient department recommendation which we just agreed to a little while ago was for a 1 percent increase in those rates. And the reason for my proposing 0.5 percent in December was trying to keep those in line, but with some reduction for the failure to provide cost report information.

The other way of looking at this and ultimately the perspective that prevailed among the Commissioners was sort of our more conventional approach of looking at the payment adequacy indicators, including significant growth in new entrants into this business. And that led to going to the lower update, namely, no update whatsoever. And the thinking among the Commissioners that I talked to was while the cross-sector pricing, as we have called it, the comparison of what we pay for ASCs and HOPDs for the same service, is an important perspective, in the grand scheme of things, that issue is not going to be really addressed by whether we give a 0.5 percent update or a zero percent update or a 1 percent update for ASCs. There's a large gap in those rates, and that's an issue that needs to be addressed separately in due course as opposed to trying to manipulate by very small amounts the update recommendation. So the prevailing view was let's apply just our usual payment adequacy analysis, and that was more supportive of a zero update than a 0.5 update. So that is, for the audience, how we got from where we were in December to this recommendation.

Peter, do you want to lead off? And I think here,

again, we could probably just do with one round of questions and comments.

MR. BUTLER: So I am going to support the recommendation, and primarily for the reasons stated, but with particular emphasis on the fact that I can't find a methodology to support 0.5 specifically. So in the absence of the cost data and the growth, I think it's better to do zero.

I have a question about the value-based purchasing which we're trying to -- we have a recommendation for 2016, and it, you know, kind of sounds good, feels good. But we're not too specific about other than infection rates and some things like that. I have a feeling in surgery centers that the percentage of bad events, if you will, are far fewer just because you have fairly straightforward -- you're not going to find as much variation as you do in hospital care in terms of some of the measures that we're looking at. So I think we need to spend a little more time thinking about what we're trying to achieve. It's an area, Rita, I think you would say, the more important thing might be looking at utilization, both under maybe endoscopies, if people are not getting their colonoscopies, as well as over

on some of the pain management, everybody go get an injection.

I wonder if, you know -- I just think we need to think a little bit more about the value-based purchasing, just saying it's a good idea. I'm not sure we're going to shine lights on too much difference unless we think through a little bit more clearly what behaviors we expect to change as a result of the program going in place.

DR. NERENZ: I will support the recommendation, but in saying that, I would also emphasize I am impressed with this issue that you mentioned about the difference in payment between the two different sites. And I think we should carry that thought forward not only in this particular comparison but in others where we talk about things being done presumably in comparable ways.

And in framing that discussion, I think it would be useful for us to think about sort of two dynamics that may run in different directions. One is that if a higher payment to the lower-priced site would actually serve as an incentive to move more in that direction, that would seem to be a good thing to do in general. But as Peter just said, if in doing that you encourage the doing of unnecessary

things in that lower-priced site, that is not a good thing. And, clearly, you have to take both those factors into account. We certainly can't settle that today, but I think to the extent staff can find any empirical evidence on those kind of dynamics or we just develop that thinking as we think about this general question of the different sites of care, it could be useful. It's going to be a complicated issue.

DR. REDBERG: I support the recommendation as well because, as I've said, I think we really have to keep in mind what are we spending our money on and what are we getting from it, and it's really not clear to me in this case because we don't have the cost data and we don't yet have quality data, although I'm gratified to hear that we have a few months of quality data starting.

But if you, for example, look at the frequently provided ASC services in Table 5.6 and just take two examples, you know, six of these services are injections in the spinal cord, which I think everyone got to hear a lot about recently because of the compounding problems with the fungal infections in steroids. And so we know these injections are a procedure that has never been shown to be

effective anyway for back pain, not studied and shown superior in clinical trials. And then colonoscopy. And, of course, we recommend colorectal cancer screening, but the U.S. Preventive Services Task Force states that you can have fecal occult blood testing or colonoscopy. They're equally effective. Most patients are never actually told that they have a choice, and they undergo colonoscopy, which is more invasive, more uncomfortable, not any more effective, but reimbursed at a much higher rate, and one of the other procedures done here.

So I think we could be doing a lot better in terms of looking at procedures, what's done in ambulatory surgical centers, and so I support this update while we're continuing to gather more data.

DR. BAICKER: I support the recommendation, and it seems quite consistent to me with our general philosophy of starting with a zero update and looking for evidence that would suggest otherwise. And it seems quite possible that as more evidence comes in, we might arrive at a different conclusion the next time we looked to think about how to encourage care in the lowest cost, highest value, high quality site that we can. But we don't have that evidence

yet that strongly argues for a different update than this.

DR. COOMBS: I originally supported the half percent, but I can support the zero. I think that the data is very important, and I think there's some lessons that can be learned on both sides that, you know, as was just mentioned, I think that it's possible that what we learn from the data may change or may alter our course.

MR. GRADISON: I support the recommendations also.

DR. HOADLEY: I support the recommendations, and I wanted to thank you for the analysis of the CON laws. It's really quite striking there that, you know, the states that seem to look harder at whether these are needed don't necessarily conclude that they are. And maybe that's something to pay some attention to, further attention to.

DR. SAMITT: I had originally supported the half a percent increase, but can certainly live with the zero percent, but solely because cost data is not available. I would hope that with the availability of cost data we will feel some comfort to provide updates in the future, primarily because there is a great deal more work to do to shift care from a site-of-service perspective.

In our system, the two primary things we highlight

are having providers work to the top of their capabilities and also to provide services in the most efficient setting. And I think that there are still many opportunities on both the provider side and the facility side to do both. And I wouldn't want this recommendation to defer the necessary movement that still must happen from hospitals to ASCs or to other outpatient settings.

MR. KUHN: I support the recommendation.

MR. GEORGE MILLER: I support the recommendation, but I do want to echo that today we don't have the evidence, and I was very impressed also, as Jack mentioned, about the CON in other states, and that may be something for us to look at. But also -- and I want to be consistent -- I have a major problem -- and I will state it publicly. I have a major problem that this site of service seems not to treat minorities and not to treat dual eligibles equitably. And I also have a major concern about that. So I'll support the recommendation as the rest of my colleagues, but it's still a major concern for me.

DR. NAYLOR: I support the recommendation.

MS. UCCELLO: I support the recommendation. I had been originally torn between the half percent and the zero,

but the more I've thought about it over the past month, I now strongly support the zero for the reasons that all of my colleagues have stated.

DR. HALL: I also support the recommendation, without prejudice against the concept of an ambulatory surgical center, which I think has a very important role in the medical care system, but without the cost data it is never going to reach its full potential.

DR. DEAN: Yeah, I support the recommendation.

DR. CHERNEW: I support the recommendation.

MR. HACKBARTH: Just one further thought on this issue of collecting cost data, which I know many people in the industry have reservations about. And I don't have any illusions that anything I'm about to say will resolve those reservations, but I did want to explain how I think about this.

I do, as Ariel described, think that there are ways to approach this that can reduce the administrative burden, and so what I have in mind is not, oh, we need full-blown mega cost reports for this.

I do think it's a very relevant piece of information going forward, particularly in this sort of

instance. Part of what is happening here is that there are changes in patient care, changes in anesthesiology, changes in surgical practice and the like, that quite appropriately are encouraging movement of some services out of higher-cost settings, including inpatient care, into ambulatory surgery in ASCs as well as hospital outpatient departments. So this is a real movement, and like Craig, I don't want to impede that. I want to encourage movement of things to lower-cost settings.

But because of that development, I think what it means is that we are likely to see year after year rapid growth in ASCs. Some years it might be a little faster than others, but there are a lot of forces pushing in that direction. In addition to the technological and patient care aspects, patients like it. When I ran a physicians group, my surgical colleagues liked it. It made their practice life more efficient and better. These are all important developments that mean that ASC involvement in our health care system is not a bad thing but a good thing, and we'll push things in that direction.

Now, if we at MedPAC apply our usual payment adequacy framework and we don't have any cost information,

we will see growth, and in general, when we see a lot of growth, we tend to react, well, maybe the rates could be lower and push down. Absent any cost data, there's no check on that impulse. I actually think it's probably in the interest of the industry to agree to a streamlined form of cost reporting so we have some check and know when that pushing has potentially gone too far and gotten to the point that it will retard a development, a movement of services that is otherwise appropriate. But without any cost information, growth generally is going to mean push the rates down, and that's a skewed picture, and I'd like the industry's help in trying to get a more complete picture of what's going on with ASCs. So that's my plea.

With that, it's time to turn to the recommendation which is on the screen. All in favor of the recommendation, please raise your hand?

[Show of hands.]

MR. HACKBARTH: Opposed?

[No response.]

MR. HACKBARTH: Abstentions?

[No response.]

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

job.

[Pause.]

MR. HACKBARTH: So now we're moving on to outpatient dialysis services.

MS. RAY: Good afternoon. Today's presentation on assessing the payment adequacy of outpatient dialysis services consists of three sections. First I'm going to try to answer some questions that Commissioners raised at the December meeting. Then I'm going to summarize the indicators of payment adequacy that we discussed in detail at the December meeting. Lastly, I will present the draft recommendation for you to discuss and vote on.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2011, there were about 365,000 Medicare fee-for-service dialysis patients, roughly 5,600 dialysis facilities. Medicare spending in 2011 was about $10.1 billion.

Bill Hall, you asked a question at the December meeting about the demographics of new dialysis patients. We have included in the briefing materials a table providing the rate of new cases by age, gender, and race. Between 2000 and 2010, new cases grew the fastest among individuals

85 years and older.

Rita, per your request, we have added references concerning the finding that researchers have shown that early initiation of dialysis was not shown to be associated with improved survival or clinical outcomes. These references include the 2010 publication of the randomized clinical trial named IDEAL.

Cori and Rita, you asked that we strengthen the language concerning the low-volume adjustment. The text now states that only low-volume facilities that are necessary to maintain access in isolated areas should receive enhanced payment. We intend to revisit this issue on the low-volume adjustment once we have obtained and analyzed 2011 volume and cost per treatment information from facilities' 2011 cost reports.

Peter, per your request, we have added a reference to our finding about dialysis patients' relatively high use of non-emergency ambulance services. The new law -- the American Taxpayer Relief Act of 2012 -- reduces the fee schedule payment amount for this service by 10 percent effective October 1, 2013.

Herb, you asked about the comorbidity adjuster

under the modernized payment method. To briefly review, CMS designated three acute and three chronic comorbidities -- and these are listed on the slide -- as beneficiary payment adjusters. These comorbidities were selected based on a statistically significant relationship between the presence of the comorbidity and cost. Industry representatives contend that facilities lack sufficient documentation to claim the adjusters. Industry representatives also contend that they incur high labor costs to obtain the necessary documentation to bill for these adjusters. They incur high labor costs to obtain the necessary documentation from the providers -- hospitals and specialists -- who typically diagnose these conditions.

So to begin to look at this issue and to begin to address the question about whether facilities are reporting comorbidities on the bills they submit to Medicare, we used 2011 claims submitted by dialysis facilities that elected to be paid under the new payment method. We determined the prevalence, the percent of patients that facilities billed for each of these six conditions.

Our analysis suggests that reporting in 2011 has improved compared to prior years, specifically older

analyses, one published by the industry, that used 2008 data. And this suggests that reporting improves once it is linked to payment.

We think that this is an issue to stay on top of. We will monitor this issue next year by comparing 2012 reporting to 2011 reporting. Also, the new law, the Taxpayer Relief Act, calls for the Secretary to conduct an analysis of the case-mix adjusters by January 1, 2016, and to make appropriate revision.

So now I'm going to move to the second part of the presentation -- a summary of the payment adequacy indicators. You've seen most of this material in December. And I'm also going to be addressing a few more questions that Commissioners asked in December.

Regarding providers' capacity, growth in the number dialysis treatment stations has kept pace with the growth in the number of dialysis patients.

Regarding access, we looked at the effect of facility closures on beneficiary access. There were few facility closures -- roughly 90 -- in 2010, and few patients were affected by these closures -- about 1 percent, or about 3,800 dialysis patients. We found that African Americans,

compared to whites, were more likely to be treated in a closed facility. Available evidence suggests that they continued to receive access at other facilities.

Herb, in answer to your December question, we found that rural facilities did not close disproportionately. Rural facilities represented 21 percent of closed facilities and 22 percent of all facilities.

Looking at the volume of services, between 2009 and 2011, growth in the number of treatments matches growth in the number of patients.

We also looked at volume changes in the use of dialysis injectable drugs, an important component of dialysis care. We have updated our analysis that now measures volume on a per treatment basis. We did this because the unit of payment is per treatment. We looked at changes in per treatment volume for ESAs, injectable iron, and vitamin D agents in 2007, the year CMS used to set the 2011 base payment rate; 2010, the year prior to the new payment method; and 2011, the first year of the new payment method.

We measured use by multiplying the number of units of the drug administered by the average 2011 average sales

price for that drug. We found that most of the decline occurred between 2010 and 2011, the first year of the new payment method.

We also found that ESAs accounted for most of the decline partly because it accounted for most of the drug utilization under the prior payment method.

Regarding quality, since implementation of the new PPS, mortality hospitalization and emergency department use, while high, have remained steady. As I just discussed, between 2010 and 2011, per treatment use of the drugs used to manage anemia, ESAs and injectable iron, declined. We also see a change between 2010 and 2011 in anemia outcomes. There is an increase in the proportion of beneficiaries with a low hemoglobin level, and the rate of blood transfusions has modestly increased.

Tom, you asked about the variation in low hemoglobin levels. We obtained 2010 and 2011 data on the regional variation in low hemoglobin levels across the 18 ESRD networks. In 2011, a greater proportion of patients had lower hemoglobin levels than in 2010, but the spread or the variation in both years was about the same, 5 to 6 percentage points.

Regarding access to capital, indicators suggest it is adequate, including growth in large and mid-sized chains.

The Medicare margins for outpatient dialysis services: the 2011 Medicare margin is estimated at 2 to 3 percent, and the 2014 margin is projected at 3 to 4 percent.

I cannot give you the distribution of 2011 margins because we lack 2011 cost report data. But in past years, the Medicare margin has been greater for the two large dialysis providers versus other facilities; has been greater for urban versus rural facilities; and greater for high-volume facilities versus low-volume ones.

The margins on the slide reflect payment updates in law and the effect of the ESRD quality incentive program. However, the margins do not reflect the change in payment policy under the recently passed American Taxpayer Relief Act of 2012.

With respect to the outpatient dialysis payment rate, the new law mandates that the Secretary rebase the dialysis payment rate effective 2014 based on changes between 2007 and 2012 in the utilization of ESAs, other drugs and biologicals, and diagnostic laboratory tests.

It also requires that the Secretary delay the

inclusion of the oral-only Part D ESRD-related drugs into the payment bundle until 2016.

Given that most of our payment adequacy indicators are positive, that providers have realized efficiencies under the modernized payment method, particularly in the use of dialysis injectable drugs, and that nearly all providers (93 percent) elected to be paid under the new payment method, our draft recommendation reads that the Congress should not increase the outpatient dialysis bundled payment rate in 2014.

This recommendation is the same as the recommendation you saw in December. There is a slight change in the language for technical reasons, but the intent is the same.

Regarding spending, this recommendation increases spending relative to current law by between $50 million and $250 million over one year and by less than $1 billion over five years. Although our recommendation has not changed between December and January, there is a change in the recommendation's budgetary implications, like you saw with the hospital update this morning, from savings to increasing Medicare outlays relative to current law. This change

occurred because of the Taxpayer Relief Act.

Our draft recommendation holds the 2014 payment rate at the 2013 level. The Taxpayer Relief Act requires that the Secretary rebase the 2014 payment rate, and then MIPPA requires that the Secretary update the payment rate.

We intend to discuss rebasing with you once we have obtained and analyzed the 2011 dialysis cost reports.

Regarding implications of this draft recommendation for beneficiaries and providers, no adverse impact on beneficiaries' access to dialysis services or providers' willingness and ability to care for beneficiaries is expected.

MR. HACKBARTH: Okay. Thank you, Nancy.

So as Nancy indicated, this is another one of those instances where the Taxpayer Relief Act switched a recommendation from being one that saved money in December when we discussed it to now one that would add to Medicare spending based on the revised baseline.

At our December meeting, we took note of the change in the use of dialysis-related drugs, especially the ESAs and, based at least in part on that change in behavior, decided that no increase in the base rate was appropriate.

So hold the rate constant.

Congress, looking at the same information, concluded that it wanted to go a step further and begin reducing the base rate to reflect this change in the pattern of care.

I feel comfortable with where we were in December given that this change in the pattern of care is relatively recent, and given that I think we need some more time to assess both its financial and clinical implications for patients, that the prudent thing to do is to hold the rates constant as opposed to move quickly to reducing the rates. It's not that I'm against rebasing in principle. I have been a strong proponent of rebasing rates in other sectors -- home health and skilled nursing facilities included -- but that was only after years' worth of evidence that the payments were out of line with the cost of care delivery. Here, in the case of dialysis, we are in the midst of an unfolding development, and my belief is that the prudent course is to hold rates constant while we allow events to unfold a bit.

So, Cori, do you want to go first?

MS. UCCELLO: Sure. This is a great chapter. I

do have a question on Table 4, which is on page 24 of the paper. I'm not sure if I'm just misinterpreting how this is supposed to be, but the anemia measures for the peritoneal dialysis, except for 2011, they don't add up to 100. And I don't know what's going on there.

MS. RAY: You know, I noticed this after the paper went out, that there's a line skip, and I can show you the numbers after the meeting.

MS. UCCELLO: Okay.

MS. RAY: I apologize for that.

MS. UCCELLO: I'm glad it's not me going crazy, at least not for that reason.

MR. HACKBARTH: Actuaries, they look to see that all the numbers add up.

DR. MARK MILLER: We purposely put one in every set of papers to keep you occupied for half a day.

[Laughter.]

MS. UCCELLO: What's going on? I think I can add. Where am I? So --

MR. HACKBARTH: MedPAC.

[Laughter.]

MS. UCCELLO: I support the recommendation, and I

think we do just need to keep an eye on these quality measures, even with our kind of zero update, and especially if that rebasing occurs, this is something that we need to keep our eyes on.

DR. HALL: I don't have any comments. I am in favor of where we are at the present time. I think I'll skip any other comments right now.

DR. DEAN: I support the recommendation. I wonder -- it struck me, the report, that the greatest growth rate in new patients is among those 85 and older. I wonder if we really are adequately informing patients as to the options, and this would be, I think, one of the ideal places where the whole shared decisionmaking concept would apply. And are patients really understanding, first of all, what they're signing up for and what their options are and so forth? I don't have an answer, but it does strike me that I really wonder if that's -- that's something that I think needs some review.

DR. CHERNEW: I support the recommendation, and I think it raises a broader question that's worthy of more thought. Specifically, if we move to worlds where there's bigger bundles and we're paying not for specific service,

for bundles, we need to think about what it means to update or not update in that world where there's a lot of utilization changes going on and how quickly we think CMS should recoup what seem like apparent efficiencies or pay more, be more volume. What will change the profitability in a bundled world is not just price but also these utilization things. And so I think in this particular case, it's prudent to wait, and I don't think we want to set a precedent that every time it looks like we're paying a little bit more, CMS is going to pull it back. On the other hand, the only way you save money in a world of bundles is if eventually CMS does change the rate. So I do believe when there's the right information, we should do that.

So I think this is just exemplary of something that I hope will be a longer discussion in more areas.

MR. BUTLER: So thank you for responding to my ambulance issue, and Congress did something, a little bit. And then I looked at the CBO scoring, and the savings occur in 2019, is when the reduction in the ambulance occurs. It's six years from now. So, well, what the heck? We can try.

But I do have a question. Okay. This is -- I

don't mean to make light of these payment rates because they're important to the people that are involved. But I'm a little unclear, similarly, in going to this rebasing in 2014, the scoring of this and the act kind of ramps this thing up. So it's only something like $200 million in 2014, and it goes up to $700 million per year in the out-years. So is there -- I was led to believe this was, you know, rebased right away. But this looks like a phase-in of -- or do we just not know? It kind of affects a little bit our own position. It looks like there could be some time to make some adjustments. But do you know more how that works and ramps up?

MS. RAY: Well, what more I can tell you is that that score that you're referring to refers to the provision of rebasing as well as delaying the inclusion of the oral-only Part D drugs in the bundle. So those drugs are going to remain in Part D for 2014 and 2015, so that probably accounts for the --

MR. BUTLER: And because these are calendar years and there's also a fiscal year, you get a bump-up in --

MS. RAY: Yes, exactly. In 2016.

MR. BUTLER: I got you

DR. MARK MILLER: It's an extra provision, and what we're still a little bit hazy on is, you know, the Commission is saying the payment rates from year one to year two should remain flat. The Congress seems to have rebased but given an update. And exactly where those two numbers fall -- you know, we're working as best we can with CBO to get an estimate, but exactly how that rebasing works in the end, just the rebasing part, is a little bit hazy to us. And then we think those numbers get bigger in the out-years because of the delay in blending in the Ds. So a different provision.

And one quick commercial. Because I want you guys to be sure that you know we listen to you, next month I think we're coming to shared decisionmaking. I'm not sure we'll be directly on point to your question, but we will get that -- we will, in fact, be directly on point in your question. I'm getting a nod. So just so you know, we do listen, and that will happen next month.

MR. BUTLER: And then one other sales pitch. As we struggle with wanting to -- sometimes we criticize Congress for not listening to us, and sometimes we don't give them very precise recommendations. I think there are

lessons to learn about what kinds of things really work and are easily transferable so that we can be most helpful as possible. We always should continue to kind of think of is this one you could just lift up and pretty easily put in or not. And I think we probably could do better in some cases. I'm not suggesting this is one of those areas. It's just a general statement.

DR. NERENZ: Looking at it, I'm okay with the recommendation for now, but I think this represents a really attractive call it "niche area" if we're looking at some expanded bundles. In thinking about that, I'm struck by a couple of features in Table 4, particularly the high admission rate, but also the remarkably high readmission rate in this population. I am under the impression that there are some things that can be done in the outpatient setting that can prevent either the index admission or the readmission, which seems to create the possibility of one of two things. One would be to actually intentionally enhance the payment for this unit of bundling to specifically support services in the outpatient arena that would have the effect of reducing admission or readmission. I appreciate that some other proposals like this have bad track records

in practice, but this might be one place where that would work. Or then the alternative would be expand the bundle to include something like a month's worth of total care to those entities willing to step up and accept that responsibility so that, again, they could invest in the services in the one setting designed to reduce the utilization in the more expensive setting. I think this is an area where I think those dynamics may really work out.

MR. HACKBARTH: I agree with all that, and you'll remember that one of the indications for which we thought C-SNPs ought to continue was ESRD for just this reason. It creates that sort of format.

DR. REDBERG: I support the recommendation, and I also agree with the idea of looking at shared decisionmaking. I note, you know, besides 85-plus, if you look at the mortality rates in Table 4 on page 25, the mortality rate in the 75-plus is 36 percent, which is quite high, and I think we could certainly do better at informing our patients about what their choices are, because, again, you know, looking at quality and cost, we spend more on dialysis in the U.S. than anywhere else in the world. Our mortality rates are the highest of anywhere else in the

world for our end-stage renal dialysis patients, and I think we could be doing a lot better for our patients with this program.

I also was interested -- we had talked and you had -- and thank you also for answering the questions from last time, and the chapter was excellent. I'm just wondering -- we did talk a little bit about it last time -- if we have this breakdown also by type of dialysis, particularly if we're looking at bundled payments, because peritoneal dialysis, if the mortality rates are different and some of the other -- and whether the volume trends were the same for PD as it was for hemodialysis.

MS. RAY: The volume changes in drugs?

DR. REDBERG: The volume changes in drugs.

MS. RAY: By modality? That I was not able to do between last month's meeting and this month's meeting, but moving forward, we can definitely look into that.

DR. REDBERG: Thank you.

MS. RAY: What I do want to mention, though, is what we do report in the paper and what others have reported is the slight uptick in the use of peritoneal dialysis under the payment bundle. Traditionally, the use of dialysis

drugs has been lower for peritoneal dialysis patients, but I just don't know about the volume changes between 2010 and 2011. But we will put that on our research agenda for next year.

DR. REDBERG: Thank you.

DR. BAICKER: I support the recommendation and echo Mike and Dave's points that this is a prime are for both changing the bundle amount and for trying to make a broader bundle going forward, but that that's a future step.

DR. COOMBS: I support the recommendation and I think it's an opportunity. As I listened to Tom, I was thinking about my practice recently in the ICU when I did a couple of days ago. I know for a fact that when you have a patient who comes in who has an established relationship, a medical home, and really is tied into an integrated system -- it's not necessarily in the hospital -- that it does make a difference with the decisionmaking capacity of the family and the patient in that scenario.

And I think we're talking about -- we're at 10,000 feet talking about dialysis but the real decisionmaking actually comes at the house or on the way to the hospital long before they get to the dialysis suite.

DR. HALL: I support the recommendation.

DR. HOADLEY: I support the recommendation. Thank you for a really nice chapter.

Do I take it from the earlier dialogue that we don't have the ability to say what the implications of the new legislation are, in terms of a percent change in payments to compare direct -- sort of apples to apples -- with our zero?

MS. RAY: The only thing that I have is the CBO score and in the first year that's $200 million.

DR. HOADLEY: Is there any way to make that as a percent -- can you express that as a percentage?

DR. MARK MILLER: Just as long as we're really clear about this....

DR. HOADLEY: Yeah, yeah.

DR. MARK MILLER: I think that translates into about 2 percent of payments. But I would not want anyone to carry out of here is whether that's what's happening with the base rate amount. We are a bit unclear on that. Okay?

DR. HOADLEY: Okay. But just as at least a magnitude -- somewhere in a very rough magnitude.

DR. MARK MILLER: Now here's what's going to

happen. It's going to be in the press that MedPAC said. And I'm coming to your house to answer the question.

[Laughter.]

DR. HOADLEY: And I know there was a GAO report on the rebasing issue. Is there anything in there that is interesting, different than any of the stuff that you've been reporting on?

MS. RAY: GAO found, looking at those three drug classes, about a 23 percent decline between 2007 and 2011. My finding was very consistent, in about a 25 percent drop. So we were very, very close.

They did give an estimate, but that would be based on 2011, of if it was rebased in 2011 what that potential change could be. Again, this is according to GAO and this is based on 2011. If you rebase the 2011 payment rate based on the changes between 2007 and 2011, it would be more on the order of $600 million upwards to $800 million, depending upon the time period -- the exact utilization data that you used.

DR. SAMITT: Great job. Thank you.

I support the recommendation. I'd echo some of the sentiments of others. I'd be curious in understanding

to what degree alternative care protocols or innovation is happening in this space. I'd be interested in understanding whether the ESRD C-SNPs or whether the pioneer ACOs or the shared savings groups are trying anything new or different as it pertains to shared decisionmaking or alternative regiments for ESRD. Maybe we'll learn some things that can help us change recommendations in the future.

And then not to lose, and I think we've echoed it as well, broadening a bundle to include non-emergent transport as part of a bundle, I think may lead to some savings and creativity in transportation for ESRD patients.

MR. KUHN: Thanks, Nancy, for the additional information on the adjustment for comorbidities. I appreciate that, and I support the recommendation.

MR. GEORGE MILLER: Yes, I'll first say it's an outstanding paper, and I really enjoyed the reading. And I greatly appreciate the information on the trends in kidney transportation, and that information was very good reading and I appreciate it.

With that said, I'm still a little bit troubled by the disproportionate of minorities, especially African-Americans, with ESRD and then the relationship with getting

kidney transplants. Again, the information certainly helped me understand a little bit better.

But part of that analysis is patient education and physician referral and physician education, and where that particular person is placed on the waiting list.

Some of the issues related -- and it's just not the allocation with either live kidney or cadaver placements. There's a whole bundle of issues.

So I would hope we spend a little more time talking about that and possibly, as a policy goal, make sure we try to increase that, particularly because of the disparity in the transplants.

But I do support the policy. I am a little concerned also, as my other colleagues had mentioned, about the 85-plus population being the fastest growing population and wondering if that's the best use of our resources. I think there are things that Rita mentioned today and last month concerning this service line is important to take in consideration, that we spend more money for this in the world, and the mortality rates are horrible. We need to spend a little more -- I think we need to spend a little more time looking at this and wondering if this is the best

use of dollars, understanding what that could mean by making that statement. But it's still something that we should look at to make sure quality is there.

Quality cannot be there if the mortality rate is where it is currently. We certainly should have a healthy discussion about that but I do support the recommendations. And again, I appreciate the staff's work on this. It was a very good paper.

DR. NAYLOR: Briefly let me just echo everyone's comments. This is an outstanding report. Thank you.

The most recent information reinforced how it should and will inform, I think, conversations not just about shared decisionmaking but when you have a little bit over 25 percent of current users 75 and older, about palliative and other kinds of alternative services.

Thank you, Tom, for starting that conversation.

Building a little bit on David's comment, hospitalization rates have, are still really, really high.

What's interesting is looking at the readmission rate for 30 days and to wonder, as we go forward, maybe we should be looking at 31 readmission rates for all of our problems to see how things are going after the 30 days.

MR. HACKBARTH: Time to vote.

DR. DEAN: I think, just to clarify this, because the concern about age-related issues can easily be misinterpreted in the same vein that Mark has raised a couple of times.

This is not a rationing issue. It's not an issue of shutting off services because someone reaches a certain age. This is a quality of life issue, because dialysis is a stress.

So I guess, just to make that absolutely clear, what we're really looking for is what's best for that patient and it may not be dialysis.

MR. HACKBARTH: And I take it from your earlier comment, which focused on shared decisionmaking, the idea is to make sure that the patient understands and can make a decision based on their own values.

DR. DEAN: What we're really trying to do is what's best for the patient and that they understand what's coming. And that's the worry.

MR. HACKBARTH: Yes, thanks for the clarification.

DR. REDBERG: Absolutely, I agree. I just think that we shouldn't be offering this to patients without

telling them what it does mean. Because it is quite a stress, and I think that is what's happening now. I don't think patients understand what it means to get a shunt in, to spend four hours a day in a dialysis center, to have the high mortality rate, and what the trade-offs are.

And if someone chooses that, we should definitely offer it, obviously.

DR. DEAN: In my case, it's also a 50-mile trip to the unit.

DR. HALL: Glenn, I'm sorry, one more comment.

A substantial portion of these patients really are not even capable of making decisions when they are put on dialysis, they are demented. And the offer of dialysis comes to a family who sees a free service being offered that is high tech.

And so again, it's more a question of functionality that should always determine our decisions in the very elderly on Medicare, as opposed to chronologic age.

MR. HACKBARTH: Okay, so it's time to vote on the draft recommendation. All in favor of the recommendation, please raise your hand?

[Show of hands.]

MR. HACKBARTH: Opposed to the recommendation.

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Okay, thank you very much. Good job, Nancy.

We will now move on to home health.

MR. CHRISTMAN: Good afternoon. Now we will review the framework as it relates to home health.

As a reminder, here is our framework. It is the same one other sectors have followed in earlier presentations. I am going to briefly review the adequacy data we presented in December and then cover some items of interest raised by the Commissioners.

Medicare spent about $18 billion on home health services in 2011. The program provided about 6.9 million episodes to 3.4 million beneficiaries.

Here is a summary of the indicators we presented in December. The supply of providers is at an all-time high. Virtually all beneficiaries live in an area served by home health, and there are over 12,000 providers in 2011. The number of episodes has grown by about two-thirds in 2002

through 2011, though I would note that after many years of rapid growth, episode volume was flat in 2011 compared to the prior year.

Access to capital is a less critical item in this sector because the capital needs are lower. However, our discussion with financial analysts indicate that access is adequate for publicly traded companies. The continued entry of new providers -- over 700 in 2011 -- indicates that new agencies are able to find start-up funds.

The functional measures of quality were either steady or showed small improvement in 2011, consistent with our results from prior years. The margins for 2011 were 14.8 percent. We project margins of 11.8 percent in 2013. The reductions in margins occur because CMS implemented payment reductions in 2012 and 2013.

Based on these factors, payments for home health agencies appear to be more than adequate.

This slide underscores how our result for 2011 are similar to prior years. The margins for home health have been very high since PPS was implemented and have been about 15 percent or more for the entire period. These consistently high margins underscore the need for

significant reductions in home health payment levels.

This year, we are also examining the performance of relatively efficient home health agencies compared to other agencies, and you asked for more information about this. To review, we identified relatively efficient home health agencies by examining costs and quality for a three-year period. Agencies were classified as relatively efficient if they were consistently in the top third of at least one of these measures in each of the three years and not in the bottom third on the other measure. We examined margins only for freestanding agencies in this analysis. About 14 percent of the agencies in our sample met the criteria. Relatively efficient providers had lower costs, were typically larger in size, and had lower hospitalization rates. Relatively efficient providers had a lower share of community-admitted episodes and they also tended to be located in the Western part of the country and the Northeast and occurred less frequently in the Southeast and Southwest.

Mary also asked about the financial performance of agencies on a couple of different metrics, including the share of episodes they provided that qualified for additional therapy payments, the share of episodes provided

to dual eligibles, and the share provided to community-admitted patients. Consistent with prior analysis presented to the Commission, agencies with more therapy episodes had higher margins in 2010. This imbalance has been an issue for several years and was a key motivation for the Commission's 2011 recommendation to revise the case mix. I would note that CMS implemented changes to the case mix in 2012 that would likely even out the margins between agencies with high and low amounts of therapy, so the spread would likely be smaller in 2012 and later years.

For share of an agency's episodes provided to dual eligibles and share of an agency's episodes provided to community-admitted patients, we had the same result. Agencies with very high shares of these types of episodes -- in the fifth quintile -- had relatively low margins of 14 percent. Agencies in the first through fourth quintiles had similar margins of around 19 percent.

It is not clear why agencies in the very high share group of these two measures would do worse, but one common factor is that a significant number of agencies in the high group of both these measures came from Texas. As I will explain on the next few slides, Texas has higher

utilization and lower Medicare margins than other areas. Factors unique to the market in this State may account for the lower margins observed in these two groups.

George and others asked about the geographic concentration in the use of home health. This slide shows how utilization compares between the top five States in utilization -- Florida, Louisiana, Mississippi, Oklahoma, and Texas -- and the rest of the country. This table shows the utilization in the top five States is double and sometimes triple the rate of utilization in the other States. This is true for both urban and rural areas. Within the top five States, the rate for rural is actually higher than the urban utilization.

George, you also asked how much lower spending would be if utilization could be brought down in high-spending counties. We noted in the paper that capping utilization in the top 25 counties so that it did not exceed 18.5 episodes per 100 beneficiaries, or the 75th percentile of this distribution, would reduce spending by about $840 million and eliminate about 300,000 episodes.

Commissioners also asked about the Medicare margins for agencies in areas that had high utilization,

speculating whether providers in these areas are a factor in the high overall margins we observed. Our review of the margins for the five highest utilization States indicated that this was not the case, that agencies in these areas actually had lower margins by about four to five percentage points. As a result, Medicare margins would be slightly higher if we excluded agencies in these areas from our analysis.

In the past, we had noted that rural utilization is very high in many areas, and in some cases, as seen in the slide earlier, it eclipses urban utilization. The higher utilization in many rural areas undermines the efficiency of a rural add-on Medicare PACE for home health, a point Tom raised at the last meeting. Recall that the rural add-on is a per episode bonus payment. As a result, the total add-on payment a rural area accumulates is proportionate to its utilization. Areas with higher utilization will accumulate more add-on payments while areas with lower utilization have comparatively lower total add-on payments.

This next table shows how this results in a poorly targeted add-on, with higher utilization areas receiving the

bulk of add-on payments. The rural counties in the top two quintiles, shown in orange, are the top 40 percent of home health utilization. They accounted for 71 percent of the episodes that qualified for the rural add-on. These counties averaged utilization of 28 episodes per 100 beneficiaries compared to the national average of 17.5.

Rural counties in the bottom two quintiles, shown in yellow, or the bottom 40 percent, accounted for 16 percent of the episodes that received the add-on. Most of the add-on payments go to areas that have relatively high home health utilization. Paying more in high-utilization areas likely does little to improve access and more targeted policies might be appropriate.

Several Commissioners expressed concern that a reduction in payment or decline in supply of home health agencies could hinder their ability to participate in new models of care. While the history of this benefit suggests that home health agencies can retool quickly when reimbursement changes, I would note that Medicare also covers services in the home under the Part B benefit, and this is an alternative to provide care in the home under fee-for-service. The fee schedule covers many similar

services, such as evaluation and management, physical therapy, and counseling. In fact, the fee schedule payments for services in the home are often lower than the comparable home health payment, though there are some structural differences between the two services that account for at least some of the differences.

A good example is physical therapy. Part B pays about $87 for a 45-minute therapy visit in the home. The comparable payment under the home health PPS would be about $187. Some of this difference is due to the unique requirements of the home health benefit, but certainly the fact that Medicare pays significantly more than cost for home health services contributes to this disparity.

The Chairman has proposed that next year's report reprint the recommendation approved for the March 2011 report, when we made several multi-year recommendations for changes to home health. The recommendation reads: The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2013 and eliminate the market basket increase in 2012.

This would reduce spending by $750 million to $2 billion in 2014 and $5 to $10 billion over five years. We

expect some contraction in supply, but the remaining supply should be adequate to provide adequate access to care.

Mary also asked for an analysis of the attributes of patients that use home health for post-acute care compared to those who use it primarily after being admitted from the community. This first slide shows how home health utilization breaks down between the two groups. The bar on the left shows the number of users in each group, and the bar on the right shows the episodes that corresponded with each group. Community-admitted users account for about half of all home health patients, but almost two-thirds of episodes. Community-admitted users average 2.6 episodes per user, while post-acute care users averaged 1.4 episodes per user.

We also examined the demographic and clinical characteristics of these two groups. Community-admitted users had fewer chronic conditions but had higher levels of dementia, were older, more likely to be minority, more likely to be dual eligible, and needed more assistance with activities of daily living. These factors, combined with the longer lengths of stay these beneficiaries have in home health, suggest that the benefit may, at least in part, be

serving as a long-term care benefit for this population.

Several Commissioners also asked about new models of care that agencies could participate in, and PPACA includes several. The first two, bundled payment for care improvement and care transitions, test different approaches to improving post-acute care. Agencies may participate in these models to help beneficiaries return home after a hospitalization. The Independence at Home model is focused on physician home care practices, effectively allowing them to act as medical homes for frail beneficiaries. Home health agencies frequently work with home care physicians to serve these beneficiaries and home health will likely be involved in the other reforms underway, such as ACOs and medical homes, particularly for models that seek to improve care transitions after a hospital stay or to improve care for community-dwelling frail elderly.

This completes my presentation. I hope you found this additional information useful. Let me know if you have any questions.

MR. HACKBARTH: Okay. Thank you, Evan.

Before we turn to the home health discussion, Alice, I just need to officially record your vote on the

dialysis update.

DR. COOMBS: [Off microphone.] Yes.

MR. HACKBARTH: Yes. Okay. Thank you.

So now, turning to home health, for people in the audience, there are several instances where we are not voting on new recommendations, home health being one of those. Another is skilled nursing facilities and still another is payment to physicians and other health professionals. The reason that we're not having separate votes on those items is that the Commission has previously made multi-year recommendations in each of those areas and we still stand by those previous recommendations.

In the case of home health, unlike SNF, we are having a discussion of the issue again today because, as Evan just indicated in his presentation, there were a number of outstanding questions that Commissioners had asked at the December meeting, and so we wanted to follow up and provide answers to those questions. In the case of SNF, we didn't have any of those outstanding questions and that's why there's no separate presentation on SNF.

So with that background, Rita, do you want to begin. And again, I think we'll just do one round.

DR. REDBERG: Sure. I support the recommendation and I was struck by the difference in the payment between the home health and the Part B benefit and certainly think we would want to come back to that in the future. Thank you.

MR. HACKBARTH: Kate.

DR. BAICKER: I support reprinting the previous recommendation and note that, in some instances, home health seems like a lens for a lot of the other issues we've talked about in terms of similar payments for similar services and ensuring that the services are delivered in the venue that best matches the patients' needs, to provide high-value, high-quality care. And in some instances, home health seems a little different from other services in that we think it's probably more price elastic than some other services, and so that, even applying the same principles to home health, in some instances pushes us toward slightly different policies. So all of that is for the longer-run thinking about how we think the principles we're discussing are going to manifest here. The recommendation, as is, seems good to me.

DR. COOMBS: I support the recommendations. And not too -- maybe not too far off in the future, this will be

incorporated in some robust health care system and we won't be having this discussion, hopefully.

MR. GRADISON: I support the recommendations and want to thank the staff for such comprehensive response to the questions that were asked earlier. Thank you.

DR. HOADLEY: Yeah. I'm supportive of the approach we're taking, using the old recommendations. Again, I think it's a good chapter.

DR. SAMITT: I support the recommendations, as well.

MR. KUHN: I, too, support the recommendations, and Evan, I want to thank you for that information you had on kind of the high five State utilization. And I think, just in the future, that's something for us to continue to look at, that data, because it might give us an opportunity for future recommendations, maybe for even more precise refinements to recommendations to get at real serious issues out there.

Also, I appreciated the response to Mary's question, the information you had on terms of community-admitted home health users, and particularly Slide 15, where you talked about the benefit is really starting to look

more, for that population, a little bit more like a long-term care benefit instead of a home health benefit. And given the improvement standard settlement case that we've talked a great deal about here, I think this is also one in the future that we need to monitor very closely, but not only monitor the overall utilization, but also geographically how it's implemented, because I have a suspicion that as CMS, with the 15 different Medicare administrative contractors, we could see variation across the country, and does this correlate with high-utilization States and will we see real spikes in some of those States even further.

So, again, I think these two issues kind of knit together very nicely for future analysis and review.

MR. GEORGE MILLER: Yeah. I also support the recommendation and also want to thank Evan for the information that I requested on the high-end users -- I'll use that term.

I think we also, particularly because of that information, make a strong statement about the integrity of the program and either recommend that the Secretary take action to deal with high utilization areas that have been

identified in documentation, whether to use her powers for freezing or not approving any more payments or whatever is at her disposal in addition to our recommendations.

DR. NAYLOR: So, Evan, I hope I didn't ruin your holiday, but anyway, thank you. I really do appreciate. I saw my name attached to many of these and --

MR. HACKBARTH: [Off microphone.]

[Off microphone.]

DR. NAYLOR: I do think it paints a really -- I mean, this new chapter, these revisions, paint a really interesting picture with a dramatic rise in one type of user and a shrinking of another when this was established as a post-acute service. So I really, really appreciate the attention. I also think, in many ways, it reinforces the recommendations, especially those that are really talking about cost sharing for community-based episodes and not for post-acute. Anyway, so I really, really appreciate all of the extra effort. I also think this is exactly the kind of information we need to move forward with this and I support the recommendation.

MS. UCCELLO: I, too, support the recommendation, and Herb mentioned the court settlement. I think that

really increases the urgency of the rebasing and making sure that we get these payments right.

I have a question regarding those high-utilization States. Do we know whether perhaps they have more agencies that are smaller?

MR. CHRISTMAN: We haven't looked at that issue precisely, but that is -- all of the data points to that situation, particularly when we saw the results for that fifth quintile group I talked about a bit. You know, Texas has added -- I think the number of -- it had a thousand agencies or so at the beginning of the last decade and then that doubled. It added a thousand agencies. And so there's been a huge influx in supply and in our -- we could look at that a little bit, but the thesis is that those agencies are small. They don't build scale. And they have lower margins.

MS. UCCELLO: Right, and so that's what I was going to say. That's why there seems to be the lower margin.

DR. HALL: So I'm also in favor of the previous recommendations, but I'm also a fan of home health care, if used properly. But an enterprise that has this high a

margin and also has the regional and geographic discrepancies cries out for continued scrutiny. So I learned a great deal from this analysis. I thank you for that.

DR. DEAN: Yeah. I certainly support the recommendation. As Bill just said, these are just very interesting data that some of the industry folks have provided about how the discrepancy or the wide variation in utilization. I think it is frustrating because we know that this is potentially -- I shouldn't say potentially -- is a very valuable service. We also know that it's overused in settings. We also know there's probably fraud and abuse. And I think a lot of that, the problem is that we have not done a very good job in defining what really the indications for the benefit are. And that may be -- that's very difficult. In fact, it may be impossible to write it, at least in a regulatory way.

And I was very struck -- it's too bad Scott isn't here because I think his perspective on this is extremely useful, and I remember him saying that in his program, they look at this very differently. They see home health as a cost saver. We are continually concerned about all the

extra resources it's consuming. And I think it argues very strongly for the fact I don't know that we can deal with any of these problems looking at home health as an isolated entity. It's got to be part of a broader system and it argues very strongly for an integrated system, and I think that's probably the only way that we'll get to an answer for this kind of a problem, because it's -- well, I'll stop there.

DR. CHERNEW: So, I support the recommendation and I support everything that Tom just said. And I think home health is just a very good example of the areas where there's underuse, overuse. We only have one tool we typically talk about. There's a few others, but mostly, the discussion is largely about payment and that's not a good enough tool to deal with the heterogeneity geographically within different organizations, even in the same place, and I think we have to resist the urge to think about the unit as, say, we're going to do this in Texas or we're going to do -- because there's good -- you know, I think there's underuse and overuse in almost every sort of area.

So I think, given what tools we have, I support the recommendation. I think the chapter was great and we've

done what I think needs to be done. But I do think, moving forward, we have to think about things more in terms of patients and types of patients as opposed to providers and how to pay the providers. We have to think of quality measures so we can understand where there's underuse. We have to think about broader incentives to deal with some of the overuse, because I think we just don't have the tools in most of what we do to solve the problem in an area where -- and I agree with you again -- I do think it's probably impossible to write down the exact right criteria and then enforce whatever criteria you were to write down. And so I think going down that road is probably not the right way to go. It's probably more changing of broad incentives, changing broad quality measures. But for where we are, I'm very supportive.

MR. BUTLER: So, on page 13, this is a real nitpick, but when I read this the first time, until you spoke it, it was unclear. My first reading was, this could cost rather than reduce, because it doesn't reference decrease increase payment. And on Slide 13, you know, it says spending implication, $750 million to $2 billion. It doesn't say --

MR. CHRISTMAN: That fell off. It should be decrease.

MR. BUTLER: So I don't know if you can modify it before you post this somewhere, but it looks like it's an increase rather than a decrease. Just to let you know I'm paying attention.

[Laughter.]

MR. BUTLER: So at the risk of -- I'm into this aggregate, you know, big picture silo spending, and so this is the last time I'll do it today, but I started with the DSH being $11 billion, and then when I say, look at these silos, the ambulatory surgery was, like, $3.4 billion. It's one-third the amount that we spend on DSH. And, like, inpatient rehab later is only $6 billion. And it just reminds me, you have levers like DSH or, let's say, GME, which is about the same amount, and we have weird ways of doing it, and yet those are really levers for either opportunities or chaos that really require careful thought as we zero in on some of these really smaller spending things. It's yet another way to kind of look at bridging behavior across silos.

And I would be interested now, on the question

side, so this is a little over three percent of Medicare spending, home health. You think that it might be more than that, but that's all it is, $18 billion. How would that -- and Rita referenced, for example, dialysis is at $10 billion, much higher than other countries. I'm just kind of curious if we have under-leveraged, in general, home health in this country compared to others. My guess is yes, but I don't know.

MR. CHRISTMAN: I haven't seen any home health sort of international comparisons. I mean, I think that it's -- you know, some of this -- what I have seen sometimes talks about differences on the long-term care side almost, because other countries approach it differently. So I don't think I have a good answer to your question. That's something we could look at. You know, it's hard enough for me to sometimes track down Medicaid spending on the comparable service because it is just a smaller piece of the pie.

MR. BUTLER: Yeah. Well, sometimes I'm tempted to take baseline and throw it out. Mike has made reference to baseline. If you had a blank piece of paper, where would you allocate the dollars? It's another way to kind of,

where would you end versus where we are now and tweaking things.

Okay. My last comment, then, again conceptual, is that you have on Slide 15 that Alzheimer's, for example, is 29 percent of the community admits have Alzheimer's. So, again, as interesting a question would be to look at the chronic diseases, COPD or CHF, and we've done this in episodes, to some extent, and look at where, okay, if 29 percent have Alzheimer's, where is Alzheimer's treated in SNF, or how does it spread across, if you were to take it as a chronic disease, where is the spending across the post-acute sectors for that disease and are we using it in an appropriate way. So if you were to enter and first be a newly diagnosed Alzheimer's patient, what would be kind of the pathway that you would look at versus what we have now in post-acute spending would be another lens to look at this through. I know that's not helpful to home health per se, but I think looking at these chronic diseases along those lines would help guide us more.

DR. NERENZ: Nothing really to add, except just to reinforce both what Tom said and then what Peter just said about possible cost savings or offsets. I think this is one

of those areas where we would like to see that happening, and in some cases, we do expect to see it. But I see, certainly in the geographic analysis, it's hard to see, because I think some of the high home care regions are high overall care regions. So you don't see an offset. So anything we can learn about that, I think, would be helpful, particularly to clarify what the point of comparison is. You know, is it up and down dollar savings within the general framework of home health? Is it doing versus not doing? Is it doing this versus doing something different? I don't have anything specific to recommend on that, but just the more we can learn about that, the better.

MR. HACKBARTH: So, I'd like to associate myself with a series of comments now about how home health can be a very useful, important service, both in terms of improving the quality of beneficiaries' lives, but also in terms of potentially saving money for the system. I agree with all that.

I don't think that overpaying for each episode of home health moves us in that direction. I think to get to an appropriate and effective use of home health, we really need to get out of paying for it as a separate line of

business and move towards integrating it with other services where we can assure the proper substitutions are occurring and where there's ongoing oversight to tailor the service to the needs of particular patients.

Okay. Since we have no vote to take here, we are done on home health. Thank you, Evan.

And we are on to inpatient rehab, our last agenda item for today.

[Pause.]

MS. SADOWNIK: In this presentation, we will continue our discussion of payment adequacy to inpatient rehabilitation facilities, or IRFs. I will briefly review the analysis and draft recommendation and also address questions that Commissioners asked during the last meeting.

As a quick sketch of the industry, 80 percent of facilities are hospital-based, but these comprise only 55 percent of Medicare discharges. Freestanding facilities represent a larger share of care to patients because of higher average bed size and occupancy rates.

Although Medicare fee-for-service is the largest payer, relatively few Medicare beneficiaries use IRFs because patients must be able to tolerate the intensive

therapy required. To ensure that IRFs are treating patients that are appropriate for this setting, facilities must meet a compliance threshold. Volume and patient mix have been sensitive to policy changes in this threshold.

I will start with addressing some of the Commissioner questions from the December meeting.

Tom, you asked about regional variation in utilization. Across the country, IRF spending per beneficiary varied twofold. Also, compared to urban areas, rural areas tend to have fewer beds, lower occupancy rates, and higher average costs per case, although some rural areas have higher IRF spending per beneficiary than the national average. Note that Medicare increases rural facilities' payment rates by 18.4 percent to compensate for these differences.

George, you asked about opportunities for consolidation in the areas with multiple IRFs. You might expect to find lower occupancy rates in areas with multiple facilities. In fact, we found that aggregate occupancy rates in these areas were relatively high, perhaps because markets with multiple facilities have higher volume due to population density or practice patterns. This is something

we could look into in the future.

George also asked about the availability of other rehabilitation options across the country. Virtually all Medicare beneficiaries live in a county with at least one post-acute care option. Thirty-one percent of beneficiaries live in a county that does not have an IRF. Among these counties that did not have an IRF, 86 percent have both a SNF and coverage from home health and the remainder have coverage from home health alone.

He also asked why Hispanic beneficiaries are under-represented as IRF and SNF users. Two findings inform this trend. Firstly, literature suggests lower rates of joint replacement, a common condition in both IRFs and SNFs, among Hispanics compared with white and black patients. And, secondly, among those who do have a procedure, Hispanic patients may be more likely to be discharged home to self-care rather than to institutional care.

I will answer additional questions throughout the presentation.

As a reminder, we'll use the same framework to analyze the payment adequacy for IRFs as for the other sectors.

I'll briefly review our access to care measures. Between 2010 and 2011, the total number of facilities and beds decreased by around one percent. The number of IRFs has declined every year since 2005, which reflects the trend of hospital-based facilities leaving the market and the number of freestanding facilities slowly increasing. The supply of IRF beds largely follows this trend, too, although the number of beds in freestanding facilities did also decline very slightly in 2011.

Fee-for-service spending sharply increased from 2010, reflecting the growth in number of cases and in payment per case. Volume has been increasing, even as the number of beds has decreased, suggesting that beneficiaries are not losing access to services overall. Occupancy rates in 2011 rose modestly and were higher in freestanding IRFs than in hospital-based IRFs.

Rita, you asked why hospital-based facilities don't have higher occupancy rates given that they could influence discharging their patients to their owner. To illustrate the answer, we estimated that the average hospital that relied only on its own patients for IRF admissions would have six beds occupied at any given point

in the year. The average number of beds in a hospital-based IRF is 25. Therefore, while some facilities may be able to rely only on their own patient discharges, most would still need referrals from other hospitals.

I'll now turn to quality of care. I first want to focus on the measure of functional improvement, or FIM gain. The 2009 number we presented in December was incorrect and we received questions on it from you and from industry. We apologize for this error. The bolded number here is corrected. We see that FIN gain increased from 26.7 points in 2009 to 27.4 points in 2010. Performance on two hospital readmission measures were roughly unchanged between the two years, and changes on other measures were small. Overall, this data suggests that quality of care across the IRF industry remained fairly stable between 2009 and 2010.

There were several Commissioner questions on quality of care. Mary, you asked about the improvement in quality over time, and I added that information to the chapter.

Kate, you asked about the difference in quality between hospital-based and freestanding facilities. Across the five measures, neither facility type was consistently

better. Hospital-based facilities had better outcomes on some measures while freestanding facilities had better outcomes on others. FIM gain was one point higher in freestanding facilities than in hospital-based facilities. For all other measures, the difference was half a percentage point or less.

Bill Hall, you asked about the distribution of performance. Among the five measures, the difference between the 25th and 75th percentiles ranged from 20 percent to twofold. This is an area we plan to expand on in the future in conjunction with work on an efficient provider analysis.

Cori, you asked about the change in FIM score on admission over time. We do see that starting FIM score has decreased over time consistent with increasing case mix and changing case type due to the compliance threshold.

Rita, you asked for more information on comparability of outcomes between rehabilitation settings. Overall, research studies are not able to conclusively identify one post-acute care setting as having better outcomes for rehabilitation patients. Recent results from the CARE tool, a uniform assessment tool used as part of a

Medicare demonstration, can help compare outcomes across settings. The risk-adjusted analysis found no significant difference in the average degree of improvement in mobility, but there was a slightly higher gain in self-care outcomes among patients who received care from an IRF or home health agency compared to other alternatives. More information is included in the mailing materials.

Kate, you asked about the share of conditions treated by IRFs versus other rehab options. Overall, three percent of all acute hospital discharges are to IRFs, compared to 20 percent to SNFs and nursing facilities and 16 percent to home health. However, the share of discharges is much higher for particular rehab-intensive conditions. For example, 19 percent of stroke discharges and 12 percent of hip and knee replacements are to IRFs. More detail on this is included in the mailing materials.

Craig, you asked about the impact of the hospital readmission penalty on sending patients to IRFs versus other post-acute care options. The three conditions to which the penalty currently applies -- heart attack, heart failure, pneumonia -- are not top conditions sent to rehabilitation care, and we have heard that the hospital readmission

penalty does not have any significant impact on choice of PAC provider now. However, as the number of conditions expands, we do expect that there will be increasing pressure for PAC providers to demonstrate their relative value to acute hospitals.

Hospital-based units have access to capital through their parent institution, and hospitals have overall maintained reasonable levels of access to capital in 2011. As for freestanding IRFs, we were able to review access to credit for one major national chain, which shows that their ability to borrow has increased, largely due to improving credit markets and the chain's strong operating performance.

I'll now review IRF margins for 2011. Overall margins were 9.6 percent in 2011. Margins varied substantially between hospital-based and freestanding IRFs. Freestanding IRFs had margins of almost 23 percent in 2011. They represent about 45 percent of Medicare discharges. In contrast, hospital-based IRFs had margins of negative 0.8 percent. I will discuss some factors driving these differences in margins shortly.

Craig, you asked to see margins for facility type by ownership status. Among freestanding facilities,

nonprofits had margins of almost 15 percent, while for-profits had margins of 25 percent. Among hospital-based IRFs, nonprofits had margins of negative 0.9 percent, while for-profits had margins of around four percent.

Let's turn to factors impacting the differences in margins. Hospital-based IRFs have higher costs than freestanding IRFs. We did not find that their patients are sicker. Instead, hospital-based IRFs tend to have fewer beds and lower occupancy rates which keep them from fully capitalizing on the economies of scale the more efficient freestanding facilities. Among hospital-based IRFs, both direct and indirect costs per case were higher than in freestanding IRFs. In 2010, direct costs were 30 percent higher and indirect costs were 11 percent higher.

Peter, you asked for more detail on why margins in hospital-based facilities have been decreasing over time while margins in freestanding facilities have been increasing. Between 2004 and 2010, freestanding facilities have contained cost growth more than hospital-based facilities have across all cost components and particularly in routine costs like room and board, as detailed in the mailing materials. As changes in the compliance threshold

resulted in lower patient volumes and higher severity of illness, freestanding facilities were more successful at containing costs because of financial necessity among the stand-alone and predominately for-profit facilities.

Peter, you also asked about the payer mix with respect to Medicaid. We found that hospital-based facilities are more likely to have Medicaid patients, but the difference is largely driven by their shares of for-profit and nonprofit facilities. Across both hospital-based and freestanding facilities, nonprofits were more likely than for-profits to have Medicaid patients. In fact, nonprofit hospital-based IRFs were less likely than nonprofit freestanding IRFs to have Medicaid patients.

Based on 2010 data, even though Medicare margins for hospital-based IRFs are negative, on average, the IRF units are able to cover their direct costs. The direct cost margin was 34 percent for hospital-based IRFs. In addition, overall Medicare margins for acute hospitals are about two percentage points higher for acute hospitals that have an IRF unit than for those without an IRF. These data indicate that IRF units are able to cover their direct costs and financially contribute to their parent hospital.

As we have seen, aggregate Medicare margins for IRFs in 2011 were 9.6 percent. To project the aggregate Medicare margin for 2013, we modeled the policy changes driving payment rates for 2012 and 2013. We project that Medicare margins for 2013 will be 8.5 percent. This decrease reflects the effects of PPACA productivity adjustments and does not account for any market changes in response, such as increased cost efficiencies.

In summary, our indicators of Medicare payment adequacy for IRFs are positive. Measures of beneficiary access suggest that capacity remains adequate to meet demand. Margins average 23 percent for freestanding facilities, which tend to have lower costs. Finally, risk-adjusted quality of care remains stable and access to credit appears adequate for both hospital-based and freestanding IRFs. We project that 2013 aggregate Medicare margins will be approximately 8.5 percent.

The draft recommendation is: The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2014.

This recommendation would decrease Federal program spending relative to the statutory update by between $50 and

$250 million in 2014 and by less than $1 billion over five years. On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the 2013 payment rate. We estimate that this recommendation will decrease Federal program spending relative to current law.

We do not expect this recommendation to have adverse impacts on Medicare beneficiaries. This recommendation may increase the financial pressure on some providers, but overall, we expect a minimal effect on reasonably efficient providers' willingness and ability to care for Medicare beneficiaries.

And with that, we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Sara. You did a great job on the cellphone test, the ringing cellphone, totally undeterred.

[Laughter.]

MR. HACKBARTH: Okay. So, let's see, where should we begin? Who looks particularly eager right now? I think, Dave, I can see a twinkle in his eye.

DR. NERENZ: Well, just if you could give us a couple of examples, on Slide 11, the higher direct and

indirect costs in the hospital IRFs. What would be a couple examples of both of those classes of costs?

MS. SADOWNIK: Direct costs include routine care and ancillary costs, so routine would be room and board, nursing, and ancillary includes therapy, drugs, and other supplies.

DR. NERENZ: And is there any connection between those higher costs and some of the things we've seen in some other topics of our discussion about the just essential costs of running a hospital? For example, is there any linkage between these classes of direct costs and some of the issues of accreditation requirements, 24-hour access, or are these just completely in the domain of the IRF itself?

MR. LISK: When you talk about in a domain, I'm trying to -- I think we're talking about those costs. I mean, all the requirements for being a hospital have to be met by all the hospital-based IRF or the freestanding IRF, in terms of those requirements. Is that what you're talking about?

DR. NERENZ: Okay. Well, let me answer the question. I didn't phrase it that way, but that would answer the question. I didn't know that that was strictly

true of the freestanding IRFs, but, yes, I can see how that's so.

MR. BUTLER: So I'm going to support the recommendation. I struggle, as I'm sure other Commissioners do, with the spread in the margins, and you've done a very good job being responsive to my questions and trying to understand it better.

I did find it interesting in the -- and I don't know how we look at this -- the AHA did write a letter to us and commented on language from the CMS final rule last year that said shifting -- this is a quote -- "shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to beneficiaries. Eighty-one percent of IRF patients were discharged home compared to 45 percent of SNF residents." And it goes on and it says, "IRF patients have shorter lengths of stay, 13 days, compared to SNF, which are 36 days."

So there are other factors that, you know, that has nothing to do with the difference, I realize, between margins between freestanding and hospital-based, but I still struggle. I think we've got to do something next year, I think, to either explain, or we can't have these kinds of

margins in the freestanding, but we've got to get at why it's so different from the hospital-based a little bit better.

MS. SADOWNIK: We need to compare apples to apples, because we have to compare patients with similar conditions in IRFs and SNFs because SNFs is such a different patient population --

MR. BUTLER: Right, but --

MS. SADOWNIK: -- the numbers are not --

MR. BUTLER: -- and I realize the question on the table here is not IRF versus SNF only. It's the difference between the freestanding that have these huge margins and tend to be for-profit and the hospital-based that are just breaking even. It's more than just meeting your direct cost issue. There are some other things that we need to understand, or, I don't know, maybe that it's just more cost effective to do it in the freestanding and we need to do something about it, so --

MS. SADOWNIK: I think there's clearly a story about freestanding versus hospital-based and it's also clear that there's a story about nonprofit versus for-profit within both categories.

MR. BUTLER: I'm sure George will pipe up, too, when we get to him around this and, you know, again, who's taking the Medicaid, who's not. But we're not -- we can't take into account. We have to look through the Medicare lens, too, we realize that, and see in Medicare alone, why are you seeing these kinds of differences, so --

DR. MARK MILLER: I would add to the exchange, you know, the quality differences. I read that, too, but it was late one evening and a few days ago, so I'm not quite sure I've absorbed it all, but those comparisons are very hard to make without common control across the two sectors, and I know you know this. This is probably more for a general comment. And remember, there was a decision, the regulatory decision they're talking about, where certain cases that they felt were inappropriate to be in IRF.

But my more direct comment is, one thing that we can -- you know, if we convince ourselves that this is not just simply a cost structure, a selection, whatever type of issue, is try and dive into the PPS system like we did with SNF and like we did with home health to see if there's anything systematically about the payment system that discriminates in one direction or another.

The only thing I would say is -- and so, for example, in SNF, we ended up thinking that certain costs were not being handled well in the system and that was driving some of the differences in margins that we saw. That dive often takes a fair amount of work to really --

MR. BUTLER: Right. It does.

I'll just make one other comment. Having either owned or run this, home care, LTCHs, et cetera, this one's a little different than the LTCH discussion to me, and we're -- also, there's an issue of who's in there and do they need to be there. And maybe the ACO world will obviously help take care of some of this rationalization and making sure people are getting in the right place at the right time. So, again, too much energy when maybe the market will take care of it. I'm not sure. But these are all a little different, a little different animals.

DR. CHERNEW: I support the recommendation and I would like to say this is just one of those examples -- well, first, let me say, it's nice in January because you get to say similar things to what you said in December, and I still feel that way. This is one of those examples where we have different types of providers that can treat similar

patients and it's very hard to tell -- I'm not sure there's an answer as to which type of provider is right. It might be which provider is right. I'm sure there's some overlap in various places.

From what I can tell from the evidence presented, there's no evidence that there's a sector that's particularly poor quality or a sector that is particularly likely to be harmed under the recommendation. So I think, all of that said, the recommendation is what it is. But I just don't think we're going to get that far along in the process of trying to understand why some people should go to IRFs and some people should go to some other facility and it's working this way in Texas and this way in Vermont. It's just very hard from where we sit to have that level of micro-adjustment. So given the tools that we have, I think -- and the information presented -- I think the recommendation is a reasonable way to go forward. There's just so much diversity, it's hard to get it exactly right.

DR. DEAN: I'd support the recommendation, and just one brief comment. I think probably comparing the IRF to the SNF, I think they really do serve different populations of patients. Primarily, there is the

requirement that if you're going to go into an IRF, you have to be able to withstand, I think it's three hours of therapy a day, and a lot of people that can't withstand that end up in the SNF. And that by itself would dictate, or would separate people into different populations.

MR. HACKBARTH: That would potentially help explain the statistics in the AHA letter about why IRF patients --

DR. DEAN: Length of stay and -- yeah, and all that, yeah.

DR. HALL: So I support the recommendations, and certainly IRFs don't only serve Medicare patients. In fact, because of the requirements for a certain amount of physical fitness, they are often suitable for somewhat younger patients. But if there's any part of the health care system that cries out for being part of a bundle, I think this is the one that would strike me as being very, very important. So I think we're on the right track here.

MS. UCCELLO: I support the recommendation.

DR. NAYLOR: As do I.

MR. GEORGE MILLER: I support the recommendations, and although Peter teed me up, the chapter is very well

written and I think my thoughts are very well known and the differences, I think, can be handled once we go to bundled payments.

MR. KUHN: I thank both Sara and Craig for this good work and I, too, support the recommendation.

DR. SAMITT: So I support the recommendation. I mean, as I work my way through this, I struggle with the two issues, one being IRF versus SNF, which is one of them, the other being hospital-based versus freestanding. I think the beauty of the discussion or the vision about bundles is it solves both problems, which is that in the setting of a post-acute bundle, a hospital and the physicians that admit to it will now be accountable for, first, determining the right site of service for post-acute care, knowing that there are risks of readmission penalties, and, frankly, if a hospital isn't efficient at providing IRF services, they'll either need to improve their efficiency or they'll need to recognize the need to outsource the service to a freestanding facility that may be able to do it more efficiently. So, again, I echo others' thoughts about the benefits of bundles here.

DR. HOADLEY: I support the recommendation, and I

keep thinking about all the different sectors where we see these very strange geographic patterns or patterns in different categories that sell these products, for-profit, freestanding, hospital-based, and maybe that is the right answer, that the more we can get past this into the bundling kind of approach, that we won't have to worry as much about that. We won't have to care as much about those differences. And if a geographic area needs -- has a gap, then somebody is going to be more inclined to try to figure out how to fill it rather than do it based simply on dollar incentives and all that kind of stuff.

My only other very small comment -- it applies to this chapter and several others -- I think it would be useful if, in the introduction to each of these chapters, we just include not only where we say how much of the money is going to this service, what percentage of all of Medicare that represents. It's just a good reminder. I think it came up in some comment Peter made last time.

MR. GRADISON: I support the recommendation, also.

DR. COOMBS: I support the recommendation, and I was thinking along the lines of the actual number of beds in a hospital-based IRF and just the notion of what they can do

with beds that are as small as six beds and what an IRF could do that's actually got all the bells and whistles. So I think that the more serious you get about benchmarks and outcomes, I think you really have to pour a lot more resources in. So your marginal cost is going to be a lot more for these six little patients that you might have versus a larger number of patients that you can distribute the charges over. And so maybe it's a geographic limitation. There might be some other factors that are coming into play for why the hospital-based group is so much smaller.

MR. LISK: The hospitals are -- I mean, the hospital-based just tend to be smaller. They'll be one floor of a wing of a hospital plus a rehab unit or something, so just smaller beds. And you do have to have certain -- you know, you are required to have, for the requirements of the IRF to have certain staffing requirements. You have to have a full-time rehabilitation director. So you're spreading that over a smaller number of patients, and that's one of the reasons why I think your routine costs, for instance, are much higher there in the hospital-based.

But if you look at the margins for the larger hospital-based facilities, their margins actually are positive, and I can't remember exactly what they are, but they're more positive and they're higher than the smaller facilities, so --

DR. COOMBS: And that makes the most sense. It's like having a virtualized unit that opens and closes depending on your need. So I was thinking about the IRFs in the same capacity.

DR. BAICKER: I support the recommendation and I thank you for the extra detail on how the hospital-based and non-hospital-based ones differ because I think it improves our understanding of how the patient pool is driving some of the differences we see, so thank you.

DR. REDBERG: Thanks for the update and the additional information. It was really helpful. I support the recommendation, and I will just add that I think it points an opportunity for bundled payment and really patient-centered kind of focused care instead of all these dividing up into little pots.

MR. HACKBARTH: So each year when we go through the update recommendations and get to about this point,

there are certain themes that are crystal clear, one of which is that updates are very limited tools for dealing with the issues that we care most about, which is assuring the patients get to the right setting for the right care at the right time, and changing the payment system, not thinking how much you change rates up and down but changing the fundamental payments systems is key to getting to where we want to go.

And I think, as I look down the road to the rest of this cycle and as we go into next year, I think that's where we need to be focusing more of our attention. We've got now underway lots of sort of innovative experiments and some fledgling programs like ACO, and all that's good, but I think if in a -- we just sort of sit back passively and allow those things to unfold, it's going to be decades before we get to where we want to go.

And so for me, the most pressing policy issue that not just we, but the Congress faces, is how do we accelerate that pace of transformation so we get a more coherent payment system supporting a more coherent care delivery system with more integration, more care coordination, and the like. So that's -- keep people going as we go through

our last set of payment updates tomorrow morning.

We do -- oh, I'm sorry.

DR. BAICKER: [Off microphone.] Do we need to vote?

MR. HACKBARTH: Yes, I was just going to turn to the vote. So on the recommendation on the IRF update, all in favor of the recommendation, please raise your hand.

[Show of hands.]

MR. HACKBARTH: Opposed.

[No response.]

MR. HACKBARTH: Abstentions.

[No response.]

MR. HACKBARTH: Okay. Thanks, Sara and Craig.

So that completes our agenda for today. We will now have our brief public comment period.

Let me just see, is there anybody else who is going to want to step to the microphone? I'd like to see who all is in the group. Okay, so we've got two.

The ground rules, please introduce yourself and the organization that you represent. And when this red light comes back on, that signifies the end of your time. Plan on two minutes.

MS. UPCHURCH: Thank you. My name is Linda Upchurch and I represent NxStage Medical.

I know this has been a very long day and I appreciate all of your hard work.

We are the leading innovator in the field of home hemodialysis. Papers from the United States Renal Data Services you may have seen before have demonstrated clear survival and transplant advantages in patients treated with home hemodialysis.

We applaud MedPAC for the appropriate focus on the benefits of and access to home hemodialysis during 2012 and encourage you to continue to study the ongoing barriers to expanded use of home hemodialysis for your 2013 research agenda.

Your accurate and consistent comments over the past several years relating to inadequate payment for home training services reflect an unresolved need to update the training payment for resource intensive home dialysis training. This remains a timely and urgent issue.

A recent paper from the American Society of Nephrology's Dialysis Advisory Group says it all: "Home hemodialysis is an underused modality in the United States."

And the facts support this. Even though most clinicians, when asked, would chose those modality for themselves, less than 2 percent of the dialysis population is currently treated with this therapy and fewer than one in four dialysis centers currently offer it to patients. Reimbursement is part of the issue.

MedPAC has cited the clinical benefits in prior publications and the data only grows stronger. With the survival, cardiovascular health and quality of life benefits delivered by home daily hemodialysis, as well as the fact that more of these patients are transplanted, it's simply an injustice that so few patients have access.

Despite good intentions, the bundle has not materially increased patient access to home hemodialysis as it has to peritoneal dialysis and we routinely hear from exasperated patients denied access simply because they are Medicare.

A husband in Chicago who calls on behalf of his wife, an advocate for her, who's been denied the therapy. She's had a head trauma, it's difficult to be transported back and forth to a clinic. He simply wants to do home hemodialysis for her and is denied access because she's a

Medicare patient and that clinic doesn't happen to offer it.

A patient in Atlanta on a wait list to train for over three months, called the week before her scheduled training and told she's no longer a candidate for home hemodialysis because her insurance has just converted from insurance primary to Medicare.

We work with these patients. These are two examples. We work with these patients to resolve issues. Routinely, the ones that find me, I help them work through the system. I talk to their nephrologist. We identify other clinics for them to go through.

But as appropriately stated earlier, many of the patients don't have the capacity to know that they can challenge this. They simply accept that they're not a candidate or that they can't have access. It's not right, what is happening.

For these nephrologists to say over half the time this is the therapy they would choose for themselves, overwhelmingly for their family members, to only have 2 percent of our patients in the country treated with this, something is wrong in the payment system. Primarily we hear it's the training.

Thank you.

MR. HUNTER: Mr. Chairman, Mr. Vice Chairman, ladies and gentleman of the Commission, my name is Justin Hunter. I'm a senior vice president with HealthSouth. We are the largest provider of rehabilitation hospital services in the country. We operate 100 free-standing rehabilitation hospitals in 27 states and Puerto Rico.

I appreciate this opportunity to briefly address you all here today in response to what was said both today and during the last meeting last month. Both today and during last month's meeting there was considerable degree of reference -- more so last month than today -- but nonetheless reference to RTI's study with regard to the PAC PRD and the CARE instrument.

There was a citation of an American Hospital Association letter earlier today that was, I believe, carbon copied to each of you.

I wanted to also highlight a letter that was sent to Chairman Hackbarth and carbon copied to Executive Director Miller that speaks directly to the PAC PRD and a couple of key aspects of it, that was sent by the Federation of American Hospitals.

Briefly, the Federation notes that this study is an important one but has its limits, as the study itself notes. For example, the -- and the Federation letter cites directly the RTI study -- the functional assessment measures comprising the CARE instrument self-care and mobility measures are new and the thresholds for defining differences that are clinically meaningful have not been established.

The FIH letter goes on to point out that RTI itself observes that the study is observational in nature "thus, the study design identifies associations but it is not suited for causal attribution as in a randomized control trial."

The FIH letter concludes by saying -- again referencing the RTI study -- "The results are preliminary and additional work is needed to define clinically meaningful differences in self-care and mobility functional status."

This is a very important study, the RTI study, of course but it has its limitations and it's very important for each and all of you to bear those limitations in mind as you discuss and deliberate these policies.

Secondly, I wanted to also briefly note this

discussion of IRF versus SNF. In the prior coverage and patient admission framework under the Medicare benefit for medical rehabilitation services, there was a standard that dealt with a less intensive setting-based analysis. In other words, if it could be determined that a patient could be treated in a SNF or some other setting of care, then it was appropriate to send the patient to that setting of care.

CMS took direct action to eliminate that reference and that framework when it established new, revised, more stringent coverage and admission criteria in 2010. And they have specifically acknowledged that hey, we're no longer concerned with whether the patient can be treated in a SNF. If they satisfy our new revised criteria they therefore are ipso facto appropriate for an IRF admission. That's very important.

And finally, a third key point that I want to reiterate, and I think I've said this in prior meetings, Mr. Chairman, and I will wrap up real quickly with this.

We've talked about the three hour rule and the fact that all IRF patients must need and receive three hours of therapy each day at least five days a week. An even more important factor that must be borne in mind or should be

borne in mind is the fact that the IRF benefit is physician driven. There is no other benefit in the post-acute care sector that requires so much of physicians as does the IRF benefit.

Physicians must review cases --

MR. HACKBARTH: Okay.

MR. HUNTER: I didn't realize that that's the red light. I beg your pardon, Mr. Chairman.

MR. HACKBARTH: It came on two-and-a-half minutes ago.

MR. HUNTER: Time flies.

Thank you for this opportunity and look forward to continuing our dialogue with you all.

MR. HACKBARTH: Thank you very much.

Okay, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 4:34 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, January 11, 2013.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 11, 2013
8:33 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
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 [8:33 a.m.]

MR. HACKBARTH: Okay. It's time for us to get started. We have three sessions today. The first two will be presentations related to long-term care hospitals and hospice services leading to final votes on recommendations to be included in our March report. Then the third session is on Part D, a status report, which we also customarily include in our March report.

So let's begin with long-term care hospitals. Dana?

MS. KELLEY: Good morning. Last month we discussed in detail our update analysis and the Chairman's draft recommendation for long-term care hospitals. You have the chapter and the recommendation in your mailing materials.

You had many questions last month about LTCHs and the patients that they serve. Where we had data available, I've addressed these questions in your written materials, and I have some additional information that I will present today. I'm happy to take questions during discussion. Today, I'll review our findings on payment adequacy for LTCH services, and then Julian and I will outline some policy

options that we are currently exploring.

You'll recall, of course, that LTCHs furnish care to patients with clinically complex problems who need hospital-level care for extended periods. In 2011, about 123,000 beneficiaries had almost 140,000 LTCH stays. The averaged Medicare-covered stay is 26 days, and the average payment is nearly $39,000 per discharge. All totaled, in 2011 Medicare spent $5.4 billion on care furnished in 424 LTCHs.

The Commission has expressed concern about LTCHs for many years. Until recently, these were among the fastest growing providers in the Medicare program. As you know, the product is not well defined, and it is often not clear what Medicare is purchasing with its higher LTCH payments. There are no established criteria for admission to an LTCH, so it's not clear whether or which patients treated there require that level of care. Remember, too, that some parts of the country have many LTCHs and others have none. The oversupply of LTCH beds in some markets may result in the admission of less complex cases that could be cared for in other, less costly settings. Medicare beneficiaries in areas without LTCHs receive similar

services in other facilities.

Last month Scott asked whether Medicare would pay more if LTCHs were paid at acute-care hospital rates, and Alice -- who is not here right now, I am sorry -- asked if it would be more costly if LTCH patients stayed in the acute-care hospital. These are complicated questions, but I will try to answer as best I can.

Regarding Scott's question, just as a very simple exercise, we recalculated payments for all LTCH claims using IPPS payments and policy to see what Medicare would pay if LTCHs were paid under the IPPS. Under this scenario, we found that aggregate payments to LTCHs would fall 43 percent.

What happens if chronically critically ill patients don't use LTCH care at all? This is the question that numerous researchers, including the Commission several years back, have asked. Some studies have looked at LTCH patients nationwide and matched them to similar patients who did not use LTCHs. To better control for severity of illness, some studies have looked only at prolonged ventilator patients who use LTCHs compared with those who don't. And other studies have looked at costs for

chronically critically ill, or CCI, patients in areas that have many LTCHs and compared them with costs for patients in areas that have no LTCHs. Some studies have compared costs just for hospital care -- meaning acute-care hospital and LTCH -- while others have included costs for other post-acute care. Regardless of the study design, the findings have been quite consistent. For most medically complex patients, Medicare payments are the same or lower when the episode includes LTCH care. But for other types of patients, the less medically complex, Medicare payments are considerably higher for episodes that include an LTCH stay.

Note that the cost to the acute-care hospital may be lower when these patients are discharged to LTCHs, but the costs to the program are higher.

MR. GRADISON: Pardon me. How do you characterize ventilator patients in terms of -- are they in the high-severity --

MS. KELLEY: Ventilator patients can be both. The prolonged ventilator patients almost always would be in the higher category.

Rita, you and others wondered whether LTCHs are helping beneficiaries achieve better outcomes. Most studies

have found that, again, for the most medically complex patients, outcomes are the same or better when the episode includes LTCHs. But for other patients, outcomes are the same or worse. CMS' CARE demonstration collected primary data on LTCH patients, allowing possibly the best risk adjustment to date that we've seen in these studies. The demo found that LTCHs had lower readmission rates compared with other PAC settings, but they performed no better on other outcomes. The better readmission rates may be due to LTCHs' ability to provide hospital-level care.

So getting to your question, Bill, who are the patients for whom LTCHs might be cost-effective? The studies most frequently have identified ventilator patients, as I said, especially those requiring prolonged mechanical ventilation. Nineteen percent of LTCH patients received at least one ventilator-related service in 2011; a smaller share than this would have received prolonged mechanical ventilation.

Among the most medically complex patients might also be those with heavy use of ICU or CCU services during their previous acute-care hospital stay. We looked at episodes of care that included LTCH stays and found that

half of them had an index acute-care hospital stay with five or more critical care days, and 38 percent spent eight or more days in the ICU or CCU before going to an LTCH. But in thinking about these numbers, it's important to remember that about one-fifth of LTCH cases don't have a previous acute-care hospital stay. So somewhat less than 38 percent of LTCH cases will have had a previous acute-care hospital stay with eight or more critical care days.

Before I turn to the summary of our update analysis, I just want to respond to one more issue that was raised last month, and that was whether LTCHs are the right setting for end-of-life care. You'll note that in Tab A, we've included an editorial from this month's issue of Medical Care, which raises some concerns about LTCH care from an ethical perspective. We know that care of CCI patients should include communication about care goals and patient preferences, transitional planning, and family support. We also know that these elements are often lacking in end-of-life care. Participants in MedPAC's expert panel on LTCH quality that we held a few years back reported that acute-care hospitals routinely discharge patients to LTCHs without having had end-of-life and care planning discussions

with patients or their families. Without these discussions, some patients and families likely have expectations of LTCH care that may not be realized.

Now I'll move on to a summary of our update analysis, starting with access to care. As you know, a moratorium on new LTCHs and beds has stabilized growth in supply, but LTCH cases per fee-for-service beneficiary continued to rise, increasing 2.8 percent between 2010 and 2011.

Turning now to quality, LTCHs just began submitting quality data to CMS this past October. CMS is required to implement an LTCH pay-for-reporting program beginning in fiscal year 2014. To start, LTCH quality will be measured on three dimensions, which I've listed here.

Until these data are available for analysis, we continue to rely on claims data to examine trends in in-facility mortality, mortality within 30 days of discharge, and readmission to acute care to assess gross changes in quality of care in LTCHs. In 2011, these rates were stable or declining for most of the common diagnoses.

Peter, last month you asked me about the average mortality rate in LTCHs. In 2011, 13 percent of LTCH cases

died in the facility, and another 12 percent died within 30 days of discharge from the LTCH. As you would expect, mortality rates vary markedly by diagnosis. For example, about half of beneficiaries with septicemia and prolonged mechanical ventilator use died either in the LTCH or within 30 days after discharge.

We also considered LTCHs' access to capital. For the past few years, the availability of capital has said more about uncertainty regarding changes to regulations and legislation governing LTCHs than it does about current reimbursement rates. Since 2007, the moratorium on new beds and facilities imposed by MMSEA and subsequent amendments has reduced opportunities for expansion and the need for capital. Now that the moratorium has expired, we may see new growth, but some market analysts believe that continued scrutiny of LTCHs and uncertainty about possible congressional action will prompt caution. Providers may opt to focus on relatively low-risk capital investments such as bed expansions.

This next slide shows 2011 Medicare margins for all LTCHs combined and for different LTCH groups, as well as the share each represents of total providers and total

cases. As you can see in the top row, the aggregate Medicare margin for 2011 was 6.9 percent. Since the LTCH PPS was implemented, the average margin has been 7.2 percent.

Jack, you asked whether there might be any relationship between margins and LTCH concentration. So this slide shows a calculation of the number of LTCH beds per beneficiary in each of the core-based statistical areas that have LTCHs and then sorts the CBSAs into deciles based on that ratio of beds to beneficiaries. And the slide shows the aggregate margin for each of these deciles. As you can see, there is no clear pattern here.

To estimate 2013 margins, we modeled the impact of several policy changes, which I've listed here. All together, we estimate that these effects will result in somewhat greater growth in provider costs than in aggregate payments, and we've projected a margin of 5.9 percent in 2013.

So our update analysis finds that access to LTCH care has grown, and the quality trends we are able to measure appear stable. Facilities' access to capital is difficult to assess, but margins are positive and we expect

that they will remain that way. These findings suggest that LTCHs are able to operate within current payment rates.

We make our recommendation to the Secretary because there is no legislated update to the LTCH PPS. The draft recommendation is that the Secretary should eliminate the update to payment rates for long-term care hospitals for fiscal year 2014.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. So eliminating the update for 2014 will decrease program spending relative to the expected regulatory update, even assuming PPACA-mandated reductions. We don't anticipate any adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

Now, before I turn it over to you, I want to lay out some policy options that Julian and I have been exploring. These options are intended to improve payment for chronically critically ill beneficiaries. CMS' report to Congress on LTCH criteria suggested specific attributes of these patients, such as prolonged mechanical ventilation, multiple organ failure, and some of the other attributes you see listed here. And in the medical literature, use of

intensive care services, as we've discussed, is also often used as a defining characteristic of these patients.

Since we know that most CCI patients are not treated in LTCHs, the options we are exploring would remove the LTCH designation and pay for cases under a modified IPPS. The IPPS modifications would improve payment accuracy for very costly CCI patients and rationalize payment across settings to remove payment incentives that favor one setting over another.

The three options we are exploring are listed here. One option would create an expanded outlier policy for CCI cases, whether they are treated in LTCHs or acute-care hospitals. A second option builds on the first by also breaking out CCI patients into separate MS-DRGs with higher payment weights. And then the third option would bundle expected post acute-care costs into the new CCI MS-DRGs so that the hospital would be responsible for overseeing associated LTCH or SNF care for CCI patients. We plan to bring you more details on these options in the coming months.

So, with that, I will turn it over to you for voting on the payment update recommendation and discussion

of future policy directions. And Julian and I are happy to take any questions that you might have.

MR. HACKBARTH: Okay. Thank you, Dana. Nice job.

I want to begin. I think what we'll do, we've only got 45 minutes allotted for this, so I think we'll do one round, and I'd like to begin with Alice. But before putting Alice on the spot, I'd like you to go back to the beginning where you responded to Alice's question at the last meeting so she can hear that.

MS. KELLEY: Sure.

MR. HACKBARTH: In fact, you may want to do both Scott's and Alice's --

MS. KELLEY: Okay. So as I was saying, last month Scott asked whether Medicare would pay more if LTCHs were paid at acute-care hospital rates, and then you asked if it would be more costly if LTCH patients stayed in the hospital. And one of the things I tried to do was answer these as simply as I could, but obviously they're complicated questions.

We recalculated payments for all LTCH claims using IPPS payment rates and policy to see what Medicare would pay if LTCHs were paid under the IPPS. And under this scenario,

we found that aggregate payments to LTCHs would fall about 43 percent.

And then I also went back to review the studies that have been done over the past decade or so on LTCH patients, and there have been a number of different studies, including early studies that were done by MedPAC, that compared patients who use LTCHs with similar patients who stay in the acute-care hospital. And there's a number of -- many different study designs, but the results, regardless of the design, have been fairly consistent that for most medically complex patients Medicare payments are the same or lower when --for the medically complex patients, Medicare payments are the same or lower when the patient uses LTCH, but for other patients, Medicare payments are the same or higher. And it's important to note there, I think, that for those patients the costs to the acute-care hospital when the patient stays in the hospital and doesn't use an LTCH may very well be higher, but the costs to the program are lower than if the patient used an LTCH.

DR. COOMBS: Thank you very much. First of all, I want to say that I actually went through your bibliography, and it was incredible, some of the same references that I

would have used and did some research on since our last meeting, so you did an outstanding job.

MS. KELLEY: Thank you.

DR. COOMBS: You know, I was really concerned about the discussion that centered around whether or not LTCHs should go away in terms of our engagement, and as a critical care physician, several things came to mind, and I actually had a chance to actually talk with our case managers and actually speak with some people who deal with this on a day-to-day basis. I just say to the case manager it's time to be placed, and they take care of it.

But one of the things that became clear in our region is that without the LTCH there is a patient flow issue, and a lot of it has to do with the limited critical care beds within an entity. So I think that that's kind of superimposed on all the other issues that we talked about.

And in terms of one of the things that was said in the reading was the risk adjustment; the Commission I guess convened in 2011 and felt that risk adjustment was not necessary for considering the LTCH.

MS. KELLEY: I think that the panelists told us that it wasn't so much that risk adjustment wasn't

necessary, but that in this setting the patients were already so complex as a group that risk adjustment was less of an issue than it might be in other settings.

DR. MARK MILLER: Just one clarification. This was a discussion of quality measures and how much risk adjustment you needed when you were looking at quality measurement.

MS. KELLEY: Absolutely correct.

DR. MARK MILLER: Not necessarily payment.

MS. KELLEY: Right.

DR. COOMBS: So I think both for quality measures and for assessment in terms of comparing apples with apples and oranges with oranges, I think that risk adjustment has a lot to add, especially every vented patient is not the same, and especially when you get to what's comorbid conditions can be, you know -- you know, we do APACHE scoring in the ICU, and that's one of the things we look at. And you alluded to that in one of the references. If you have two to three organ systems that are failing, then your morbidity is high, but your mortality is incredibly high. So that patient is already earmarked for a destiny that the cards are already dealt.

In terms of us taking the logic of the mortality rate is very high at LTCHs and, therefore, we should send them to hospice, I think that's going down a path which it says that you look at the end results and you say there's very little potential for change. And I don't think that even a 40 percent mortality cumulated over a 30-day period is rationale for us to say that the default decisionmaking should go toward comfort measures or hospice arrangement. And hospice does have both, I understand that, because we do send in some patients who are respiratory cripples to the hospital.

One of the things that you propose on Slide -- I guess it's the very last slide, Slide 16. Of all the three of these, I think that what is really attractive is number three, and to get to number three will require major landscape changes, unfortunately, because of the regional and geographic differences. And Mark and I have spoken, extensively I think, regarding some of the issues that are centered around this in terms of incentives to take care of patients.

My point will center around the fact that I think we need to realize that the -- and I think everyone around

the table appreciates that LTCHs have a significant role in patient flow in the hospital and provides the appropriate care in the right setting. Going forward, I think it's a charge that we should have for the Secretary that we better define who gets cared for at the LTCHs, because the role of the LTCHs I think is well established from the literature that you have provided. And most patients do have advantages in terms of medical treatment and management.

They have protocolized regimens for weaning that are far superior to the tertiary hospitals, and that's what they specialize in. And so if you want to get a patient off of vent and you have a successful entry back into the home, I think this is the place to go. And I would say that I'd support the recommendation of the Chair, and I think that there's a lot of opportunity to do some innovative things with this rather than to negate the impact of LTCHs.

And thank you very much. You did an awesome job.

DR. BAICKER: I, too, support the recommendation, and I think the points that Alice has raised, as well as the others in the chapter, highlight that there's an appropriate role for LTCHs, but that it is probably not very well focused right now. There are probably patients there who

would be better served elsewhere, and there may be patients elsewhere who would be better served there. And the bundling options seems like the direction that might best align that going forward. But clearly the other options have to be fleshed out as well. But I wouldn't be surprised, based on the evidence you've presented, if the optimal role was much pared back from where it is, but our job is to design the incentives so that the right patients end up in the right site.

DR. REDBERG: Thanks, and I support the recommendation. I really appreciate all the additional research you did in response to our questions. What I take away is that for medically complex patients we could get better outcomes or equal outcomes and equal costs at LTCHs, and that some of the options that you presented at the end as alternatives to LTCHs would also be interesting to explore in the future.

Thank you.

DR. NERENZ: Just a quick question. On some of the other sites of care that we've had topics for discussion, the distinction between hospital-based and free-standing has been a significant one in terms of underlying

cost margins. That's not a prominent issue in this analysis. Are there issues there that we should pay any attention to at all?

MS. KELLEY: The issues regarding hospital-based and freestanding facilities are different in LTCHs because LTCHs are required to be a separate financial entity, regardless of where they're located. So they don't have the same -- within their sort of cost structure that is reported on their cost reports, they don't have the same overhead issues that we have difficulty parsing through with the other settings, such as SNFs and rehab facilities.

So, historically, we have looked at freestanding and what we call hospital-within-hospital LTCHs. And over time, it's become difficult to determine what the differences between these facilities. Some LTCHs are located on the fourth floor of an acute care hospital. Many are located across the street from a hospital. And in terms of the availability of that care close by for a hospital, it's not clear what difference that really makes, if you know what I'm saying, since it is a separate financial entity.

So it's a distinction that exists and one that I

do have information on that I can share with you, but it's not -- their margins are very similar. Their cost structures are fairly similar. Their patient mix is fairly similar, especially now that CMS has applied some rules to hospitals-within-hospitals that limit the share of patients they can receive from their host hospital.

DR. NERENZ: [Off microphone.] Thank you.

MR. BUTLER: So what I think you've done a great job at is helping us begin to frame what could be some significant recommendations for next year. So I would encourage you to -- because between the -- well, obviously, identifying the very different outcomes and positive outcomes for complex care is very important. Now we need to kind of size that population. I don't know what percentage of the total may fall into that. I would suspect that the larger metropolitan urban markets would have enough to justify, then, the freestanding units of significant size that would have great value, but for the less densely populated things, it might be a little bit different solution.

So my only question related to it right now is as you kind of highlighted the differences in the populations,

what percent would you think would be the complex, typically, or not just typically. If you take the landscape of all of the LTCH business, what percentage clearly looks like it belongs there and is benefitting from it versus the grayer areas?

MS. KELLEY: I don't think we know the answer to that now. I think this is something we've been trying to circle around. During the presentation, I talked about the fact that we do think that it's -- the medically complex are, for example, ventilator patients who need weaning or attempts at weaning from ventilators and also patients with heavy ICU and CCU use. We know that less, around 20 percent, of current LTCH patients do receive at least one ventilator-related service, and as I said, about half of the patients stay five or more days in the ICU and about 38 percent eight or more days.

So it's, I think, safe to say some fraction of the current patients would fall under this medically complex label, and I hope that Julian and I can work more on kind of helping to determine that a little bit more closely.

MR. BUTLER: And for those, I'm a believer that having the freestanding LTCH not only helps Alice's flow

issues, but those people actually, you know, they get better care because that's the business that they're in and they don't get mucked up with the rest of the ICU business that's there, so --

MS. KELLEY: Well, I think the appeal, as we were saying earlier, of a bundling approach is that it would allow the clinicians to make the decisions that make the most clinical sense.

DR. MARK MILLER: And the only thing I would add to that exchange is that there may be areas without LTCHs, and so you want a payment system that accommodates wherever that person lands, because if you talk to the hospitals that are not in the range of LTCH, they're pretty annoyed by the payment system that doesn't deal with those patients. So I think some of what we're trying to do is --

DR. CHERNEW: I want to pick up on that, and I agree completely. So, first, a question. You talked about a lot of different types of studies that measure costs and quality and stuff, and the ones that I just want to make sure I didn't lose is some of them compared areas where there's a lot of LTCHs and areas where there's none or not very much. And I just wanted to confirm that my take from

your talk was that, for the most part, with the measures of quality we have, the quality across those two areas is about the same. Is that -- did I follow that right?

MS. KELLEY: Yes. Yes. But again, that's looking at outcomes. Those analyses -- many of those analyses use claims data, so it was looking at outcomes just in terms of morbidity and readmissions.

DR. CHERNEW: Right. So there may be some weaknesses in terms of our quality measures --

MS. KELLEY: Absolutely.

DR. CHERNEW: -- but at least given the measures we have, they're about the same. And what that suggests to me is that the health care system adapts one way or another, and our focus on LTCHs, in some sense, is because of the way the payment system works and a focus on the patients, these types of patients, it strikes me, will enable us to do much better for serving the patients as opposed to a focus on the providers and different types of providers. It seems to me, at least based on what you said, and again, I recognize the limitations of the data, that LTCHs aren't essential for high-quality care, but the health care system obviously has to transform in certain ways to handle these patients

regardless whether there's an LTCH or not. So my guess is the acute-care hospitals are, as Peter was sort of alluding to, are very different in places where there are LTCHs.

MS. KELLEY: I think that could be a fair assumption, and I would also suggest that maybe in areas without LTCHs, SNFs might be providing a different type of care, as well.

DR. CHERNEW: Well, fine. Right. Right. So there's going to be some adjustment one way or another to deal with the patients, because the patients need a certain set of services.

And the one that I just wanted to confirm, based on the limited information we have, it seems that when the health care systems adjust, the outcomes seem to be reasonably comparable. And so having an LTCH in an area doesn't seem to be essential to high-quality care for these types of patients. It might be in ways that I just don't have the clinical knowledge or we don't have the measures to know, but based on what we have, it doesn't seem that that's the case.

MS. KELLEY: I think that's fair.

DR. CHERNEW: Right. And so that's helpful to

know. And then I'll just close with I support the Chairman's recommendation.

DR. DEAN: I support the recommendation and I certainly would agree with the approach that Mike just laid out. I think the focus really ought to be on patients with certain types of problems and then trying to figure out what the best approach is, and maybe there's more than one approach. I mean, there must be more than one approach because these patients seem to do reasonably, I shouldn't say well -- they don't obviously all do well -- but they do equally well whether or not these facilities are there. So the question -- we've been struggling with this for as long as I've been on the Commission, I think. But I think -- I appreciate your presentation because I think we are getting closer to understanding this whole problem. But, anyway, I support the recommendation.

DR. HALL: Sort of looking at this through the lens of the Medicare patients and families, when I read through this, one analogy would be about 70 years ago, there used to be a different kind of an LTCH. These were called wards for polio patients, where there would be 50 or 100 iron lungs. You see these pictures once in a while when

there is fundraising for something. And the whole idea of that was that you needed a specialized place to provide sort of quality care for people with what was presumed to be permanent respiratory insufficiency.

And in my experience, which isn't global, of course, LTCHs are largely that kind of a unit. They do get some other diagnoses, but those other diagnoses are almost always in people who have primarily respiratory problems.

So then the question is, these people are with us and what do we do about it? I agree with the consensus around the room that LTCHs probably do a better job at caring for these people, particularly in terms of kind of, you might say, the amenities of quality of care in a disease that has a 50 or 60 percent mortality. It is better, I think, by and large, for families, and it's particularly better in a health care system that has a critical mass of beds, because one of these patients in an ICU, as I'm sure Alice would agree, takes up a huge amount of the day-to-day, 24-hour a day, resources of the unit, which then probably means some compromise of care of other people there. They also tend to be harbingers of very common drug-resistant infections.

So there are a lot of reasons that if you had the critical mass of people that might need them that you would put a unit like this in place. But the services can be provided in other arenas and often are. In our community, we closed our LTCH ten years ago and actually upgraded one of our nursing homes to have an entire floor of ventilator patients.

Another issue that comes up is -- it's been alluded to -- what about end-of-life care, palliative care? This is not palliative care in the sense that I think of it. This is high-tech therapy aimed at keeping people alive. It may have some aspects of care as people reach a terminal stage of life, but we had better be a little careful. It's a little bit tricky in the vocabulary to say an LTCH is a place for palliative care. That has a political connotation that I think we don't want to get into.

So I think we'll -- again, we keep coming back to it looks like we're going to bundle everything next year, almost everything we talked about.

[Laughter.]

DR. HALL: This is becoming an almost impossible package to pick up, I think.

DR. DEAN: Solution to everything.

DR. HALL: And so it probably is the solution to a few things, but at any rate, I think that's where this would fall eventually. But as for now, I'm in favor of the recommendations.

DR. CHERNEW: So what happened when the LTCH closed?

DR. HALL: When the LTCH closed? Well, it didn't just close overnight. I mean, this was a planned transition.

DR. CHERNEW: [Off microphone.] But is care a lot worse now than ten years ago?

DR. HALL: I don't think so, no. Three of our hospitals are in the top hospitals we talked about yesterday.

MS. UCCELLO: So I support the recommendation and agree with comments my colleagues have already made. I think that LTCHs might be appropriate in certain cases, but it does seem clear that they're inappropriately used now and so we need to find a better way to rationalize the payments, and I think the direction that we're moving in is the right one.

And the comments that Alice and Bill have made about hospice and the relationship of LTCH and hospice remind me of comments that Karen Borman made either last year or the year before where she, I thought, provided some valuable insights and cautioned us against seeing these as -- - as hospice as a substitute for an LTCH. So what I think -- - when we think about this, we may want to bring in some of the discussion that we had yesterday about shared decision making and that's maybe how to think about some of this, and making sure that patients or their families have the information they need to make the appropriate decisions.

In terms of -- I'm a little -- I think I need more information regarding this patient flow issue and kind of what that means. I guess I don't want to be moving people out if they're not going to the right place and is this a matter of somehow changing the resources around, either in the hospital or elsewhere. I just want to be able to understand that a little better, because we don't -- I'm not sure that we want that to be driving the policy.

DR. NAYLOR: I also support the recommendation, although -- and I think you did a great job -- I'm walking away with a little different interpretation than other

colleagues. So Slides 4 and 5, I thought what I heard is that if we do the right targeting, the medically -- most complex medically are showing either similar or better changes than traditional post-acute services. If we do the right targeting. And I totally agree that if that's also complemented with the right kind of shared decision making. People are making choices and understand what's available to them. So it seems to me that at least the available evidence suggests potential benefit right now relative to existing options.

And then the take-home for me is what can we learn about the services that are being provided there. One big concern, I think, going forward, is that we've only started pay-for-reporting in this environment and the measures really don't align well with what these people's needs are. And so the top reasons for use of long-term care hospitals are respiratory and septicemia and the measures are about catheters and -- well, one, I think, blood stream infection, yeah, so catheter-induced. So that aligns with septicemia. But I do think that there's real work that needs to be done to get measures that are aligned with the challenges and issues that these people are confronting.

The last thing is a question. In the recommendations going forward, in the bundle, it says hospital responsible. I mean, do you envision potentially where these environments for complex, medically complex people, don't start or don't end or aren't aligned with an acute hospital?

DR. MARK MILLER: The way I would answer that is the way I see the three paths that we're trying to sort through is whether -- and again, in trying to respond to some of the comments that were made over here -- we want to end up with a payment system that works for this patient whatever the post-acute and acute-care hospital configuration is in the market, because some markets don't have long-term care hospitals.

And so one of the ideas is you have sort of a very large outlier payment, so when a patient comes into this level of care, whether they're in a hospital or whether they're in an LTCH, there's a payment that begins to attach itself and tracks to this patient more accurately. And so if you're in a place where you have an hospital and you don't have an LTCH and you have configured your hospital to deal with these patients, you're getting compensated for it.

The last one, the bundling one, would work a little bit different. That's just a concept at one end of the continuum. Another continuum is you say, here's the payment to the hospital when this patient begins to climb into this very high level of complex care. It is now the hospital's decision to decide how it's going to manage this patient -- in the hospital, I'm going to go out to post-acute care, but the hospital will be making that decision and have the resources to compensate whoever they engage to do it. And we're trying to give you a continuum that you can think through of options here.

DR. NAYLOR: I was just suggesting, because there's a coalition that's really trying to work on this population, that another alterative might be to say it's not connected to the hospital. It is connected to people's needs and intervening right at the time needs surface, but not necessarily with the acute sector, so --

MR. HACKBARTH: We often talk about bundling as a concept and one of its virtues being that it creates appropriate incentives. And, for sure, that's true. But the other aspect of it is flexibility in deploying resources so that they are best used to meet the needs of patients,

perhaps regardless of the institutional configuration that exists in different markets, because that varies.

And I think for this especially challenging group of patients, that's even more important, that flexibility in deploying resources to meet their challenging needs in unique ways, perhaps, or different ways in different markets. And that's what appeals to me about some of these options.

Early in our MedPAC journey on this, we focused on patient characteristics, you know, who should be eligible to be admitted to an LTCH, and while that seemed like a good idea at the time, it is deficient on this score. It still accepts that, oh, there's an institutional type LTCH and what we need to do is monitor the gate. It does not create this flexibility in deploying of resources across all sorts of different configurations of acute-care hospitals, LTCHs, skilled nursing facilities.

So I see these options as potentially -- especially the -- well, all of these options, in various ways, as potentially good steps in terms of flexibility and deploying resources.

MR. GEORGE MILLER: Let me add my voice to

compliment the work done, and the information was fascinating and even this discussion is fascinating, particularly the evolution of our thought processes in dealing with this very complex issue.

But as Mary started on this dialogue, I had a couple notes on the same issue. What would we do, and I think, Dana, you said that one-fifth of the admissions do not start in the hospital. So how do we deal with that issue?

I think one of the things that Alice said bears merit, you know, the fact that the mortality rate is about 40 percent. But my question would be, what would they be if there were not LTCHs in those localities? Would they be higher? I don't know, but I look at the map and the reading and those States that have no LTCHs, it seems to me that, at least from what we've read, that the mortality rates don't appear to be significantly different one way or the other. So how do we design the best system with those parameters? Bundled payments certainly seems to have some attractiveness, but I like what Mark was talking about. Maybe the payment should go with the patient. But, again, if one starts without a hospitalization, who would be

responsible for that bundle of payment?

And someone mentioned about patient flow. I think it was Cori about patient flow. As a hospital CEO, that's one of our challenges, is the throughout, is trying to eliminate the bottlenecks. There are usually bottlenecks in the ED and there are bottlenecks in the ICU, particularly with our payment system. So we then tried to find post-acute places where a patient should go. But then if the payment is attached to the patient, that may drive a different decision making process. So we need to weigh all of those things together.

And one thing that was not in this reading but was in last month's reading, and I certainly want to kind of tease that out, and that is that, still, if I remember correctly from last month's reading, that minorities, particularly Hispanics, did not seem to benefit from LTCHs no matter where they were in the country, and that still is a major concern for me, if I remember the demographics correctly from last month's reading, and I wonder if we know why.

And then, finally, my final question is, have we also identified what an efficient LTCH would look like, like

we did for the hospitals, and then any work on that, using the measures of quality, cost, and determine an efficient LTCH. Do we know what that looks like and can we apply that same measure as we have done to the hospital to see if there's learning.

And one final comment. Have we studied and looked at why there's over-supply in places on this map, what drives that type of demand for that business in those areas?

And then, finally, I do support the recommendations.

MS. KELLEY: As far as the efficient provider analysis goes, that's something we haven't done in LTCHs because of the limited quality data that we have. But I hope in the future, as we have more quality data, that we'll be able to do that kind of an analysis.

Regarding the geographic distribution, I think it's fair to say that it is almost completely dependent on certificate of need laws from state to state.

MR. KUHN: First of all, let me start by saying I do support the recommendation, but I do have a question about it -- if you could put up Slide 14? -- and on the implications, and particularly a question about the spending

implications.

If I recall correctly, there is no statutory mandate for an update in current law for LTCHs, and so basically my understanding of scoring is that we would start at zero. So if we -- so are we basing this on what CMS has already put in place and that's why we're able to yield savings? Because, otherwise, I would think that the baseline would say zero, and then anything that would be above zero would be an actual cost.

DR. MARK MILLER: The baseline, I think, and I think what CBO is assuming in the baseline is a market basket update, even though it lies in the Secretary's authority to grant it.

MR. KUHN: Okay. That helps me understand.

DR. MARK MILLER: I think that's probably based on history and that type of thing. So it's not a zero starting point.

MR. KUHN: Thanks. That was helpful to understand because I kept looking at that and I kept thinking how can we have an assumption there.

The second thing is just to kind of reflect a little bit on the research that you all laid out, and both

you and Julian have done a nice job of putting this forward. I would just ask that if we could also think a little bit about, again, the whole issue that has been going on now for a decade about really trying to come up with an admissions criteria or a patient criteria for LTCHs. You know, this is where CMS had the RTI study to help kind of evaluate this. This is what the CARE tool was supposed to kind of help us get at. But when you look at all the other post acute-care providers, whether it's rehab financials or home health or skilled nursing, they all have an assessment tool. LTCHs are the only ones that don't. And as a result, they're suffering through this process, and we're suffering through this process trying to understand who are the right patients and the right place to put out there.

I know when I was at CMS, I spent an awful lot of time working on LTCHs, the policy area, and had a chance to tour a number of them across the country, both hospital within hospital as well as free-standing, and I am impressed with the work that they do, particularly for ventilator-dependent patients and wound care patients. They do some really good work.

But, again, what we know about LTCHs is they are

basically an acute-care hospital with an average length of stay of 25 days. And if they do have that kind of criteria and they are post acute-care provider, they really do need some kind of assessment activity out there.

So if there's a way we could continue to look at these issues that you have here but also look at maybe as a transitional piece or whatever the case might be, but really go back and see if there's anything we can do in the assessment area, I just think that continues to make sense.

MR. BUTLER: I just want to make one more quick comment on the flow before we want until next year. I was involved in starting one of these 20 years ago with other hospitals, and if you go into a hospital, like say a 20-bed ICU, at any given point in time, you can find three or four patients that have been there a long time with complex -- often on a ventilator, and you sit there and you say, Hmm, these are a different animal, I know that they're expensive to do in my own institution, and I don't know that I'm doing that good a job. If I could get together with others that have a similar number -- which we did -- and pool them in one place where they get focused care, we'd be a lot better off. It would be cheaper. It would be better care. And

that's kind of the flow issue.

Then the ER gets swamped and you say, oh, if we just didn't have those three or four that were sitting in ICU, we would have some flexibility to respond. It sets kind of the flow issue that can be addressed.

MR. GEORGE MILLER: Yes, throughput.

DR. SAMITT: So I support the recommendation as well. I also agree with the sentiments that there's a place for LTCHs, and I think we want to create an incentive system that encourages the best use of that best place.

My concern with the current methodology is we're -- you know, focusing on characteristics or administrative rules is often a very imperfect way to say here's the best way to use LTCHs. And we certainly shouldn't use LTCHs for flow reasons. I mean, I think that if we need greater capacity in intensive care units in hospitals, then we should incent the expansion of that.

To add to that, I would underscore the importance of Slide 16 and especially the last bullet, the bundles, because incentives should encourage a focus on patient preference, and it should rely upon the clinical judgment of the providers in determining the best site of care. And in

my experience, bundles are the best way to achieve both of those. You know, living in the world of bundles for many, many years, our primary focus is first asking the patient about preferences and then having the clinicians decide which best alternatives meet those patient preferences. It's very hard to do that in a fragmented environment. It's much easier to accomplish that in a bundle environment.

DR. HOADLEY: Yeah, I definitely support the recommendation, and this really has been a great analysis and a great presentation on these issues.

The two words that keep coming to my head are sort of targeting and flexibility. We've heard them, and I don't know that I can say a whole lot more, but, I mean, this issue of how to target to the right patients and whether a set of rules gets you there or whether it just needs something that is more flexible, and so there's that flexibility, but there's also clearly the flexibility especially if we go down the route of bundles, making sure that it's going to work the same way in a state, in a community that has an LTCH and one that doesn't, and that it's going to work the same way for the patients who start through the acute-care hospitals and the ones that don't, or

whether, you know, the ones that don't just go into some totally different world. But if we can think of ways and a bundle that can be defined flexibly enough that it can do all those things, then we may really accomplish something useful.

The other thought I had, which, again, others have talked about, is -- and you talked about it in the presentation -- the question of how often end-of-life counseling occurs for these kinds of patients, not because, you know, we're equating this to hospice but because people do have to understand their choices and there's implications, and, you know, maybe the shared decisionmaking framework is a good way to think about that, doesn't carry some of the baggage perhaps that end-of-life counseling has come to do, although, you know, that really is in many cases what we're talking about. So I think it's just really important we keep that part of the issue in the framework of this discussion as well.

MR. GRADISON: I, too, support the recommendations. My takeaway from this is that bundling has to be comprehensive to be meaningful, that is to say, it has to include all post-acute settings. I don't think that's a

revolutionary comment. But I do think that there is a challenge in thinking through bundling, as others have indicated, in the sense that it's different, really, from the focus on the patient. It really starts with the focus on the institution, at least in many -- we say, well, let's start with the acute-care hospitals and then we'll figure out something for the rest of them, which may be backwards. It may be you almost have to figure out a way to start with the patient.

Another takeaway that I have, if I'm correct about the complications -- I'm for bundling. Don't misunderstand. But the difficulties of doing it are very real -- that we may need to consider changes with regard to LTCHs without waiting until we have some kind of an overarching concept for bundling. That's sort of a possibility. I'd put it out as something that I'm sort of thinking along those lines right now.

In certain respects, in my opinion, bundling is not only more consequential but more challenging than PPS in the sense that it was possible to put the Prospective Payment System concept into effect, kind of one layer at a time. You start with post acute-care hospitals. We have

some places we don't do it at all right now. I mean, we're in various transitions. But for the bundling to make sense, it really, I think, has to -- can't leave out any major post-acute setting, which I think means it would be a much bigger step in that sense than starting down the road, which was difficult in itself, to apply PPS to the hospital setting as the first step.

Thank you.

MR. HACKBARTH: I think you're right, Bill, about the challenges, and to me, a critical challenge that you touched on is that bundling that goes across, say, the whole post-acute sector, inpatient and post-acute, means you're crossing institutional lines. And that creates both complexity in terms of how the bundles are potentially managed; it creates political challenges, et cetera. And so bundling has some real significant aspects to it.

I'm not sure I entirely agree that you have to do the whole thing in order to make progress. I'm just not sure one way or the other. In fact, as I look at the first two bullets on page 16, in a sense, to me they seem like they could be sort of semi-bundles in the sense that, although these are both characterized as changes to the

acute hospital payment system, I imagine that the way you would do it is that you could say that the acute hospital could transfer the patient to a building that currently has long-term care hospital over the door, maybe across the street or down the block or on the other side of the city, so long as it's not triggering a new Medicare payment. You know, you could have care that spans what are currently different organizational lines for the specific long-term care hospital patients and not get involved in all of the SNF and all of the home health.

So there's sort of a question mark at the end of that. You know, we usually -- the transferring of patients is a significant event because it triggers a new flow of dollars from Medicare. If it's not triggering a new flow of dollars, we could have a different set of rules about moving patients to specialized facilities, is my question.

DR. CHERNEW: I think the challenge -- and I recognize how difficult it is -- is we need to have a payment system that recognizes existing organizational structures which vary across markets, but a payment system that doesn't encourage inefficient organizational structures, that, in other words, allows some sense of

efficiency. And that's a challenge to do, and I think that's why we have sort of some directions, but we don't have a particular answer to that question. But I do think there is -- it's important to recognize that our job isn't to maintain a payment structure to support an existing organizational setting that might not be right or best. But, on the other hand, we can't be so naive to think that if we change the payment structure and just assume the organizations were different, the world would be a better place, because the organizations are important.

DR. MARK MILLER: What I was going to say is, you know, our attempt, as always, is to bring peace and harmony to the entire world.

MR. HACKBARTH: You're not doing very well.

[Laughter.]

DR. MARK MILLER: Yeah, I figure we'll have this wrapped up at the end of the month. So I want you to understand that the whole range of comments here, I would have said about Glenn's comment -- and I'm not just saying this because he's the Chairman and could fire me immediately -- that I do think that that is correct that the way that we're thinking about, that the payment would move -- when

the patient reached a certain complexity, the payment would kick in behind it; and if the hospital had a way that they dealt with this patient, they could do that. There's nothing that would prevent them. And the thing we are trying to navigate is this triggering another payment.

And to the discussion that you two were having but was implicit throughout all of this, we're trying to come back to the Commission with a bundled option, which has all its issues and problems, and different options, which also have their own issues and problems, and bring you a continuum and let you work through each of them.

MR. HACKBARTH: Okay. So this was very thought-provoking. We do have the business of final vote on the recommendation, which Dana will put up.

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

[Show of hands.]

MR. HACKBARTH: Opposed to the recommendation?

[No response.]

MR. HACKBARTH: Abstentions?

[No response.]

MR. HACKBARTH: Okay. Thank you. Good work. I

look forward to hearing more about it.

And now we move on to hospice.

[Pause.]

MS. NEUMAN: Good morning. I'm going to review our indicators of payment adequacy for hospice before you vote on an update recommendation. We discussed these data in more detail at the December meeting, and your paper also has more detail.

Before I do that, I'll give a brief overview of hospice and respond to questions from the December meeting.

Hospice provides palliative and supportive services to beneficiaries with a life expectancy of six months or less who choose to enroll. In 2011, over 1.2 million Medicare beneficiaries received hospice care, including 45 percent of decedents, and Medicare spending totaled $13.8 billion.

At the December meeting, there were several questions.

Jack, you noted the substantial difference in hospice average length of stay (86 days) and median length of stay (17 days) and asked for more information on the distribution of length of stay by beneficiary and provider

characteristics. We've included a chart -- Table 6 -- in your paper that has the distributional data, and I'd be happy to discuss it in detail on question.

Mary noted that some patients in LTCHs are likely hospice eligible and asked about the cost differences of LTCH care and hospice care. And as just discussed in the LTCH session this morning, some patients are in LTCHs because LTCH care matches with their goals and preferences. But as a recent article in Medical Care pointed out, there are also some patients being transferred to LTCHs without receiving clear information about their prognosis, and some may make different choices if they did, including some possibly choosing hospice.

As far as the cost differences between LTCHs and hospice care, hospice is paid a daily rate that ranges from about $150 per day for routine care, which is the vast majority of days, to between roughly $700 and $900 per day for inpatient hospice care or continuous home care. LTCHs are paid per discharge, but they have an average payment per day that's about $1,400, or a little bit more than that.

At the December meeting, several Commissioners expressed an interest in facilitating appropriate use of

hospice among patients for whom hospice fits with their preferences and other ways to improve quality and payment approaches for end-of-life care more generally. I will come back to this and lay out some potential research we could consider at the end of the presentation for your feedback.

So the next couple charts summarize our indicators of payment adequacy for hospice providers. As discussed in December, our indicators of payment adequacy are generally positive.

The supply of hospice providers continues to increase, driven almost entirely by growth in for-profit providers. The number of for-profit providers grew 5 percent in 2011, which resulted in a 2.5 percent increase in the total number of providers.

The percent of decedents using hospice continues to increase. Forty-five percent of decedents used hospice in 2011, up from 44 percent in 2010 and 23 percent in 2000.

Average length of stay, which grew substantially since 2000, was steady at 86 days in 2011.

Unlike most of the other sectors, we do not have quality data for hospices. A voluntary quality reporting program will begin in 2013, and hospices that do not report

will face a 2 percentage point reduction in their 2014 update. We expect the vast majority of hospices to report in 2013.

Access to capital appears adequate. We continue to see entry of for-profit providers as I noted, suggesting adequate access to capital for this group. Less is known about access to capital for nonprofit free-standing hospices which may be more limited. Hospital-based and home health-based provider have access to capital through their parent provider.

In terms of the margins, the aggregate margin was 7.5 percent in 2010. 2010 is the year for which we have the most recent data in this sector.

You'll recall that this estimate does not count cap overpayments as revenues, and it excludes nonreimbursable bereavement and volunteer costs.

Margins vary by type of provider. Free-standing hospices have higher margins than provider-based hospices. This is due in part to higher indirect costs among provider-based hospices due to the allocation of overhead from the parent provider.

For-profit providers have higher margins than

nonprofits, and urban providers have somewhat higher margins than rurals.

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

So this brings us to our 2013 margin projection. This slide outlines our assumptions, and based on those assumptions, we project a margin of 6.3 percent in 2013.

One policy of note for 2014 is the phase-out of the wage index budget neutrality adjustment which will reduce payments an additional 0.6 percentage points in 2014.

So this brings us to the draft recommendation. It reads: The Congress should eliminate the update to the hospice payment rates for fiscal year 2014.

This recommendation would decrease spending relative to the statutory update by between $50 million and $250 million over one year and between $1 billion and $5 billion over five years. And we expect no adverse impact on beneficiary access to care or providers' ability or willingness to serve Medicare beneficiaries.

In addition to the update recommendation, we also plan to print in the March report the two standing

recommendations the Commission made in March 2009.

The first is the payment reform recommendation. This is the U-shaped curve. It would increase the per diem payments at the beginning of the episode and at the end of the episode near the time of the patient's death, and lower them in the middle, and this would better align payments with the service intensity of care. It has the potential to improve the accuracy of the payment system and make it more neutral toward length of stay. It also would affect the distribution of payments across providers, increasing payments for providers that currently have lower margins and decreasing payments to providers that have higher margin.

The second recommendation is for focused medical review of claims exceeding 180 days for hospices with unusually high numbers of patients with long stays. This recommendation was in response to concerns we heard from the hospice community about the need to target regulatory scrutiny toward those providers where it was most warranted. PPACA included a similar medical review provision, but CMS has not implemented it.

At the December meeting, Commissioners discussed the importance of hospice as an option for beneficiaries and

expressed a desire to facilitate appropriate hospice use among patients for whom hospice fits with their preferences, and to improve quality of and payment approaches to care for patients in the terminal stages of illness. This slide is in response to that discussion and outlines some research areas that we could consider exploring.

First is shared decisionmaking. Many patients with advanced illnesses do not get full, timely, or clear information about their prognosis and options for care. So, shared decisionmaking tools may offer an opportunity for improved physician-patient communication and help empower patients to make end-of-life care choices consistent with their goals and preferences. As mentioned at yesterday's meeting, we anticipate updating the Commission on our work on shared decisionmaking later this spring.

Another thing we could explore is including hospice in Medicare Advantage instead of the current carve-out. Currently, Medicare Advantage enrollees receive hospice care outside of the plan from a hospice provider paid directly by Medicare just like fee-for-service beneficiaries. With the health care system moving toward more integration of care, it raises questions about whether

having hospice carved out of Medicare Advantage makes sense. If hospice were included in Medicare Advantage for Medicare Advantage enrollees, plans would have flexibility to provide more expansive hospice benefits than fee-for-service if they chose to do so.

We could also explore fee-for-service demonstrations that test more flexibility in the hospice eligibility criteria. PPACA included a demonstration to test concurrent hospice and conventional care. Funds for the demonstration were not appropriated. Some of the interest in concurrent care has been spurred by Aetna's program in the commercially insured working-age population that expands hospice eligibility and allows concurrent care, and that Aetna reports has not increased costs. That program, though, exists in a managed care environment among a younger population where cancer is more prevalent. It is not clear that we'd see similar results in Medicare fee-for-service. With that in mind, we could consider exploring fee-for-service demonstrations focused on specific conditions where more flexibility in hospice eligibility is thought to have the best chance of not increasing spending.

Another area we could explore is bundling.

Research is currently underway to develop and test bundled payment for episodes of care that include post-acute care, and we could explore whether there would be benefits to including hospice within such bundles.

Finally, there is the issue of quality measurement. Quality measurement focused on end-of-life care is very limited. Quality reporting is beginning for hospices in 2013, but this initial step may not be very robust. There is very little quality measurement focused on care for patients in the terminal stages of illness outside of hospice. We could explore whether there are ways to broaden quality measurement across settings for care of patients with advanced illnesses.

So, with that, that concludes my presentation. I look forward to your discussion and any questions.

MR. HACKBARTH: Thank you, Kim.

Can I ask a question about payment reform? My recollection is that PPACA directed the Secretary to modify the payment system along the lines that we described with our U-shaped concept, but do so not before fiscal year 2014. Is that correct? Is my recollection correct?

MS. NEUMAN: Yes, the Secretary cannot make any

changes before fiscal year 2014. The caveat is that she has full discretion about what, if any, changes to make, so it could look different from our recommendation.

MR. HACKBARTH: Okay. So it wasn't prescriptive in terms of the sort of payment reform.

MS. NEUMAN: Right.

MR. HACKBARTH: Okay. Is the department working on reforming the hospice payment system? If I missed it when I was out, if you talked about, I apologize.

MS. NEUMAN: So they have research underway, contracts underway to look at this, and they have a technical expert panel of industry groups that are providing input to them. So there is activity underway as they move in this direction of considering this.

MR. HACKBARTH: Okay. But fiscal 2014 is not that far away. It doesn't look like they have something planned for 2014?

MS. NEUMAN: It seems unlikely that there would be something for 2014.

MR. HACKBARTH: Okay. Mary, do you want to lead off our round of questions and comments?

[Laughter.]

DR. NAYLOR: I certainly do. Thank you for this opportunity.

[Laughter.]

DR. NAYLOR: So similar to home care, I think hospice represents a huge, critically important opportunity, and thank you, Kim, for a terrific report and for your responsiveness to some of the questions.

Let me just say if we were to do it right, to target it to the right population, and it's a match and aligned with their needs, this is a huge opportunity for us to really advance the care and outcomes of Medicare beneficiaries and to yield high quality of life. It's great to see the growth from 23 percent to 45 percent in the period we have. It's of concern that the length of stay, even though there are the outliers at the 90th percentile, that we still have difficulty getting some people in. As a matter of fact, we have difficulty getting many people to have access to the benefit to really maximize on the benefit, so entering too late into the program.

It's of concern that there are certain subgroups, including dual eligibles and African Americans and Hispanics, that at least as your data present are not

accessing the benefit, so the opportunity to really target it, et cetera.

It's great to see the growth in non-cancer because this started out one way and it's great to see movement to recognize that people live with multiple, complex chronic conditions, and only one of them gets captured and so on.

So there are so many important things. In terms of your options -- and I will get to the recommendation -- I really like the notion of focusing on shared decisionmaking. I'm aware of Aetna's Compassionate Care Program, and I think some kind of really robust effort to look at what we've been trying to look at, which is broadening the benefit, concurrent cure, maybe looking at extending it and so on. And I think the attention to end-of-life quality measures makes a lot of sense.

I would have to think conceptually about hospice in bundled payments even though I'm a bundled payment -- someone who supports that, as many others do here.

The thing in terms of the margins, I think the margin of 6.3, you know, it doesn't include the 1.4 for bereavement, and it doesn't include -- and I know we've had many conversations with many other Commissioners in the past

-- the 0.3 for volunteers, which are critically part of the benefit program. But I think the biggest challenge with the margins, as we've related to and seen in other areas, are the differences we're seeing in for-profit versus not-for-profit.

With all that said, I think that we are in an area where there's opportunity, huge opportunities, with beginning efforts in measuring pain and allowing organizations to begin to report at least three quality indicators to get us further. You know, I support the recommendation, but I really, really, really support our continued efforts to refine and forge a path that would really promote greater access to the right time for the right targeted population when it's aligned with their needs.

MS. UCCELLO: I agree with pretty much everything that Mary said, and in terms of the growth in the non-cancer users of this service, I think, you know, because of their longer lengths of stay, this really increases the importance of getting the payments right and shifting to that U-shaped curve. So we may want to highlight that.

And in terms of these potential options, I, too,

really want to look more into the shared decisionmaking, so I look forward to our discussions on that.

DR. HALL: Well, I guess in my experience, the hospice movement has been one of the most important changes in medical care that I've seen over my career. It has all the right things. It started out largely as a voluntary movement. It was often community-based, the very best people. They knew about shared decisionmaking before we knew there was such a thing as shared decisionmaking.

As Mary has mentioned, it's not just a place to go to die, whether a real or a virtual place, but it's a way of living during this stage of your life. It has relatively seamless transitions between home care, respite care. Some of the best people around in terms of pain control are involved in the hospice movement. It's a wonderful example of doing the right thing and extremely important for, I think, Medicare recipients.

So I think if there are some areas that need to be tightened up, like quality indicators, looking at the for-profit sector, I'm all for that. I think this is the kind of tightening up that will allow this movement to continue to flourish.

As far as bundling this again say in an MA program, there probably are some practical problems. I don't know how it is in your area, but if you look at the renewal cycle for MA programs and the advertisements, it's usually a bunch of oldsters frolicking on the beach at Cancun. It doesn't show somebody at terminal stages of life who is seeking pain control.

So there is this sort of image issue about hospice, although that, too, is changing. So anything we can do to tighten up this program and encourage its used, I think that would be a great blow for justice, for the Commission, so I'm very much in favor of this.

DR. DEAN: I would support the recommendation. I had a question on Table 7 of mailing material which had to do with the live discharges, and I didn't understand the -- you know, I understand the point of the table, but I didn't understand those percentages. Those are percentages of what?

MS. NEUMAN: That is the percentage of benefit periods that end in a live discharge. So, for example, I'm just looking at Period 1 in that table -- go ahead.

DR. DEAN: So -- I'm sorry. Go ahead.

MS. NEUMAN: I was just going to say, so it says basically that for everybody who enters their first hospice benefit period, a little under 9 percent of those end in a live discharge as opposed to dying or staying on into a second benefit period.

DR. DEAN: I see. And how does the overall percentage of live discharges, does that -- those wouldn't -- we wouldn't add those us to get that, but we --

MS. NEUMAN: We wouldn't because there are -- if someone isn't in the percentage for the first benefit period, then they move into the second, and then there's one of three outcomes in the second and so on. So you raise a good point. It would be helpful to have the overall rate.

DR. DEAN: Of all the patients that enter into hospice care, do we have a measure of the portion that result in live discharges?

MS. NEUMAN: We do, and --

DR. DEAN: And I know it varies. I know it's been an area of question, and it varies, as I recall, quite a lot between programs, which is an important bit of information, I think.

MS. NEUMAN: Exactly. It varies between

providers. It varies by diagnosis. And that number -- the number that we have reported is a little bit under 20 percent, but it would be helpful if I could give you the specifics of how that number is defined. So why don't I put that in the paper and add that information.

DR. DEAN: Okay. I think that would be useful because it does raise the question of selection, proper selection of people entering into care. Otherwise, I certainly support everything that Bill just said.

Actually, just a historical bit. When I was a medical student, I went to a lecture by Dame Cicely Saunders in London, who I think is the sort of grandmother of this whole movement, and it was a powerful lecture. That was a long time ago.

[Laughter.]

DR. CHERNEW: Every time we go around the clock about hospice, I think there's just this groundswell of support for the aspects of the program, and I think I share that and I think it's well-known that we don't do a great job surrounding end of life, generally speaking, for a whole bunch of reasons, and we can do better, and I think that's important.

My only general caveat, which is a little bit like a broken record, is the more we can concentrate on the people and what different types of people need and less about where they're getting their care and other aspects of things, I think in general the better we would do. But that said, a portion of that is clearly going to be these hospice services, however they're paid for or configured. And I think we have to make sure we can preserve that in a responsible manner. So I support the recommendation.

MR. BUTLER: On page 7, I just want to be a little clearer on -- we've said the spending implications of our recommendation saves money, but I'm a little less clear on what happens in the absence of sequestration, and by law, what -- go back to the one before that. What happens? When you sort all that out, what's the increase next year, if any?

MS. NEUMAN: The estimated statutory update next year is between 1.8 and 2.1 percent.

MR. BUTLER: So that's what we're eliminating, essentially.

MS. NEUMAN: Yeah.

MR. BUTLER: Right. Okay. So then on your

research page, the last page, the one other aspect we haven't talked about -- we've tracked well and shown how increasing neurological illnesses and other things are occupying actually over half of the hospice business, so to speak, versus cancer. Most hospices have broadened their involvement into palliative care significantly and intervened not at a time when somebody might be dying, but they come in and they reset drugs, they reset pain, they recalibrate and often save money and improve life. And I see that only growing, but I'm not sure, because it is not a hospice -- these patients do not qualify for hospice, but this is, again, something we would want to incentivize. I would think that we need to begin to think how that fits into a bundle or how it fits into kind of something beyond just us narrowly looking at those people that are expected to die within six months that qualify for hospice.

DR. NERENZ: A couple things. First of all, I will support the recommendation. But if we could flip back to Slide 6, just a couple comments in preface.

First of all, I would second Bill's and Tom's points about the benefits and worth of hospice. I certainly share that idea and believe it's something that we should

encourage and support.

Like Mike, I'm going to now sound like a broken record on my point of the second bullet point, the striking differences in margin between the hospital-based and the free-standing. I do take your point about how some of this just reflects decisions about allocation of indirects. But as we get close to our last bit here, this is a pattern that we see over and over again across these different domains of payment. So if somehow this one was just reflecting some decisions about allocation, we would expect perhaps in another domain of payment you'd see a positive margin. But in almost everything hospital-based, we need negative margins.

And it would seem then that we have to take a couple different general views of this. One is we either accept that the underlying cost structure in hospitals, regardless of whether it's IRFs, whether it's dialysis, whether it's this, is higher and that we actually should intentionally encourage the movement of these services away from hospital settings into settings that are truly lower cost. We could take that view. Or we could take the view that there are good reasons for doing a whole set of these

things, not just hospice but others, in hospital settings because of some advantages that we'd have to articulate. And if that's the view, then we would be concerned about something like negative 16 percent.

Now, I think folks on the Commission who are specifically from hospitals or representing hospital groups can probably speak about this more eloquently than I can, but having seen this now over and over again, I am a bit concerned about this.

MR. HACKBARTH: My initial reaction, Dave, is that I think that there are different reasons for this pattern. The pattern is consistent, but it's not always caused by the same factors. So there are some services -- home health, and I think hospice probably also applies -- where if you add a share of hospital overhead, that puts the hospice or the home health provider at a significant disadvantage in terms of cost structure compared to home health providers and hospices that don't have hospital overhead. These are not organizations that typically have hospital-type organizational structure and cost. So that's an issue in some of them.

In other cases, we've found that, in fact, there

are issues with the payment system. So an example of hospital-based SNFs, what we've found is, well, there may be some allocation issues, but we also found that hospital-based SNFs were hurt disproportionately by flaws in the SNF payment system, specifically that we overpay for therapy services and underpay for non-therapy ancillary services. And if you fix that flaw in the payment system, the hospital financial performance for hospital-based SNFs improves dramatically.

In the case of hospice, it may be -- and you may know the answer to this, Kim -- that we know overall that hospices that tend to have shorter lengths of stay tend to have poorer financial performance than the hospices that have really long st analyst. And so if the way hospice has evolved in hospital-based SNFs is they tend to have short-stay patients, that could contribute to the poor financial performance over and above any allocation issues.

So the pattern is consistent, as you say, but I think the reasons for it may vary somewhat at least sector by sector.

Kim, do you want to --

MS. NEUMAN: Yeah, that's exactly it for the

hospital-based hospices. They have higher overhead, and then they also have shorter stays. So it's a combination of those two things.

DR. NERENZ: And that's fine and all understood. I guess I just would have to state then the obvious point. If the indirects were allocated in a different way, it would just mean that another sector would be more negative or appear more negative than it does now if those costs have to go somewhere.

DR. MARK MILLER: I'm not saying that it overcomes this completely, but then does that also mean if you go to the U-shaped curve it tends to push these guys up?

MS. NEUMAN: Exactly. They would have higher payments under a U-shaped curve.

DR. MARK MILLER: So I just wanted to hard-wire that to your mind. We've also tried to think about that, and if they would move forward with it, it should help this situation.

MR. HACKBARTH: The analog to refining the SNF payments [off microphone].

DR. NERENZ: Yes, understood. Thank you.

DR. REDBERG: Thanks very much for an excellent

report, and I support the recommendation and agree with a lot of what Mary and others have said about the importance of the hospice benefit, and in particular, I like the options for future research, looking at shared decisionmaking, because I think it's certainly true that this is an underutilized benefit currently and that, you know, you look -- I assume the difference between the median and the average length of stay is because a lot of hospice stays are still very short, which I assume is because people didn't know about it until very late. And, also, you know, notoriously, I think a lot of the end-of-life care in the Medicare population is either cancer or congestive heart failure, and we have research over and over showing that, for whatever reasons, and perhaps good intentions, doctors are particularly poor at recognizing when our congestive health failure and cancer patients are at end of life and, therefore, are not offering hospice to these patients. And so I think perhaps it's part of our care coordination, but if there's more coming from primary care physicians and more focus really from within the profession on recognizing and in our training programs on recognizing when our patients are at end of life, because it's really not -- as well

intentioned as it is, it's not a service to a patient who really had a few months to live to not be aware of that, not offer hospice treatment, and not, frankly, you know, do all the other end-of-life planning that patients need to do instead of -- I mean, I frequently see patients that are clearly at end of life in ICU getting chemotherapy that has absolutely no chance of helping them, where I think if they had a choice -- and that's a big pot of shared decisionmaking -- they would not choose to be in that setting.

So I look forward to future research and our own efforts also within the profession to better recognize and offer hospice as an option.

My only other question was from the mailing materials there was reference to the 2009 recommendations and some anecdotal reports of questionable relationships between nursing facilities and hospices. Has anything more happened in that area?

MS. NEUMAN: We continue to hear similar reports, so I don't think that the situation has changed. The Commission did recommend that the OIG take a look at hospices that focus on nursing facilities, and the OIG did

issue a report where they found that there was -- you know, there's a subgroup of providers who really focus on nursing facilities, and these tend to be for-profit providers. These facilities tend to have patients that have longer stays, less complex care needs, and the OIG wound up recommending a payment reduction for hospice care in nursing facilities as a result of that report.

So it's an issue that we continue to do research on ourselves, but that's sort of the status of what happened.

DR. BAICKER: I support the recommendation and am particularly intrigued by the directions for future research, looking at more flexible benefits and, you know, drawing on the examples from the private sector that you've outlined and that we've heard reports about. Encouraging patients to use hospice care while not denying curative care can both improve well-being and lower costs. This seems like a great avenue for future research, and I'm supportive of the recommendation. That's it.

DR. COOMBS: So I support the recommendation, and I had a similar question to David's, but it's already answered. I'm also interested in those patients who

actually get discharged from hospice. It's always a different kind of paradigm for them.

MR. GRADISON: I support the recommendation. A little bit of history. I was pretty heavily involved in getting this benefit added to Medicare, and it was an interesting experience because the executive branch was totally opposed to this. The significance of that is that the design was pretty much written by the Congress, and it didn't invent it. It basically looked at the hospices that existed at the time and, like the 80/20 rule and stuff like that, wrote that into statute.

To me, what is remarkable isn't really that we did such a great job in those days but, rather, that something like 30 years has gone by and somebody -- Rip Van Winkle -- who saw this in its first days, looking at it today would recognize the benefit structure and probably would comment particularly on how gratifying it is, how it is voluntary, it's an option, you don't have to do it, the way that it has gained acceptance, however slowly. I personally think there is room for a major review of the nature of the benefit. We certainly didn't contemplate these long stays at that time. That wasn't even in the discussion. And the unevenness of

cost spread over time is highly important to review that, as well as the other suggestions that are up here. So I just want to -- I'm really making this point just to say that, you know, here's somebody you might expect to just defend it just as it is. That's not the case at all. I think after 25 or 30 years it's probably a good idea to take another look.

DR. HOADLEY: Thank you, Kim, for really good information and following up on the questions. I do support the recommendation, and I'm really looking forward to the options forthcoming.

You know, it's interesting. There's clearly some issues, and particularly on this idea of different eligibility criteria and these issues about the concurrent care. And, you know, I don't have an opinion on whether that's the right direction to go at all, and so I'm really interested in hearing what some of the pros and cons are. I mean, I could see some real strengths in that. I could see some real drawbacks if it means people don't confront the choices about whether to continue treatment because, oh, well, we can sort of get the best of both somehow. Hopefully in this environment that would lead to actually

shared decisionmaking and thinking through and all that.

You know, the long-stay cases are intriguing, and, you know, the distributions you showed suggest it's not really concentrated just at the 90th and 95th percentile, but there are some pretty long stays out at the 75th percentile. So there's a fair amount of people that are in those long-stay tails, and I think the more we can understand, you know, who those are and what are those circumstances -- and they may be appropriate because of the different patterns of illness and disease.

And the only other comment, sort of taking off on Bill's comment, you have the note in the text about there's been on recalibration or rebasing of this system really since the beginning, and, you know, we had a lot of discussion about rebasing on a couple of the systems yesterday, and it strikes me as maybe that's a sign that's really a pretty well working system, but I guess it always opens up that question of is there a need for looking back at that. And maybe the answer is on.

DR. SAMITT: Thanks, Kim. Great job. I support the recommendation. I guess my perspective is that it's clear that there are some settings where hospice is actually

being overutilized, but even more importantly, I think the bigger problem is that hospice is being underutilized and plays a very significant role. And I frankly don't think we're doing beneficiaries a service because we're not maximizing the use of this very critical benefit. And I think Bill put it, you know, that we need to both tighten up the program, but even more importantly, encourage its use.

And I like the research because I think that it will begin to help us focus on how we can encourage greater use. But I'm not even sure it goes far enough. I know that our place is to recommend payment policy, but one of the things that I don't think we talk about enough is sort of recommending data policy.

Someone over here had mentioned the fact that, you know, physicians don't know when they should be using hospice more. I don't know how effective a job we play or CMS plays in sharing information with providers about, for their population, the average hospice use versus what would be expected in a certain population or average hospice length or, you know, to the degree we are sending patients to hospice too soon or too late. To what degree do physicians, who are the primary drivers of these decisions,

and/or hospitals, get to see that information? We share that a lot. I think that in general we should be sharing that a lot more. And I don't know if that becomes part of the research recommendations or it goes broader, but we should encourage greater sharing of information with providers.

MR. KUHN: I support the recommendation.

MR. GEORGE MILLER: Yeah, I support the recommendation, and I first want to thank Mary for teeing it up, and all of the other colleagues who have made important statements about this important part of the continuum. I think hospice is the right seamless part of the American health care system. Particularly we engage in shared decisionmaking. And to Craig's point, one of the things that I think not only should we encourage the use, but I think that it should be a part of the discussion early on in the continuum of care, particularly when we have discussions about living wills. The percentage of patients that don't have living wills or DNRs is just still astounding in this age of information. And we could talk about the hospice benefit in the beginning and explain how it could be used, so maybe the other sectors we've talked about, utilization

may just naturally go down, and both the physician and the patient is fully informed of that benefit to help them make that decision going down through the continuum of care.

And sometimes, though, those decisions are difficult, but so often, quite frankly, in operating hospitals we see sometimes the right theoretical reason physicians use heroic efforts and try to do things valiantly, and it's unfortunately just a waste of resources, quite honestly and quite frankly, and not going down the road of trying to take decisions from someone, but just knowing all the options, and this gives us that opportunity.

So the encouragement of getting data and quality so we can give people the opportunity to make informed decisions is important.

MR. HACKBARTH: Craig, on your point about feedback, in years past we have made some recommendations about CMS providing more feedback to physicians on how their practice patterns compare to their peers'. Based at least in part on one of our recommendations, Congress required CMS to do that. And it would actually be good for us at some point in the not too distant future to delve back into that review, the progress that has been made or not been made on

that effort. I think last I heard, it was proving somewhat challenging in terms of really being effective in reaching physicians and engaging them. But I'm eager to get an update on that.

DR. MARK MILLER: This is an awkward point. We just had this conversation internally of like, "What ever happened with that?" and had not gotten back to it. You're right.

MR. HACKBARTH: Yes.

MR. KUHN: I would just make a point on that one. When I was at CMS, we did engage in that activity. We did a number of focus groups where we brought together physicians to look at their own data to begin trying to get a sense of how we could array it, how we could present it to them, et cetera.

The reactions were interesting, and I think the reactions were interesting because it's driven by the fee-for-service program. Rather than looking at where they position themselves with their colleagues and where they perform, where they really focused on is where their colleagues were doing more volume from where they were and where were their missed opportunities. And so the data had

just the opposite effect of what we thought it would be. So it's driven by the fee-for-service system, and that's what we go.

So I think it's an area worth exploring into the future, but be careful what you ask for.

MR. HACKBARTH: So, Kim, would you put up the draft recommendation, please?

For the audience, just a word about this recommendation in particular and our recommendations in general. It's phrased as "should eliminate the update." What I want to be clear about and what our report will be clear about is that the way we are thinking about these recommendations for hospice and other providers is that we make recommendations relative to the current base rate. And so what this recommendation means for hospice is if you take the base rates that prevail in FY2013, we're saying they should be unchanged in FY2014.

There are other things going on in the environment, like the sequester, that reduce rates. To the extent that the sequester reduces the rate below the level that prevails in fiscal year 2013, it would be inconsistent with the MedPAC recommendation. It's Congress' prerogative

to do that, but our recommendation is that the prevailing rates be held constant through fiscal 2014.

So we're not saying, just to pound the point one more time, eliminate the update and go ahead and take the sequester and we're okay with the net result of that. We're saying the rate should be held constant at the now prevailing levels for hospice and other providers.

So it's time to vote on the draft recommendation. All in favor of the recommendation, please raise your hand?

[Show of hands.]

MR. HACKBARTH: Opposed?

[No response.]

MR. HACKBARTH: Abstentions?

[No response.]

MR. HACKBARTH: Okay. Thank you, Kim

[Pause.]

MR. HACKBARTH: And our final session is on the status of Part D.

MS. SUZUKI: Good morning. In this presentation, I'll provide a status update on Part D with a focus on access and cost and how Part D program is working for the enrollees.

And before I start, I wanted to thank Katelyn Smalley for her work on this project.

Here's a quick overview of the Part D program. Spending for Part D totalled about $60 billion in 2011. In 2012, over 30 million beneficiaries were enrolled in Part D, and Part D enrollees filled, on average, four prescriptions at $230 per enrollee per month in 2010. In 2013, over 1,000 stand-alone PDPs were available nationwide, along with over 1,600 MA-PDs.

Here's a quick overview of how this presentation will proceed. I'll first discuss Medicare beneficiaries' access to prescription drugs. We'll cover topics such as Part D enrollment and plan offerings and take a closer look at ten percent of the beneficiaries who do not have creditable coverage and discuss recent trend in plan offerings that use tiered pharmacy networks. Next, we'll look at costs of the program with a focus on the use of generics and how that has affected Part D prices. Finally, I'll report some findings from our analysis of voluntary plan switching by Part D enrollees.

In general, Medicare beneficiaries seem to have good access to prescription drugs. All individuals have

access to many Part D plan options and many continue to receive drug coverage through former employers. Survey indicates that beneficiaries enrolled in Part D are generally satisfied with the Part D program and with their plans.

In 2012, about 65 percent of beneficiaries were enrolled in Part D plans and an additional nine percent had coverage through employer plans that receive Medicare's retiree drug subsidy. Some beneficiaries receive their drug coverage through other sources of creditable coverage, such as the Veterans Affairs and TRICARE and Federal Employees Health Benefit Plans. Although we do not have data for 2012, a subset of beneficiaries likely have no drug coverage or coverage less generous than Part D.

There hasn't been a dramatic shift in the Part D enrollment patterns from year to year. In 2012, about 63 percent of Part D enrollees were in stand-alone PDPs and the rest were in MA-PD plans. As in previous years, most LIS enrollees continued to be enrolled in PDPs. A larger share of MA-PD enrollees have enhanced benefits, such as coverage in the gap.

In 2013, about the same number of plans are

available as in 2012. There are between 23 and 38 stand-alone PDPs available, depending on the region. And the typical county has five to ten MA-PD plans.

In 2013, more PDPs are offering a coverage in the gap compared to 2012. The extent of the gap coverage varies from plan to plan, with some plans providing coverage for only a few generics and others providing coverage for both generics and brands.

Although having some coverage in the gap may provide important protection, particularly for people with high drug spending, this will become less important over time as the coverage gap is gradually phased out.

In 2013, beneficiaries will pay a cost sharing that is slightly less than 50 percent for brand name drugs and 79 percent coinsurance for generic drugs, which is a reduction from 86 percent last year.

This pie chart shows the drug coverage for all Medicare beneficiaries. According to data released by CMS, in 2010, about 60 percent of beneficiaries were in Part D. Fourteen percent were in plans that received their RDS. And another 17 percent had other creditable coverage. The remaining ten percent either did not have drug coverage or

had coverage less generous than Part D's benefit. Although the composition of the sources of creditable coverage has changed somewhat since the program began, the ten percent without creditable coverage has been pretty much unchanged.

Since 2012 data are not available, we looked at 2010 Medicare Current Beneficiary Survey data on coverage and access to prescription drugs to better understand this group of beneficiaries. We found that not everyone in that ten percent went without drug coverage in 2010. Four in ten indicated that they had some drug coverage. The remaining did not report having had any drug coverage. When asked why they did not enroll in the Part D program, slightly over half reported that they did not take enough medications to need such coverage or they would not benefit from enrolling in Part D. A small number of individuals reported cost as one of the reasons for not enrolling in Part D.

Beneficiaries with no creditable coverage differ in many respects from those enrolled in Part D. For example, they tended to be younger, have higher income, and have somewhat more education, on average, compared with Part D enrollees. They also tended to be healthier, with 26 percent reporting being in excellent health compared with 13

percent reporting being in excellent health among Part D enrollees.

So we just saw the plan availability hasn't changed much for 2013, but there are some changes in plan features. One relatively new trend we're seeing is the use of tiered pharmacy networks that classified some pharmacies as preferred and others as non-preferred. In 2012, six stand-alone PDPs have both preferred and non-preferred pharmacies in their networks and used differential cost sharing. Enrollment in these six plans accounted for about 12.5 percent of the total PDP enrollment. The share of pharmacies classified as preferred pharmacies varied across plans, from about eight percent for Humana Walmart Preferred plan to about 30 percent for BlueMedicare plan in Florida. Most had cost sharing differentials between preferred and non-preferred pharmacies that range from $5 to $10 for generics and up to a 19 percentage point difference for brand name drugs. At least five plans had announced addition of preferred pharmacies for 2013 at the time this analysis was conducted.

One reason we're keeping an eye on this trend is because this could have an effect on beneficiaries' access

to medications. Plans must meet a network adequacy requirement that CMS has established to ensure beneficiaries' access to pharmacies. For plans with tiered pharmacy networks, since both preferred and non-preferred pharmacies are considered to be in network, a plan could meet the network adequacy requirement by having only non-preferred pharmacies in some areas.

Although CMS rule allows tiered networks only if the cost sharing is not so significant as to discourage enrollees in certain areas from enrolling in that plan, it appears that plans have interpreted this rule in different ways, with some plans charging 60 percent coinsurance in non-preferred pharmacies for certain brand name drugs while charging 40 percent coinsurance in preferred pharmacies. Other plans have no difference in coinsurance for brand name drugs or a difference of a few dollars.

Another concern is whether enrollees were aware of plans' use of tiered pharmacy networks. The impact of cost sharing differentials between preferred and non-preferred pharmacies could be significant, particularly if beneficiaries were unaware or did not understand the distinction.

Although the population currently affected by the tiered pharmacy network is relatively small, many more could be affected in the coming years. Access and cost implications of tiered pharmacy networks are not yet known and we will continue to monitor the plans' use of tiered pharmacy networks and the effects on beneficiaries' access to medications.

Cost is another aspect of the program that we closely monitor. This chart shows the year-to-year changes in the average bids from plan sponsors. As you can see, the bids have fluctuated over the years. The national average bid for 2013 is about the same as it was for 2012, but there are some notable changes in the expected costs of the individual components, as you can see from comparing the last two bars to the right.

The direct subsidy portion, which is in green, is a much smaller portion compared to 2012, decreasing by over nine percent between 2012 and 2013. On the other hand, the reinsurance portion, which is the orange piece, is expected to grow by about 14 percent between 2012 and 2013. The higher growth in the reinsurance component of the bid may, in part, be due to the expectation that the gradual phase-

out of the coverage gap will result in higher reinsurance costs.

The base beneficiaries' premium will be $31 in 2013, which is about the same as in 2012. Higher-income beneficiaries pay a surcharge calculated based on income, similar to the income-related premium under Part B.

The average plan bid we just saw reflects plans' expectations about what it would cost to provide basic coverage for a beneficiary with average health. Here, we're looking at the actual program spending. Payments for low-income subsidy continues to be the single largest component of Part D spending. Spending for this subsidy has grown by 36 percent cumulatively between 2007 and 2012. Payments for individual reinsurance has grown the fastest between 2007 and 2012, with a cumulative growth of 84 percent. This is the subsidy that covers most of the cash costs for beneficiaries who have very high drug spending.

In our analysis of the Part D data last year, we found that people with spending high enough to reach the catastrophic phase of the benefit filled more prescriptions, on average, and the cost of each prescription tended to be higher because more of them were for brand name drugs. We

also found that over 80 percent of the people with high drug spending received the low-income subsidy. These findings led us to recommend that the Congress give the Secretary the authority to provide stronger financial incentives for beneficiaries who receive the low-income subsidy to use lower-cost generics when they're available.

Finally, I wanted to quickly note that spending for the retiree drug subsidy, which is at the bottom, in green, has been decreasing over the years, and this reflects the drop in the number of people who receive their coverage through former employers who receive the subsidy. This trend may have been accelerated by the changes made in PPACA that no longer allows employers to deduct prescription drug expenses that are covered by this subsidy.

One way plans manage their drug costs is to structure their formularies to encourage their enrollees to use generics in place of their brand counterparts. The use of generic drugs has been increasing over the years. Based on our analysis of the Part D data, the overall average generic dispensing rate, or GDR, has increased from 61 percent in 2007 to 74 percent in 2010. During this period, some of the most popular brand name drugs have lost patent,

which has increased the opportunity for generic substitution.

As you can see from the table, GDR varies across different groups of beneficiaries. On average, people enrolled in MA-PDs are more likely to use generics, with GDRs for MA-PD enrollees consistently exceeding the GDRs for PDP enrollees by about five percentage points. GDRs for LIS enrollees, on average, are lower than for non-LIS enrollees, and the difference has grown from about two percentage points in 2007 to five percentage points in 2010. Multiple factors, such as differences in health status and prescriber behaviors, as well as financial incentives, likely contribute to differences in GDRs among groups of beneficiaries. Our recommendation last year attempts to address the financial incentives for LIS enrollees while being mindful of the clinical appropriateness.

One way to see how the use of generic drugs have resulted in lower costs for the Part D program and its enrollees is to look at average drug prices. Overall, Part D drug prices based on the individual drug products -- that is the red line at the top -- rose 23 percent between January of 2006 and December of 2010. However, when the

generic substitution is taken into account -- that's the yellow line at the bottom -- prices rose by only two percent over the same period. Here, the shift in volume from brand name drugs to their generic equivalents resulted in dramatic differences. We see that with generic substitution, prices remained mostly stable during this period. This chart also suggests that prices for brand name drugs have been growing rapidly over this period.

The last topic I'll discuss is related to Part D's competitive design. Part D uses competing private plans to deliver prescription drug benefits. Medicare's payments to plans are based on bids submitted by plan sponsors, and plans compete for enrollees based on their premiums, formularies, quality of services, and network of pharmacies. The idea was for competition among plans to provide strong incentives for plan sponsors to manage drug use and keep the spending growth in check. Part D enrollees choose a plan that provides access to drugs they need at the premiums and cost sharing they are willing to pay, and their willingness to reevaluate their plan choices from time to time is important in keeping plans' incentives for controlling costs while providing attractive benefit packages.

One way to see whether Part D enrollees reevaluate their plan choices from time to time is to look at whether they are changing plans voluntarily, meaning that those changes in plans are not due to factors such as a plan exiting from a market or CMS's reassignment for plans that lose their benchmark status. According to CMS's analysis, during the first few years of the program, only about six percent of non-LIS enrollees switched plans voluntarily each year. This rate is similar to the rate of switching observed among FEHBP enrollees. Analysis of more recent data suggest that a larger share of enrollees are voluntarily switching plans.

In 2010, nearly 14 percent of non-LIS enrollees voluntarily switched plans. We found that younger enrollees, who are ages between 65 and 69, were more likely to switch plans, compared to older enrollees. We also found that whites were more likely to switch plans than non-whites. Most people who changed plans tended to choose the same type of plans, with 90 percent of MA-PD enrollees choosing another MA-PD and about 80 percent of PDP enrollees choosing another PDP. The results were similar for 2011.

So to summarize, we found that beneficiaries

appear to have good access to prescription drugs. Plan offerings remained stable between 2012 and 2013. We are seeing an increase in use of tiered pharmacy networks. In terms of costs, low-income subsidy continues to be the single largest component of Part D spending, and reinsurance continues to grow rapidly. An increase in use of generic drugs have kept the Part D prices stable. And we are seeing that more Part D enrollees may be voluntarily switching plans than during the first few years of the Part D program.

That concludes my presentation.

MR. HACKBARTH: Okay. Thank you, Shinobu.

Jack, do you want to lead off.

DR. HOADLEY: Sure. Thanks, Shinobu. This is a great analysis raising a lot of, I think, really important issues and hitting a lot of the issues that I think are really worth doing. Let me comment on four of the areas that you talked about.

The first one you raised was the set of people, the ten percent with no creditable coverage, and I think it's really good that we're taking a look at that because it's a real puzzle, I think, and it's clear from your data that there's a subset of those that are voluntary, rational

choosers of having no coverage. We don't know how well they've researched it, but certainly their drug use suggests that it may be a perfectly sensible decision for them to forego this coverage and that there are probably some others where that's not the truth.

The one thing that I got to thinking about was you're basing this obviously on the only available source of data which we have right now, which is the MCBS, and if there are some people that are really kind of missing out and just kind of don't even really know Part D is there, they may also be the kinds of people that a survey is going to tend to miss. I sometimes call them the off-the-grid types that are just not attentive to what's going on. I don't know any way to get at that, but we should think about that and whether there's part of that ten percent that just aren't even showing up in the survey.

Also, continuing, and I think the way you presented it kind of allows for this, but thinking about where the distribution of those people is rather bimodal, I mean, it really may be these two very different groups, the rational choosers and the kind of missing the availability.

The second issue was the preferred pharmacy. I

think this is clearly a trend in the program and I think plans probably -- they would say -- their term would be they're innovating and trying to come up with a way to target use, get better bargains through negotiating with preferred pharmacies, and that's all fine. I think the issues, and you allude to a number of these, are very real. If people don't understand the choices they're getting into. The fact that network adequacy can be based on the entire network, not just on the preferred pharmacies means -- and I know when I've looked at it, it does seem clear that people who are picking these plans may be people for whom there's no preferred pharmacy very close to them and they may or may not understand that CMS has made some improvements in the plan finder to help on that point.

But I think the fact that they do that, and yet the copay calculation, they do actuarial equivalents, is based on the preferred pharmacy rates. So we're saying, on the one hand, network adequacy is based on all pharmacies, but the actuarial equivalents for the copay structure you design is only based on the preferred pharmacies, may be an inconsistency there and something we should think about whether there's a policy issue there.

The third one that I wanted to talk about was the reinsurance, and you point out very clearly that that's the growing piece of the program. And I think, also, and I know you've looked at this in the past, as well, is the extent to which reinsurance needs to be changed possibly in some way. I mean, reinsurance means that a plan, when a particular beneficiary is a high spender, over the catastrophic threshold, 80 percent of that cost is being picked up by the Federal Government, five percent by the enrollee, only 15 percent exposure by the plans. Is that enough exposure to the plans to kind of get the incentives set the way we'd like to see them? It was designed, in part, to make sure plans were encouraged to enter the program. That's clearly not an issue at this point.

Are we at a point where we ought to change that ratio and reduce the amount of reinsurance? That doesn't change the subsidy, because there's a direct trade-off between the reinsurance and the direct plan payment, so those all still add up to that 75, 74.5 percent Federal subsidy. But thinking about how we might want to rejigger that, I think, is something that we might want to take a look at.

And then, last, on the plan switching, as you know, we've talked about this. This is something I think is very important and I'm doing some research on this, as well, and so I'm really glad to start to see these kinds of calculations made. The one caveat that I would put out there is we're sort of relying on the six percent CMS reported result as being kind of where things might have been at the beginning and it may turn out that that's based on other data sources and really isn't a good reflection of what. So characterizing this as a trend towards more switching over time may turn out not to be accurate if we look at what's going on in the earlier years through the kind of data.

And then the only other addendum I would put, among things that you didn't mention in the presentation, but you did in the paper, is the exception and appeals, and I know there's some intent to look more at that, and I think that's a really important area and I do encourage more of a look at that area.

MR. GRADISON: Thank you. From a beneficiary's point of view, I understand the excellent comparisons you've given us with regard to preferred or non-preferred

pharmacies, but I don't believe you mentioned, nor do I remember seeing any data, on where mail order fits into this from a point of view of its availability or its pricing attractiveness or unattractiveness as compared with the pharmacies.

MS. SUZUKI: So we've looked at the utilization. I don't actually have the percent of plans and the cost sharing amounts that apply to mail order. But my understanding is that there's a level playing field between mail order and the retail pharmacy cost sharing so they could not use a preferred cost sharing for mail order pharmacies. That's one.

And when we look at the utilization, we have not seen a lot of use of mail order pharmacies in general in Part D. My recollection is, maybe in the single percentage points.

MR. GRADISON: Thank you.

DR. COOMBS: I was interested in the bar graph that actually has the proportion of low-income subsidy. First of all, I'd like to say, a great report, and I saw Jack in there as a reference. I was very impressed.

Is there some kind of projection, because this is

a big quagmire in terms of how you get costs under control with this specific entity, which it doesn't sound like we have no -- we don't have a strategy to kind of rein it in. So is there some kind of projection as to where we're going with the LIS portion of this?

DR. MARK MILLER: Could you give us another pass at the question? I'm not sure I followed it.

DR. COOMBS: So if you had a projection strategically of how big this component would be, what would you do to kind of limit the impact of that in terms of -- because it seems like this is the -- you know, this is the 36 percent on the graph, and it seems to grow at a rate that's in excess of any of the other components. And so if we were to say five to ten years this would continue this kind of growth, is there some kind of intervention that we could have to control this piece?

DR. MARK MILLER: Okay. Unless Shinobu would really like to take this question, I mean, just a couple of quick things.

One thing we are going to put some focus on, as Jack just said, the reinsurance is growing fairly fast, and so we are going to look at that.

On the LIS, I would say no, I don't think we have looked at this and said we think the projected component should be a specific percent, a priori, as it were. But we have seen some rapid growth here, and at least one of the things we've focused on is the difference in the generic use rates and have tried to propose some structural changes in the benefit that might influence that. But I will say overall, at least speaking for myself, I haven't thought about, well, should this be a particular number, and I would definitely defer to anyone else who wanted to comment on it.

MR. HACKBARTH: To what extent is that growth a function of more people qualifying for the low-income subsidy as opposed to faster rate of growth for each low-income eligible?

MS. SUZUKI: So we looked up PMPM spending for 2007 to 2010, and in terms of gross spending, LIS enrollees, their spending is growing much faster than non-LIS enrollees. And --

MR. HACKBARTH: On a per enrollee basis?

MS. SUZUKI: On a per enrollee basis. So given the LIS population itself hasn't grown very much since the program began, I think a lot of it may be on the PMPM

portion.

MR. HACKBARTH: Okay. And then within that, one portion that we have looked at is the higher use of brand-name drugs among the LIS population.

MS. SUZUKI: Mm-hmm.

DR. COOMBS: So maybe something like what Bill was saying in terms of being able to go outside the loop of cost escalation, a mail-order arrangement might be something that would get some targeted -- a lowering of the cost.

MR. HACKBARTH: Yeah. As Shinobu indicated in her presentation, we did recommend a couple years ago that the Secretary reward more strongly LIS enrollees for using generic drugs as opposed to brand names.

DR. MARK MILLER: And one of the surprises there -- and make sure I get this right, Shinobu -- was not so much that they were using vastly different drugs that didn't have generic substitutes, for many of the same drugs that the non-LIS, they were just using brand-name versions of that.

I think I mangled that, but I hopefully got it.

MS. SUZUKI: I think that's correct. And another thing I would point out is low-income cost-sharing subsidy portion picks up the co-insurance or co-pays that people

face at the counter. So it's also a function of the prices that are growing, too.

DR. COOMBS: So are there local things that might be happening at the pharmacy in terms of preferential prescription for, you know, things that might not be on the formulary in certain places? Would that enter into this equation in terms of costs per beneficiary going up out of proportion to the other group?

DR. MARK MILLER: Why don't we get back to you [off microphone]?

MS. SUZUKI: Yes.

DR. BAICKER: The chapter was chock full of really interesting data that raised a lot of questions. I just want to focus on different things.

One, on Slide 13, I think, I was very interested in the price trends, and I have two questions about that. One is I was not entirely clear from the chapter what data we have on prices actually paid net of rebates versus before rebates and how the price information that we're seeing here reflects actual transaction prices versus pre-rebate prices that may map very differently to net prices.

And the second question on this is when we look at

substitution, the very flat price trend, once substitution to generics is taken into account, does that also take into account substitution across branded drugs? Or is this holding that constant and just looking at branded versus generic? Because you would also imagine that as part of the design, the competitive design where insurers are negotiating with pharmaceutical manufacturers, they should be -- people should be substituting towards the drugs on formulary where the insurers have negotiated the better prices. So those are two questions on this, and then I have a separate question on reinsurance.

MS. SUZUKI: Okay. So on the prices that are used, this is the prices that are paid at the retail pharmacy. We have no rebate data. And on the calculation -- so this is volume weighted. And so the way the top line -- top red line, is at the individual NDC level, and the bottom line is more of a chemical equivalent price, so brand-generic combined. I guess brand-to-brand substitution is reflected in both cases to the extent that the volume weights account for that.

DR. BAICKER: So both of these are volume weighted.

MS. SUZUKI: Mm-hmm.

DR. BAICKER: Okay. And then going back to the rebate question, in the absence of line-item rebate data, which I know doesn't exist, is there any sense of the overall magnitude of rebates and how that's changing over time? Because it would be good to know whether these trends reflect anything real in the aggregate, even if not in the detailed drug-by-drug level, or we just have no idea what the net transaction prices are.

MS. SUZUKI: I think we have the aggregate -- trustees report aggregate rebate information, and I don't have the exact number, so let me get back to you on that.

DR. BAICKER: I think that would be helpful in understanding at least on the aggregate level how we should decompose changes into prices versus volume.

And then going to the question of reinsurance, I at least hadn't thought carefully until you pointed it out in the chapter about the interaction between filling in the doughnut hole and reinsurance costs. And I suspect that that was not a very salient point in the debate about thinking about filling in the doughnut hole is the extent to which that falls on individuals versus insurers versus

manufacturers versus the program. And I wasn't entirely clear about which of the manufacturers' rebates got eventually passed through into reinsurance versus the change in the generic co-payments in filling in that, got eventually passed through into reinsurance. And I had been thinking about this primarily from the patient's out-of-pocket perspective. But that's clearly not the input into the reinsurance component as you highlighted. So how do all of those separate components of the filling in the doughnut hole pass through into program costs for reinsurance?

MS. SUZUKI: So there are a couple things that go in different directions. I think the big change is the 50 percent manufacturer discount essentially reducing by half beneficiaries' out-of-pocket. But the manufacturer discount portion actually counts towards your out-of-pocket limit, so you pay less out-of-pocket and get to the catastrophic phase more quickly.

But generics drugs are cheaper, on average, and you do have some reduction in cost sharing also taking place, so those were the two things. And then I think during the ten-year phase-in of the -- or closing of the hole, the threshold is lower, so that puts more people in

the catastrophic phase more quickly than they would have otherwise.

DR. MARK MILLER: Shinobu aren't you glad you wrote that e-mail?

[Laughter.]

DR. MARK MILLER: This [off microphone] internally, but it does raise a question that I want to put a marker down, at least with you and Jack and anybody else. When we re-examined that reinsurance thing, it does, in fact -- you know, Jack's point about the percentage of subsidy remains the same, but it also raises a question of what will the plans' behavior be? Will they pass that through to the premium? And I think we have to think through some of this transaction in thinking about it.

DR. REDBERG: Thanks for a very informative report. I had sort of two comments, anecdotes, and a question. One was on the 10 percent who don't have credible -- I mean, my mom is 86, and she does not have any Part D coverage, mainly because she's in good health and she's on one generic prescription for hypertension, and yet at the time we did the calculations, and there was no way it was going to be worthwhile for her. And perhaps there are

others in that good health category even in the older group.

The other is related to the -- because it's clearly a really important issue, the generics and brand name, and there's a lot of potential for people to be switched to generic drugs with no difference in quality and much difference in cost. The cost differences are huge. And we know, you know, there are a lot -- we have direct-to-consumer advertising for drugs in the U.S., and most of the direct-to-consumer advertising is, of course, for brand-name drugs, and often when there are generics available, and very similar. I would just note in the Choosing Wisely campaign that the ABIM Foundation launched, which is about to launch, I think, 17 more specialty societies, but the original primary care top five that we published in the Archives of Internal Medicine like a year and a half ago, one of the top five -- and, actually, the one that had the biggest cost implications -- was to use generic statins whenever possible, which is almost always, instead of brand-name statins.

And just a little plug again, but we just ran -- and I'll send it to you; that's what I just tried to do -- in the January 7th issue of JAMA Internal Medicine a series

of articles on why people are still using brand names instead of generic drugs. Harlan Krumholz's group estimated that at least $20 billion are being spent on brand-name drugs when there are clear generics available for a number of different reasons, including brand names when the exact drug is available in generic but the brand name is protected because it's an (S) enantiomer of the generic version that's out there, and they're all very highly marketed, and they tend to be statins, proton pump inhibitors, and things like that, that are common and direct-to-consumer advertised.

And I think there's also a misperception among physicians. When my daughter had that eye injury and she was on a bunch of eyedrops, we had this very confusing evening in the pharmacy because her pressure was still high so the fellow, the glaucoma fellow, had given us another prescription, and the pharmacy refused to fill it because he said we had it. And I said, "Well, she just gave it to us." It turned out it was the brand name of the generic she was already on, and so he called the glaucoma fellow, and she said, "No. This one's much better." And it was the exact same drug. And so I talked to some ophthalmology colleagues, and they said it's a very common perception,

particularly among the younger doctors, and it is, he told me, increased by the marketing of these that they tell them brand names are better, and so there's no data.

So I think there's a lot of room, clearly some outside of this Commission, that we can do in educating doctors and patients and certainly tiering reimbursement to incentivize that education that generics are equivalent to brand name. We did not fill that brand-name prescription.

Now my question is on Slide 16. On the non-LIS enrollees that voluntarily switched plans, do you know the reasons? Is that generally because there's a drug not available that they want? Or what is their usual reason for switching plans?

MS. SUZUKI: So the analysis was done looking at their enrollment patterns. It doesn't really get to why people are switching. But I think in talking to SHIP counselors we've heard that people sometimes find that their premiums are going up, so they try to find a plan that has lower premiums. Other cases are that their drugs were not covered by their plan, so they were trying to find a plan that would cover their drug. So I think it could be, you know, varied.

We did in our preliminary analysis find that people who do switch may be switching to maximize coverage, so maybe they're taking a little more drugs after the switch, for example.

DR. BAICKER: I don't know if you have the data to replicate some of the outside research that suggests that there's money on the table for the people who don't switch and that the people who do switch are likely to pay less out-of-pocket after the switch and that the magnitude is enough to make it surprising that other people aren't switching more.

DR. MARK MILLER: We talked a little bit about this a little bit, too -- right -- and I'm trying to now recover. We were talking among ourselves whether we could focus in on whether the premium was lower after the switch. She has raised the out-of-pocket overall --

DR. BAICKER: But yeah, premium plus out-of-pocket, total.

DR. MARK MILLER: I caught what you said. Where were we? Because we were talking about this I think yesterday, or a couple days ago, I guess.

MS. SUZUKI: We've looked at out-of-pocket, and on

average, it tended to be lower for switchers afterwards compared to non-switchers.

DR. HOADLEY: But there is some evidence from some of the other literature that people will switch to, you know, plans without deductibles or things that aren't necessarily advantageous to their situation. So they're swayed sometimes by factors that look good but don't necessarily lower out-of-pocket costs. So my guess is you'll see a mix on that variable.

DR. NERENZ: Just one question about the employer ole in this. On page 27 of the chapter, there's a statement that employers no longer offering drug coverage to their employees typically move Medicare-eligible members to Part D, which would suggest sort of an up trend in the employer contribution. But then on Slide 11, if you can go there, you have an arrow in the lower right drawing our attention to a decrease. So tell us a little more what this story is. It looks like employers are ceasing to do two things: either they're doing less direct drug coverage and also, apparently, less input into Part D. And I'm just not sure how to read the implications, including the question of if that's true, then what happens next? Where do people go?

MS. SUZUKI: So the retiree drug subsidy that's shown on the graph, the green part, is the payment from Medicare to employers who provide drug subsidy, and the law says Medicare will cover a portion of their spending on providing this coverage to their retirees. And what I'm saying in the text is that more employers are deciding not to provide this retiree coverage, which reduces the number of people we're paying subsidy for under this program.

DR. NERENZ: Okay, okay. All right. I'm sorry. I perhaps misinterpreted. But then now the second question: When that happens, then what happens next? Do those people just pay more out-of-pocket? Or does it shift largely to either the low-income subsidy or the direct subsidy? Do we know about just where that -- who picks that up? Or do people just then go out of Part D entirely?

MS. SUZUKI: So I don't have a complete analysis to figure out where these people are ending up. Some of the anecdotal evidence is that employers who are dropping the coverage will move their retirees to Part D. So they enroll in Part D plans, or the plan itself becomes a Part D plan. So they're actually now covered by the direct subsidy, the other portion of the spending, rather than the retiree drug

subsidy.

DR. MARK MILLER: At least one thing I would say is I don't think either what we hear or if you kind of connect the dots across a bunch of slides, we think these people are moving to having no coverage. We think they're moving to D. But when she said that, you had a reaction like that something didn't make sense to you. So pick up there. Does that not make sense?

DR. NERENZ: Well, I guess now I'm still -- because I -- the way I originally read the text I think is consistent with the last thing you said. But then as you offered the first response to my question, I thought we were talking about a change within D, that people were in D and now they're in D in a different way with a less employer contribution. So I will confess that I'm still somewhat confused about being out of D and into D versus being in D with or without an employer contribution.

MS. SUZUKI: So maybe I --

MR. HACKBARTH: Let me just take a piece of it. So when a person is covered by an employer plan and the employer is receiving the employer subsidy on this graph, do we consider that person to be in Part D or outside Part D?

I think that's part of --

DR. NERENZ: Right, because I just assumed that all these graphics and everything were about D.

MR. HACKBARTH: Were just different varieties of Part D, yeah.

DR. HOADLEY: Yeah. I mean, that's part of the complication. I mean, they're in Part D in the sense that the subsidy operates as part of Part D. And when the actuary does the global calculations, that's counted as Part D. But when we get inside the part of Part D we can look at as Part D plans, they're not in there. But one of the things that happens is when these people -- when these employers stop providing their direct coverage, they may subsidize people going into a Part D plan, they're going to move --

MR. HACKBARTH: Some other variety, yeah.

DR. HOADLEY: -- parts of the bars on our graphs, but the employer may still say active in the program.

DR. MARK MILLER: I think using his framework just for a second [off microphone] move from one kind of Part D to a different kind of Part D.

MR. HACKBARTH: And we've got different data. So

if they're in the employer subsidy piece of Part D, what I hear Jack saying is that's a little bit of a data hole for us; whereas, if they move into a Part D plan that's receiving a direct subsidy, we've got a different set of data sources.

DR. NERENZ: Thank you. I was confused, because it's confusing, and now I'm less confused.

[Laughter.]

DR. NERENZ: Then the only last point, the green-shaded part of this, does that include both of these flavors, let's call it, of employer subsidy, either direct or to people who are in a Part D plan?

MS. SUZUKI: So once they move into a Part D plan, then they're in the gray part, the direct subsidy part.

MR. HACKBARTH: And they would be there -- even if the employer is helping to subsidize that, they would still be counted as part of the direct subsidy pool.

MS. SUZUKI: Right.

DR. NERENZ: All right. Okay. I think I've got it.

DR. MARK MILLER: Just another [off microphone] may be whether the dollar travels to a plan or whether the

dollar travels to an employer. Does that help you at all?

DR. NERENZ: No, no, this is complicated. I'm just trying to track it.

MR. BUTLER: So this, I think, on balance people would say a pretty popular program that has worked maybe better than people thought, although it's expensive.

Now, having said that, I'd try to remind ourselves what is our legislatively mandated role here. We obviously are required by legislation to comment on updates for the fee-for-service silos that we just did. We also respond to specific congressionally mandated reports like ambulance.

Here we're giving a status report. Is this because we are required to give an annual, quote, status report? Or is --

DR. MARK MILLER: I don't have the legislative language in front of me. I went through this a few years ago. The expectation of the legislative language is that we report on this, and my recollection -- and I may not have the language exactly right -- make recommendations as appropriate. And so we aren't -- because there's no administered update, we don't make an update recommendation. But, for example, last year we made recommendations on LIS

on cost sharing.

MR. HACKBARTH: Yes, so think of it as sort of analogous to MA, and so we don't make update recommendations because of the pricing mechanism used, but we make other types of policy recommendations.

MR. BUTLER: And that's kind of fluid or up to us to some extent how boldly we want to take on recommendations which more typically show up in the June rather than the March report, right?

DR. MARK MILLER: Except that if, again -- and I haven't looked at the legislative language recently. I am pretty sure we are asked to report on this in the March report, which is why we do this and do it in this particular way.

MR. BUTLER: Okay. So what strikes me at the end of the second day here is, you know, this is our first -- I think the first discussion of drugs, Part D, this year. Is that right? You know, for a $60 billion program that -- it's an interesting one because at four prescriptions per month, it is the most broadly, widely used Medicare benefit there is, just in terms of number and encounters. And it's interesting how much time we spend on talking about

integrating the silos and across post-acute and things like that, and the use, the under- and overuse of drugs is so integral to all this, everything from, you know, readmission rates are affected by drugs and yet we don't -- I know staff have limited time, but we really don't look at this as, you know, a key factor and impacting the entire continuum.

MR. HACKBARTH: One of the differences, of course, is here the choice was made to delegate responsibility for management of the drugs and the pricing and the formularies to private entities as opposed to doing that through the government insurance program. So we've got a large number of private people who have assumed both that responsibility and the associated financial risk.

MR. BUTLER: Right. I understand that. But then we also should be thinking about -- I wonder what the outcomes are for the -- for not just the financial risk they're assuming, but, you know, are some of these doing a better job in impacting other aspects of the health outcomes of -- it's a very complicated thing to do. But what I find is both the amount of time we spend on it, given the impact it has on health, is pretty limited. And let me just say a couple other things, and then I'll let you respond to the

overall issue.

It also is frustrating that, as you look at the -- as a source of savings, it looks ripe. Yet it is not a -- you know, in that SGR list of offsets, which we haven't vetted, the single biggest opportunity was in drug. Yet, you know, you sit there and you say what is our responsibility in, say, moving that one ahead as an opportunity because it's not in our legislative mandate, yet it is something that's just begging to be, you know, addressed. It just seems we can't quite figure out how this integrates maybe with some of the other activity that we've discussed and formally acted upon -- in my own mind, anyway.

MR. HACKBARTH: I don't see it as our legislative mandate is constrained on Part D or on Medicare Advantage in particular. I do think there is a fundamental difference in terms of what I said earlier, that we have private entities that have assumed responsibility and financial risk for managing; whereas, other parts of the Medicare program -- it's only the government insurer that's focused on that, and so I think it's maybe appropriate for us to focus somewhat more heavily on those issues.

But I think we've got a broad license to recommend

changes in Part D that we think can further enhance the competition, save money, as with our recommendation on the LIS cost sharing, or potentially, you know, changing the rebates for the dual eligibles. I don't feel our mandate is constrained.

DR. MARK MILLER: And what I would add is a couple things. One, I've been trying to get Shinobu to work through weekends now for, you know, a long period of time, and so I appreciate this comment --

[Laughter.]

DR. MARK MILLER: -- because I can bring some additional pressure to her. But, also, I've been sitting here looking ahead to March and April, and we have on the March agenda some research that we've had going in the background on the effect of drugs on A/B, you know, so kind of the connection, and our expectation is to bring that forward in March, I believe. I don't always like to promise that, but that's on our -- so we have been thinking about this a bit.

I think the reinsurance point does kind of get at, hmm, maybe the risk is not spread fairly and we should be revisiting it and maybe an opportunity.

And then to your point on the rebates, you're right about that. It's a bit hard to unpack and come at it because we're not able to get -- that's proprietary data. It doesn't break down to the individual drugs. But it doesn't mean we shouldn't be paying attention to it. I think you're right about that.

MR. BUTLER: I understand -- last comment -- the risk being passed along to these plans, and so it does maybe put pressure on drug companies. And I have a lot of admiration for drug companies, but it's one of the few sectors that just has this -- you talk about fee-for-service incentives and the more the better. It is so embedded in their business model and still present in our hallways that it just like -- you know, how do you get everybody's skin in the game working in the same direction? There's a lot of momentum against that still in this particular site and services.

MR. HACKBARTH: As always, Peter, I really welcome the way you think about things. You step back and look at the bigger picture, and let me use that as the platform for raising a question.

So back in the very early stages of Part D, in

fact, even before the legislation, one of the policy questions that sometimes was discussed is what will be the effect of having two separate insurance pockets for drug coverage versus medical services in separate Part D plans as opposed to Medicare Advantage where you integrate both the drug coverage and the medical coverage. And thinking about it just in an abstract way, you might wonder whether the incentives are right.

If you're running a Part D plan, you want to keep the drug costs low, and you may make choices to keep the drug costs low even if by raising drug costs you could have reduced medical costs. You're not worried about medical costs. You don't have financial responsibility for those.

In MA, the two responsibilities are integrated, and so the incentives are right to substitute drug spending for medical spending with separate insurance pools. They are not necessarily correct. Now we have a number of years of experience with Part D. Do the data allow us to shed any light on whether that fear was justified or not? Can we look at MA-PD spending patterns compared to free-standing plans' spending patterns and see whether those distorted incentives are coming into play.

MS. SUZUKI: And I would say that's a little difficult to look at at this point without claims for Part C's medical use. We do see some differences in patterns of drug use between MA-PDs and PDPs. For example, we often mention the generic use rate, even for a given therapeutic class. Oftentimes MA-PD plans tend to -- or MA-PD enrollees tend to use more generics compared to PDP enrollees. There may be some differences in the classes of drugs that are used, but it is difficult to distinguish between whether that's a clinically appropriate difference because of the differences in health status or not. Those are sort of typical things.

DR. CHERNEW: I think this conversation is going in the exact right way, so I'm going to try and say something in responding to this discussion and then a few things that I otherwise would have said.

We've been looking at this a little bit, and I do think there are some differences between MA-PD and PDP formularies, so you can look at the formularies. One thing to understand, there's a lot of companies have both MA-PD and PDP plans, and they will sometimes use the same basic formularies across the different ones. So my

characterization is I think there are differences. I don't think the differences are so enormous.

I think it is useful to note that the CBO recently changed their assumptions about Part D spending to a credit and offset, so greater Part D spending or, more correctly, greater drug spending would be given some offset in the non-drug area. But it's not one for one. You still spend more money. You just don't spend as much more because of the extra drugs.

I do think this use of drugs is important because often this whole discussion is done as if it's all a cost, where a lot of times there is a lot of quality for many of these drugs. Some of them there's a gain clearly because of financial savings -- again, not 100 percent offset, but you could reduce hospitalizations. But, frankly, it's good not to have a heart attack apart from going to the hospital because you had a heart attack. So --

DR. MARK MILLER: I'm sorry. What was that? [off microphone]

DR. CHERNEW: It's good not to have a heart attack. I don't know if I said that loud enough for the mic. That's the one quote I want.

MR. HACKBARTH: It's a bold statement [off microphone].

DR. CHERNEW: Yeah, exactly. It's a bold, politically complicated thing. We should have fewer heart attacks. But we should have fewer heart attacks even if we didn't save a lot of money because having fewer heart attacks, it's a good thing not to have fewer heart attacks. And so a lot of these drugs do very good clinical things, and a lot of the discussion, though, recognizes -- and many of these discussions is -- that said, we don't always purchase them in the most efficient way for a bunch of reasons. I take the presentation -- and maybe I didn't read the tone right or didn't hear the presentation right -- as saying that for the most part, the Part D program is pretty successful in this delegation to private firms. There's a lot of substitution that they do for the generics. The prices when you do the appropriate generic substitutions are relatively stable. Costs aren't soaring. Whether that's due to the structure of the program or the, you know, expiration of patents is a separate controversial thing.

There's not a lot of switching, which I don't at the face of it take as a bad sign. I mean, in a perfectly

competitive market, you could have everybody choosing and being happy with their choice. That said, I think there is some growing evidence that people don't make the right choices. They choose plans that are too expensive for them relative to the drugs that they're using or would expect to use.

So I think that there are a lot of interesting questions about how people choose. My general sense is that most -- that the program is basically working well, that health care -- that spending growth on drugs is slower than almost all forecasting. The CBO is lowering their projections of drug spending. OACT is lowering their projections of drug spending over time. There's a lot of evidence that the drugs are doing good things both clinically and non-clinically. But within that general positive view, there's a lot of areas of serious concern about people buying drugs inefficiently, joining plans that were inefficient, subsidies that discourage efficient purchasing of various things.

So I do think there's a lot of work we can do, but generally I think it's within the construct of a basic program that is relatively well functioning.

I don't know if that's your tone, but that was the tone that I took from the chapter and from the presentation. So if that's the wrong tone, that would be good to know.

MR. HACKBARTH: I think your tone is a reasonable one. I think it is generally a successful program, but still lots of issues to be addressed.

Let me just add one more to that while I'm thinking of it, and then we need to complete the rest of the round.

I remember back in the early years of the program when John Bertko from Humana was a member of the Commission and an ardent proponent of Part D. John used to say one of his concerns for the future was the ability of the plans to negotiate about sole-source drugs, the price of sole-source drugs. And if sole-source drugs, the price of them grew rapidly and the utilization of them grew for clinical reasons, that that could be a real challenge. If there's any way that we can disaggregate data and bring information to bear on that question, I think that would also be useful.

MS. SUZUKI: So --

MR. HACKBARTH: Why don't you go ahead, Shinobu, and then let Rita --

MS. SUZUKI: Last year when we looked at the high-cost population, we found that the majority of them had high spending because they were using just lots of drugs, rather than the high-cost biologics and those kinds of things. That's from 2009 data. So we can continue to monitor this trend to see whether the single-source drugs are driving the trend.

DR. REDBERG: I just wanted to comment that, of course, it is good not to have a heart attack, and it's a brilliant --

DR. CHERNEW: [off microphone].

[Laughter.]

DR. REDBERG: We never covered that in my cardiology training.

[Laughter.]

DR. REDBERG: But I'm learning a lot. But that there are also -- and some drugs certainly can avoid hospitalizations. But as Shinobu just mentioned, there's just an increased number of drugs in general, and a lot of them are actually bad for you and are causing a lot of problems. And we know in our seniors, you know, people are on many more drugs on average than they were 10, 15 years

ago, and maybe if you just look at the last few years, you're not going to see differences.

We published a study about a year ago on older people where they just arbitrarily stopped five drugs in each of these patients in a randomized trial, and the group that had their drugs arbitrarily stopped did better and actually lived longer than the group of older people that did not. I mean, we know that there are a lot more interactions and adverse effects when people are on more than five drugs, and lots of our Medicare beneficiaries are now on more than five drugs. And so while certainly some of these drugs are beneficial, make people feel better and avoid hospitalizations, a lot of them are also doing the opposite, and that we really could be doing better.

DR. CHERNEW: That's almost an A/B medical primary care, primary medical home kind of question as opposed to a Part D. In other words, the drugs are being prescribed by somebody.

MR. HACKBARTH: Okay. We are raising some interesting issues, but we are running behind so we need to move ahead and get through our final round.

DR. DEAN: I would certainly just reinforce what

Rita just said about the number of drugs has escalated, and the dilemma from a primary care physician's point of view is that, as patients move around from doctor to doctor, each one adds a drug, they come back to me and very often I don't know exactly why that was started. I really don't think it probably is necessary. On the other hand, I'm very uneasy about stopping it because I -- and so the indications for stopping drugs are very difficult sometimes. You know, it's beyond the scope of this discussion, but it's an important issue.

I guess I would just raise one other point that Jack mentioned, the preferred pharmacies, and I think I've mentioned this before, that we do need to keep the pressure on the insurance companies because, you know, we've had companies come into our area and sell policies, and then we find -- or then the beneficiary finds out they don't have any approved pharmacy, and the nearest approved pharmacy is 50 miles away, and it's happened a lot. And, you know, amazingly, people in my area put up with that. I don't think they should, but they do. So I think just trying to make sure that there's fair marketing is important.

DR. HALL: Shinobu, could you just look at page 13

again, the graph of the use of generics. Just the rising trajectory in the red line, is that largely just biologics that are making that go up? The use of biologics, which are more expensive and not generic?

MS. SUZUKI: I wouldn't say it's primarily biologics, given that it's volume-weighted. So the utilization also drives how much of the weight is put on. But they do grow much -- some of the biologics do grow much faster than this 23 percent. But other brand name drugs also have grown.

DR. HALL: I mean, the time course from 2006 going up is just -- correlates perfectly with the introduction of a lot of generics -- or biologics that are now being touted for a lot of chronic illnesses of older adults. And -- pardon?

DR. BAICKER: [Off microphone.]

DR. HALL: Prices. Oh, I see. That's prices. So that would -- but if there were more biologics being used, it would come in there.

Didn't we also talk about, at one of our previous meetings, that among either high-cost recipients or -- I'm not sure what the context was -- that there was a tendency

to use brand names rather than generics? What population specifically was that?

MS. SUZUKI: So we looked at people enter into the catastrophic phase, high-cost beneficiaries, which the majority of them were low-income subsidy recipients.

DR. HALL: Right.

MS. SUZUKI: And when we looked at their drug utilization, they tended to use more brands compared to non-LIS enrollees.

DR. HALL: Right, and one of the notions there was that they're probably not making that choice personally, that that's a choice being made somewhere in the delivery system for them.

MS. SUZUKI: And it could be -- the prescribing behavior, it could be their health status.

DR. HALL: Right.

MS. SUZUKI: When we talk to beneficiaries, among non-LIS enrollees, we often heard how they've asked their physicians to switch their prescriptions to generics to lower their cost sharing, and so there is a role for beneficiaries to play, too, as well as for other players.

DR. HALL: Okay. Thank you.

MS. UCCELLO: Just a couple of things. Like Kate, I am really interested in understanding more about these switchers and whether the switchers are choosing the best way, the best plan for them, and if the non-switchers are also correct in non-switching, and understanding more about what part of the plan components are driving their decisions. Are they over-emphasizing premiums? Are they incorporating not just premiums but also the cost sharing and also the benefits that are covered? So thinking through all of those things.

And I would also suggest that we look at this not only for Part D, but also for MA plans, especially as we move forward on looking at competitively priced contributions -- CPC. I think that's important, and I would expect a little difference between how well people do under Part D choosing as opposed to MA plans, because Part D drugs, drugs in general, are going to be probably more predictable than medical care for people. So I think looking at both of those could be good.

As an actuary, I have to also note that if everybody chooses perfectly, if all beneficiaries are choosing the best plan for them, that's going to be raising

the costs for all the plans. That doesn't mean I don't think people should be choosing appropriately. I want that on the record. I want people choosing appropriately. But I think this just illustrates how do we strike the right balance between plan choice, flexibility, and standardization and costs and how all of those are interrelated. I think we just need to remind ourselves of that.

Also, in terms of Jack's -- I think made a good point about how network adequacy may be determined differently than actuarial equivalents, and I'll just say that we've had to think about this, as well, for actuarial value under the ACA medal tier plans and how to incorporate tiered networks into that. And I would be happy to, offline, talk to you more about that, if this is something you want to pursue.

DR. NAYLOR: Great report. Just three brief comments.

One is to build on earlier conversations about, and I don't know if it's here or if it's elsewhere, but the context for medications and what we're witnessing in terms of use of medications for Medicare beneficiaries. We're

witnessing in our studies reduced costs, more use of generic, but many, many more drugs. And so I think that trying to place this and its impact on A, B, and D would be really helpful.

On the issue -- and you've done this. You throughout have talked about the effects of the Affordable Care Act, but I'm just wondering if there might be even a chart that would talk -- summarize those provisions and potential impact on Part D going forward, so as we expect these changes and continued growth of reinsurance or employers, et cetera.

And, finally, the quality section. It's good to see that in 2013, we're going to place more attention on medication safety and on appropriate use of medications and interactions and side effects, et cetera, but it's hard for me to know and understand how 18 CMS measures align with 49 MA measures in this star system. I wasn't quite clear how it all gives you a robust assessment. So I don't know if it does give us a robust assessment of key quality indicators. And certainly, continuing to monitor what's happening in different groups, especially low-income, in terms of quality performance, I think, is important. So thank you.

MR. GEORGE MILLER: Yeah. Excellent report, and I enjoyed both the context of the chapter and certainly the discussion around the table.

I, too, like Mary just indicated, would love to just see the impact on A, B, and D, just from a policy standpoint.

I want to reflect on what Rita said, and the part about her daughter, that she is a cardiologist and physician. She asks questions. She had to push that issue even further to get the right decision, and I'm concerned about a large segment of the population may not have that knowledge base, first of all, to ask those questions, and then, secondly, have the fortitude to keep asking to get the right decision, and what impact that may have.

And then Tom brought a very interesting point up about the distance, especially in the rural areas, from a preferred provider to not-preferred. So on Slide 8, do we know, or have we done a study to know the location of and distances from preferred providers to communities, particularly in the rural communities, to see if that is a benefit -- or a hindrance, I should say, if they're not located -- have we looked at that type of distribution and

segregation? I guess "segregation" is not the correct word, but stratification is the best word. Yeah.

MS. SUZUKI: So we have not looked at the data to see whether this preferred/non-preferred has had an effect on, say, rural areas.

MR. GEORGE MILLER: Right. Right.

MS. SUZUKI: And we will continue to monitor this, and as more people are affected, I think we'll look more closely into this.

DR. MARK MILLER: Shinobu, I don't know, a year, two years ago, didn't we also have a --

MS. SUZUKI: Right. When we looked at the pharmacy access, we did not find that rural areas had less access to prescription drugs, generally, but that was --

MR. GEORGE MILLER: But I guess it would depend on how you defined access. I mean, if it's 50 miles away, as Tom's example, that's access, but is that access?

DR. MARK MILLER: Just a couple of things. There's what we did in the rural report. But then, before that, wasn't there a contractor report about how the networks are kind of working out in --

MS. SUZUKI: So I have to get back to you on that.

DR. MARK MILLER: I didn't mean to put you on the line.

MR. GEORGE MILLER: You'll be working weekends.

DR. MARK MILLER: Yeah. We'll come back to you on this point. We did look at this a little bit. But you were still correct that there's a new wrinkle developing out there and we need to stay focused on that.

MS. SUZUKI: Right. Our study, I believe, was before this trend had begun.

MR. GEORGE MILLER: Okay. Thank you.

MR. KUHN: Two questions or points to raise here. One has to do, like Jack and Kate, I was interested in the reinsurance issue. I think, like anybody, I was struck that it went up 24 percent between 2010 and 2011, so I think that ought to get people's attention.

They both explored some of the notions there, but the one that struck me, as a little bit more refinement, was the new incentives now for this decade as we move to get rid of the doughnut hole or the benefit gap. There are a number of incentives to not only get people to enter that gap sooner, but to accelerate them through and get them out so that they can take advantage of the reinsurance opportunity.

The attachment point language that's in the ACA and some other things accelerate that.

But the one issue that I'm really interested in is this 50 percent discount now on brand name drugs that are there. And so the discount as well as the drug price count towards the out-of-pocket, so again, part of the accelerator that's through there. So are we starting to see now that if people are choosing brand name drugs when they go in the gap in order to accelerate them through, are they staying on those drugs when they come out or are they substituting back to the generics, and is that impacting what's going on, as well? And if not, over a decade, we could see some real behavior change in terms of movement of people starting on generics, then in the brand names, and then staying on brand names.

So I was intrigued by Jack's point about plan exposure and would that be an incentive, then, for the plans to move people back to the generic, or are there other incentives, if we think that that phenomena is really occurring. And so that's just something I'm really interested in, seeing if the data shows that, and we can understand, are we starting on generics, moving to brand

name to get through the gap, and then what happens after that. It would be interesting to see.

The other thing I was kind of struck by the information was the fact that 77 percent of the LIS beneficiaries are in PDP plans only and not in MA-PDP, and I'm just struck by that because I think that's a population that would do very well by the care coordination that's out there.

And so kind of a little bit like Craig talked about yesterday, and I really liked his conversation about how do we ultimately get the data to begin to compare fee-for-service with MA in the future, is there a way we can start to collect data that kind of begins to look at the beneficiary cost side of all this? So if you think about those that are in fee-for-service, you have the fee-for-service cost. Many of them are buying Medigap policies. They've got the Part B premium. And we all know that that first-dollar coverage is probably incenting towards higher utilization in terms of services out there. Is there a way to look at the beneficiary cost that those that chose MA or an MA-PDP compared to what goes on on the other side if they do a la carte and they do fee-for-service and Medigap and

then a PDP plan and try to get some of that evidence and some of that information so we can have a better informed consumer as part of the process, as well?

Just something that I was struck when I saw that LIS data, because that just seems just so peculiar. That's a population that would benefit more from that care coordination and they're not reaping the full benefits of the program.

DR. SAMITT: So, thanks for a great report. You have a very hard job. It was great to see more detail.

So I want to jump right to where Peter was, because I agree that I don't quite feel we're spending enough time on discussion about drugs. I think in the world of value, one of the first places we look for opportunities is in drug expenditures because the opportunity is so vast.

As I read the chapter and heard the presentation today, I am really struck by, even in the setting of transfer of risk, the degree of tremendous opportunity that still exists. I mean, to think about $5 billion related to opportunities in generic substitutions alone, not to mention all the things that other Commissioners have referenced regarding polypharmacy or step therapy or other things that

are really in the prescriber's control, I just -- I wonder, the degree to which these Part D plans are an arm's length -- have an arm's-length relationship from the providers. You know, I would have imagined, given the transfer of risk, that they would focus much more on working with the physicians, working with others to really influence a very dramatic change in prescribing.

So I think there's a wealth of things that we should be talking about here and really figuring out how we further improve the quality of and reduce the cost of the pharmacy benefit, because I sent that even though the Part D program is very effective, that we've only just scratched the surface.

MR. HACKBARTH: One of the issues that the idea that it would make sense for the plans, the Part D plans, to work more closely with clinicians really makes a lot of sense to me. And I try to connect that with what I've heard so often from doctors. One of their frustrations is dealing with multiple plans, each of which has its own distinctive formulary, and the complexity involved in that clinician-plan interaction. And if there's some way that we could help facilitate those interactions, make them less

complicated, there might be more opportunity for that collaboration.

DR. SAMITT: I think they are complicated but my perspective are the themes are still the same. So if our focus is on generic prescribing, our focus is on polypharmacy, our focus is on step therapy, it really doesn't matter so much what the formulary looks like. The principles are still the same.

I think the other thing is with the continued evolution of electronic health records and the automation of even programming formularies into EHRs for some of the physicians, it makes some of the complexity a bit diminished in the world of technology.

So I would hope that we can overcome those barriers.

DR. NAYLOR: I think a related concept here is the investment of the Medicare program, $62 billion in Part D, and what we know about the lack of adherence to meds even when we make those expenditures. It's extraordinary.

And so to the extent that we could think in ways that Peter and Craig have talked about, which is the kinds of policies that also promote what we know about getting

people engaged to want to take these meds to prevent that heart attack is really critical.

MR. HACKBARTH: Okay, Shinobu, you gave us lots of food for thought and we gave you lots of work to do. That's a fair trade.

So we are now finished our sessions. We will have a brief public comment period.

Let me just say a word about the ground rules. Please begin by introducing yourself and your organization and limit your comments to two minutes, please. When the red light comes back on, that signifies the end of your time.

Thank you.

MS. CARLSON: I'll be brief.

I'm Eileen Carlson from the American Nurses Association.

Many patients and families are thrown into crisis mode when a triggering acute care event or episode happens, regardless of the patient's previous underlying condition, because as a culture we don't deal very well with death.

And I think MedPAC, the Commission, could really do a great service to patients by encouraging or developing

policies that streamline the choices, provide educational materials, et cetera. I mean, a lot of families have -- they've got emotional issues. There's a ticking clock. It's sort of like being thrown in Grand Central Station and you have five minutes to get to your train and buy your ticket.

Providers are not encouraged or really paid for appropriate end-of-life counseling. And sometimes there are issues as to which providers are the appropriate one to do that counseling in and of itself.

So anything that MedPAC can do to incentivize and encourage appropriate choices and really engage the patients and provide educational resources would be wonderful.

And then, with respect to Part D, the non-integration between the delivery of care and the actual drugs is so strange in some circumstances that -- as you may or may not be aware -- some patients actually have to go to a pharmacy, purchase a vaccine, and bring it to their provider which is not a good thing, as you can imagine.

MR. HACKBARTH: Okay, we're adjourned.

[Whereupon, at 11:46 a.m., the meeting was adjourned.]