

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 MA enrollment continues to grow. From 2011 to
9 2012, enrollment grew by about 10 percent up to 13.3 million
10 beneficiaries. Again, in 2012, about 27 percent of Medicare
11 beneficiaries were enrolled in MA plans.

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

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

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

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

3 Now I want to summarize MA payment policy.

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

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

22 If a plan bids above the benchmark, Medicare pays

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

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

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

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

22 PPACA reduced benchmarks which resulted in zero

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

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

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

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

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

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

15 The quality bonus program, as a pay-for-
16 performance system, has resulted in changes in plan
17 behavior. Plan star ratings went up between 2012 and 2013.
18 Looking at the distribution of enrollment as of November
19 2012, the new 2013 star ratings will have the effect of
20 including a greater proportion of the enrollment in higher
21 rated plans. The most dramatic increase in star ratings was
22 among local PPOs. Under the 2012 star ratings, 13 percent

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

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

14 Although about one-third of the process and
15 intermediate outcome measures showed improved results
16 between 2012 and 2013, it is hard to say how much of the
17 improvement in the numbers reflects improved quality between
18 2011 and 2012 in MA. There are two things that the numbers
19 reflect: better quality of care among providers in the
20 plans, and better documentation and coding at the provider
21 level and at the plan level. It is hard to disaggregate the
22 two.

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

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

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

22 The Commission has also recommended that pay-for-

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

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

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

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

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

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

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

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

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

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

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

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

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

1 whether SNPs encourage a more integrated delivery system.

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

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

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

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

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

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

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

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

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

1 chronically ill.

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

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

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

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

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

3 Direct the Secretary, within three years, to
4 permit MA plans to enhance benefit designs so that benefits
5 can vary based on the medical needs of individuals with
6 specific chronic or disabling conditions;

7 And permit current C-SNPs to continue operating
8 during the transition period as the Secretary develops
9 standards. Except for the conditions noted above, impose a
10 moratorium for all other C-SNPs as of January 1, 2014.

11 The draft recommendation imports the C-SNP model
12 of care into regular MA plans. C-SNP authority would expire
13 for the majority of conditions that are currently eligible
14 for C-SNPs. But MA plans would be given the flexibility to
15 offer specialized benefit packages. We anticipate that MA
16 plans would be held to some or all of the existing C-SNP
17 model-of-care requirements. The Secretary would have three
18 years to develop the needed regulations. Our intention is
19 for the benefit design flexibility to be fully implemented
20 and the transition period to end no later than December 31,
21 2016. During the transition periods, current C-SNPs would
22 continue operating, but no new C-SNPs would be permitted to

1 enter the program for the conditions with expiring
2 authority.

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

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

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

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

1 continue.

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

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

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

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

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

10 This brings us to the third draft recommendation.
11 It reads: The Congress should permanently reauthorize dual
12 eligible special needs plans that assume clinical and
13 financial responsibility for Medicare and Medicaid benefits
14 and allow the authority for all other D-SNPs to expire.

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

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

22 We do not expect beneficiaries or plans to be

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

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

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

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

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

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

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

9 We do not expect this recommendation to affect
10 program spending.

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

14 This slide presents a summary of the draft
15 recommendations.

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

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

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

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

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

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

1 makes sense to us.

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

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

19 So those are distinct advantages for private
20 plans.

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

1 which provide it an advantage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 That is not to say that we are opposed to pay-for-
9 performance for Medicare Advantage plans. That is not to
10 say that we don't think that plans will respond to
11 incentives to improve quality. Indeed, back in the early
12 2000s, the very first provider group that we recommended go
13 to pay-for-performance was Medicare Advantage plans because
14 we thought, in fact, plans should be rewarded for quality
15 and would respond to the incentives. But that is a separate
16 question from whether this is an appropriate use of the
17 Secretary's demonstration authority. You can believe plans
18 respond to incentives and this was not an appropriate thing
19 for the Secretary to do. Those are not mutually
20 inconsistent.

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

1 that the Commission has been on for a while now.

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

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

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

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

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

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

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

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

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

5 MR. ZARABOZO: In terms of the minorities, the
6 situation is still that it's about -- the proportion of
7 blacks, for example, in MA is similar to the general
8 population. Hispanics are more likely to be enrolling in
9 MA. That has not changed. This is based on our look at the
10 2011 data.

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

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

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

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

6 MR. KUHN: Okay.

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

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

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

12 DR. HARRISON: Right.

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

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

16 MR. HACKBARTH: Right.

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

20 DR. HARRISON: In a sense, it's really a permanent
21 0.2 percent upward adjustment.

22 MR. KUHN: Okay. Thank you.

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

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

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

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

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

1 the country and then drops. So there were some private fee-
2 for-service zero premium with drug plans and they may have
3 dialed back a bit. We know, in general, that private fee-
4 for-service has dialed back and I think some of the loss may
5 be due to that. But, you know, the year before that, it was
6 85, so it could have been one plan that affected this.

7 MR. GEORGE MILLER: Okay. Thank you.

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

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

21 DR. NAYLOR: A comparable --

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

1 DR. NAYLOR: Great.

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

4 DR. NAYLOR: Great.

5 [Laughter.]

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

15 DR. HARRISON: Yeah --

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

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

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

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

2 DR. HARRISON: Right.

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

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

16 DR. NAYLOR: Thank you.

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

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

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

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

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

10 MS. UCCELLO: But even beyond --

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

14 MS. UCCELLO: -- pushes it up. And then on Slide
15 8, I really want to commend the quality write-up. I
16 remember last year, there was just so much information in
17 there, and I think it did a really good job this year of
18 sorting through that.

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

21 [Laughter.]

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

1 saying that, Cori.

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

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

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

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

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

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

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

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

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

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

1 [Laughter.]

2 DR. DEAN: Yeah, it did clarify a lot of things.

3 I second what Bill said.

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

13 MR. ZARABOZO: That's correct, yes.

14 DR. DEAN: Okay.

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

20 DR. HARRISON: The 12 you mean?

21 DR. CHERNEW: Yeah.

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

1 a beneficiary sitting down, you have 12 choices.

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

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

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

9 DR. HARRISON: Correct.

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

13 DR. HARRISON: Right.

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

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

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

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

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

5 DR. CHERNEW: Right.

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

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

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

17 DR. CHERNEW: Okay.

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

1 MR. ZARABOZO: Looking at SNP overall, yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the existing set of benchmarks that way.

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

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

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

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

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

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

1 product to that end.

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

6 MR. HACKBARTH: Rita, clarifying questions?

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

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

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

22 [Laughter.]

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

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

16 MR. ZARABOZO: Right, yeah.

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

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

1 overall rating over these 50 measures of --

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

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

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

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

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

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

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

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

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

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

1 MR. HACKBARTH: Right.

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

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

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

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

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

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

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

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

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

19 I think I'll leave it at that.

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

1 that the question?

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

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

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

12 DR. COOMBS: Okay.

13 DR. HARRISON: The regional PPOs, it does.

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

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

22 DR. COOMBS: Okay. Thank you.

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

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

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

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

1 low-income people.

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

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

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

1 past.

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

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

19 Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 DR. HARRISON: So the benchmarks are up at 110,
19 111 percent of fee-for-service.

20 DR. SAMITT: Yeah.

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

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

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

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

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

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

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

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

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

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

12 We haven't found anything as far as competition.

13 What was the other piece?

14 DR. SAMITT: Quality.

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

19 DR. SAMITT: So they shadow the benchmarks.

20 DR. HARRISON: It could be.

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

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

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

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

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

19 DR. SAMITT: And then finally, Christine, on slide
20 28, will the fourth recommendation sort of address and
21 resolve the industry concerns about state restrictions to
22 integration? So will this -- I think we've got some

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

3 Will this resolve this? Will this resolve their
4 concerns?

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

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

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

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

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

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

8 So Herb, set a good example for us here.

9 MR. KUHN: I support all four recommendations.

10 MR. HACKBARTH: That's a sterling example.

11 [Laughter.]

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

14 MR. GEORGE MILLER: I support all four
15 recommendations.

16 MR. HACKBARTH: And....

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

22 DR. NAYLOR: I support all four recommendations.

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

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

8 Thank you.

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

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

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

22 The integration of C-SNPs into overall MA plan is

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

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

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

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

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

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

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

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

11 DR. CHERNEW: I support the recommendations.

12 MR. BUTLER: I will support the recommendations.

13 DR. NERENZ: I will also support them.

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

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

22 DR. BAICKER: I support the recommendations and,

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

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

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

18 MR. GRADISON: I support them, as well.

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

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

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

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

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

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

21 [Show of hands.]

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

1 back.

2 Opposed to recommendation one?

3 [No response]

4 MR. HACKBARTH: Abstentions.

5 [No response]

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

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

9 [Show of hands]

10 MR. HACKBARTH: Opposed

11 [No response.]

12 MR. HACKBARTH: Abstentions.

13 [No response.]

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

16 [Show of hands.]

17 MR. HACKBARTH: Opposed.

18 [No response.]

19 MR. HACKBARTH: Abstentions.

20 [No response.]

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

1 [Show of hands.]

2 MR. HACKBARTH: Opposed.

3 [No response.]

4 MR. HACKBARTH: Abstentions.

5 [No response.]

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

7 [Pause.]

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

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

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

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

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

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

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

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

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

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

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

17 Next, if we turn to Medicare margins, we found
18 that the aggregate overall Medicare margin in 2011 was minus
19 5.8 percent. Remember the overall Medicare margin measures
20 Medicare costs and Medicare payments for most lines of
21 services in the hospital, including inpatient, outpatient,
22 all the lines of post-acute care services that hospital may

1 offer, and graduate medical education.

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

11 We expect payments to grow by roughly 4 percent,
12 accounting for payment rate updates and payment policy
13 changes like the new readmission payment penalty that took
14 effect in 2013. We expect costs to grow faster than payment
15 rate updates, rising roughly 5 to 6 percent from 2011 to
16 2013. However, this 1- to 2-percent difference between
17 payments and cost growth should largely be offset by higher
18 payments for health information technology. We estimate
19 that health information technology payments in 2013 will
20 likely be \$2 to \$2.5 billion higher than they were in 2011.

21 Jeff will now continue with our discussion.

22 DR. STENSLAND: So Craig discussed average

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

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

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

17 First, there was a question on occupancy. One
18 factor behind the 10 percent lower inpatient costs in the
19 efficient group is they have a 10 percent higher occupancy.
20 The 63 percent occupancy on average of this group is about
21 10 percent higher than the 56 percent occupancy for the
22 other group.

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

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

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

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

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

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

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

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

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

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

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

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

22 In 2008 CMS implemented MS-DRGs to improve

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

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

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

1 that two additional adjustments are needed at this point to
2 make the transition to MS-DRGs budget neutral. One is an
3 adjustment to prevent further overpayments of between 0.6
4 percent and 0.8 percent. The second is a recovery of over
5 \$11 billion in past overpayments that took place from 2010
6 to 2012.

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

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

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

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

4 Now, I also want to remind you of something from
5 last month, because last month we noted that cost growth in
6 2009 and 2010 was the lowest in the last decade. So we have
7 this odd phenomenon of somehow case mix grows faster than it
8 has in a long time and cost growth grows lower than it has
9 in a long time and why are these things different. And I
10 think a large part of the explanation is that increase in
11 case mix was due to coding and not actual increase in the
12 expect costliness of the cases.

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

1 two systems.

2 CMS has already recovered overpayments that
3 occurred in 2009 and has the authority to stop future
4 overpayments of 0.6 to 0.8 percent. However, CMS originally
5 did not have the authority to recover the overpayments from
6 2010 to 2013, and that's the authority they were granted
7 under the new American Taxpayer Relief Act last week.

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

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

22 In January, one year from now, the outpatient

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

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

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

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

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

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

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

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

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

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

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

8 First, we see outpatient volume growth.

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

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

19 For example, we see E&M visits up 8 percent per
20 capita in hospitals and echocardiograms up 18 percent in
21 2011. In contrast, the volume of these services actually
22 fell in physician offices where the payment rates were

1 lower.

2 Now we'll open it up for discussion.

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

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

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

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

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

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

6 MR. HACKBARTH: Yes, okay. Thank you.

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

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

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

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

4 DR. SAMITT: Okay.

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

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

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

14 DR. SAMITT: Okay.

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

18 DR. SAMITT: Okay, great. Thank you.

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

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

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

8 DR. HOADLEY: Has authority but not with
9 discretion?

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

19 DR. HOADLEY: Okay. So if they just did the one
20 the way you've previously described it, we'd be at something
21 like a minus -- the new revised current law would be a minus
22 0.6. And we're saying instead it should be a plus 1.0 in

1 our draft recommendation.

2 DR. STENSLAND: Correct.

3 DR. HOADLEY: Thank you.

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

10 DR. STENSLAND: This number is really coming from
11 CBO, and when CBO did their budgetary estimates of what's
12 going to happen under this Taxpayer Relief Act, they assumed
13 roughly equal recoveries of the \$11 billion. So they're
14 basically assuming that in 2014 the Secretary would reduce
15 payments by something on the order of \$2 billion or more to
16 take roughly a quarter of that needed recovery, and that's
17 what's really driving this increase in spending, because
18 they're saying current law is to drop that spending down by
19 2 percent, and we're saying no, don't drop it down by that
20 much. So that's why we're spending more.

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

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

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

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

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

1 between.

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

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

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

21 DR. COOMBS: Right.

22 DR. STENSLAND: The other thing that would happen

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

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

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

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

7 DR. COOMBS: Right.

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

10 DR. COOMBS: Okay. Thank you very much.

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

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

1 share hospitals.

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

4 DR. COOMBS: Right.

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

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

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

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

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

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

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

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

21 DR. STENSLAND: Well --

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

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

11 DR. NERENZ: Cover the marginal cost.

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

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

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

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

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

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

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

18 DR. MARK MILLER: Well, no. No.

19 [Laughter.]

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

22 DR. NERENZ: I do.

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

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

10 The second thing, hopefully -- no, no, it was
11 good. That's why I asked the question. Slide 11, we look
12 at 2014. I'm a little surprised that there hasn't been a
13 little more attention to the coverage expansion features of
14 ACA that kick into effect in 2014, and it would seem to me
15 that part of the reason for some of the cuts in the hospital
16 sector that have come into place already this year and in
17 2014 perhaps could be phrased as negotiated offsets against
18 the reduction of uncompensated burden. Is there anything at
19 all that we should be thinking about for 2014 in that
20 specific area, meaning the reduction in uncompensated care
21 burden that we presume will be coming?

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

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

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

16 DR. STENSLAND: Yes.

17 DR. NERENZ: Okay.

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

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

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

9 So in October 1 of this year, that gets reduced by
10 75 percent, for starters. So the hospitals on October 1
11 actually, on average -- on average -- if you were at ten
12 percent, would have a 7.5 percent reduction to your DRG
13 payments because DSH is added on to the DRG payments on
14 October 1.

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

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

1 MR. BUTLER: Right. Yes. Yes.

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

5 MR. BUTLER: So the tricky part about this,
6 obviously, is, so, let's take my institution, \$170 million
7 in inpatient payments, \$22 million, or in our case, like, 13
8 percent in DSH payments. All of that -- 75 percent of that
9 \$22 million goes away on October 1 and, hopefully, in our
10 case, the expansion of Medicaid -- so some people that are
11 coming in with no insurance now will be paying Medicaid and
12 some will be signing up through the health exchange for
13 mandatory insurance, and those things together, on balance
14 in the whole system, will be paying for what's dropped from
15 the 75 percent DSH cut.

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

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

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

11 Was that a question?

12 MR. HACKBARTH: So --

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

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

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

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

3 MR. BUTLER: Right.

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

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

13 MR. BUTLER: And when do you pay it.

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

1 be out the money until all the data comes in.

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

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

13 DR. MARK MILLER: [Off microphone.]

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

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

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

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

8 MR. BUTLER: It would be good to learn more about
9 this, because I'm a believer that, ultimately, we probably
10 need to de-link the inpatient and outpatient updates. When
11 I look at inpatient, you know, we bundle into a DRG. You
12 have more variables to work with -- length of stay, supply
13 chain, process improvement -- to kind of live within a rate.
14 On the outpatient side, because the bundle, the APCs, are
15 smaller, it's hard to kind of -- if you ask the typical
16 operator, how do you get every year that kind of
17 productivity gain when you don't have the utilization, you
18 know, variable within the bundle to work with, it's a lot
19 tougher. And I think we need -- with almost 30 percent or
20 35 percent in outpatient, we just need to understand it
21 better. And it obviously is very complicated because things
22 like the E&M codes is a totally different issue. But it's a

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

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

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

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

1 the inpatient side than a PPS hospital.

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

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

13 DR. HALL: I'm okay.

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

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

1 we could look at it if you want us to.

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

8 MR. LISK: Remember, the overall total -- I mean,
9 the total all-payer margin is what really matters to the
10 hospital in the bottom line, and those are -- those have
11 been pretty high and there's not as big a difference between
12 those hospitals and for the efficient and unefficient [sic]
13 groups. I can't remember -- that was on the earlier slide,
14 2, I think.

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

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

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

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

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

12 MR. GEORGE MILLER: Yes.

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

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

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

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

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

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

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

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

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

11 MR. GEORGE MILLER: Yeah.

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

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

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

1 where they are from 2011 to 2013.

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

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

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

18 DR. STENSLAND: Yeah --

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

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

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

4 MR. KUHN: Thank you.

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

9 Craig.

10 DR. SAMITT: I agree with the recommendation.

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

15 MR. GRADISON: I also support the recommendations.

16 DR. COOMBS: I support the recommendations.

17 DR. BAICKER: Likewise.

18 DR. REDBERG: I support the recommendations.

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

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

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

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

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

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

1 might happen in sequestration.

2 We're saying that based on what the rates are
3 today, we think they ought to go up 1 percent on October 1,
4 2013.

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

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

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

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

1 But I support the recommendation.

2 DR. HALL: I also support the recommendation.

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

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

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

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

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

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

22 So you can kind of think of our outpatient savings

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

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

7 DR. NAYLOR: I support the recommendation.

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

11 MR. KUHN: I support the recommendation.

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

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

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

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

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

11 [Show of hands.]

12 MR. HACKBARTH: Opposed

13 [No response.]

14 MR. HACKBARTH: Abstentions.

15 [No response.]

16 MR. HACKBARTH: Okay, now thank you very much.

17 Good work.

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

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

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

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

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

14 MS. MIHALICH-LEVIN: Great. Good morning.

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

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

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

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

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

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

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

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

5 So thank you.

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

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

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

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

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

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

12 So thank you very much.

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

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

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

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

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

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

21 [Laughter.]

22 MS. BLONIARZ: And then he will review the

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

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

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

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

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

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

8 MS. BLONJARZ: That's right.

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

11 MS. BLONJARZ: That's right. It's of
12 beneficiaries reporting they're looking for a primary care
13 physician.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 available are unlikely to change in the near term.

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

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

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

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

22 The Congress could also choose to phase in these

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

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

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

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

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

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

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

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

22 In addition to that, we have a large cohort of

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

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

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

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

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

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

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

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

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

20 MR. HACKBARTH: Absolutely.

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

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

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

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

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

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

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

8 DR. HAYES: That sounds right.

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

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

21 So just those two comments.

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

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

4 MS. BLONJARZ: Sure, and Kevin --

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

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

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

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

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

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

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

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

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

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

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

22 I also want to make one other comment as we think

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

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

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

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

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

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

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

6 MR. GEORGE MILLER: Okay.

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

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

10 DR. HAYES: You've got it.

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

13 DR. HAYES: Well, okay.

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

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

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

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

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

8 MR. KUHN: Okay.

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

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

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

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

1 MR. KUHN: Okay. Thank you.

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

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

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

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

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

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

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

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

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

1 be aware of, if it were to change.

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

12 MS. BLONJARZ: The measurement period is 2013 for
13 penalties and 2015.

14 DR. HOADLEY: Okay.

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

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

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

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

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

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

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

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

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

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

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

1 say that that is the case.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 DR. MARK MILLER: Fifty to 60.

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

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

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

1 MR. BUTLER: I just took \$25 billion, divided by
2 \$550 billion, which was the --

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

7 [Laughter.]

8 DR. MARK MILLER: -- can't always distinguish.
9 You always look worried. Kate occasionally looks happy.
10 I want to just focus you on this \$25 billion.
11 This \$25 billion is a one-year fix.

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

15 DR. MARK MILLER: Okay.

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

19 DR. MARK MILLER: Right.

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

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

5 MR. HACKBARTH: Yeah, okay.

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

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

12 DR. CHERNEW: [Off microphone.] Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

1 beneficiaries, those margins, those types of things.

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

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

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

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

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

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

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

16 As we described in our December presentation,
17 important facts about ASCs in 2011 include that Medicare
18 payments to ASCs were about \$3.4 billion; the number of fee-
19 for-service beneficiaries that were served in ASCs was about
20 3.4 million; and the number of Medicare-certified ASCs was
21 5,344.

22 Also, ASCs have benefits relative to hospital

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 agencies.

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

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

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

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

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

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

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

17 MR. HACKBARTH: Thank you.

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

1 In addition to the discussion that occurred at the
2 December public meeting, I talked to each individual
3 Commissioner about this, as well as all the other updates,
4 and in the course of that, it became clear that, in fact,
5 the consensus position among the Commissioners was for the
6 lower update, namely, no update in the rates as opposed to
7 0.5.

8 In formulating the draft recommendation for the
9 0.5 update, I emphasized looking at the ASC issue through
10 the lens of comparing what we pay for the same services
11 provided in different locations -- ASCs versus hospital
12 outpatient departments -- and as I explained in December,
13 that way of thinking about the issue led me to think that we
14 wanted to take care not to widen what is already a
15 significant difference in payment between ASCs and hospital
16 outpatient departments for the same services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 yet that strongly argues for a different update than this.

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

8 MR. GRADISON: I support the recommendations also.

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

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

22 In our system, the two primary things we highlight

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

8 MR. KUHN: I support the recommendation.

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

20 DR. NAYLOR: I support the recommendation.

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

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

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

9 DR. DEAN: Yeah, I support the recommendation.

10 DR. CHERNEW: I support the recommendation.

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

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

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

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

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

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

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

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

17 [Show of hands.]

18 MR. HACKBARTH: Opposed?

19 [No response.]

20 MR. HACKBARTH: Abstentions?

21 [No response.]

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

1 job.

2 [Pause.]

3 MR. HACKBARTH: So now we're moving on to
4 outpatient dialysis services.

5 MS. RAY: Good afternoon. Today's presentation on
6 assessing the payment adequacy of outpatient dialysis
7 services consists of three sections. First I'm going to try
8 to answer some questions that Commissioners raised at the
9 December meeting. Then I'm going to summarize the
10 indicators of payment adequacy that we discussed in detail
11 at the December meeting. Lastly, I will present the draft
12 recommendation for you to discuss and vote on.

13 Outpatient dialysis services are used to treat
14 most patients with end-stage renal disease. In 2011, there
15 were about 365,000 Medicare fee-for-service dialysis
16 patients, roughly 5,600 dialysis facilities. Medicare
17 spending in 2011 was about \$10.1 billion.

18 Bill Hall, you asked a question at the December
19 meeting about the demographics of new dialysis patients. We
20 have included in the briefing materials a table providing
21 the rate of new cases by age, gender, and race. Between
22 2000 and 2010, new cases grew the fastest among individuals

1 85 years and older.

2 Rita, per your request, we have added references
3 concerning the finding that researchers have shown that
4 early initiation of dialysis was not shown to be associated
5 with improved survival or clinical outcomes. These
6 references include the 2010 publication of the randomized
7 clinical trial named IDEAL.

8 Cori and Rita, you asked that we strengthen the
9 language concerning the low-volume adjustment. The text now
10 states that only low-volume facilities that are necessary to
11 maintain access in isolated areas should receive enhanced
12 payment. We intend to revisit this issue on the low-volume
13 adjustment once we have obtained and analyzed 2011 volume
14 and cost per treatment information from facilities' 2011
15 cost reports.

16 Peter, per your request, we have added a reference
17 to our finding about dialysis patients' relatively high use
18 of non-emergency ambulance services. The new law -- the
19 American Taxpayer Relief Act of 2012 -- reduces the fee
20 schedule payment amount for this service by 10 percent
21 effective October 1, 2013.

22 Herb, you asked about the comorbidity adjuster

1 under the modernized payment method. To briefly review, CMS
2 designated three acute and three chronic comorbidities --
3 and these are listed on the slide -- as beneficiary payment
4 adjusters. These comorbidities were selected based on a
5 statistically significant relationship between the presence
6 of the comorbidity and cost. Industry representatives
7 contend that facilities lack sufficient documentation to
8 claim the adjusters. Industry representatives also contend
9 that they incur high labor costs to obtain the necessary
10 documentation to bill for these adjusters. They incur high
11 labor costs to obtain the necessary documentation from the
12 providers -- hospitals and specialists -- who typically
13 diagnose these conditions.

14 So to begin to look at this issue and to begin to
15 address the question about whether facilities are reporting
16 comorbidities on the bills they submit to Medicare, we used
17 2011 claims submitted by dialysis facilities that elected to
18 be paid under the new payment method. We determined the
19 prevalence, the percent of patients that facilities billed
20 for each of these six conditions.

21 Our analysis suggests that reporting in 2011 has
22 improved compared to prior years, specifically older

1 analyses, one published by the industry, that used 2008
2 data. And this suggests that reporting improves once it is
3 linked to payment.

4 We think that this is an issue to stay on top of.
5 We will monitor this issue next year by comparing 2012
6 reporting to 2011 reporting. Also, the new law, the
7 Taxpayer Relief Act, calls for the Secretary to conduct an
8 analysis of the case-mix adjusters by January 1, 2016, and
9 to make appropriate revision.

10 So now I'm going to move to the second part of the
11 presentation -- a summary of the payment adequacy
12 indicators. You've seen most of this material in December.
13 And I'm also going to be addressing a few more questions
14 that Commissioners asked in December.

15 Regarding providers' capacity, growth in the
16 number dialysis treatment stations has kept pace with the
17 growth in the number of dialysis patients.

18 Regarding access, we looked at the effect of
19 facility closures on beneficiary access. There were few
20 facility closures -- roughly 90 -- in 2010, and few patients
21 were affected by these closures -- about 1 percent, or about
22 3,800 dialysis patients. We found that African Americans,

1 compared to whites, were more likely to be treated in a
2 closed facility. Available evidence suggests that they
3 continued to receive access at other facilities.

4 Herb, in answer to your December question, we
5 found that rural facilities did not close
6 disproportionately. Rural facilities represented 21 percent
7 of closed facilities and 22 percent of all facilities.

8 Looking at the volume of services, between 2009
9 and 2011, growth in the number of treatments matches growth
10 in the number of patients.

11 We also looked at volume changes in the use of
12 dialysis injectable drugs, an important component of
13 dialysis care. We have updated our analysis that now
14 measures volume on a per treatment basis. We did this
15 because the unit of payment is per treatment. We looked at
16 changes in per treatment volume for ESAs, injectable iron,
17 and vitamin D agents in 2007, the year CMS used to set the
18 2011 base payment rate; 2010, the year prior to the new
19 payment method; and 2011, the first year of the new payment
20 method.

21 We measured use by multiplying the number of units
22 of the drug administered by the average 2011 average sales

1 price for that drug. We found that most of the decline
2 occurred between 2010 and 2011, the first year of the new
3 payment method.

4 We also found that ESAs accounted for most of the
5 decline partly because it accounted for most of the drug
6 utilization under the prior payment method.

7 Regarding quality, since implementation of the new
8 PPS, mortality hospitalization and emergency department use,
9 while high, have remained steady. As I just discussed,
10 between 2010 and 2011, per treatment use of the drugs used
11 to manage anemia, ESAs and injectable iron, declined. We
12 also see a change between 2010 and 2011 in anemia outcomes.
13 There is an increase in the proportion of beneficiaries with
14 a low hemoglobin level, and the rate of blood transfusions
15 has modestly increased.

16 Tom, you asked about the variation in low
17 hemoglobin levels. We obtained 2010 and 2011 data on the
18 regional variation in low hemoglobin levels across the 18
19 ESRD networks. In 2011, a greater proportion of patients
20 had lower hemoglobin levels than in 2010, but the spread or
21 the variation in both years was about the same, 5 to 6
22 percentage points.

1 Regarding access to capital, indicators suggest it
2 is adequate, including growth in large and mid-sized chains.

3 The Medicare margins for outpatient dialysis
4 services: the 2011 Medicare margin is estimated at 2 to 3
5 percent, and the 2014 margin is projected at 3 to 4 percent.

6 I cannot give you the distribution of 2011 margins
7 because we lack 2011 cost report data. But in past years,
8 the Medicare margin has been greater for the two large
9 dialysis providers versus other facilities; has been greater
10 for urban versus rural facilities; and greater for high-
11 volume facilities versus low-volume ones.

12 The margins on the slide reflect payment updates
13 in law and the effect of the ESRD quality incentive program.
14 However, the margins do not reflect the change in payment
15 policy under the recently passed American Taxpayer Relief
16 Act of 2012.

17 With respect to the outpatient dialysis payment
18 rate, the new law mandates that the Secretary rebase the
19 dialysis payment rate effective 2014 based on changes
20 between 2007 and 2012 in the utilization of ESAs, other
21 drugs and biologicals, and diagnostic laboratory tests.

22 It also requires that the Secretary delay the

1 inclusion of the oral-only Part D ESRD-related drugs into
2 the payment bundle until 2016.

3 Given that most of our payment adequacy indicators
4 are positive, that providers have realized efficiencies
5 under the modernized payment method, particularly in the use
6 of dialysis injectable drugs, and that nearly all providers
7 (93 percent) elected to be paid under the new payment
8 method, our draft recommendation reads that the Congress
9 should not increase the outpatient dialysis bundled payment
10 rate in 2014.

11 This recommendation is the same as the
12 recommendation you saw in December. There is a slight
13 change in the language for technical reasons, but the intent
14 is the same.

15 Regarding spending, this recommendation increases
16 spending relative to current law by between \$50 million and
17 \$250 million over one year and by less than \$1 billion over
18 five years. Although our recommendation has not changed
19 between December and January, there is a change in the
20 recommendation's budgetary implications, like you saw with
21 the hospital update this morning, from savings to increasing
22 Medicare outlays relative to current law. This change

1 occurred because of the Taxpayer Relief Act.

2 Our draft recommendation holds the 2014 payment
3 rate at the 2013 level. The Taxpayer Relief Act requires
4 that the Secretary rebase the 2014 payment rate, and then
5 MIPPA requires that the Secretary update the payment rate.

6 We intend to discuss rebasing with you once we
7 have obtained and analyzed the 2011 dialysis cost reports.

8 Regarding implications of this draft
9 recommendation for beneficiaries and providers, no adverse
10 impact on beneficiaries' access to dialysis services or
11 providers' willingness and ability to care for beneficiaries
12 is expected.

13 MR. HACKBARTH: Okay. Thank you, Nancy.

14 So as Nancy indicated, this is another one of
15 those instances where the Taxpayer Relief Act switched a
16 recommendation from being one that saved money in December
17 when we discussed it to now one that would add to Medicare
18 spending based on the revised baseline.

19 At our December meeting, we took note of the
20 change in the use of dialysis-related drugs, especially the
21 ESAs and, based at least in part on that change in behavior,
22 decided that no increase in the base rate was appropriate.

1 So hold the rate constant.

2 Congress, looking at the same information,
3 concluded that it wanted to go a step further and begin
4 reducing the base rate to reflect this change in the pattern
5 of care.

6 I feel comfortable with where we were in December
7 given that this change in the pattern of care is relatively
8 recent, and given that I think we need some more time to
9 assess both its financial and clinical implications for
10 patients, that the prudent thing to do is to hold the rates
11 constant as opposed to move quickly to reducing the rates.
12 It's not that I'm against rebasing in principle. I have
13 been a strong proponent of rebasing rates in other sectors -
14 - home health and skilled nursing facilities included -- but
15 that was only after years' worth of evidence that the
16 payments were out of line with the cost of care delivery.
17 Here, in the case of dialysis, we are in the midst of an
18 unfolding development, and my belief is that the prudent
19 course is to hold rates constant while we allow events to
20 unfold a bit.

21 So, Cori, do you want to go first?

22 MS. UCCELLO: Sure. This is a great chapter. I

1 do have a question on Table 4, which is on page 24 of the
2 paper. I'm not sure if I'm just misinterpreting how this is
3 supposed to be, but the anemia measures for the peritoneal
4 dialysis, except for 2011, they don't add up to 100. And I
5 don't know what's going on there.

6 MS. RAY: You know, I noticed this after the paper
7 went out, that there's a line skip, and I can show you the
8 numbers after the meeting.

9 MS. UCCELLO: Okay.

10 MS. RAY: I apologize for that.

11 MS. UCCELLO: I'm glad it's not me going crazy, at
12 least not for that reason.

13 MR. HACKBARTH: Actuaries, they look to see that
14 all the numbers add up.

15 DR. MARK MILLER: We purposely put one in every
16 set of papers to keep you occupied for half a day.

17 [Laughter.]

18 MS. UCCELLO: What's going on? I think I can add.

19 Where am I? So --

20 MR. HACKBARTH: MedPAC.

21 [Laughter.]

22 MS. UCCELLO: I support the recommendation, and I

1 think we do just need to keep an eye on these quality
2 measures, even with our kind of zero update, and especially
3 if that rebasing occurs, this is something that we need to
4 keep our eyes on.

5 DR. HALL: I don't have any comments. I am in
6 favor of where we are at the present time. I think I'll
7 skip any other comments right now.

8 DR. DEAN: I support the recommendation. I wonder
9 -- it struck me, the report, that the greatest growth rate
10 in new patients is among those 85 and older. I wonder if we
11 really are adequately informing patients as to the options,
12 and this would be, I think, one of the ideal places where
13 the whole shared decisionmaking concept would apply. And
14 are patients really understanding, first of all, what
15 they're signing up for and what their options are and so
16 forth? I don't have an answer, but it does strike me that I
17 really wonder if that's -- that's something that I think
18 needs some review.

19 DR. CHERNEW: I support the recommendation, and I
20 think it raises a broader question that's worthy of more
21 thought. Specifically, if we move to worlds where there's
22 bigger bundles and we're paying not for specific service,

1 for bundles, we need to think about what it means to update
2 or not update in that world where there's a lot of
3 utilization changes going on and how quickly we think CMS
4 should recoup what seem like apparent efficiencies or pay
5 more, be more volume. What will change the profitability in
6 a bundled world is not just price but also these utilization
7 things. And so I think in this particular case, it's
8 prudent to wait, and I don't think we want to set a
9 precedent that every time it looks like we're paying a
10 little bit more, CMS is going to pull it back. On the other
11 hand, the only way you save money in a world of bundles is
12 if eventually CMS does change the rate. So I do believe
13 when there's the right information, we should do that.

14 So I think this is just exemplary of something
15 that I hope will be a longer discussion in more areas.

16 MR. BUTLER: So thank you for responding to my
17 ambulance issue, and Congress did something, a little bit.
18 And then I looked at the CBO scoring, and the savings occur
19 in 2019, is when the reduction in the ambulance occurs.
20 It's six years from now. So, well, what the heck? We can
21 try.

22 But I do have a question. Okay. This is -- I

1 don't mean to make light of these payment rates because
2 they're important to the people that are involved. But I'm
3 a little unclear, similarly, in going to this rebasing in
4 2014, the scoring of this and the act kind of ramps this
5 thing up. So it's only something like \$200 million in 2014,
6 and it goes up to \$700 million per year in the out-years.
7 So is there -- I was led to believe this was, you know,
8 rebased right away. But this looks like a phase-in of -- or
9 do we just not know? It kind of affects a little bit our
10 own position. It looks like there could be some time to
11 make some adjustments. But do you know more how that works
12 and ramps up?

13 MS. RAY: Well, what more I can tell you is that
14 that score that you're referring to refers to the provision
15 of rebasing as well as delaying the inclusion of the oral-
16 only Part D drugs in the bundle. So those drugs are going
17 to remain in Part D for 2014 and 2015, so that probably
18 accounts for the --

19 MR. BUTLER: And because these are calendar years
20 and there's also a fiscal year, you get a bump-up in --

21 MS. RAY: Yes, exactly. In 2016.

22 MR. BUTLER: I got you

1 DR. MARK MILLER: It's an extra provision, and
2 what we're still a little bit hazy on is, you know, the
3 Commission is saying the payment rates from year one to year
4 two should remain flat. The Congress seems to have rebased
5 but given an update. And exactly where those two numbers
6 fall -- you know, we're working as best we can with CBO to
7 get an estimate, but exactly how that rebasing works in the
8 end, just the rebasing part, is a little bit hazy to us.
9 And then we think those numbers get bigger in the out-years
10 because of the delay in blending in the Ds. So a different
11 provision.

12 And one quick commercial. Because I want you guys
13 to be sure that you know we listen to you, next month I
14 think we're coming to shared decisionmaking. I'm not sure
15 we'll be directly on point to your question, but we will get
16 that -- we will, in fact, be directly on point in your
17 question. I'm getting a nod. So just so you know, we do
18 listen, and that will happen next month.

19 MR. BUTLER: And then one other sales pitch. As
20 we struggle with wanting to -- sometimes we criticize
21 Congress for not listening to us, and sometimes we don't
22 give them very precise recommendations. I think there are

1 lessons to learn about what kinds of things really work and
2 are easily transferable so that we can be most helpful as
3 possible. We always should continue to kind of think of is
4 this one you could just lift up and pretty easily put in or
5 not. And I think we probably could do better in some cases.
6 I'm not suggesting this is one of those areas. It's just a
7 general statement.

8 DR. NERENZ: Looking at it, I'm okay with the
9 recommendation for now, but I think this represents a really
10 attractive call it "niche area" if we're looking at some
11 expanded bundles. In thinking about that, I'm struck by a
12 couple of features in Table 4, particularly the high
13 admission rate, but also the remarkably high readmission
14 rate in this population. I am under the impression that
15 there are some things that can be done in the outpatient
16 setting that can prevent either the index admission or the
17 readmission, which seems to create the possibility of one of
18 two things. One would be to actually intentionally enhance
19 the payment for this unit of bundling to specifically
20 support services in the outpatient arena that would have the
21 effect of reducing admission or readmission. I appreciate
22 that some other proposals like this have bad track records

1 in practice, but this might be one place where that would
2 work. Or then the alternative would be expand the bundle to
3 include something like a month's worth of total care to
4 those entities willing to step up and accept that
5 responsibility so that, again, they could invest in the
6 services in the one setting designed to reduce the
7 utilization in the more expensive setting. I think this is
8 an area where I think those dynamics may really work out.

9 MR. HACKBARTH: I agree with all that, and you'll
10 remember that one of the indications for which we thought
11 C-SNPs ought to continue was ESRD for just this reason. It
12 creates that sort of format.

13 DR. REDBERG: I support the recommendation, and I
14 also agree with the idea of looking at shared
15 decisionmaking. I note, you know, besides 85-plus, if you
16 look at the mortality rates in Table 4 on page 25, the
17 mortality rate in the 75-plus is 36 percent, which is quite
18 high, and I think we could certainly do better at informing
19 our patients about what their choices are, because, again,
20 you know, looking at quality and cost, we spend more on
21 dialysis in the U.S. than anywhere else in the world. Our
22 mortality rates are the highest of anywhere else in the

1 world for our end-stage renal dialysis patients, and I think
2 we could be doing a lot better for our patients with this
3 program.

4 I also was interested -- we had talked and you had
5 -- and thank you also for answering the questions from last
6 time, and the chapter was excellent. I'm just wondering --
7 we did talk a little bit about it last time -- if we have
8 this breakdown also by type of dialysis, particularly if
9 we're looking at bundled payments, because peritoneal
10 dialysis, if the mortality rates are different and some of
11 the other -- and whether the volume trends were the same for
12 PD as it was for hemodialysis.

13 MS. RAY: The volume changes in drugs?

14 DR. REDBERG: The volume changes in drugs.

15 MS. RAY: By modality? That I was not able to do
16 between last month's meeting and this month's meeting, but
17 moving forward, we can definitely look into that.

18 DR. REDBERG: Thank you.

19 MS. RAY: What I do want to mention, though, is
20 what we do report in the paper and what others have reported
21 is the slight uptick in the use of peritoneal dialysis under
22 the payment bundle. Traditionally, the use of dialysis

1 drugs has been lower for peritoneal dialysis patients, but I
2 just don't know about the volume changes between 2010 and
3 2011. But we will put that on our research agenda for next
4 year.

5 DR. REDBERG: Thank you.

6 DR. BAICKER: I support the recommendation and
7 echo Mike and Dave's points that this is a prime area for
8 both changing the bundle amount and for trying to make a
9 broader bundle going forward, but that that's a future step.

10 DR. COOMBS: I support the recommendation and I
11 think it's an opportunity. As I listened to Tom, I was
12 thinking about my practice recently in the ICU when I did a
13 couple of days ago. I know for a fact that when you have a
14 patient who comes in who has an established relationship, a
15 medical home, and really is tied into an integrated system -
16 - it's not necessarily in the hospital -- that it does make
17 a difference with the decisionmaking capacity of the family
18 and the patient in that scenario.

19 And I think we're talking about -- we're at 10,000
20 feet talking about dialysis but the real decisionmaking
21 actually comes at the house or on the way to the hospital
22 long before they get to the dialysis suite.

1 DR. HALL: I support the recommendation.

2 DR. HOADLEY: I support the recommendation. Thank
3 you for a really nice chapter.

4 Do I take it from the earlier dialogue that we
5 don't have the ability to say what the implications of the
6 new legislation are, in terms of a percent change in
7 payments to compare direct -- sort of apples to apples --
8 with our zero?

9 MS. RAY: The only thing that I have is the CBO
10 score and in the first year that's \$200 million.

11 DR. HOADLEY: Is there any way to make that as a
12 percent -- can you express that as a percentage?

13 DR. MARK MILLER: Just as long as we're really
14 clear about this....

15 DR. HOADLEY: Yeah, yeah.

16 DR. MARK MILLER: I think that translates into
17 about 2 percent of payments. But I would not want anyone to
18 carry out of here is whether that's what's happening with
19 the base rate amount. We are a bit unclear on that. Okay?

20 DR. HOADLEY: Okay. But just as at least a
21 magnitude -- somewhere in a very rough magnitude.

22 DR. MARK MILLER: Now here's what's going to

1 happen. It's going to be in the press that MedPAC said.

2 And I'm coming to your house to answer the question.

3 [Laughter.]

4 DR. HOADLEY: And I know there was a GAO report on
5 the rebasing issue. Is there anything in there that is
6 interesting, different than any of the stuff that you've
7 been reporting on?

8 MS. RAY: GAO found, looking at those three drug
9 classes, about a 23 percent decline between 2007 and 2011.
10 My finding was very consistent, in about a 25 percent drop.
11 So we were very, very close.

12 They did give an estimate, but that would be based
13 on 2011, of if it was rebased in 2011 what that potential
14 change could be. Again, this is according to GAO and this
15 is based on 2011. If you rebase the 2011 payment rate based
16 on the changes between 2007 and 2011, it would be more on
17 the order of \$600 million upwards to \$800 million, depending
18 upon the time period -- the exact utilization data that you
19 used.

20 DR. SAMITT: Great job. Thank you.

21 I support the recommendation. I'd echo some of
22 the sentiments of others. I'd be curious in understanding

1 to what degree alternative care protocols or innovation is
2 happening in this space. I'd be interested in understanding
3 whether the ESRD C-SNPs or whether the pioneer ACOs or the
4 shared savings groups are trying anything new or different
5 as it pertains to shared decisionmaking or alternative
6 regiments for ESRD. Maybe we'll learn some things that can
7 help us change recommendations in the future.

8 And then not to lose, and I think we've echoed it
9 as well, broadening a bundle to include non-emergent
10 transport as part of a bundle, I think may lead to some
11 savings and creativity in transportation for ESRD patients.

12 MR. KUHN: Thanks, Nancy, for the additional
13 information on the adjustment for comorbidities. I
14 appreciate that, and I support the recommendation.

15 MR. GEORGE MILLER: Yes, I'll first say it's an
16 outstanding paper, and I really enjoyed the reading. And I
17 greatly appreciate the information on the trends in kidney
18 transportation, and that information was very good reading
19 and I appreciate it.

20 With that said, I'm still a little bit troubled by
21 the disproportionate of minorities, especially African-
22 Americans, with ESRD and then the relationship with getting

1 kidney transplants. Again, the information certainly helped
2 me understand a little bit better.

3 But part of that analysis is patient education and
4 physician referral and physician education, and where that
5 particular person is placed on the waiting list.

6 Some of the issues related -- and it's just not
7 the allocation with either live kidney or cadaver
8 placements. There's a whole bundle of issues.

9 So I would hope we spend a little more time
10 talking about that and possibly, as a policy goal, make sure
11 we try to increase that, particularly because of the
12 disparity in the transplants.

13 But I do support the policy. I am a little
14 concerned also, as my other colleagues had mentioned, about
15 the 85-plus population being the fastest growing population
16 and wondering if that's the best use of our resources. I
17 think there are things that Rita mentioned today and last
18 month concerning this service line is important to take in
19 consideration, that we spend more money for this in the
20 world, and the mortality rates are horrible. We need to
21 spend a little more -- I think we need to spend a little
22 more time looking at this and wondering if this is the best

1 use of dollars, understanding what that could mean by making
2 that statement. But it's still something that we should
3 look at to make sure quality is there.

4 Quality cannot be there if the mortality rate is
5 where it is currently. We certainly should have a healthy
6 discussion about that but I do support the recommendations.
7 And again, I appreciate the staff's work on this. It was a
8 very good paper.

9 DR. NAYLOR: Briefly let me just echo everyone's
10 comments. This is an outstanding report. Thank you.

11 The most recent information reinforced how it
12 should and will inform, I think, conversations not just
13 about shared decisionmaking but when you have a little bit
14 over 25 percent of current users 75 and older, about
15 palliative and other kinds of alternative services.

16 Thank you, Tom, for starting that conversation.

17 Building a little bit on David's comment,
18 hospitalization rates have, are still really, really high.

19 What's interesting is looking at the readmission
20 rate for 30 days and to wonder, as we go forward, maybe we
21 should be looking at 31 readmission rates for all of our
22 problems to see how things are going after the 30 days.

1 MR. HACKBARTH: Time to vote.

2 DR. DEAN: I think, just to clarify this, because
3 the concern about age-related issues can easily be
4 misinterpreted in the same vein that Mark has raised a
5 couple of times.

6 This is not a rationing issue. It's not an issue
7 of shutting off services because someone reaches a certain
8 age. This is a quality of life issue, because dialysis is a
9 stress.

10 So I guess, just to make that absolutely clear,
11 what we're really looking for is what's best for that
12 patient and it may not be dialysis.

13 MR. HACKBARTH: And I take it from your earlier
14 comment, which focused on shared decisionmaking, the idea is
15 to make sure that the patient understands and can make a
16 decision based on their own values.

17 DR. DEAN: What we're really trying to do is
18 what's best for the patient and that they understand what's
19 coming. And that's the worry.

20 MR. HACKBARTH: Yes, thanks for the clarification.

21 DR. REDBERG: Absolutely, I agree. I just think
22 that we shouldn't be offering this to patients without

1 telling them what it does mean. Because it is quite a
2 stress, and I think that is what's happening now. I don't
3 think patients understand what it means to get a shunt in,
4 to spend four hours a day in a dialysis center, to have the
5 high mortality rate, and what the trade-offs are.

6 And if someone chooses that, we should definitely
7 offer it, obviously.

8 DR. DEAN: In my case, it's also a 50-mile trip to
9 the unit.

10 DR. HALL: Glenn, I'm sorry, one more comment.

11 A substantial portion of these patients really are
12 not even capable of making decisions when they are put on
13 dialysis, they are demented. And the offer of dialysis
14 comes to a family who sees a free service being offered that
15 is high tech.

16 And so again, it's more a question of
17 functionality that should always determine our decisions in
18 the very elderly on Medicare, as opposed to chronologic age.

19 MR. HACKBARTH: Okay, so it's time to vote on the
20 draft recommendation. All in favor of the recommendation,
21 please raise your hand?

22 [Show of hands.]

1 MR. HACKBARTH: Opposed to the recommendation.

2 [No response.]

3 MR. HACKBARTH: Abstentions.

4 [No response.]

5 MR. HACKBARTH: Okay, thank you very much. Good
6 job, Nancy.

7 We will now move on to home health.

8 MR. CHRISTMAN: Good afternoon. Now we will
9 review the framework as it relates to home health.

10 As a reminder, here is our framework. It is the
11 same one other sectors have followed in earlier
12 presentations. I am going to briefly review the adequacy
13 data we presented in December and then cover some items of
14 interest raised by the Commissioners.

15 Medicare spent about \$18 billion on home health
16 services in 2011. The program provided about 6.9 million
17 episodes to 3.4 million beneficiaries.

18 Here is a summary of the indicators we presented
19 in December. The supply of providers is at an all-time
20 high. Virtually all beneficiaries live in an area served by
21 home health, and there are over 12,000 providers in 2011.
22 The number of episodes has grown by about two-thirds in 2002

1 through 2011, though I would note that after many years of
2 rapid growth, episode volume was flat in 2011 compared to
3 the prior year.

4 Access to capital is a less critical item in this
5 sector because the capital needs are lower. However, our
6 discussion with financial analysts indicate that access is
7 adequate for publicly traded companies. The continued entry
8 of new providers -- over 700 in 2011 -- indicates that new
9 agencies are able to find start-up funds.

10 The functional measures of quality were either
11 steady or showed small improvement in 2011, consistent with
12 our results from prior years. The margins for 2011 were
13 14.8 percent. We project margins of 11.8 percent in 2013.
14 The reductions in margins occur because CMS implemented
15 payment reductions in 2012 and 2013.

16 Based on these factors, payments for home health
17 agencies appear to be more than adequate.

18 This slide underscores how our result for 2011 are
19 similar to prior years. The margins for home health have
20 been very high since PPS was implemented and have been about
21 15 percent or more for the entire period. These
22 consistently high margins underscore the need for

1 significant reductions in home health payment levels.

2 This year, we are also examining the performance
3 of relatively efficient home health agencies compared to
4 other agencies, and you asked for more information about
5 this. To review, we identified relatively efficient home
6 health agencies by examining costs and quality for a three-
7 year period. Agencies were classified as relatively
8 efficient if they were consistently in the top third of at
9 least one of these measures in each of the three years and
10 not in the bottom third on the other measure. We examined
11 margins only for freestanding agencies in this analysis.
12 About 14 percent of the agencies in our sample met the
13 criteria. Relatively efficient providers had lower costs,
14 were typically larger in size, and had lower hospitalization
15 rates. Relatively efficient providers had a lower share of
16 community-admitted episodes and they also tended to be
17 located in the Western part of the country and the Northeast
18 and occurred less frequently in the Southeast and Southwest.

19 Mary also asked about the financial performance of
20 agencies on a couple of different metrics, including the
21 share of episodes they provided that qualified for
22 additional therapy payments, the share of episodes provided

1 to dual eligibles, and the share provided to community-
2 admitted patients. Consistent with prior analysis presented
3 to the Commission, agencies with more therapy episodes had
4 higher margins in 2010. This imbalance has been an issue
5 for several years and was a key motivation for the
6 Commission's 2011 recommendation to revise the case mix. I
7 would note that CMS implemented changes to the case mix in
8 2012 that would likely even out the margins between agencies
9 with high and low amounts of therapy, so the spread would
10 likely be smaller in 2012 and later years.

11 For share of an agency's episodes provided to dual
12 eligibles and share of an agency's episodes provided to
13 community-admitted patients, we had the same result.
14 Agencies with very high shares of these types of episodes --
15 in the fifth quintile -- had relatively low margins of 14
16 percent. Agencies in the first through fourth quintiles had
17 similar margins of around 19 percent.

18 It is not clear why agencies in the very high
19 share group of these two measures would do worse, but one
20 common factor is that a significant number of agencies in
21 the high group of both these measures came from Texas. As I
22 will explain on the next few slides, Texas has higher

1 utilization and lower Medicare margins than other areas.
2 Factors unique to the market in this State may account for
3 the lower margins observed in these two groups.

4 George and others asked about the geographic
5 concentration in the use of home health. This slide shows
6 how utilization compares between the top five States in
7 utilization -- Florida, Louisiana, Mississippi, Oklahoma,
8 and Texas -- and the rest of the country. This table shows
9 the utilization in the top five States is double and
10 sometimes triple the rate of utilization in the other
11 States. This is true for both urban and rural areas.
12 Within the top five States, the rate for rural is actually
13 higher than the urban utilization.

14 George, you also asked how much lower spending
15 would be if utilization could be brought down in high-
16 spending counties. We noted in the paper that capping
17 utilization in the top 25 counties so that it did not exceed
18 18.5 episodes per 100 beneficiaries, or the 75th percentile
19 of this distribution, would reduce spending by about \$840
20 million and eliminate about 300,000 episodes.

21 Commissioners also asked about the Medicare
22 margins for agencies in areas that had high utilization,

1 speculating whether providers in these areas are a factor in
2 the high overall margins we observed. Our review of the
3 margins for the five highest utilization States indicated
4 that this was not the case, that agencies in these areas
5 actually had lower margins by about four to five percentage
6 points. As a result, Medicare margins would be slightly
7 higher if we excluded agencies in these areas from our
8 analysis.

9 In the past, we had noted that rural utilization
10 is very high in many areas, and in some cases, as seen in
11 the slide earlier, it eclipses urban utilization. The
12 higher utilization in many rural areas undermines the
13 efficiency of a rural add-on Medicare PACE for home health,
14 a point Tom raised at the last meeting. Recall that the
15 rural add-on is a per episode bonus payment. As a result,
16 the total add-on payment a rural area accumulates is
17 proportionate to its utilization. Areas with higher
18 utilization will accumulate more add-on payments while areas
19 with lower utilization have comparatively lower total add-on
20 payments.

21 This next table shows how this results in a poorly
22 targeted add-on, with higher utilization areas receiving the

1 bulk of add-on payments. The rural counties in the top two
2 quintiles, shown in orange, are the top 40 percent of home
3 health utilization. They accounted for 71 percent of the
4 episodes that qualified for the rural add-on. These
5 counties averaged utilization of 28 episodes per 100
6 beneficiaries compared to the national average of 17.5.

7 Rural counties in the bottom two quintiles, shown
8 in yellow, or the bottom 40 percent, accounted for 16
9 percent of the episodes that received the add-on. Most of
10 the add-on payments go to areas that have relatively high
11 home health utilization. Paying more in high-utilization
12 areas likely does little to improve access and more targeted
13 policies might be appropriate.

14 Several Commissioners expressed concern that a
15 reduction in payment or decline in supply of home health
16 agencies could hinder their ability to participate in new
17 models of care. While the history of this benefit suggests
18 that home health agencies can retool quickly when
19 reimbursement changes, I would note that Medicare also
20 covers services in the home under the Part B benefit, and
21 this is an alternative to provide care in the home under
22 fee-for-service. The fee schedule covers many similar

1 services, such as evaluation and management, physical
2 therapy, and counseling. In fact, the fee schedule payments
3 for services in the home are often lower than the comparable
4 home health payment, though there are some structural
5 differences between the two services that account for at
6 least some of the differences.

7 A good example is physical therapy. Part B pays
8 about \$87 for a 45-minute therapy visit in the home. The
9 comparable payment under the home health PPS would be about
10 \$187. Some of this difference is due to the unique
11 requirements of the home health benefit, but certainly the
12 fact that Medicare pays significantly more than cost for
13 home health services contributes to this disparity.

14 The Chairman has proposed that next year's report
15 reprint the recommendation approved for the March 2011
16 report, when we made several multi-year recommendations for
17 changes to home health. The recommendation reads: The
18 Congress should direct the Secretary to begin a two-year
19 rebasing of home health rates in 2013 and eliminate the
20 market basket increase in 2012.

21 This would reduce spending by \$750 million to \$2
22 billion in 2014 and \$5 to \$10 billion over five years. We

1 expect some contraction in supply, but the remaining supply
2 should be adequate to provide adequate access to care.

3 Mary also asked for an analysis of the attributes
4 of patients that use home health for post-acute care
5 compared to those who use it primarily after being admitted
6 from the community. This first slide shows how home health
7 utilization breaks down between the two groups. The bar on
8 the left shows the number of users in each group, and the
9 bar on the right shows the episodes that corresponded with
10 each group. Community-admitted users account for about half
11 of all home health patients, but almost two-thirds of
12 episodes. Community-admitted users average 2.6 episodes per
13 user, while post-acute care users averaged 1.4 episodes per
14 user.

15 We also examined the demographic and clinical
16 characteristics of these two groups. Community-admitted
17 users had fewer chronic conditions but had higher levels of
18 dementia, were older, more likely to be minority, more
19 likely to be dual eligible, and needed more assistance with
20 activities of daily living. These factors, combined with
21 the longer lengths of stay these beneficiaries have in home
22 health, suggest that the benefit may, at least in part, be

1 serving as a long-term care benefit for this population.

2 Several Commissioners also asked about new models
3 of care that agencies could participate in, and PPACA
4 includes several. The first two, bundled payment for care
5 improvement and care transitions, test different approaches
6 to improving post-acute care. Agencies may participate in
7 these models to help beneficiaries return home after a
8 hospitalization. The Independence at Home model is focused
9 on physician home care practices, effectively allowing them
10 to act as medical homes for frail beneficiaries. Home
11 health agencies frequently work with home care physicians to
12 serve these beneficiaries and home health will likely be
13 involved in the other reforms underway, such as ACOs and
14 medical homes, particularly for models that seek to improve
15 care transitions after a hospital stay or to improve care
16 for community-dwelling frail elderly.

17 This completes my presentation. I hope you found
18 this additional information useful. Let me know if you have
19 any questions.

20 MR. HACKBARTH: Okay. Thank you, Evan.

21 Before we turn to the home health discussion,
22 Alice, I just need to officially record your vote on the

1 dialysis update.

2 DR. COOMBS: [Off microphone.] Yes.

3 MR. HACKBARTH: Yes. Okay. Thank you.

4 So now, turning to home health, for people in the
5 audience, there are several instances where we are not
6 voting on new recommendations, home health being one of
7 those. Another is skilled nursing facilities and still
8 another is payment to physicians and other health
9 professionals. The reason that we're not having separate
10 votes on those items is that the Commission has previously
11 made multi-year recommendations in each of those areas and
12 we still stand by those previous recommendations.

13 In the case of home health, unlike SNF, we are
14 having a discussion of the issue again today because, as
15 Evan just indicated in his presentation, there were a number
16 of outstanding questions that Commissioners had asked at the
17 December meeting, and so we wanted to follow up and provide
18 answers to those questions. In the case of SNF, we didn't
19 have any of those outstanding questions and that's why
20 there's no separate presentation on SNF.

21 So with that background, Rita, do you want to
22 begin. And again, I think we'll just do one round.

1 DR. REDBERG: Sure. I support the recommendation
2 and I was struck by the difference in the payment between
3 the home health and the Part B benefit and certainly think
4 we would want to come back to that in the future. Thank
5 you.

6 MR. HACKBARTH: Kate.

7 DR. BAICKER: I support reprinting the previous
8 recommendation and note that, in some instances, home health
9 seems like a lens for a lot of the other issues we've talked
10 about in terms of similar payments for similar services and
11 ensuring that the services are delivered in the venue that
12 best matches the patients' needs, to provide high-value,
13 high-quality care. And in some instances, home health seems
14 a little different from other services in that we think it's
15 probably more price elastic than some other services, and so
16 that, even applying the same principles to home health, in
17 some instances pushes us toward slightly different policies.
18 So all of that is for the longer-run thinking about how we
19 think the principles we're discussing are going to manifest
20 here. The recommendation, as is, seems good to me.

21 DR. COOMBS: I support the recommendations. And
22 not too -- maybe not too far off in the future, this will be

1 incorporated in some robust health care system and we won't
2 be having this discussion, hopefully.

3 MR. GRADISON: I support the recommendations and
4 want to thank the staff for such comprehensive response to
5 the questions that were asked earlier. Thank you.

6 DR. HOADLEY: Yeah. I'm supportive of the
7 approach we're taking, using the old recommendations.
8 Again, I think it's a good chapter.

9 DR. SAMITT: I support the recommendations, as
10 well.

11 MR. KUHN: I, too, support the recommendations,
12 and Evan, I want to thank you for that information you had
13 on kind of the high five State utilization. And I think,
14 just in the future, that's something for us to continue to
15 look at, that data, because it might give us an opportunity
16 for future recommendations, maybe for even more precise
17 refinements to recommendations to get at real serious issues
18 out there.

19 Also, I appreciated the response to Mary's
20 question, the information you had on terms of community-
21 admitted home health users, and particularly Slide 15, where
22 you talked about the benefit is really starting to look

1 more, for that population, a little bit more like a long-
2 term care benefit instead of a home health benefit. And
3 given the improvement standard settlement case that we've
4 talked a great deal about here, I think this is also one in
5 the future that we need to monitor very closely, but not
6 only monitor the overall utilization, but also
7 geographically how it's implemented, because I have a
8 suspicion that as CMS, with the 15 different Medicare
9 administrative contractors, we could see variation across
10 the country, and does this correlate with high-utilization
11 States and will we see real spikes in some of those States
12 even further.

13 So, again, I think these two issues kind of knit
14 together very nicely for future analysis and review.

15 MR. GEORGE MILLER: Yeah. I also support the
16 recommendation and also want to thank Evan for the
17 information that I requested on the high-end users -- I'll
18 use that term.

19 I think we also, particularly because of that
20 information, make a strong statement about the integrity of
21 the program and either recommend that the Secretary take
22 action to deal with high utilization areas that have been

1 identified in documentation, whether to use her powers for
2 freezing or not approving any more payments or whatever is
3 at her disposal in addition to our recommendations.

4 DR. NAYLOR: So, Evan, I hope I didn't ruin your
5 holiday, but anyway, thank you. I really do appreciate. I
6 saw my name attached to many of these and --

7 MR. HACKBARTH: [Off microphone.]

8 [Off microphone.]

9 DR. NAYLOR: I do think it paints a really -- I
10 mean, this new chapter, these revisions, paint a really
11 interesting picture with a dramatic rise in one type of user
12 and a shrinking of another when this was established as a
13 post-acute service. So I really, really appreciate the
14 attention. I also think, in many ways, it reinforces the
15 recommendations, especially those that are really talking
16 about cost sharing for community-based episodes and not for
17 post-acute. Anyway, so I really, really appreciate all of
18 the extra effort. I also think this is exactly the kind of
19 information we need to move forward with this and I support
20 the recommendation.

21 MS. UCCELLO: I, too, support the recommendation,
22 and Herb mentioned the court settlement. I think that

1 really increases the urgency of the rebasing and making sure
2 that we get these payments right.

3 I have a question regarding those high-utilization
4 States. Do we know whether perhaps they have more agencies
5 that are smaller?

6 MR. CHRISTMAN: We haven't looked at that issue
7 precisely, but that is -- all of the data points to that
8 situation, particularly when we saw the results for that
9 fifth quintile group I talked about a bit. You know, Texas
10 has added -- I think the number of -- it had a thousand
11 agencies or so at the beginning of the last decade and then
12 that doubled. It added a thousand agencies. And so there's
13 been a huge influx in supply and in our -- we could look at
14 that a little bit, but the thesis is that those agencies are
15 small. They don't build scale. And they have lower
16 margins.

17 MS. UCCELLO: Right, and so that's what I was
18 going to say. That's why there seems to be the lower
19 margin.

20 DR. HALL: So I'm also in favor of the previous
21 recommendations, but I'm also a fan of home health care, if
22 used properly. But an enterprise that has this high a

1 margin and also has the regional and geographic
2 discrepancies cries out for continued scrutiny. So I
3 learned a great deal from this analysis. I thank you for
4 that.

5 DR. DEAN: Yeah. I certainly support the
6 recommendation. As Bill just said, these are just very
7 interesting data that some of the industry folks have
8 provided about how the discrepancy or the wide variation in
9 utilization. I think it is frustrating because we know that
10 this is potentially -- I shouldn't say potentially -- is a
11 very valuable service. We also know that it's overused in
12 settings. We also know there's probably fraud and abuse.
13 And I think a lot of that, the problem is that we have not
14 done a very good job in defining what really the indications
15 for the benefit are. And that may be -- that's very
16 difficult. In fact, it may be impossible to write it, at
17 least in a regulatory way.

18 And I was very struck -- it's too bad Scott isn't
19 here because I think his perspective on this is extremely
20 useful, and I remember him saying that in his program, they
21 look at this very differently. They see home health as a
22 cost saver. We are continually concerned about all the

1 extra resources it's consuming. And I think it argues very
2 strongly for the fact I don't know that we can deal with any
3 of these problems looking at home health as an isolated
4 entity. It's got to be part of a broader system and it
5 argues very strongly for an integrated system, and I think
6 that's probably the only way that we'll get to an answer for
7 this kind of a problem, because it's -- well, I'll stop
8 there.

9 DR. CHERNEW: So, I support the recommendation and
10 I support everything that Tom just said. And I think home
11 health is just a very good example of the areas where
12 there's underuse, overuse. We only have one tool we
13 typically talk about. There's a few others, but mostly, the
14 discussion is largely about payment and that's not a good
15 enough tool to deal with the heterogeneity geographically
16 within different organizations, even in the same place, and
17 I think we have to resist the urge to think about the unit
18 as, say, we're going to do this in Texas or we're going to
19 do -- because there's good -- you know, I think there's
20 underuse and overuse in almost every sort of area.

21 So I think, given what tools we have, I support
22 the recommendation. I think the chapter was great and we've

1 done what I think needs to be done. But I do think, moving
2 forward, we have to think about things more in terms of
3 patients and types of patients as opposed to providers and
4 how to pay the providers. We have to think of quality
5 measures so we can understand where there's underuse. We
6 have to think about broader incentives to deal with some of
7 the overuse, because I think we just don't have the tools in
8 most of what we do to solve the problem in an area where --
9 and I agree with you again -- I do think it's probably
10 impossible to write down the exact right criteria and then
11 enforce whatever criteria you were to write down. And so I
12 think going down that road is probably not the right way to
13 go. It's probably more changing of broad incentives,
14 changing broad quality measures. But for where we are, I'm
15 very supportive.

16 MR. BUTLER: So, on page 13, this is a real
17 nitpick, but when I read this the first time, until you
18 spoke it, it was unclear. My first reading was, this could
19 cost rather than reduce, because it doesn't reference
20 decrease increase payment. And on Slide 13, you know, it
21 says spending implication, \$750 million to \$2 billion. It
22 doesn't say --

1 MR. CHRISTMAN: That fell off. It should be
2 decrease.

3 MR. BUTLER: So I don't know if you can modify it
4 before you post this somewhere, but it looks like it's an
5 increase rather than a decrease. Just to let you know I'm
6 paying attention.

7 [Laughter.]

8 MR. BUTLER: So at the risk of -- I'm into this
9 aggregate, you know, big picture silo spending, and so this
10 is the last time I'll do it today, but I started with the
11 DSH being \$11 billion, and then when I say, look at these
12 silos, the ambulatory surgery was, like, \$3.4 billion. It's
13 one-third the amount that we spend on DSH. And, like,
14 inpatient rehab later is only \$6 billion. And it just
15 reminds me, you have levers like DSH or, let's say, GME,
16 which is about the same amount, and we have weird ways of
17 doing it, and yet those are really levers for either
18 opportunities or chaos that really require careful thought
19 as we zero in on some of these really smaller spending
20 things. It's yet another way to kind of look at bridging
21 behavior across silos.

22 And I would be interested now, on the question

1 side, so this is a little over three percent of Medicare
2 spending, home health. You think that it might be more than
3 that, but that's all it is, \$18 billion. How would that --
4 and Rita referenced, for example, dialysis is at \$10
5 billion, much higher than other countries. I'm just kind of
6 curious if we have under-leveraged, in general, home health
7 in this country compared to others. My guess is yes, but I
8 don't know.

9 MR. CHRISTMAN: I haven't seen any home health
10 sort of international comparisons. I mean, I think that
11 it's -- you know, some of this -- what I have seen sometimes
12 talks about differences on the long-term care side almost,
13 because other countries approach it differently. So I don't
14 think I have a good answer to your question. That's
15 something we could look at. You know, it's hard enough for
16 me to sometimes track down Medicaid spending on the
17 comparable service because it is just a smaller piece of the
18 pie.

19 MR. BUTLER: Yeah. Well, sometimes I'm tempted to
20 take baseline and throw it out. Mike has made reference to
21 baseline. If you had a blank piece of paper, where would
22 you allocate the dollars? It's another way to kind of,

1 where would you end versus where we are now and tweaking
2 things.

3 Okay. My last comment, then, again conceptual, is
4 that you have on Slide 15 that Alzheimer's, for example, is
5 29 percent of the community admits have Alzheimer's. So,
6 again, as interesting a question would be to look at the
7 chronic diseases, COPD or CHF, and we've done this in
8 episodes, to some extent, and look at where, okay, if 29
9 percent have Alzheimer's, where is Alzheimer's treated in
10 SNF, or how does it spread across, if you were to take it as
11 a chronic disease, where is the spending across the post-
12 acute sectors for that disease and are we using it in an
13 appropriate way. So if you were to enter and first be a
14 newly diagnosed Alzheimer's patient, what would be kind of
15 the pathway that you would look at versus what we have now
16 in post-acute spending would be another lens to look at this
17 through. I know that's not helpful to home health per se,
18 but I think looking at these chronic diseases along those
19 lines would help guide us more.

20 DR. NERENZ: Nothing really to add, except just to
21 reinforce both what Tom said and then what Peter just said
22 about possible cost savings or offsets. I think this is one

1 of those areas where we would like to see that happening,
2 and in some cases, we do expect to see it. But I see,
3 certainly in the geographic analysis, it's hard to see,
4 because I think some of the high home care regions are high
5 overall care regions. So you don't see an offset. So
6 anything we can learn about that, I think, would be helpful,
7 particularly to clarify what the point of comparison is.
8 You know, is it up and down dollar savings within the
9 general framework of home health? Is it doing versus not
10 doing? Is it doing this versus doing something different?
11 I don't have anything specific to recommend on that, but
12 just the more we can learn about that, the better.

13 MR. HACKBARTH: So, I'd like to associate myself
14 with a series of comments now about how home health can be a
15 very useful, important service, both in terms of improving
16 the quality of beneficiaries' lives, but also in terms of
17 potentially saving money for the system. I agree with all
18 that.

19 I don't think that overpaying for each episode of
20 home health moves us in that direction. I think to get to
21 an appropriate and effective use of home health, we really
22 need to get out of paying for it as a separate line of

1 business and move towards integrating it with other services
2 where we can assure the proper substitutions are occurring
3 and where there's ongoing oversight to tailor the service to
4 the needs of particular patients.

5 Okay. Since we have no vote to take here, we are
6 done on home health. Thank you, Evan.

7 And we are on to inpatient rehab, our last agenda
8 item for today.

9 [Pause.]

10 MS. SADOWNIK: In this presentation, we will
11 continue our discussion of payment adequacy to inpatient
12 rehabilitation facilities, or IRFs. I will briefly review
13 the analysis and draft recommendation and also address
14 questions that Commissioners asked during the last meeting.

15 As a quick sketch of the industry, 80 percent of
16 facilities are hospital-based, but these comprise only 55
17 percent of Medicare discharges. Freestanding facilities
18 represent a larger share of care to patients because of
19 higher average bed size and occupancy rates.

20 Although Medicare fee-for-service is the largest
21 payer, relatively few Medicare beneficiaries use IRFs
22 because patients must be able to tolerate the intensive

1 therapy required. To ensure that IRFs are treating patients
2 that are appropriate for this setting, facilities must meet
3 a compliance threshold. Volume and patient mix have been
4 sensitive to policy changes in this threshold.

5 I will start with addressing some of the
6 Commissioner questions from the December meeting.

7 Tom, you asked about regional variation in
8 utilization. Across the country, IRF spending per
9 beneficiary varied twofold. Also, compared to urban areas,
10 rural areas tend to have fewer beds, lower occupancy rates,
11 and higher average costs per case, although some rural areas
12 have higher IRF spending per beneficiary than the national
13 average. Note that Medicare increases rural facilities'
14 payment rates by 18.4 percent to compensate for these
15 differences.

16 George, you asked about opportunities for
17 consolidation in the areas with multiple IRFs. You might
18 expect to find lower occupancy rates in areas with multiple
19 facilities. In fact, we found that aggregate occupancy
20 rates in these areas were relatively high, perhaps because
21 markets with multiple facilities have higher volume due to
22 population density or practice patterns. This is something

1 we could look into in the future.

2 George also asked about the availability of other
3 rehabilitation options across the country. Virtually all
4 Medicare beneficiaries live in a county with at least one
5 post-acute care option. Thirty-one percent of beneficiaries
6 live in a county that does not have an IRF. Among these
7 counties that did not have an IRF, 86 percent have both a
8 SNF and coverage from home health and the remainder have
9 coverage from home health alone.

10 He also asked why Hispanic beneficiaries are
11 under-represented as IRF and SNF users. Two findings inform
12 this trend. Firstly, literature suggests lower rates of
13 joint replacement, a common condition in both IRFs and SNFs,
14 among Hispanics compared with white and black patients.
15 And, secondly, among those who do have a procedure, Hispanic
16 patients may be more likely to be discharged home to self-
17 care rather than to institutional care.

18 I will answer additional questions throughout the
19 presentation.

20 As a reminder, we'll use the same framework to
21 analyze the payment adequacy for IRFs as for the other
22 sectors.

1 I'll briefly review our access to care measures.
2 Between 2010 and 2011, the total number of facilities and
3 beds decreased by around one percent. The number of IRFs
4 has declined every year since 2005, which reflects the trend
5 of hospital-based facilities leaving the market and the
6 number of freestanding facilities slowly increasing. The
7 supply of IRF beds largely follows this trend, too, although
8 the number of beds in freestanding facilities did also
9 decline very slightly in 2011.

10 Fee-for-service spending sharply increased from
11 2010, reflecting the growth in number of cases and in
12 payment per case. Volume has been increasing, even as the
13 number of beds has decreased, suggesting that beneficiaries
14 are not losing access to services overall. Occupancy rates
15 in 2011 rose modestly and were higher in freestanding IRFs
16 than in hospital-based IRFs.

17 Rita, you asked why hospital-based facilities
18 don't have higher occupancy rates given that they could
19 influence discharging their patients to their owner. To
20 illustrate the answer, we estimated that the average
21 hospital that relied only on its own patients for IRF
22 admissions would have six beds occupied at any given point

1 in the year. The average number of beds in a hospital-based
2 IRF is 25. Therefore, while some facilities may be able to
3 rely only on their own patient discharges, most would still
4 need referrals from other hospitals.

5 I'll now turn to quality of care. I first want to
6 focus on the measure of functional improvement, or FIM gain.
7 The 2009 number we presented in December was incorrect and
8 we received questions on it from you and from industry. We
9 apologize for this error. The bolded number here is
10 corrected. We see that FIN gain increased from 26.7 points
11 in 2009 to 27.4 points in 2010. Performance on two hospital
12 readmission measures were roughly unchanged between the two
13 years, and changes on other measures were small. Overall,
14 this data suggests that quality of care across the IRF
15 industry remained fairly stable between 2009 and 2010.

16 There were several Commissioner questions on
17 quality of care. Mary, you asked about the improvement in
18 quality over time, and I added that information to the
19 chapter.

20 Kate, you asked about the difference in quality
21 between hospital-based and freestanding facilities. Across
22 the five measures, neither facility type was consistently

1 better. Hospital-based facilities had better outcomes on
2 some measures while freestanding facilities had better
3 outcomes on others. FIM gain was one point higher in
4 freestanding facilities than in hospital-based facilities.
5 For all other measures, the difference was half a percentage
6 point or less.

7 Bill Hall, you asked about the distribution of
8 performance. Among the five measures, the difference
9 between the 25th and 75th percentiles ranged from 20 percent
10 to twofold. This is an area we plan to expand on in the
11 future in conjunction with work on an efficient provider
12 analysis.

13 Cori, you asked about the change in FIM score on
14 admission over time. We do see that starting FIM score has
15 decreased over time consistent with increasing case mix and
16 changing case type due to the compliance threshold.

17 Rita, you asked for more information on
18 comparability of outcomes between rehabilitation settings.
19 Overall, research studies are not able to conclusively
20 identify one post-acute care setting as having better
21 outcomes for rehabilitation patients. Recent results from
22 the CARE tool, a uniform assessment tool used as part of a

1 Medicare demonstration, can help compare outcomes across
2 settings. The risk-adjusted analysis found no significant
3 difference in the average degree of improvement in mobility,
4 but there was a slightly higher gain in self-care outcomes
5 among patients who received care from an IRF or home health
6 agency compared to other alternatives. More information is
7 included in the mailing materials.

8 Kate, you asked about the share of conditions
9 treated by IRFs versus other rehab options. Overall, three
10 percent of all acute hospital discharges are to IRFs,
11 compared to 20 percent to SNFs and nursing facilities and 16
12 percent to home health. However, the share of discharges is
13 much higher for particular rehab-intensive conditions. For
14 example, 19 percent of stroke discharges and 12 percent of
15 hip and knee replacements are to IRFs. More detail on this
16 is included in the mailing materials.

17 Craig, you asked about the impact of the hospital
18 readmission penalty on sending patients to IRFs versus other
19 post-acute care options. The three conditions to which the
20 penalty currently applies -- heart attack, heart failure,
21 pneumonia -- are not top conditions sent to rehabilitation
22 care, and we have heard that the hospital readmission

1 penalty does not have any significant impact on choice of
2 PAC provider now. However, as the number of conditions
3 expands, we do expect that there will be increasing pressure
4 for PAC providers to demonstrate their relative value to
5 acute hospitals.

6 Hospital-based units have access to capital
7 through their parent institution, and hospitals have overall
8 maintained reasonable levels of access to capital in 2011.
9 As for freestanding IRFs, we were able to review access to
10 credit for one major national chain, which shows that their
11 ability to borrow has increased, largely due to improving
12 credit markets and the chain's strong operating performance.

13 I'll now review IRF margins for 2011. Overall
14 margins were 9.6 percent in 2011. Margins varied
15 substantially between hospital-based and freestanding IRFs.
16 Freestanding IRFs had margins of almost 23 percent in 2011.
17 They represent about 45 percent of Medicare discharges. In
18 contrast, hospital-based IRFs had margins of negative 0.8
19 percent. I will discuss some factors driving these
20 differences in margins shortly.

21 Craig, you asked to see margins for facility type
22 by ownership status. Among freestanding facilities,

1 nonprofits had margins of almost 15 percent, while for-
2 profits had margins of 25 percent. Among hospital-based
3 IRFs, nonprofits had margins of negative 0.9 percent, while
4 for-profits had margins of around four percent.

5 Let's turn to factors impacting the differences in
6 margins. Hospital-based IRFs have higher costs than
7 freestanding IRFs. We did not find that their patients are
8 sicker. Instead, hospital-based IRFs tend to have fewer
9 beds and lower occupancy rates which keep them from fully
10 capitalizing on the economies of scale the more efficient
11 freestanding facilities. Among hospital-based IRFs, both
12 direct and indirect costs per case were higher than in
13 freestanding IRFs. In 2010, direct costs were 30 percent
14 higher and indirect costs were 11 percent higher.

15 Peter, you asked for more detail on why margins in
16 hospital-based facilities have been decreasing over time
17 while margins in freestanding facilities have been
18 increasing. Between 2004 and 2010, freestanding facilities
19 have contained cost growth more than hospital-based
20 facilities have across all cost components and particularly
21 in routine costs like room and board, as detailed in the
22 mailing materials. As changes in the compliance threshold

1 resulted in lower patient volumes and higher severity of
2 illness, freestanding facilities were more successful at
3 containing costs because of financial necessity among the
4 stand-alone and predominately for-profit facilities.

5 Peter, you also asked about the payer mix with
6 respect to Medicaid. We found that hospital-based
7 facilities are more likely to have Medicaid patients, but
8 the difference is largely driven by their shares of for-
9 profit and nonprofit facilities. Across both hospital-based
10 and freestanding facilities, nonprofits were more likely
11 than for-profits to have Medicaid patients. In fact,
12 nonprofit hospital-based IRFs were less likely than
13 nonprofit freestanding IRFs to have Medicaid patients.

14 Based on 2010 data, even though Medicare margins
15 for hospital-based IRFs are negative, on average, the IRF
16 units are able to cover their direct costs. The direct cost
17 margin was 34 percent for hospital-based IRFs. In addition,
18 overall Medicare margins for acute hospitals are about two
19 percentage points higher for acute hospitals that have an
20 IRF unit than for those without an IRF. These data indicate
21 that IRF units are able to cover their direct costs and
22 financially contribute to their parent hospital.

1 As we have seen, aggregate Medicare margins for
2 IRFs in 2011 were 9.6 percent. To project the aggregate
3 Medicare margin for 2013, we modeled the policy changes
4 driving payment rates for 2012 and 2013. We project that
5 Medicare margins for 2013 will be 8.5 percent. This
6 decrease reflects the effects of PPACA productivity
7 adjustments and does not account for any market changes in
8 response, such as increased cost efficiencies.

9 In summary, our indicators of Medicare payment
10 adequacy for IRFs are positive. Measures of beneficiary
11 access suggest that capacity remains adequate to meet
12 demand. Margins average 23 percent for freestanding
13 facilities, which tend to have lower costs. Finally, risk-
14 adjusted quality of care remains stable and access to credit
15 appears adequate for both hospital-based and freestanding
16 IRFs. We project that 2013 aggregate Medicare margins will
17 be approximately 8.5 percent.

18 The draft recommendation is: The Congress should
19 eliminate the update to the Medicare payment rates for
20 inpatient rehabilitation facilities in fiscal year 2014.

21 This recommendation would decrease Federal program
22 spending relative to the statutory update by between \$50 and

1 \$250 million in 2014 and by less than \$1 billion over five
2 years. On the basis of our analysis, we believe that IRFs
3 could absorb cost increases and continue to provide care
4 with no update to the 2013 payment rate. We estimate that
5 this recommendation will decrease Federal program spending
6 relative to current law.

7 We do not expect this recommendation to have
8 adverse impacts on Medicare beneficiaries. This
9 recommendation may increase the financial pressure on some
10 providers, but overall, we expect a minimal effect on
11 reasonably efficient providers' willingness and ability to
12 care for Medicare beneficiaries.

13 And with that, we look forward to your discussion.

14 MR. HACKBARTH: Okay. Thank you, Sara. You did a
15 great job on the cellphone test, the ringing cellphone,
16 totally undeterred.

17 [Laughter.]

18 MR. HACKBARTH: Okay. So, let's see, where should
19 we begin? Who looks particularly eager right now? I think,
20 Dave, I can see a twinkle in his eye.

21 DR. NERENZ: Well, just if you could give us a
22 couple of examples, on Slide 11, the higher direct and

1 indirect costs in the hospital IRFs. What would be a couple
2 examples of both of those classes of costs?

3 MS. SADOWNIK: Direct costs include routine care
4 and ancillary costs, so routine would be room and board,
5 nursing, and ancillary includes therapy, drugs, and other
6 supplies.

7 DR. NERENZ: And is there any connection between
8 those higher costs and some of the things we've seen in some
9 other topics of our discussion about the just essential
10 costs of running a hospital? For example, is there any
11 linkage between these classes of direct costs and some of
12 the issues of accreditation requirements, 24-hour access, or
13 are these just completely in the domain of the IRF itself?

14 MR. LISK: When you talk about in a domain, I'm
15 trying to -- I think we're talking about those costs. I
16 mean, all the requirements for being a hospital have to be
17 met by all the hospital-based IRF or the freestanding IRF,
18 in terms of those requirements. Is that what you're talking
19 about?

20 DR. NERENZ: Okay. Well, let me answer the
21 question. I didn't phrase it that way, but that would
22 answer the question. I didn't know that that was strictly

1 true of the freestanding IRFs, but, yes, I can see how
2 that's so.

3 MR. BUTLER: So I'm going to support the
4 recommendation. I struggle, as I'm sure other Commissioners
5 do, with the spread in the margins, and you've done a very
6 good job being responsive to my questions and trying to
7 understand it better.

8 I did find it interesting in the -- and I don't
9 know how we look at this -- the AHA did write a letter to us
10 and commented on language from the CMS final rule last year
11 that said shifting -- this is a quote -- "shifting IRF
12 patients toward SNF care does not necessarily improve the
13 quality of care provided to beneficiaries. Eighty-one
14 percent of IRF patients were discharged home compared to 45
15 percent of SNF residents." And it goes on and it says, "IRF
16 patients have shorter lengths of stay, 13 days, compared to
17 SNF, which are 36 days."

18 So there are other factors that, you know, that
19 has nothing to do with the difference, I realize, between
20 margins between freestanding and hospital-based, but I still
21 struggle. I think we've got to do something next year, I
22 think, to either explain, or we can't have these kinds of

1 margins in the freestanding, but we've got to get at why
2 it's so different from the hospital-based a little bit
3 better.

4 MS. SADOWNIK: We need to compare apples to
5 apples, because we have to compare patients with similar
6 conditions in IRFs and SNFs because SNFs is such a different
7 patient population --

8 MR. BUTLER: Right, but --

9 MS. SADOWNIK: -- the numbers are not --

10 MR. BUTLER: -- and I realize the question on the
11 table here is not IRF versus SNF only. It's the difference
12 between the freestanding that have these huge margins and
13 tend to be for-profit and the hospital-based that are just
14 breaking even. It's more than just meeting your direct cost
15 issue. There are some other things that we need to
16 understand, or, I don't know, maybe that it's just more cost
17 effective to do it in the freestanding and we need to do
18 something about it, so --

19 MS. SADOWNIK: I think there's clearly a story
20 about freestanding versus hospital-based and it's also clear
21 that there's a story about nonprofit versus for-profit
22 within both categories.

1 MR. BUTLER: I'm sure George will pipe up, too,
2 when we get to him around this and, you know, again, who's
3 taking the Medicaid, who's not. But we're not -- we can't
4 take into account. We have to look through the Medicare
5 lens, too, we realize that, and see in Medicare alone, why
6 are you seeing these kinds of differences, so --

7 DR. MARK MILLER: I would add to the exchange, you
8 know, the quality differences. I read that, too, but it was
9 late one evening and a few days ago, so I'm not quite sure
10 I've absorbed it all, but those comparisons are very hard to
11 make without common control across the two sectors, and I
12 know you know this. This is probably more for a general
13 comment. And remember, there was a decision, the regulatory
14 decision they're talking about, where certain cases that
15 they felt were inappropriate to be in IRF.

16 But my more direct comment is, one thing that we
17 can -- you know, if we convince ourselves that this is not
18 just simply a cost structure, a selection, whatever type of
19 issue, is try and dive into the PPS system like we did with
20 SNF and like we did with home health to see if there's
21 anything systematically about the payment system that
22 discriminates in one direction or another.

1 The only thing I would say is -- and so, for
2 example, in SNF, we ended up thinking that certain costs
3 were not being handled well in the system and that was
4 driving some of the differences in margins that we saw.
5 That dive often takes a fair amount of work to really --

6 MR. BUTLER: Right. It does.

7 I'll just make one other comment. Having either
8 owned or run this, home care, LTCHs, et cetera, this one's a
9 little different than the LTCH discussion to me, and we're -
10 - also, there's an issue of who's in there and do they need
11 to be there. And maybe the ACO world will obviously help
12 take care of some of this rationalization and making sure
13 people are getting in the right place at the right time.
14 So, again, too much energy when maybe the market will take
15 care of it. I'm not sure. But these are all a little
16 different, a little different animals.

17 DR. CHERNEW: I support the recommendation and I
18 would like to say this is just one of those examples --
19 well, first, let me say, it's nice in January because you
20 get to say similar things to what you said in December, and
21 I still feel that way. This is one of those examples where
22 we have different types of providers that can treat similar

1 patients and it's very hard to tell -- I'm not sure there's
2 an answer as to which type of provider is right. It might
3 be which provider is right. I'm sure there's some overlap
4 in various places.

5 From what I can tell from the evidence presented,
6 there's no evidence that there's a sector that's
7 particularly poor quality or a sector that is particularly
8 likely to be harmed under the recommendation. So I think,
9 all of that said, the recommendation is what it is. But I
10 just don't think we're going to get that far along in the
11 process of trying to understand why some people should go to
12 IRFs and some people should go to some other facility and
13 it's working this way in Texas and this way in Vermont.
14 It's just very hard from where we sit to have that level of
15 micro-adjustment. So given the tools that we have, I think
16 -- and the information presented -- I think the
17 recommendation is a reasonable way to go forward. There's
18 just so much diversity, it's hard to get it exactly right.

19 DR. DEAN: I'd support the recommendation, and
20 just one brief comment. I think probably comparing the IRF
21 to the SNF, I think they really do serve different
22 populations of patients. Primarily, there is the

1 requirement that if you're going to go into an IRF, you have
2 to be able to withstand, I think it's three hours of therapy
3 a day, and a lot of people that can't withstand that end up
4 in the SNF. And that by itself would dictate, or would
5 separate people into different populations.

6 MR. HACKBARTH: That would potentially help
7 explain the statistics in the AHA letter about why IRF
8 patients --

9 DR. DEAN: Length of stay and -- yeah, and all
10 that, yeah.

11 DR. HALL: So I support the recommendations, and
12 certainly IRFs don't only serve Medicare patients. In fact,
13 because of the requirements for a certain amount of physical
14 fitness, they are often suitable for somewhat younger
15 patients. But if there's any part of the health care system
16 that cries out for being part of a bundle, I think this is
17 the one that would strike me as being very, very important.
18 So I think we're on the right track here.

19 MS. UCCELLO: I support the recommendation.

20 DR. NAYLOR: As do I.

21 MR. GEORGE MILLER: I support the recommendations,
22 and although Peter teed me up, the chapter is very well

1 written and I think my thoughts are very well known and the
2 differences, I think, can be handled once we go to bundled
3 payments.

4 MR. KUHN: I thank both Sara and Craig for this
5 good work and I, too, support the recommendation.

6 DR. SAMITT: So I support the recommendation. I
7 mean, as I work my way through this, I struggle with the two
8 issues, one being IRF versus SNF, which is one of them, the
9 other being hospital-based versus freestanding. I think the
10 beauty of the discussion or the vision about bundles is it
11 solves both problems, which is that in the setting of a
12 post-acute bundle, a hospital and the physicians that admit
13 to it will now be accountable for, first, determining the
14 right site of service for post-acute care, knowing that
15 there are risks of readmission penalties, and, frankly, if a
16 hospital isn't efficient at providing IRF services, they'll
17 either need to improve their efficiency or they'll need to
18 recognize the need to outsource the service to a
19 freestanding facility that may be able to do it more
20 efficiently. So, again, I echo others' thoughts about the
21 benefits of bundles here.

22 DR. HOADLEY: I support the recommendation, and I

1 keep thinking about all the different sectors where we see
2 these very strange geographic patterns or patterns in
3 different categories that sell these products, for-profit,
4 freestanding, hospital-based, and maybe that is the right
5 answer, that the more we can get past this into the bundling
6 kind of approach, that we won't have to worry as much about
7 that. We won't have to care as much about those
8 differences. And if a geographic area needs -- has a gap,
9 then somebody is going to be more inclined to try to figure
10 out how to fill it rather than do it based simply on dollar
11 incentives and all that kind of stuff.

12 My only other very small comment -- it applies to
13 this chapter and several others -- I think it would be
14 useful if, in the introduction to each of these chapters, we
15 just include not only where we say how much of the money is
16 going to this service, what percentage of all of Medicare
17 that represents. It's just a good reminder. I think it
18 came up in some comment Peter made last time.

19 MR. GRADISON: I support the recommendation, also.

20 DR. COOMBS: I support the recommendation, and I
21 was thinking along the lines of the actual number of beds in
22 a hospital-based IRF and just the notion of what they can do

1 with beds that are as small as six beds and what an IRF
2 could do that's actually got all the bells and whistles. So
3 I think that the more serious you get about benchmarks and
4 outcomes, I think you really have to pour a lot more
5 resources in. So your marginal cost is going to be a lot
6 more for these six little patients that you might have
7 versus a larger number of patients that you can distribute
8 the charges over. And so maybe it's a geographic
9 limitation. There might be some other factors that are
10 coming into play for why the hospital-based group is so much
11 smaller.

12 MR. LISK: The hospitals are -- I mean, the
13 hospital-based just tend to be smaller. They'll be one
14 floor of a wing of a hospital plus a rehab unit or
15 something, so just smaller beds. And you do have to have
16 certain -- you know, you are required to have, for the
17 requirements of the IRF to have certain staffing
18 requirements. You have to have a full-time rehabilitation
19 director. So you're spreading that over a smaller number of
20 patients, and that's one of the reasons why I think your
21 routine costs, for instance, are much higher there in the
22 hospital-based.

1 But if you look at the margins for the larger
2 hospital-based facilities, their margins actually are
3 positive, and I can't remember exactly what they are, but
4 they're more positive and they're higher than the smaller
5 facilities, so --

6 DR. COOMBS: And that makes the most sense. It's
7 like having a virtualized unit that opens and closes
8 depending on your need. So I was thinking about the IRFs in
9 the same capacity.

10 DR. BAICKER: I support the recommendation and I
11 thank you for the extra detail on how the hospital-based and
12 non-hospital-based ones differ because I think it improves
13 our understanding of how the patient pool is driving some of
14 the differences we see, so thank you.

15 DR. REDBERG: Thanks for the update and the
16 additional information. It was really helpful. I support
17 the recommendation, and I will just add that I think it
18 points an opportunity for bundled payment and really
19 patient-centered kind of focused care instead of all these
20 dividing up into little pots.

21 MR. HACKBARTH: So each year when we go through
22 the update recommendations and get to about this point,

1 there are certain themes that are crystal clear, one of
2 which is that updates are very limited tools for dealing
3 with the issues that we care most about, which is assuring
4 the patients get to the right setting for the right care at
5 the right time, and changing the payment system, not
6 thinking how much you change rates up and down but changing
7 the fundamental payments systems is key to getting to where
8 we want to go.

9 And I think, as I look down the road to the rest
10 of this cycle and as we go into next year, I think that's
11 where we need to be focusing more of our attention. We've
12 got now underway lots of sort of innovative experiments and
13 some fledgling programs like ACO, and all that's good, but I
14 think if in a -- we just sort of sit back passively and
15 allow those things to unfold, it's going to be decades
16 before we get to where we want to go.

17 And so for me, the most pressing policy issue that
18 not just we, but the Congress faces, is how do we accelerate
19 that pace of transformation so we get a more coherent
20 payment system supporting a more coherent care delivery
21 system with more integration, more care coordination, and
22 the like. So that's -- keep people going as we go through

1 our last set of payment updates tomorrow morning.

2 We do -- oh, I'm sorry.

3 DR. BAICKER: [Off microphone.] Do we need to
4 vote?

5 MR. HACKBARTH: Yes, I was just going to turn to
6 the vote. So on the recommendation on the IRF update, all
7 in favor of the recommendation, please raise your hand.

8 [Show of hands.]

9 MR. HACKBARTH: Opposed.

10 [No response.]

11 MR. HACKBARTH: Abstentions.

12 [No response.]

13 MR. HACKBARTH: Okay. Thanks, Sara and Craig.

14 So that completes our agenda for today. We will
15 now have our brief public comment period.

16 Let me just see, is there anybody else who is
17 going to want to step to the microphone? I'd like to see
18 who all is in the group. Okay, so we've got two.

19 The ground rules, please introduce yourself and
20 the organization that you represent. And when this red
21 light comes back on, that signifies the end of your time.
22 Plan on two minutes.

1 MS. UPCHURCH: Thank you. My name is Linda
2 Upchurch and I represent NxStage Medical.

3 I know this has been a very long day and I
4 appreciate all of your hard work.

5 We are the leading innovator in the field of home
6 hemodialysis. Papers from the United States Renal Data
7 Services you may have seen before have demonstrated clear
8 survival and transplant advantages in patients treated with
9 home hemodialysis.

10 We applaud MedPAC for the appropriate focus on the
11 benefits of and access to home hemodialysis during 2012 and
12 encourage you to continue to study the ongoing barriers to
13 expanded use of home hemodialysis for your 2013 research
14 agenda.

15 Your accurate and consistent comments over the
16 past several years relating to inadequate payment for home
17 training services reflect an unresolved need to update the
18 training payment for resource intensive home dialysis
19 training. This remains a timely and urgent issue.

20 A recent paper from the American Society of
21 Nephrology's Dialysis Advisory Group says it all: "Home
22 hemodialysis is an underused modality in the United States."

1 And the facts support this. Even though most clinicians,
2 when asked, would chose those modality for themselves, less
3 than 2 percent of the dialysis population is currently
4 treated with this therapy and fewer than one in four
5 dialysis centers currently offer it to patients.

6 Reimbursement is part of the issue.

7 MedPAC has cited the clinical benefits in prior
8 publications and the data only grows stronger. With the
9 survival, cardiovascular health and quality of life benefits
10 delivered by home daily hemodialysis, as well as the fact
11 that more of these patients are transplanted, it's simply an
12 injustice that so few patients have access.

13 Despite good intentions, the bundle has not
14 materially increased patient access to home hemodialysis as
15 it has to peritoneal dialysis and we routinely hear from
16 exasperated patients denied access simply because they are
17 Medicare.

18 A husband in Chicago who calls on behalf of his
19 wife, an advocate for her, who's been denied the therapy.
20 She's had a head trauma, it's difficult to be transported
21 back and forth to a clinic. He simply wants to do home
22 hemodialysis for her and is denied access because she's a

1 Medicare patient and that clinic doesn't happen to offer it.

2 A patient in Atlanta on a wait list to train for
3 over three months, called the week before her scheduled
4 training and told she's no longer a candidate for home
5 hemodialysis because her insurance has just converted from
6 insurance primary to Medicare.

7 We work with these patients. These are two
8 examples. We work with these patients to resolve issues.
9 Routinely, the ones that find me, I help them work through
10 the system. I talk to their nephrologist. We identify
11 other clinics for them to go through.

12 But as appropriately stated earlier, many of the
13 patients don't have the capacity to know that they can
14 challenge this. They simply accept that they're not a
15 candidate or that they can't have access. It's not right,
16 what is happening.

17 For these nephrologists to say over half the time
18 this is the therapy they would choose for themselves,
19 overwhelmingly for their family members, to only have 2
20 percent of our patients in the country treated with this,
21 something is wrong in the payment system. Primarily we hear
22 it's the training.

1 Thank you.

2 MR. HUNTER: Mr. Chairman, Mr. Vice Chairman,
3 ladies and gentleman of the Commission, my name is Justin
4 Hunter. I'm a senior vice president with HealthSouth. We
5 are the largest provider of rehabilitation hospital services
6 in the country. We operate 100 free-standing rehabilitation
7 hospitals in 27 states and Puerto Rico.

8 I appreciate this opportunity to briefly address
9 you all here today in response to what was said both today
10 and during the last meeting last month. Both today and
11 during last month's meeting there was considerable degree of
12 reference -- more so last month than today -- but
13 nonetheless reference to RTI's study with regard to the PAC
14 PRD and the CARE instrument.

15 There was a citation of an American Hospital
16 Association letter earlier today that was, I believe, carbon
17 copied to each of you.

18 I wanted to also highlight a letter that was sent
19 to Chairman Hackbarth and carbon copied to Executive
20 Director Miller that speaks directly to the PAC PRD and a
21 couple of key aspects of it, that was sent by the Federation
22 of American Hospitals.

1 Briefly, the Federation notes that this study is
 2 an important one but has its limits, as the study itself
 3 notes. For example, the -- and the Federation letter cites
 4 directly the RTI study -- the functional assessment measures
 5 comprising the CARE instrument self-care and mobility
 6 measures are new and the thresholds for defining differences
 7 that are clinically meaningful have not been established.

8 The FIH letter goes on to point out that RTI
 9 itself observes that the study is observational in nature
 10 "thus, the study design identifies associations but it is
 11 not suited for causal attribution as in a randomized control
 12 trial."

13 The FIH letter concludes by saying -- again
 14 referencing the RTI study -- "The results are preliminary
 15 and additional work is needed to define clinically
 16 meaningful differences in self-care and mobility functional
 17 status."

18 This is a very important study, the RTI study, of
 19 course but it has its limitations and it's very important
 20 for each and all of you to bear those limitations in mind as
 21 you discuss and deliberate these policies.

22 Secondly, I wanted to also briefly note this

1 discussion of IRF versus SNF. In the prior coverage and
2 patient admission framework under the Medicare benefit for
3 medical rehabilitation services, there was a standard that
4 dealt with a less intensive setting-based analysis. In
5 other words, if it could be determined that a patient could
6 be treated in a SNF or some other setting of care, then it
7 was appropriate to send the patient to that setting of care.

8 CMS took direct action to eliminate that reference
9 and that framework when it established new, revised, more
10 stringent coverage and admission criteria in 2010. And they
11 have specifically acknowledged that hey, we're no longer
12 concerned with whether the patient can be treated in a SNF.
13 If they satisfy our new revised criteria they therefore are
14 ipso facto appropriate for an IRF admission. That's very
15 important.

16 And finally, a third key point that I want to
17 reiterate, and I think I've said this in prior meetings, Mr.
18 Chairman, and I will wrap up real quickly with this.

19 We've talked about the three hour rule and the
20 fact that all IRF patients must need and receive three hours
21 of therapy each day at least five days a week. An even more
22 important factor that must be borne in mind or should be

1 borne in mind is the fact that the IRF benefit is physician
2 driven. There is no other benefit in the post-acute care
3 sector that requires so much of physicians as does the IRF
4 benefit.

5 Physicians must review cases --

6 MR. HACKBARTH: Okay.

7 MR. HUNTER: I didn't realize that that's the red
8 light. I beg your pardon, Mr. Chairman.

9 MR. HACKBARTH: It came on two-and-a-half minutes
10 ago.

11 MR. HUNTER: Time flies.

12 Thank you for this opportunity and look forward to
13 continuing our dialogue with you all.

14 MR. HACKBARTH: Thank you very much.

15 Okay, we are adjourned until 8:30 tomorrow
16 morning.

17 [Whereupon, at 4:34 p.m., the meeting was
18 recessed, to reconvene at 8:30 a.m. on Friday, January 11,
19 2013.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, January 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

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1 P R O C E E D I N G S [8:33 a.m.]

2 MR. HACKBARTH: Okay. It's time for us to get
3 started. We have three sessions today. The first two will
4 be presentations related to long-term care hospitals and
5 hospice services leading to final votes on recommendations
6 to be included in our March report. Then the third session
7 is on Part D, a status report, which we also customarily
8 include in our March report.

9 So let's begin with long-term care hospitals.
10 Dana?

11 MS. KELLEY: Good morning. Last month we
12 discussed in detail our update analysis and the Chairman's
13 draft recommendation for long-term care hospitals. You have
14 the chapter and the recommendation in your mailing
15 materials.

16 You had many questions last month about LTCHs and
17 the patients that they serve. Where we had data available,
18 I've addressed these questions in your written materials,
19 and I have some additional information that I will present
20 today. I'm happy to take questions during discussion.
21 Today, I'll review our findings on payment adequacy for LTCH
22 services, and then Julian and I will outline some policy

1 options that we are currently exploring.

2 You'll recall, of course, that LTCHs furnish care
3 to patients with clinically complex problems who need
4 hospital-level care for extended periods. In 2011, about
5 123,000 beneficiaries had almost 140,000 LTCH stays. The
6 averaged Medicare-covered stay is 26 days, and the average
7 payment is nearly \$39,000 per discharge. All totaled, in
8 2011 Medicare spent \$5.4 billion on care furnished in 424
9 LTCHs.

10 The Commission has expressed concern about LTCHs
11 for many years. Until recently, these were among the
12 fastest growing providers in the Medicare program. As you
13 know, the product is not well defined, and it is often not
14 clear what Medicare is purchasing with its higher LTCH
15 payments. There are no established criteria for admission
16 to an LTCH, so it's not clear whether or which patients
17 treated there require that level of care. Remember, too,
18 that some parts of the country have many LTCHs and others
19 have none. The oversupply of LTCH beds in some markets may
20 result in the admission of less complex cases that could be
21 cared for in other, less costly settings. Medicare
22 beneficiaries in areas without LTCHs receive similar

1 services in other facilities.

2 Last month Scott asked whether Medicare would pay
3 more if LTCHs were paid at acute-care hospital rates, and
4 Alice -- who is not here right now, I am sorry -- asked if
5 it would be more costly if LTCH patients stayed in the
6 acute-care hospital. These are complicated questions, but I
7 will try to answer as best I can.

8 Regarding Scott's question, just as a very simple
9 exercise, we recalculated payments for all LTCH claims using
10 IPPS payments and policy to see what Medicare would pay if
11 LTCHs were paid under the IPPS. Under this scenario, we
12 found that aggregate payments to LTCHs would fall 43
13 percent.

14 What happens if chronically critically ill
15 patients don't use LTCH care at all? This is the question
16 that numerous researchers, including the Commission several
17 years back, have asked. Some studies have looked at LTCH
18 patients nationwide and matched them to similar patients who
19 did not use LTCHs. To better control for severity of
20 illness, some studies have looked only at prolonged
21 ventilator patients who use LTCHs compared with those who
22 don't. And other studies have looked at costs for

1 chronically critically ill, or CCI, patients in areas that
2 have many LTCHs and compared them with costs for patients in
3 areas that have no LTCHs. Some studies have compared costs
4 just for hospital care -- meaning acute-care hospital and
5 LTCH -- while others have included costs for other post-
6 acute care. Regardless of the study design, the findings
7 have been quite consistent. For most medically complex
8 patients, Medicare payments are the same or lower when the
9 episode includes LTCH care. But for other types of
10 patients, the less medically complex, Medicare payments are
11 considerably higher for episodes that include an LTCH stay.

12 Note that the cost to the acute-care hospital may
13 be lower when these patients are discharged to LTCHs, but
14 the costs to the program are higher.

15 MR. GRADISON: Pardon me. How do you characterize
16 ventilator patients in terms of -- are they in the high-
17 severity --

18 MS. KELLEY: Ventilator patients can be both. The
19 prolonged ventilator patients almost always would be in the
20 higher category.

21 Rita, you and others wondered whether LTCHs are
22 helping beneficiaries achieve better outcomes. Most studies

1 have found that, again, for the most medically complex
2 patients, outcomes are the same or better when the episode
3 includes LTCHs. But for other patients, outcomes are the
4 same or worse. CMS' CARE demonstration collected primary
5 data on LTCH patients, allowing possibly the best risk
6 adjustment to date that we've seen in these studies. The
7 demo found that LTCHs had lower readmission rates compared
8 with other PAC settings, but they performed no better on
9 other outcomes. The better readmission rates may be due to
10 LTCHs' ability to provide hospital-level care.

11 So getting to your question, Bill, who are the
12 patients for whom LTCHs might be cost-effective? The
13 studies most frequently have identified ventilator patients,
14 as I said, especially those requiring prolonged mechanical
15 ventilation. Nineteen percent of LTCH patients received at
16 least one ventilator-related service in 2011; a smaller
17 share than this would have received prolonged mechanical
18 ventilation.

19 Among the most medically complex patients might
20 also be those with heavy use of ICU or CCU services during
21 their previous acute-care hospital stay. We looked at
22 episodes of care that included LTCH stays and found that

1 half of them had an index acute-care hospital stay with five
2 or more critical care days, and 38 percent spent eight or
3 more days in the ICU or CCU before going to an LTCH. But in
4 thinking about these numbers, it's important to remember
5 that about one-fifth of LTCH cases don't have a previous
6 acute-care hospital stay. So somewhat less than 38 percent
7 of LTCH cases will have had a previous acute-care hospital
8 stay with eight or more critical care days.

9 Before I turn to the summary of our update
10 analysis, I just want to respond to one more issue that was
11 raised last month, and that was whether LTCHs are the right
12 setting for end-of-life care. You'll note that in Tab A,
13 we've included an editorial from this month's issue of
14 Medical Care, which raises some concerns about LTCH care
15 from an ethical perspective. We know that care of CCI
16 patients should include communication about care goals and
17 patient preferences, transitional planning, and family
18 support. We also know that these elements are often lacking
19 in end-of-life care. Participants in MedPAC's expert panel
20 on LTCH quality that we held a few years back reported that
21 acute-care hospitals routinely discharge patients to LTCHs
22 without having had end-of-life and care planning discussions

1 with patients or their families. Without these discussions,
2 some patients and families likely have expectations of LTCH
3 care that may not be realized.

4 Now I'll move on to a summary of our update
5 analysis, starting with access to care. As you know, a
6 moratorium on new LTCHs and beds has stabilized growth in
7 supply, but LTCH cases per fee-for-service beneficiary
8 continued to rise, increasing 2.8 percent between 2010 and
9 2011.

10 Turning now to quality, LTCHs just began
11 submitting quality data to CMS this past October. CMS is
12 required to implement an LTCH pay-for-reporting program
13 beginning in fiscal year 2014. To start, LTCH quality will
14 be measured on three dimensions, which I've listed here.

15 Until these data are available for analysis, we
16 continue to rely on claims data to examine trends in in-
17 facility mortality, mortality within 30 days of discharge,
18 and readmission to acute care to assess gross changes in
19 quality of care in LTCHs. In 2011, these rates were stable
20 or declining for most of the common diagnoses.

21 Peter, last month you asked me about the average
22 mortality rate in LTCHs. In 2011, 13 percent of LTCH cases

1 died in the facility, and another 12 percent died within 30
2 days of discharge from the LTCH. As you would expect,
3 mortality rates vary markedly by diagnosis. For example,
4 about half of beneficiaries with septicemia and prolonged
5 mechanical ventilator use died either in the LTCH or within
6 30 days after discharge.

7 We also considered LTCHs' access to capital. For
8 the past few years, the availability of capital has said
9 more about uncertainty regarding changes to regulations and
10 legislation governing LTCHs than it does about current
11 reimbursement rates. Since 2007, the moratorium on new beds
12 and facilities imposed by MMSEA and subsequent amendments
13 has reduced opportunities for expansion and the need for
14 capital. Now that the moratorium has expired, we may see
15 new growth, but some market analysts believe that continued
16 scrutiny of LTCHs and uncertainty about possible
17 congressional action will prompt caution. Providers may opt
18 to focus on relatively low-risk capital investments such as
19 bed expansions.

20 This next slide shows 2011 Medicare margins for
21 all LTCHs combined and for different LTCH groups, as well as
22 the share each represents of total providers and total

1 cases. As you can see in the top row, the aggregate
2 Medicare margin for 2011 was 6.9 percent. Since the LTCH
3 PPS was implemented, the average margin has been 7.2
4 percent.

5 Jack, you asked whether there might be any
6 relationship between margins and LTCH concentration. So
7 this slide shows a calculation of the number of LTCH beds
8 per beneficiary in each of the core-based statistical areas
9 that have LTCHs and then sorts the CBSAs into deciles based
10 on that ratio of beds to beneficiaries. And the slide shows
11 the aggregate margin for each of these deciles. As you can
12 see, there is no clear pattern here.

13 To estimate 2013 margins, we modeled the impact of
14 several policy changes, which I've listed here. All
15 together, we estimate that these effects will result in
16 somewhat greater growth in provider costs than in aggregate
17 payments, and we've projected a margin of 5.9 percent in
18 2013.

19 So our update analysis finds that access to LTCH
20 care has grown, and the quality trends we are able to
21 measure appear stable. Facilities' access to capital is
22 difficult to assess, but margins are positive and we expect

1 that they will remain that way. These findings suggest that
2 LTCHs are able to operate within current payment rates.

3 We make our recommendation to the Secretary
4 because there is no legislated update to the LTCH PPS. The
5 draft recommendation is that the Secretary should eliminate
6 the update to payment rates for long-term care hospitals for
7 fiscal year 2014.

8 CMS historically has used the market basket as a
9 starting point for establishing updates to LTCH payments.
10 So eliminating the update for 2014 will decrease program
11 spending relative to the expected regulatory update, even
12 assuming PPACA-mandated reductions. We don't anticipate any
13 adverse impact on beneficiaries or on providers' willingness
14 and ability to care for patients.

15 Now, before I turn it over to you, I want to lay
16 out some policy options that Julian and I have been
17 exploring. These options are intended to improve payment
18 for chronically critically ill beneficiaries. CMS' report
19 to Congress on LTCH criteria suggested specific attributes
20 of these patients, such as prolonged mechanical ventilation,
21 multiple organ failure, and some of the other attributes you
22 see listed here. And in the medical literature, use of

1 intensive care services, as we've discussed, is also often
2 used as a defining characteristic of these patients.

3 Since we know that most CCI patients are not
4 treated in LTCHs, the options we are exploring would remove
5 the LTCH designation and pay for cases under a modified
6 IPPS. The IPPS modifications would improve payment accuracy
7 for very costly CCI patients and rationalize payment across
8 settings to remove payment incentives that favor one setting
9 over another.

10 The three options we are exploring are listed
11 here. One option would create an expanded outlier policy
12 for CCI cases, whether they are treated in LTCHs or acute-
13 care hospitals. A second option builds on the first by also
14 breaking out CCI patients into separate MS-DRGs with higher
15 payment weights. And then the third option would bundle
16 expected post acute-care costs into the new CCI MS-DRGs so
17 that the hospital would be responsible for overseeing
18 associated LTCH or SNF care for CCI patients. We plan to
19 bring you more details on these options in the coming
20 months.

21 So, with that, I will turn it over to you for
22 voting on the payment update recommendation and discussion

1 of future policy directions. And Julian and I are happy to
2 take any questions that you might have.

3 MR. HACKBARTH: Okay. Thank you, Dana. Nice job.

4 I want to begin. I think what we'll do, we've
5 only got 45 minutes allotted for this, so I think we'll do
6 one round, and I'd like to begin with Alice. But before
7 putting Alice on the spot, I'd like you to go back to the
8 beginning where you responded to Alice's question at the
9 last meeting so she can hear that.

10 MS. KELLEY: Sure.

11 MR. HACKBARTH: In fact, you may want to do both
12 Scott's and Alice's --

13 MS. KELLEY: Okay. So as I was saying, last month
14 Scott asked whether Medicare would pay more if LTCHs were
15 paid at acute-care hospital rates, and then you asked if it
16 would be more costly if LTCH patients stayed in the
17 hospital. And one of the things I tried to do was answer
18 these as simply as I could, but obviously they're
19 complicated questions.

20 We recalculated payments for all LTCH claims using
21 IPPS payment rates and policy to see what Medicare would pay
22 if LTCHs were paid under the IPPS. And under this scenario,

1 we found that aggregate payments to LTCHs would fall about
2 43 percent.

3 And then I also went back to review the studies
4 that have been done over the past decade or so on LTCH
5 patients, and there have been a number of different studies,
6 including early studies that were done by MedPAC, that
7 compared patients who use LTCHs with similar patients who
8 stay in the acute-care hospital. And there's a number of --
9 many different study designs, but the results, regardless of
10 the design, have been fairly consistent that for most
11 medically complex patients Medicare payments are the same or
12 lower when --for the medically complex patients, Medicare
13 payments are the same or lower when the patient uses LTCH,
14 but for other patients, Medicare payments are the same or
15 higher. And it's important to note there, I think, that for
16 those patients the costs to the acute-care hospital when the
17 patient stays in the hospital and doesn't use an LTCH may
18 very well be higher, but the costs to the program are lower
19 than if the patient used an LTCH.

20 DR. COOMBS: Thank you very much. First of all, I
21 want to say that I actually went through your bibliography,
22 and it was incredible, some of the same references that I

1 would have used and did some research on since our last
2 meeting, so you did an outstanding job.

3 MS. KELLEY: Thank you.

4 DR. COOMBS: You know, I was really concerned
5 about the discussion that centered around whether or not
6 LTCHs should go away in terms of our engagement, and as a
7 critical care physician, several things came to mind, and I
8 actually had a chance to actually talk with our case
9 managers and actually speak with some people who deal with
10 this on a day-to-day basis. I just say to the case manager
11 it's time to be placed, and they take care of it.

12 But one of the things that became clear in our
13 region is that without the LTCH there is a patient flow
14 issue, and a lot of it has to do with the limited critical
15 care beds within an entity. So I think that that's kind of
16 superimposed on all the other issues that we talked about.

17 And in terms of one of the things that was said in
18 the reading was the risk adjustment; the Commission I guess
19 convened in 2011 and felt that risk adjustment was not
20 necessary for considering the LTCH.

21 MS. KELLEY: I think that the panelists told us
22 that it wasn't so much that risk adjustment wasn't

1 necessary, but that in this setting the patients were
2 already so complex as a group that risk adjustment was less
3 of an issue than it might be in other settings.

4 DR. MARK MILLER: Just one clarification. This
5 was a discussion of quality measures and how much risk
6 adjustment you needed when you were looking at quality
7 measurement.

8 MS. KELLEY: Absolutely correct.

9 DR. MARK MILLER: Not necessarily payment.

10 MS. KELLEY: Right.

11 DR. COOMBS: So I think both for quality measures
12 and for assessment in terms of comparing apples with apples
13 and oranges with oranges, I think that risk adjustment has a
14 lot to add, especially every vented patient is not the same,
15 and especially when you get to what's comorbid conditions
16 can be, you know -- you know, we do APACHE scoring in the
17 ICU, and that's one of the things we look at. And you
18 alluded to that in one of the references. If you have two
19 to three organ systems that are failing, then your morbidity
20 is high, but your mortality is incredibly high. So that
21 patient is already earmarked for a destiny that the cards
22 are already dealt.

1 In terms of us taking the logic of the mortality
2 rate is very high at LTCHs and, therefore, we should send
3 them to hospice, I think that's going down a path which it
4 says that you look at the end results and you say there's
5 very little potential for change. And I don't think that
6 even a 40 percent mortality cumulated over a 30-day period
7 is rationale for us to say that the default decisionmaking
8 should go toward comfort measures or hospice arrangement.
9 And hospice does have both, I understand that, because we do
10 send in some patients who are respiratory cripples to the
11 hospital.

12 One of the things that you propose on Slide -- I
13 guess it's the very last slide, Slide 16. Of all the three
14 of these, I think that what is really attractive is number
15 three, and to get to number three will require major
16 landscape changes, unfortunately, because of the regional
17 and geographic differences. And Mark and I have spoken,
18 extensively I think, regarding some of the issues that are
19 centered around this in terms of incentives to take care of
20 patients.

21 My point will center around the fact that I think
22 we need to realize that the -- and I think everyone around

1 the table appreciates that LTCHs have a significant role in
2 patient flow in the hospital and provides the appropriate
3 care in the right setting. Going forward, I think it's a
4 charge that we should have for the Secretary that we better
5 define who gets cared for at the LTCHs, because the role of
6 the LTCHs I think is well established from the literature
7 that you have provided. And most patients do have
8 advantages in terms of medical treatment and management.

9 They have protocolized regimens for weaning that
10 are far superior to the tertiary hospitals, and that's what
11 they specialize in. And so if you want to get a patient off
12 of vent and you have a successful entry back into the home,
13 I think this is the place to go. And I would say that I'd
14 support the recommendation of the Chair, and I think that
15 there's a lot of opportunity to do some innovative things
16 with this rather than to negate the impact of LTCHs.

17 And thank you very much. You did an awesome job.

18 DR. BAICKER: I, too, support the recommendation,
19 and I think the points that Alice has raised, as well as the
20 others in the chapter, highlight that there's an appropriate
21 role for LTCHs, but that it is probably not very well
22 focused right now. There are probably patients there who

1 would be better served elsewhere, and there may be patients
2 elsewhere who would be better served there. And the
3 bundling options seems like the direction that might best
4 align that going forward. But clearly the other options
5 have to be fleshed out as well. But I wouldn't be
6 surprised, based on the evidence you've presented, if the
7 optimal role was much pared back from where it is, but our
8 job is to design the incentives so that the right patients
9 end up in the right site.

10 DR. REDBERG: Thanks, and I support the
11 recommendation. I really appreciate all the additional
12 research you did in response to our questions. What I take
13 away is that for medically complex patients we could get
14 better outcomes or equal outcomes and equal costs at LTCHs,
15 and that some of the options that you presented at the end
16 as alternatives to LTCHs would also be interesting to
17 explore in the future.

18 Thank you.

19 DR. NERENZ: Just a quick question. On some of
20 the other sites of care that we've had topics for
21 discussion, the distinction between hospital-based and free-
22 standing has been a significant one in terms of underlying

1 cost margins. That's not a prominent issue in this
2 analysis. Are there issues there that we should pay any
3 attention to at all?

4 MS. KELLEY: The issues regarding hospital-based
5 and freestanding facilities are different in LTCHs because
6 LTCHs are required to be a separate financial entity,
7 regardless of where they're located. So they don't have the
8 same -- within their sort of cost structure that is reported
9 on their cost reports, they don't have the same overhead
10 issues that we have difficulty parsing through with the
11 other settings, such as SNFs and rehab facilities.

12 So, historically, we have looked at freestanding
13 and what we call hospital-within-hospital LTCHs. And over
14 time, it's become difficult to determine what the
15 differences between these facilities. Some LTCHs are
16 located on the fourth floor of an acute care hospital. Many
17 are located across the street from a hospital. And in terms
18 of the availability of that care close by for a hospital,
19 it's not clear what difference that really makes, if you
20 know what I'm saying, since it is a separate financial
21 entity.

22 So it's a distinction that exists and one that I

1 do have information on that I can share with you, but it's
2 not -- their margins are very similar. Their cost
3 structures are fairly similar. Their patient mix is fairly
4 similar, especially now that CMS has applied some rules to
5 hospitals-within-hospitals that limit the share of patients
6 they can receive from their host hospital.

7 DR. NERENZ: [Off microphone.] Thank you.

8 MR. BUTLER: So what I think you've done a great
9 job at is helping us begin to frame what could be some
10 significant recommendations for next year. So I would
11 encourage you to -- because between the -- well, obviously,
12 identifying the very different outcomes and positive
13 outcomes for complex care is very important. Now we need to
14 kind of size that population. I don't know what percentage
15 of the total may fall into that. I would suspect that the
16 larger metropolitan urban markets would have enough to
17 justify, then, the freestanding units of significant size
18 that would have great value, but for the less densely
19 populated things, it might be a little bit different
20 solution.

21 So my only question related to it right now is as
22 you kind of highlighted the differences in the populations,

1 what percent would you think would be the complex,
2 typically, or not just typically. If you take the landscape
3 of all of the LTCH business, what percentage clearly looks
4 like it belongs there and is benefitting from it versus the
5 grayer areas?

6 MS. KELLEY: I don't think we know the answer to
7 that now. I think this is something we've been trying to
8 circle around. During the presentation, I talked about the
9 fact that we do think that it's -- the medically complex
10 are, for example, ventilator patients who need weaning or
11 attempts at weaning from ventilators and also patients with
12 heavy ICU and CCU use. We know that less, around 20
13 percent, of current LTCH patients do receive at least one
14 ventilator-related service, and as I said, about half of the
15 patients stay five or more days in the ICU and about 38
16 percent eight or more days.

17 So it's, I think, safe to say some fraction of the
18 current patients would fall under this medically complex
19 label, and I hope that Julian and I can work more on kind of
20 helping to determine that a little bit more closely.

21 MR. BUTLER: And for those, I'm a believer that
22 having the freestanding LTCH not only helps Alice's flow

1 issues, but those people actually, you know, they get better
2 care because that's the business that they're in and they
3 don't get mucked up with the rest of the ICU business that's
4 there, so --

5 MS. KELLEY: Well, I think the appeal, as we were
6 saying earlier, of a bundling approach is that it would
7 allow the clinicians to make the decisions that make the
8 most clinical sense.

9 DR. MARK MILLER: And the only thing I would add
10 to that exchange is that there may be areas without LTCHs,
11 and so you want a payment system that accommodates wherever
12 that person lands, because if you talk to the hospitals that
13 are not in the range of LTCH, they're pretty annoyed by the
14 payment system that doesn't deal with those patients. So I
15 think some of what we're trying to do is --

16 DR. CHERNEW: I want to pick up on that, and I
17 agree completely. So, first, a question. You talked about
18 a lot of different types of studies that measure costs and
19 quality and stuff, and the ones that I just want to make
20 sure I didn't lose is some of them compared areas where
21 there's a lot of LTCHs and areas where there's none or not
22 very much. And I just wanted to confirm that my take from

1 your talk was that, for the most part, with the measures of
2 quality we have, the quality across those two areas is about
3 the same. Is that -- did I follow that right?

4 MS. KELLEY: Yes. Yes. But again, that's looking
5 at outcomes. Those analyses -- many of those analyses use
6 claims data, so it was looking at outcomes just in terms of
7 morbidity and readmissions.

8 DR. CHERNEW: Right. So there may be some
9 weaknesses in terms of our quality measures --

10 MS. KELLEY: Absolutely.

11 DR. CHERNEW: -- but at least given the measures
12 we have, they're about the same. And what that suggests to
13 me is that the health care system adapts one way or another,
14 and our focus on LTCHs, in some sense, is because of the way
15 the payment system works and a focus on the patients, these
16 types of patients, it strikes me, will enable us to do much
17 better for serving the patients as opposed to a focus on the
18 providers and different types of providers. It seems to me,
19 at least based on what you said, and again, I recognize the
20 limitations of the data, that LTCHs aren't essential for
21 high-quality care, but the health care system obviously has
22 to transform in certain ways to handle these patients

1 regardless whether there's an LTCH or not. So my guess is
2 the acute-care hospitals are, as Peter was sort of alluding
3 to, are very different in places where there are LTCHs.

4 MS. KELLEY: I think that could be a fair
5 assumption, and I would also suggest that maybe in areas
6 without LTCHs, SNFs might be providing a different type of
7 care, as well.

8 DR. CHERNEW: Well, fine. Right. Right. So
9 there's going to be some adjustment one way or another to
10 deal with the patients, because the patients need a certain
11 set of services.

12 And the one that I just wanted to confirm, based
13 on the limited information we have, it seems that when the
14 health care systems adjust, the outcomes seem to be
15 reasonably comparable. And so having an LTCH in an area
16 doesn't seem to be essential to high-quality care for these
17 types of patients. It might be in ways that I just don't
18 have the clinical knowledge or we don't have the measures to
19 know, but based on what we have, it doesn't seem that that's
20 the case.

21 MS. KELLEY: I think that's fair.

22 DR. CHERNEW: Right. And so that's helpful to

1 know. And then I'll just close with I support the
2 Chairman's recommendation.

3 DR. DEAN: I support the recommendation and I
4 certainly would agree with the approach that Mike just laid
5 out. I think the focus really ought to be on patients with
6 certain types of problems and then trying to figure out what
7 the best approach is, and maybe there's more than one
8 approach. I mean, there must be more than one approach
9 because these patients seem to do reasonably, I shouldn't
10 say well -- they don't obviously all do well -- but they do
11 equally well whether or not these facilities are there. So
12 the question -- we've been struggling with this for as long
13 as I've been on the Commission, I think. But I think -- I
14 appreciate your presentation because I think we are getting
15 closer to understanding this whole problem. But, anyway, I
16 support the recommendation.

17 DR. HALL: Sort of looking at this through the
18 lens of the Medicare patients and families, when I read
19 through this, one analogy would be about 70 years ago, there
20 used to be a different kind of an LTCH. These were called
21 wards for polio patients, where there would be 50 or 100
22 iron lungs. You see these pictures once in a while when

1 there is fundraising for something. And the whole idea of
2 that was that you needed a specialized place to provide sort
3 of quality care for people with what was presumed to be
4 permanent respiratory insufficiency.

5 And in my experience, which isn't global, of
6 course, LTCHs are largely that kind of a unit. They do get
7 some other diagnoses, but those other diagnoses are almost
8 always in people who have primarily respiratory problems.

9 So then the question is, these people are with us
10 and what do we do about it? I agree with the consensus
11 around the room that LTCHs probably do a better job at
12 caring for these people, particularly in terms of kind of,
13 you might say, the amenities of quality of care in a disease
14 that has a 50 or 60 percent mortality. It is better, I
15 think, by and large, for families, and it's particularly
16 better in a health care system that has a critical mass of
17 beds, because one of these patients in an ICU, as I'm sure
18 Alice would agree, takes up a huge amount of the day-to-day,
19 24-hour a day, resources of the unit, which then probably
20 means some compromise of care of other people there. They
21 also tend to be harbingers of very common drug-resistant
22 infections.

1 So there are a lot of reasons that if you had the
2 critical mass of people that might need them that you would
3 put a unit like this in place. But the services can be
4 provided in other arenas and often are. In our community,
5 we closed our LTCH ten years ago and actually upgraded one
6 of our nursing homes to have an entire floor of ventilator
7 patients.

8 Another issue that comes up is -- it's been
9 alluded to -- what about end-of-life care, palliative care?
10 This is not palliative care in the sense that I think of it.
11 This is high-tech therapy aimed at keeping people alive. It
12 may have some aspects of care as people reach a terminal
13 stage of life, but we had better be a little careful. It's
14 a little bit tricky in the vocabulary to say an LTCH is a
15 place for palliative care. That has a political connotation
16 that I think we don't want to get into.

17 So I think we'll -- again, we keep coming back to
18 it looks like we're going to bundle everything next year,
19 almost everything we talked about.

20 [Laughter.]

21 DR. HALL: This is becoming an almost impossible
22 package to pick up, I think.

1 DR. DEAN: Solution to everything.

2 DR. HALL: And so it probably is the solution to a
3 few things, but at any rate, I think that's where this would
4 fall eventually. But as for now, I'm in favor of the
5 recommendations.

6 DR. CHERNEW: So what happened when the LTCH
7 closed?

8 DR. HALL: When the LTCH closed? Well, it didn't
9 just close overnight. I mean, this was a planned
10 transition.

11 DR. CHERNEW: [Off microphone.] But is care a lot
12 worse now than ten years ago?

13 DR. HALL: I don't think so, no. Three of our
14 hospitals are in the top hospitals we talked about
15 yesterday.

16 MS. UCCELLO: So I support the recommendation and
17 agree with comments my colleagues have already made. I
18 think that LTCHs might be appropriate in certain cases, but
19 it does seem clear that they're inappropriately used now and
20 so we need to find a better way to rationalize the payments,
21 and I think the direction that we're moving in is the right
22 one.

1 And the comments that Alice and Bill have made
2 about hospice and the relationship of LTCH and hospice
3 remind me of comments that Karen Borman made either last
4 year or the year before where she, I thought, provided some
5 valuable insights and cautioned us against seeing these as -
6 - as hospice as a substitute for an LTCH. So what I think -
7 - when we think about this, we may want to bring in some of
8 the discussion that we had yesterday about shared decision
9 making and that's maybe how to think about some of this, and
10 making sure that patients or their families have the
11 information they need to make the appropriate decisions.

12 In terms of -- I'm a little -- I think I need more
13 information regarding this patient flow issue and kind of
14 what that means. I guess I don't want to be moving people
15 out if they're not going to the right place and is this a
16 matter of somehow changing the resources around, either in
17 the hospital or elsewhere. I just want to be able to
18 understand that a little better, because we don't -- I'm not
19 sure that we want that to be driving the policy.

20 DR. NAYLOR: I also support the recommendation,
21 although -- and I think you did a great job -- I'm walking
22 away with a little different interpretation than other

1 colleagues. So Slides 4 and 5, I thought what I heard is
2 that if we do the right targeting, the medically -- most
3 complex medically are showing either similar or better
4 changes than traditional post-acute services. If we do the
5 right targeting. And I totally agree that if that's also
6 complemented with the right kind of shared decision making.
7 People are making choices and understand what's available to
8 them. So it seems to me that at least the available
9 evidence suggests potential benefit right now relative to
10 existing options.

11 And then the take-home for me is what can we learn
12 about the services that are being provided there. One big
13 concern, I think, going forward, is that we've only started
14 pay-for-reporting in this environment and the measures
15 really don't align well with what these people's needs are.
16 And so the top reasons for use of long-term care hospitals
17 are respiratory and septicemia and the measures are about
18 catheters and -- well, one, I think, blood stream infection,
19 yeah, so catheter-induced. So that aligns with septicemia.
20 But I do think that there's real work that needs to be done
21 to get measures that are aligned with the challenges and
22 issues that these people are confronting.

1 The last thing is a question. In the
2 recommendations going forward, in the bundle, it says
3 hospital responsible. I mean, do you envision potentially
4 where these environments for complex, medically complex
5 people, don't start or don't end or aren't aligned with an
6 acute hospital?

7 DR. MARK MILLER: The way I would answer that is
8 the way I see the three paths that we're trying to sort
9 through is whether -- and again, in trying to respond to
10 some of the comments that were made over here -- we want to
11 end up with a payment system that works for this patient
12 whatever the post-acute and acute-care hospital
13 configuration is in the market, because some markets don't
14 have long-term care hospitals.

15 And so one of the ideas is you have sort of a very
16 large outlier payment, so when a patient comes into this
17 level of care, whether they're in a hospital or whether
18 they're in an LTCH, there's a payment that begins to attach
19 itself and tracks to this patient more accurately. And so
20 if you're in a place where you have an hospital and you
21 don't have an LTCH and you have configured your hospital to
22 deal with these patients, you're getting compensated for it.

1 The last one, the bundling one, would work a
2 little bit different. That's just a concept at one end of
3 the continuum. Another continuum is you say, here's the
4 payment to the hospital when this patient begins to climb
5 into this very high level of complex care. It is now the
6 hospital's decision to decide how it's going to manage this
7 patient -- in the hospital, I'm going to go out to post-
8 acute care, but the hospital will be making that decision
9 and have the resources to compensate whoever they engage to
10 do it. And we're trying to give you a continuum that you
11 can think through of options here.

12 DR. NAYLOR: I was just suggesting, because
13 there's a coalition that's really trying to work on this
14 population, that another alternative might be to say it's not
15 connected to the hospital. It is connected to people's
16 needs and intervening right at the time needs surface, but
17 not necessarily with the acute sector, so --

18 MR. HACKBARTH: We often talk about bundling as a
19 concept and one of its virtues being that it creates
20 appropriate incentives. And, for sure, that's true. But
21 the other aspect of it is flexibility in deploying resources
22 so that they are best used to meet the needs of patients,

1 perhaps regardless of the institutional configuration that
2 exists in different markets, because that varies.

3 And I think for this especially challenging group
4 of patients, that's even more important, that flexibility in
5 deploying resources to meet their challenging needs in
6 unique ways, perhaps, or different ways in different
7 markets. And that's what appeals to me about some of these
8 options.

9 Early in our MedPAC journey on this, we focused on
10 patient characteristics, you know, who should be eligible to
11 be admitted to an LTCH, and while that seemed like a good
12 idea at the time, it is deficient on this score. It still
13 accepts that, oh, there's an institutional type LTCH and
14 what we need to do is monitor the gate. It does not create
15 this flexibility in deploying of resources across all sorts
16 of different configurations of acute-care hospitals, LTCHs,
17 skilled nursing facilities.

18 So I see these options as potentially --
19 especially the -- well, all of these options, in various
20 ways, as potentially good steps in terms of flexibility and
21 deploying resources.

22 MR. GEORGE MILLER: Let me add my voice to

1 compliment the work done, and the information was
2 fascinating and even this discussion is fascinating,
3 particularly the evolution of our thought processes in
4 dealing with this very complex issue.

5 But as Mary started on this dialogue, I had a
6 couple notes on the same issue. What would we do, and I
7 think, Dana, you said that one-fifth of the admissions do
8 not start in the hospital. So how do we deal with that
9 issue?

10 I think one of the things that Alice said bears
11 merit, you know, the fact that the mortality rate is about
12 40 percent. But my question would be, what would they be if
13 there were not LTCHs in those localities? Would they be
14 higher? I don't know, but I look at the map and the reading
15 and those States that have no LTCHs, it seems to me that, at
16 least from what we've read, that the mortality rates don't
17 appear to be significantly different one way or the other.
18 So how do we design the best system with those parameters?
19 Bundled payments certainly seems to have some
20 attractiveness, but I like what Mark was talking about.
21 Maybe the payment should go with the patient. But, again,
22 if one starts without a hospitalization, who would be

1 responsible for that bundle of payment?

2 And someone mentioned about patient flow. I think
3 it was Cori about patient flow. As a hospital CEO, that's
4 one of our challenges, is the throughout, is trying to
5 eliminate the bottlenecks. There are usually bottlenecks in
6 the ED and there are bottlenecks in the ICU, particularly
7 with our payment system. So we then tried to find post-
8 acute places where a patient should go. But then if the
9 payment is attached to the patient, that may drive a
10 different decision making process. So we need to weigh all
11 of those things together.

12 And one thing that was not in this reading but was
13 in last month's reading, and I certainly want to kind of
14 tease that out, and that is that, still, if I remember
15 correctly from last month's reading, that minorities,
16 particularly Hispanics, did not seem to benefit from LTCHs
17 no matter where they were in the country, and that still is
18 a major concern for me, if I remember the demographics
19 correctly from last month's reading, and I wonder if we know
20 why.

21 And then, finally, my final question is, have we
22 also identified what an efficient LTCH would look like, like

1 we did for the hospitals, and then any work on that, using
2 the measures of quality, cost, and determine an efficient
3 LTCH. Do we know what that looks like and can we apply that
4 same measure as we have done to the hospital to see if
5 there's learning.

6 And one final comment. Have we studied and looked
7 at why there's over-supply in places on this map, what
8 drives that type of demand for that business in those areas?

9 And then, finally, I do support the
10 recommendations.

11 MS. KELLEY: As far as the efficient provider
12 analysis goes, that's something we haven't done in LTCHs
13 because of the limited quality data that we have. But I
14 hope in the future, as we have more quality data, that we'll
15 be able to do that kind of an analysis.

16 Regarding the geographic distribution, I think
17 it's fair to say that it is almost completely dependent on
18 certificate of need laws from state to state.

19 MR. KUHN: First of all, let me start by saying I
20 do support the recommendation, but I do have a question
21 about it -- if you could put up Slide 14? -- and on the
22 implications, and particularly a question about the spending

1 implications.

2 If I recall correctly, there is no statutory
3 mandate for an update in current law for LTCHs, and so
4 basically my understanding of scoring is that we would start
5 at zero. So if we -- so are we basing this on what CMS has
6 already put in place and that's why we're able to yield
7 savings? Because, otherwise, I would think that the
8 baseline would say zero, and then anything that would be
9 above zero would be an actual cost.

10 DR. MARK MILLER: The baseline, I think, and I
11 think what CBO is assuming in the baseline is a market
12 basket update, even though it lies in the Secretary's
13 authority to grant it.

14 MR. KUHN: Okay. That helps me understand.

15 DR. MARK MILLER: I think that's probably based on
16 history and that type of thing. So it's not a zero starting
17 point.

18 MR. KUHN: Thanks. That was helpful to understand
19 because I kept looking at that and I kept thinking how can
20 we have an assumption there.

21 The second thing is just to kind of reflect a
22 little bit on the research that you all laid out, and both

1 you and Julian have done a nice job of putting this forward.
2 I would just ask that if we could also think a little bit
3 about, again, the whole issue that has been going on now for
4 a decade about really trying to come up with an admissions
5 criteria or a patient criteria for LTCHs. You know, this is
6 where CMS had the RTI study to help kind of evaluate this.
7 This is what the CARE tool was supposed to kind of help us
8 get at. But when you look at all the other post acute-care
9 providers, whether it's rehab financials or home health or
10 skilled nursing, they all have an assessment tool. LTCHs
11 are the only ones that don't. And as a result, they're
12 suffering through this process, and we're suffering through
13 this process trying to understand who are the right patients
14 and the right place to put out there.

15 I know when I was at CMS, I spent an awful lot of
16 time working on LTCHs, the policy area, and had a chance to
17 tour a number of them across the country, both hospital
18 within hospital as well as free-standing, and I am impressed
19 with the work that they do, particularly for ventilator-
20 dependent patients and wound care patients. They do some
21 really good work.

22 But, again, what we know about LTCHs is they are

1 basically an acute-care hospital with an average length of
2 stay of 25 days. And if they do have that kind of criteria
3 and they are post acute-care provider, they really do need
4 some kind of assessment activity out there.

5 So if there's a way we could continue to look at
6 these issues that you have here but also look at maybe as a
7 transitional piece or whatever the case might be, but really
8 go back and see if there's anything we can do in the
9 assessment area, I just think that continues to make sense.

10 MR. BUTLER: I just want to make one more quick
11 comment on the flow before we want until next year. I was
12 involved in starting one of these 20 years ago with other
13 hospitals, and if you go into a hospital, like say a 20-bed
14 ICU, at any given point in time, you can find three or four
15 patients that have been there a long time with complex --
16 often on a ventilator, and you sit there and you say, Hmm,
17 these are a different animal, I know that they're expensive
18 to do in my own institution, and I don't know that I'm doing
19 that good a job. If I could get together with others that
20 have a similar number -- which we did -- and pool them in
21 one place where they get focused care, we'd be a lot better
22 off. It would be cheaper. It would be better care. And

1 that's kind of the flow issue.

2 Then the ER gets swamped and you say, oh, if we
3 just didn't have those three or four that were sitting in
4 ICU, we would have some flexibility to respond. It sets
5 kind of the flow issue that can be addressed.

6 MR. GEORGE MILLER: Yes, throughput.

7 DR. SAMITT: So I support the recommendation as
8 well. I also agree with the sentiments that there's a place
9 for LTCHs, and I think we want to create an incentive system
10 that encourages the best use of that best place.

11 My concern with the current methodology is we're -
12 - you know, focusing on characteristics or administrative
13 rules is often a very imperfect way to say here's the best
14 way to use LTCHs. And we certainly shouldn't use LTCHs for
15 flow reasons. I mean, I think that if we need greater
16 capacity in intensive care units in hospitals, then we
17 should incent the expansion of that.

18 To add to that, I would underscore the importance
19 of Slide 16 and especially the last bullet, the bundles,
20 because incentives should encourage a focus on patient
21 preference, and it should rely upon the clinical judgment of
22 the providers in determining the best site of care. And in

1 my experience, bundles are the best way to achieve both of
2 those. You know, living in the world of bundles for many,
3 many years, our primary focus is first asking the patient
4 about preferences and then having the clinicians decide
5 which best alternatives meet those patient preferences.
6 It's very hard to do that in a fragmented environment. It's
7 much easier to accomplish that in a bundle environment.

8 DR. HOADLEY: Yeah, I definitely support the
9 recommendation, and this really has been a great analysis
10 and a great presentation on these issues.

11 The two words that keep coming to my head are sort
12 of targeting and flexibility. We've heard them, and I don't
13 know that I can say a whole lot more, but, I mean, this
14 issue of how to target to the right patients and whether a
15 set of rules gets you there or whether it just needs
16 something that is more flexible, and so there's that
17 flexibility, but there's also clearly the flexibility
18 especially if we go down the route of bundles, making sure
19 that it's going to work the same way in a state, in a
20 community that has an LTCH and one that doesn't, and that
21 it's going to work the same way for the patients who start
22 through the acute-care hospitals and the ones that don't, or

1 whether, you know, the ones that don't just go into some
2 totally different world. But if we can think of ways and a
3 bundle that can be defined flexibly enough that it can do
4 all those things, then we may really accomplish something
5 useful.

6 The other thought I had, which, again, others have
7 talked about, is -- and you talked about it in the
8 presentation -- the question of how often end-of-life
9 counseling occurs for these kinds of patients, not because,
10 you know, we're equating this to hospice but because people
11 do have to understand their choices and there's
12 implications, and, you know, maybe the shared decisionmaking
13 framework is a good way to think about that, doesn't carry
14 some of the baggage perhaps that end-of-life counseling has
15 come to do, although, you know, that really is in many cases
16 what we're talking about. So I think it's just really
17 important we keep that part of the issue in the framework of
18 this discussion as well.

19 MR. GRADISON: I, too, support the
20 recommendations. My takeaway from this is that bundling has
21 to be comprehensive to be meaningful, that is to say, it has
22 to include all post-acute settings. I don't think that's a

1 revolutionary comment. But I do think that there is a
2 challenge in thinking through bundling, as others have
3 indicated, in the sense that it's different, really, from
4 the focus on the patient. It really starts with the focus
5 on the institution, at least in many -- we say, well, let's
6 start with the acute-care hospitals and then we'll figure
7 out something for the rest of them, which may be backwards.
8 It may be you almost have to figure out a way to start with
9 the patient.

10 Another takeaway that I have, if I'm correct about
11 the complications -- I'm for bundling. Don't misunderstand.
12 But the difficulties of doing it are very real -- that we
13 may need to consider changes with regard to LTCHs without
14 waiting until we have some kind of an overarching concept
15 for bundling. That's sort of a possibility. I'd put it out
16 as something that I'm sort of thinking along those lines
17 right now.

18 In certain respects, in my opinion, bundling is
19 not only more consequential but more challenging than PPS in
20 the sense that it was possible to put the Prospective
21 Payment System concept into effect, kind of one layer at a
22 time. You start with post acute-care hospitals. We have

1 some places we don't do it at all right now. I mean, we're
2 in various transitions. But for the bundling to make sense,
3 it really, I think, has to -- can't leave out any major
4 post-acute setting, which I think means it would be a much
5 bigger step in that sense than starting down the road, which
6 was difficult in itself, to apply PPS to the hospital
7 setting as the first step.

8 Thank you.

9 MR. HACKBARTH: I think you're right, Bill, about
10 the challenges, and to me, a critical challenge that you
11 touched on is that bundling that goes across, say, the whole
12 post-acute sector, inpatient and post-acute, means you're
13 crossing institutional lines. And that creates both
14 complexity in terms of how the bundles are potentially
15 managed; it creates political challenges, et cetera. And so
16 bundling has some real significant aspects to it.

17 I'm not sure I entirely agree that you have to do
18 the whole thing in order to make progress. I'm just not
19 sure one way or the other. In fact, as I look at the first
20 two bullets on page 16, in a sense, to me they seem like
21 they could be sort of semi-bundles in the sense that,
22 although these are both characterized as changes to the

1 acute hospital payment system, I imagine that the way you
2 would do it is that you could say that the acute hospital
3 could transfer the patient to a building that currently has
4 long-term care hospital over the door, maybe across the
5 street or down the block or on the other side of the city,
6 so long as it's not triggering a new Medicare payment. You
7 know, you could have care that spans what are currently
8 different organizational lines for the specific long-term
9 care hospital patients and not get involved in all of the
10 SNF and all of the home health.

11 So there's sort of a question mark at the end of
12 that. You know, we usually -- the transferring of patients
13 is a significant event because it triggers a new flow of
14 dollars from Medicare. If it's not triggering a new flow of
15 dollars, we could have a different set of rules about moving
16 patients to specialized facilities, is my question.

17 DR. CHERNEW: I think the challenge -- and I
18 recognize how difficult it is -- is we need to have a
19 payment system that recognizes existing organizational
20 structures which vary across markets, but a payment system
21 that doesn't encourage inefficient organizational
22 structures, that, in other words, allows some sense of

1 efficiency. And that's a challenge to do, and I think
2 that's why we have sort of some directions, but we don't
3 have a particular answer to that question. But I do think
4 there is -- it's important to recognize that our job isn't
5 to maintain a payment structure to support an existing
6 organizational setting that might not be right or best.
7 But, on the other hand, we can't be so naive to think that
8 if we change the payment structure and just assume the
9 organizations were different, the world would be a better
10 place, because the organizations are important.

11 DR. MARK MILLER: What I was going to say is, you
12 know, our attempt, as always, is to bring peace and harmony
13 to the entire world.

14 MR. HACKBARTH: You're not doing very well.

15 [Laughter.]

16 DR. MARK MILLER: Yeah, I figure we'll have this
17 wrapped up at the end of the month. So I want you to
18 understand that the whole range of comments here, I would
19 have said about Glenn's comment -- and I'm not just saying
20 this because he's the Chairman and could fire me immediately
21 -- that I do think that that is correct that the way that
22 we're thinking about, that the payment would move -- when

1 the patient reached a certain complexity, the payment would
2 kick in behind it; and if the hospital had a way that they
3 dealt with this patient, they could do that. There's
4 nothing that would prevent them. And the thing we are
5 trying to navigate is this triggering another payment.

6 And to the discussion that you two were having but
7 was implicit throughout all of this, we're trying to come
8 back to the Commission with a bundled option, which has all
9 its issues and problems, and different options, which also
10 have their own issues and problems, and bring you a
11 continuum and let you work through each of them.

12 MR. HACKBARTH: Okay. So this was very thought-
13 provoking. We do have the business of final vote on the
14 recommendation, which Dana will put up.

15 All in favor of the recommendation, please raise
16 your hand?

17 [Show of hands.]

18 MR. HACKBARTH: Opposed to the recommendation?

19 [No response.]

20 MR. HACKBARTH: Abstentions?

21 [No response.]

22 MR. HACKBARTH: Okay. Thank you. Good work. I

1 look forward to hearing more about it.

2 And now we move on to hospice.

3 [Pause.]

4 MS. NEUMAN: Good morning. I'm going to review
5 our indicators of payment adequacy for hospice before you
6 vote on an update recommendation. We discussed these data
7 in more detail at the December meeting, and your paper also
8 has more detail.

9 Before I do that, I'll give a brief overview of
10 hospice and respond to questions from the December meeting.

11 Hospice provides palliative and supportive
12 services to beneficiaries with a life expectancy of six
13 months or less who choose to enroll. In 2011, over 1.2
14 million Medicare beneficiaries received hospice care,
15 including 45 percent of decedents, and Medicare spending
16 totaled \$13.8 billion.

17 At the December meeting, there were several
18 questions.

19 Jack, you noted the substantial difference in
20 hospice average length of stay (86 days) and median length
21 of stay (17 days) and asked for more information on the
22 distribution of length of stay by beneficiary and provider

1 characteristics. We've included a chart -- Table 6 -- in
2 your paper that has the distributional data, and I'd be
3 happy to discuss it in detail on question.

4 Mary noted that some patients in LTCHs are likely
5 hospice eligible and asked about the cost differences of
6 LTCH care and hospice care. And as just discussed in the
7 LTCH session this morning, some patients are in LTCHs
8 because LTCH care matches with their goals and preferences.
9 But as a recent article in Medical Care pointed out, there
10 are also some patients being transferred to LTCHs without
11 receiving clear information about their prognosis, and some
12 may make different choices if they did, including some
13 possibly choosing hospice.

14 As far as the cost differences between LTCHs and
15 hospice care, hospice is paid a daily rate that ranges from
16 about \$150 per day for routine care, which is the vast
17 majority of days, to between roughly \$700 and \$900 per day
18 for inpatient hospice care or continuous home care. LTCHs
19 are paid per discharge, but they have an average payment per
20 day that's about \$1,400, or a little bit more than that.

21 At the December meeting, several Commissioners
22 expressed an interest in facilitating appropriate use of

1 hospice among patients for whom hospice fits with their
2 preferences and other ways to improve quality and payment
3 approaches for end-of-life care more generally. I will come
4 back to this and lay out some potential research we could
5 consider at the end of the presentation for your feedback.

6 So the next couple charts summarize our indicators
7 of payment adequacy for hospice providers. As discussed in
8 December, our indicators of payment adequacy are generally
9 positive.

10 The supply of hospice providers continues to
11 increase, driven almost entirely by growth in for-profit
12 providers. The number of for-profit providers grew 5
13 percent in 2011, which resulted in a 2.5 percent increase in
14 the total number of providers.

15 The percent of decedents using hospice continues
16 to increase. Forty-five percent of decedents used hospice
17 in 2011, up from 44 percent in 2010 and 23 percent in 2000.

18 Average length of stay, which grew substantially
19 since 2000, was steady at 86 days in 2011.

20 Unlike most of the other sectors, we do not have
21 quality data for hospices. A voluntary quality reporting
22 program will begin in 2013, and hospices that do not report

1 will face a 2 percentage point reduction in their 2014
2 update. We expect the vast majority of hospices to report
3 in 2013.

4 Access to capital appears adequate. We continue
5 to see entry of for-profit providers as I noted, suggesting
6 adequate access to capital for this group. Less is known
7 about access to capital for nonprofit free-standing hospices
8 which may be more limited. Hospital-based and home health-
9 based provider have access to capital through their parent
10 provider.

11 In terms of the margins, the aggregate margin was
12 7.5 percent in 2010. 2010 is the year for which we have the
13 most recent data in this sector.

14 You'll recall that this estimate does not count
15 cap overpayments as revenues, and it excludes
16 nonreimbursable bereavement and volunteer costs.

17 Margins vary by type of provider. Free-standing
18 hospices have higher margins than provider-based hospices.
19 This is due in part to higher indirect costs among provider-
20 based hospices due to the allocation of overhead from the
21 parent provider.

22 For-profit providers have higher margins than

1 nonprofits, and urban providers have somewhat higher margins
2 than rurals.

3 As we've noted, margins are higher for providers
4 with longer stays and for providers with more patients in
5 nursing facilities and assisted living facilities.

6 So this brings us to our 2013 margin projection.
7 This slide outlines our assumptions, and based on those
8 assumptions, we project a margin of 6.3 percent in 2013.

9 One policy of note for 2014 is the phase-out of
10 the wage index budget neutrality adjustment which will
11 reduce payments an additional 0.6 percentage points in 2014.

12 So this brings us to the draft recommendation. It
13 reads: The Congress should eliminate the update to the
14 hospice payment rates for fiscal year 2014.

15 This recommendation would decrease spending
16 relative to the statutory update by between \$50 million and
17 \$250 million over one year and between \$1 billion and \$5
18 billion over five years. And we expect no adverse impact on
19 beneficiary access to care or providers' ability or
20 willingness to serve Medicare beneficiaries.

21 In addition to the update recommendation, we also
22 plan to print in the March report the two standing

1 recommendations the Commission made in March 2009.

2 The first is the payment reform recommendation.

3 This is the U-shaped curve. It would increase the per diem
4 payments at the beginning of the episode and at the end of
5 the episode near the time of the patient's death, and lower
6 them in the middle, and this would better align payments
7 with the service intensity of care. It has the potential to
8 improve the accuracy of the payment system and make it more
9 neutral toward length of stay. It also would affect the
10 distribution of payments across providers, increasing
11 payments for providers that currently have lower margins and
12 decreasing payments to providers that have higher margin.

13 The second recommendation is for focused medical
14 review of claims exceeding 180 days for hospices with
15 unusually high numbers of patients with long stays. This
16 recommendation was in response to concerns we heard from the
17 hospice community about the need to target regulatory
18 scrutiny toward those providers where it was most warranted.
19 PPACA included a similar medical review provision, but CMS
20 has not implemented it.

21 At the December meeting, Commissioners discussed
22 the importance of hospice as an option for beneficiaries and

1 expressed a desire to facilitate appropriate hospice use
2 among patients for whom hospice fits with their preferences,
3 and to improve quality of and payment approaches to care for
4 patients in the terminal stages of illness. This slide is
5 in response to that discussion and outlines some research
6 areas that we could consider exploring.

7 First is shared decisionmaking. Many patients
8 with advanced illnesses do not get full, timely, or clear
9 information about their prognosis and options for care. So,
10 shared decisionmaking tools may offer an opportunity for
11 improved physician-patient communication and help empower
12 patients to make end-of-life care choices consistent with
13 their goals and preferences. As mentioned at yesterday's
14 meeting, we anticipate updating the Commission on our work
15 on shared decisionmaking later this spring.

16 Another thing we could explore is including
17 hospice in Medicare Advantage instead of the current carve-
18 out. Currently, Medicare Advantage enrollees receive
19 hospice care outside of the plan from a hospice provider
20 paid directly by Medicare just like fee-for-service
21 beneficiaries. With the health care system moving toward
22 more integration of care, it raises questions about whether

1 having hospice carved out of Medicare Advantage makes sense.
2 If hospice were included in Medicare Advantage for Medicare
3 Advantage enrollees, plans would have flexibility to provide
4 more expansive hospice benefits than fee-for-service if they
5 chose to do so.

6 We could also explore fee-for-service
7 demonstrations that test more flexibility in the hospice
8 eligibility criteria. PPACA included a demonstration to
9 test concurrent hospice and conventional care. Funds for
10 the demonstration were not appropriated. Some of the
11 interest in concurrent care has been spurred by Aetna's
12 program in the commercially insured working-age population
13 that expands hospice eligibility and allows concurrent care,
14 and that Aetna reports has not increased costs. That
15 program, though, exists in a managed care environment among
16 a younger population where cancer is more prevalent. It is
17 not clear that we'd see similar results in Medicare fee-for-
18 service. With that in mind, we could consider exploring
19 fee-for-service demonstrations focused on specific
20 conditions where more flexibility in hospice eligibility is
21 thought to have the best chance of not increasing spending.

22 Another area we could explore is bundling.

1 Research is currently underway to develop and test bundled
2 payment for episodes of care that include post-acute care,
3 and we could explore whether there would be benefits to
4 including hospice within such bundles.

5 Finally, there is the issue of quality
6 measurement. Quality measurement focused on end-of-life
7 care is very limited. Quality reporting is beginning for
8 hospices in 2013, but this initial step may not be very
9 robust. There is very little quality measurement focused on
10 care for patients in the terminal stages of illness outside
11 of hospice. We could explore whether there are ways to
12 broaden quality measurement across settings for care of
13 patients with advanced illnesses.

14 So, with that, that concludes my presentation. I
15 look forward to your discussion and any questions.

16 MR. HACKBARTH: Thank you, Kim.

17 Can I ask a question about payment reform? My
18 recollection is that PPACA directed the Secretary to modify
19 the payment system along the lines that we described with
20 our U-shaped concept, but do so not before fiscal year 2014.
21 Is that correct? Is my recollection correct?

22 MS. NEUMAN: Yes, the Secretary cannot make any

1 changes before fiscal year 2014. The caveat is that she has
2 full discretion about what, if any, changes to make, so it
3 could look different from our recommendation.

4 MR. HACKBARTH: Okay. So it wasn't prescriptive
5 in terms of the sort of payment reform.

6 MS. NEUMAN: Right.

7 MR. HACKBARTH: Okay. Is the department working
8 on reforming the hospice payment system? If I missed it
9 when I was out, if you talked about, I apologize.

10 MS. NEUMAN: So they have research underway,
11 contracts underway to look at this, and they have
12 a technical expert panel of industry groups that are
13 providing input to them. So there is activity underway as
14 they move in this direction of considering this.

15 MR. HACKBARTH: Okay. But fiscal 2014 is not that
16 far away. It doesn't look like they have something planned
17 for 2014?

18 MS. NEUMAN: It seems unlikely that there would be
19 something for 2014.

20 MR. HACKBARTH: Okay. Mary, do you want to lead
21 off our round of questions and comments?

22 [Laughter.]

1 DR. NAYLOR: I certainly do. Thank you for this
2 opportunity.

3 [Laughter.]

4 DR. NAYLOR: So similar to home care, I think
5 hospice represents a huge, critically important opportunity,
6 and thank you, Kim, for a terrific report and for your
7 responsiveness to some of the questions.

8 Let me just say if we were to do it right, to
9 target it to the right population, and it's a match and
10 aligned with their needs, this is a huge opportunity for us
11 to really advance the care and outcomes of Medicare
12 beneficiaries and to yield high quality of life. It's great
13 to see the growth from 23 percent to 45 percent in the
14 period we have. It's of concern that the length of stay,
15 even though there are the outliers at the 90th percentile,
16 that we still have difficulty getting some people in. As a
17 matter of fact, we have difficulty getting many people to
18 have access to the benefit to really maximize on the
19 benefit, so entering too late into the program.

20 It's of concern that there are certain subgroups,
21 including dual eligibles and African Americans and
22 Hispanics, that at least as your data present are not

1 accessing the benefit, so the opportunity to really target
2 it, et cetera.

3 It's great to see the growth in non-cancer because
4 this started out one way and it's great to see movement to
5 recognize that people live with multiple, complex chronic
6 conditions, and only one of them gets captured and so on.

7 So there are so many important things. In terms
8 of your options -- and I will get to the recommendation -- I
9 really like the notion of focusing on shared decisionmaking.
10 I'm aware of Aetna's Compassionate Care Program, and I think
11 some kind of really robust effort to look at what we've been
12 trying to look at, which is broadening the benefit,
13 concurrent cure, maybe looking at extending it and so on.
14 And I think the attention to end-of-life quality measures
15 makes a lot of sense.

16 I would have to think conceptually about hospice
17 in bundled payments even though I'm a bundled payment --
18 someone who supports that, as many others do here.

19 The thing in terms of the margins, I think the
20 margin of 6.3, you know, it doesn't include the 1.4 for
21 bereavement, and it doesn't include -- and I know we've had
22 many conversations with many other Commissioners in the past

1 -- the 0.3 for volunteers, which are critically part of the
2 benefit program. But I think the biggest challenge with the
3 margins, as we've related to and seen in other areas, are
4 the differences we're seeing in for-profit versus not-for-
5 profit.

6 With all that said, I think that we are in an area
7 where there's opportunity, huge opportunities, with
8 beginning efforts in measuring pain and allowing
9 organizations to begin to report at least three quality
10 indicators to get us further. You know, I support the
11 recommendation, but I really, really, really support our
12 continued efforts to refine and forge a path that would
13 really promote greater access to the right time for the
14 right targeted population when it's aligned with their
15 needs.

16 MS. UCCELLO: I agree with pretty much everything
17 that Mary said, and in terms of the growth in the non-cancer
18 users of this service, I think, you know, because of their
19 longer lengths of stay, this really increases the importance
20 of getting the payments right and shifting to that U-shaped
21 curve. So we may want to highlight that.

22 And in terms of these potential options, I, too,

1 really want to look more into the shared decisionmaking, so
2 I look forward to our discussions on that.

3 DR. HALL: Well, I guess in my experience, the
4 hospice movement has been one of the most important changes
5 in medical care that I've seen over my career. It has all
6 the right things. It started out largely as a voluntary
7 movement. It was often community-based, the very best
8 people. They knew about shared decisionmaking before we
9 knew there was such a thing as shared decisionmaking.

10 As Mary has mentioned, it's not just a place to go
11 to die, whether a real or a virtual place, but it's a way of
12 living during this stage of your life. It has relatively
13 seamless transitions between home care, respite care. Some
14 of the best people around in terms of pain control are
15 involved in the hospice movement. It's a wonderful example
16 of doing the right thing and extremely important for, I
17 think, Medicare recipients.

18 So I think if there are some areas that need to be
19 tightened up, like quality indicators, looking at the for-
20 profit sector, I'm all for that. I think this is the kind
21 of tightening up that will allow this movement to continue
22 to flourish.

1 As far as bundling this again say in an MA
2 program, there probably are some practical problems. I
3 don't know how it is in your area, but if you look at the
4 renewal cycle for MA programs and the advertisements, it's
5 usually a bunch of oldsters frolicking on the beach at
6 Cancun. It doesn't show somebody at terminal stages of life
7 who is seeking pain control.

8 So there is this sort of image issue about
9 hospice, although that, too, is changing. So anything we
10 can do to tighten up this program and encourage its used, I
11 think that would be a great blow for justice, for the
12 Commission, so I'm very much in favor of this.

13 DR. DEAN: I would support the recommendation. I
14 had a question on Table 7 of mailing material which had to
15 do with the live discharges, and I didn't understand the --
16 you know, I understand the point of the table, but I didn't
17 understand those percentages. Those are percentages of
18 what?

19 MS. NEUMAN: That is the percentage of benefit
20 periods that end in a live discharge. So, for example, I'm
21 just looking at Period 1 in that table -- go ahead.

22 DR. DEAN: So -- I'm sorry. Go ahead.

1 MS. NEUMAN: I was just going to say, so it says
2 basically that for everybody who enters their first hospice
3 benefit period, a little under 9 percent of those end in a
4 live discharge as opposed to dying or staying on into a
5 second benefit period.

6 DR. DEAN: I see. And how does the overall
7 percentage of live discharges, does that -- those wouldn't --
8 -- we wouldn't add those us to get that, but we --

9 MS. NEUMAN: We wouldn't because there are -- if
10 someone isn't in the percentage for the first benefit
11 period, then they move into the second, and then there's one
12 of three outcomes in the second and so on. So you raise a
13 good point. It would be helpful to have the overall rate.

14 DR. DEAN: Of all the patients that enter into
15 hospice care, do we have a measure of the portion that
16 result in live discharges?

17 MS. NEUMAN: We do, and --

18 DR. DEAN: And I know it varies. I know it's been
19 an area of question, and it varies, as I recall, quite a lot
20 between programs, which is an important bit of information,
21 I think.

22 MS. NEUMAN: Exactly. It varies between

1 providers. It varies by diagnosis. And that number -- the
2 number that we have reported is a little bit under 20
3 percent, but it would be helpful if I could give you the
4 specifics of how that number is defined. So why don't I put
5 that in the paper and add that information.

6 DR. DEAN: Okay. I think that would be useful
7 because it does raise the question of selection, proper
8 selection of people entering into care. Otherwise, I
9 certainly support everything that Bill just said.

10 Actually, just a historical bit. When I was a
11 medical student, I went to a lecture by Dame Cicely Saunders
12 in London, who I think is the sort of grandmother of this
13 whole movement, and it was a powerful lecture. That was a
14 long time ago.

15 [Laughter.]

16 DR. CHERNEW: Every time we go around the clock
17 about hospice, I think there's just this groundswell of
18 support for the aspects of the program, and I think I share
19 that and I think it's well-known that we don't do a great
20 job surrounding end of life, generally speaking, for a whole
21 bunch of reasons, and we can do better, and I think that's
22 important.

1 My only general caveat, which is a little bit like
2 a broken record, is the more we can concentrate on the
3 people and what different types of people need and less
4 about where they're getting their care and other aspects of
5 things, I think in general the better we would do. But that
6 said, a portion of that is clearly going to be these hospice
7 services, however they're paid for or configured. And I
8 think we have to make sure we can preserve that in a
9 responsible manner. So I support the recommendation.

10 MR. BUTLER: On page 7, I just want to be a little
11 clearer on -- we've said the spending implications of our
12 recommendation saves money, but I'm a little less clear on
13 what happens in the absence of sequestration, and by law,
14 what -- go back to the one before that. What happens? When
15 you sort all that out, what's the increase next year, if
16 any?

17 MS. NEUMAN: The estimated statutory update next
18 year is between 1.8 and 2.1 percent.

19 MR. BUTLER: So that's what we're eliminating,
20 essentially.

21 MS. NEUMAN: Yeah.

22 MR. BUTLER: Right. Okay. So then on your

1 research page, the last page, the one other aspect we
2 haven't talked about -- we've tracked well and shown how
3 increasing neurological illnesses and other things are
4 occupying actually over half of the hospice business, so to
5 speak, versus cancer. Most hospices have broadened their
6 involvement into palliative care significantly and
7 intervened not at a time when somebody might be dying, but
8 they come in and they reset drugs, they reset pain, they
9 recalibrate and often save money and improve life. And I
10 see that only growing, but I'm not sure, because it is not a
11 hospice -- these patients do not qualify for hospice, but
12 this is, again, something we would want to incentivize. I
13 would think that we need to begin to think how that fits
14 into a bundle or how it fits into kind of something beyond
15 just us narrowly looking at those people that are expected
16 to die within six months that qualify for hospice.

17 DR. NERENZ: A couple things. First of all, I
18 will support the recommendation. But if we could flip back
19 to Slide 6, just a couple comments in preface.

20 First of all, I would second Bill's and Tom's
21 points about the benefits and worth of hospice. I certainly
22 share that idea and believe it's something that we should

1 encourage and support.

2 Like Mike, I'm going to now sound like a broken
3 record on my point of the second bullet point, the striking
4 differences in margin between the hospital-based and the
5 free-standing. I do take your point about how some of this
6 just reflects decisions about allocation of indirects. But
7 as we get close to our last bit here, this is a pattern that
8 we see over and over again across these different domains of
9 payment. So if somehow this one was just reflecting some
10 decisions about allocation, we would expect perhaps in
11 another domain of payment you'd see a positive margin. But
12 in almost everything hospital-based, we need negative
13 margins.

14 And it would seem then that we have to take a
15 couple different general views of this. One is we either
16 accept that the underlying cost structure in hospitals,
17 regardless of whether it's IRFs, whether it's dialysis,
18 whether it's this, is higher and that we actually should
19 intentionally encourage the movement of these services away
20 from hospital settings into settings that are truly lower
21 cost. We could take that view. Or we could take the view
22 that there are good reasons for doing a whole set of these

1 things, not just hospice but others, in hospital settings
2 because of some advantages that we'd have to articulate.
3 And if that's the view, then we would be concerned about
4 something like negative 16 percent.

5 Now, I think folks on the Commission who are
6 specifically from hospitals or representing hospital groups
7 can probably speak about this more eloquently than I can,
8 but having seen this now over and over again, I am a bit
9 concerned about this.

10 MR. HACKBARTH: My initial reaction, Dave, is that
11 I think that there are different reasons for this pattern.
12 The pattern is consistent, but it's not always caused by the
13 same factors. So there are some services -- home health,
14 and I think hospice probably also applies -- where if you
15 add a share of hospital overhead, that puts the hospice or
16 the home health provider at a significant disadvantage in
17 terms of cost structure compared to home health providers
18 and hospices that don't have hospital overhead. These are
19 not organizations that typically have hospital-type
20 organizational structure and cost. So that's an issue in
21 some of them.

22 In other cases, we've found that, in fact, there

1 are issues with the payment system. So an example of
2 hospital-based SNFs, what we've found is, well, there may be
3 some allocation issues, but we also found that hospital-
4 based SNFs were hurt disproportionately by flaws in the SNF
5 payment system, specifically that we overpay for therapy
6 services and underpay for non-therapy ancillary services.
7 And if you fix that flaw in the payment system, the hospital
8 financial performance for hospital-based SNFs improves
9 dramatically.

10 In the case of hospice, it may be -- and you may
11 know the answer to this, Kim -- that we know overall that
12 hospices that tend to have shorter lengths of stay tend to
13 have poorer financial performance than the hospices that
14 have really long stay patients. And so if the way hospice has
15 evolved in hospital-based SNFs is they tend to have short-
16 stay patients, that could contribute to the poor financial
17 performance over and above any allocation issues.

18 So the pattern is consistent, as you say, but I
19 think the reasons for it may vary somewhat at least sector
20 by sector.

21 Kim, do you want to --

22 MS. NEUMAN: Yeah, that's exactly it for the

1 hospital-based hospices. They have higher overhead, and
2 then they also have shorter stays. So it's a combination of
3 those two things.

4 DR. NERENZ: And that's fine and all understood.
5 I guess I just would have to state then the obvious point.
6 If the indirects were allocated in a different way, it would
7 just mean that another sector would be more negative or
8 appear more negative than it does now if those costs have to
9 go somewhere.

10 DR. MARK MILLER: I'm not saying that it overcomes
11 this completely, but then does that also mean if you go to
12 the U-shaped curve it tends to push these guys up?

13 MS. NEUMAN: Exactly. They would have higher
14 payments under a U-shaped curve.

15 DR. MARK MILLER: So I just wanted to hard-wire
16 that to your mind. We've also tried to think about that,
17 and if they would move forward with it, it should help this
18 situation.

19 MR. HACKBARTH: The analog to refining the SNF
20 payments [off microphone].

21 DR. NERENZ: Yes, understood. Thank you.

22 DR. REDBERG: Thanks very much for an excellent

1 report, and I support the recommendation and agree with a
2 lot of what Mary and others have said about the importance
3 of the hospice benefit, and in particular, I like the
4 options for future research, looking at shared
5 decisionmaking, because I think it's certainly true that
6 this is an underutilized benefit currently and that, you
7 know, you look -- I assume the difference between the median
8 and the average length of stay is because a lot of hospice
9 stays are still very short, which I assume is because people
10 didn't know about it until very late. And, also, you know,
11 notoriously, I think a lot of the end-of-life care in the
12 Medicare population is either cancer or congestive heart
13 failure, and we have research over and over showing that,
14 for whatever reasons, and perhaps good intentions, doctors
15 are particularly poor at recognizing when our congestive
16 health failure and cancer patients are at end of life and,
17 therefore, are not offering hospice to these patients. And
18 so I think perhaps it's part of our care coordination, but
19 if there's more coming from primary care physicians and more
20 focus really from within the profession on recognizing and
21 in our training programs on recognizing when our patients
22 are at end of life, because it's really not -- as well

1 intentioned as it is, it's not a service to a patient who
2 really had a few months to live to not be aware of that, not
3 offer hospice treatment, and not, frankly, you know, do all
4 the other end-of-life planning that patients need to do
5 instead of -- I mean, I frequently see patients that are
6 clearly at end of life in ICU getting chemotherapy that has
7 absolutely no chance of helping them, where I think if they
8 had a choice -- and that's a big pot of shared
9 decisionmaking -- they would not choose to be in that
10 setting.

11 So I look forward to future research and our own
12 efforts also within the profession to better recognize and
13 offer hospice as an option.

14 My only other question was from the mailing
15 materials there was reference to the 2009 recommendations
16 and some anecdotal reports of questionable relationships
17 between nursing facilities and hospices. Has anything more
18 happened in that area?

19 MS. NEUMAN: We continue to hear similar reports,
20 so I don't think that the situation has changed. The
21 Commission did recommend that the OIG take a look at
22 hospices that focus on nursing facilities, and the OIG did

1 issue a report where they found that there was -- you know,
2 there's a subgroup of providers who really focus on nursing
3 facilities, and these tend to be for-profit providers.
4 These facilities tend to have patients that have longer
5 stays, less complex care needs, and the OIG wound up
6 recommending a payment reduction for hospice care in nursing
7 facilities as a result of that report.

8 So it's an issue that we continue to do research
9 on ourselves, but that's sort of the status of what
10 happened.

11 DR. BAICKER: I support the recommendation and am
12 particularly intrigued by the directions for future
13 research, looking at more flexible benefits and, you know,
14 drawing on the examples from the private sector that you've
15 outlined and that we've heard reports about. Encouraging
16 patients to use hospice care while not denying curative care
17 can both improve well-being and lower costs. This seems
18 like a great avenue for future research, and I'm supportive
19 of the recommendation. That's it.

20 DR. COOMBS: So I support the recommendation, and
21 I had a similar question to David's, but it's already
22 answered. I'm also interested in those patients who

1 actually get discharged from hospice. It's always a
2 different kind of paradigm for them.

3 MR. GRADISON: I support the recommendation. A
4 little bit of history. I was pretty heavily involved in
5 getting this benefit added to Medicare, and it was an
6 interesting experience because the executive branch was
7 totally opposed to this. The significance of that is that
8 the design was pretty much written by the Congress, and it
9 didn't invent it. It basically looked at the hospices that
10 existed at the time and, like the 80/20 rule and stuff like
11 that, wrote that into statute.

12 To me, what is remarkable isn't really that we did
13 such a great job in those days but, rather, that something
14 like 30 years has gone by and somebody -- Rip Van Winkle --
15 who saw this in its first days, looking at it today would
16 recognize the benefit structure and probably would comment
17 particularly on how gratifying it is, how it is voluntary,
18 it's an option, you don't have to do it, the way that it has
19 gained acceptance, however slowly. I personally think there
20 is room for a major review of the nature of the benefit. We
21 certainly didn't contemplate these long stays at that time.
22 That wasn't even in the discussion. And the unevenness of

1 cost spread over time is highly important to review that, as
2 well as the other suggestions that are up here. So I just
3 want to -- I'm really making this point just to say that,
4 you know, here's somebody you might expect to just defend it
5 just as it is. That's not the case at all. I think after
6 25 or 30 years it's probably a good idea to take another
7 look.

8 DR. HOADLEY: Thank you, Kim, for really good
9 information and following up on the questions. I do support
10 the recommendation, and I'm really looking forward to the
11 options forthcoming.

12 You know, it's interesting. There's clearly some
13 issues, and particularly on this idea of different
14 eligibility criteria and these issues about the concurrent
15 care. And, you know, I don't have an opinion on whether
16 that's the right direction to go at all, and so I'm really
17 interested in hearing what some of the pros and cons are. I
18 mean, I could see some real strengths in that. I could see
19 some real drawbacks if it means people don't confront the
20 choices about whether to continue treatment because, oh,
21 well, we can sort of get the best of both somehow.
22 Hopefully in this environment that would lead to actually

1 shared decisionmaking and thinking through and all that.

2 You know, the long-stay cases are intriguing, and,
3 you know, the distributions you showed suggest it's not
4 really concentrated just at the 90th and 95th percentile,
5 but there are some pretty long stays out at the 75th
6 percentile. So there's a fair amount of people that are in
7 those long-stay tails, and I think the more we can
8 understand, you know, who those are and what are those
9 circumstances -- and they may be appropriate because of the
10 different patterns of illness and disease.

11 And the only other comment, sort of taking off on
12 Bill's comment, you have the note in the text about there's
13 been on recalibration or rebasing of this system really
14 since the beginning, and, you know, we had a lot of
15 discussion about rebasing on a couple of the systems
16 yesterday, and it strikes me as maybe that's a sign that's
17 really a pretty well working system, but I guess it always
18 opens up that question of is there a need for looking back
19 at that. And maybe the answer is on.

20 DR. SAMITT: Thanks, Kim. Great job. I support
21 the recommendation. I guess my perspective is that it's
22 clear that there are some settings where hospice is actually

1 being overutilized, but even more importantly, I think the
2 bigger problem is that hospice is being underutilized and
3 plays a very significant role. And I frankly don't think
4 we're doing beneficiaries a service because we're not
5 maximizing the use of this very critical benefit. And I
6 think Bill put it, you know, that we need to both tighten up
7 the program, but even more importantly, encourage its use.

8 And I like the research because I think that it
9 will begin to help us focus on how we can encourage greater
10 use. But I'm not even sure it goes far enough. I know that
11 our place is to recommend payment policy, but one of the
12 things that I don't think we talk about enough is sort of
13 recommending data policy.

14 Someone over here had mentioned the fact that, you
15 know, physicians don't know when they should be using
16 hospice more. I don't know how effective a job we play or
17 CMS plays in sharing information with providers about, for
18 their population, the average hospice use versus what would
19 be expected in a certain population or average hospice
20 length or, you know, to the degree we are sending patients
21 to hospice too soon or too late. To what degree do
22 physicians, who are the primary drivers of these decisions,

1 and/or hospitals, get to see that information? We share
2 that a lot. I think that in general we should be sharing
3 that a lot more. And I don't know if that becomes part of
4 the research recommendations or it goes broader, but we
5 should encourage greater sharing of information with
6 providers.

7 MR. KUHN: I support the recommendation.

8 MR. GEORGE MILLER: Yeah, I support the
9 recommendation, and I first want to thank Mary for teeing it
10 up, and all of the other colleagues who have made important
11 statements about this important part of the continuum. I
12 think hospice is the right seamless part of the American
13 health care system. Particularly we engage in shared
14 decisionmaking. And to Craig's point, one of the things
15 that I think not only should we encourage the use, but I
16 think that it should be a part of the discussion early on in
17 the continuum of care, particularly when we have discussions
18 about living wills. The percentage of patients that don't
19 have living wills or DNRs is just still astounding in this
20 age of information. And we could talk about the hospice
21 benefit in the beginning and explain how it could be used,
22 so maybe the other sectors we've talked about, utilization

1 may just naturally go down, and both the physician and the
2 patient is fully informed of that benefit to help them make
3 that decision going down through the continuum of care.

4 And sometimes, though, those decisions are
5 difficult, but so often, quite frankly, in operating
6 hospitals we see sometimes the right theoretical reason
7 physicians use heroic efforts and try to do things
8 valiantly, and it's unfortunately just a waste of resources,
9 quite honestly and quite frankly, and not going down the
10 road of trying to take decisions from someone, but just
11 knowing all the options, and this gives us that opportunity.

12 So the encouragement of getting data and quality
13 so we can give people the opportunity to make informed
14 decisions is important.

15 MR. HACKBARTH: Craig, on your point about
16 feedback, in years past we have made some recommendations
17 about CMS providing more feedback to physicians on how their
18 practice patterns compare to their peers'. Based at least
19 in part on one of our recommendations, Congress required CMS
20 to do that. And it would actually be good for us at some
21 point in the not too distant future to delve back into that
22 review, the progress that has been made or not been made on

1 that effort. I think last I heard, it was proving somewhat
2 challenging in terms of really being effective in reaching
3 physicians and engaging them. But I'm eager to get an
4 update on that.

5 DR. MARK MILLER: This is an awkward point. We
6 just had this conversation internally of like, "What ever
7 happened with that?" and had not gotten back to it. You're
8 right.

9 MR. HACKBARTH: Yes.

10 MR. KUHN: I would just make a point on that one.
11 When I was at CMS, we did engage in that activity. We did a
12 number of focus groups where we brought together physicians
13 to look at their own data to begin trying to get a sense of
14 how we could array it, how we could present it to them, et
15 cetera.

16 The reactions were interesting, and I think the
17 reactions were interesting because it's driven by the fee-
18 for-service program. Rather than looking at where they
19 position themselves with their colleagues and where they
20 perform, where they really focused on is where their
21 colleagues were doing more volume from where they were and
22 where were their missed opportunities. And so the data had

1 just the opposite effect of what we thought it would be. So
2 it's driven by the fee-for-service system, and that's what
3 we go.

4 So I think it's an area worth exploring into the
5 future, but be careful what you ask for.

6 MR. HACKBARTH: So, Kim, would you put up the
7 draft recommendation, please?

8 For the audience, just a word about this
9 recommendation in particular and our recommendations in
10 general. It's phrased as "should eliminate the update."
11 What I want to be clear about and what our report will be
12 clear about is that the way we are thinking about these
13 recommendations for hospice and other providers is that we
14 make recommendations relative to the current base rate. And
15 so what this recommendation means for hospice is if you take
16 the base rates that prevail in FY2013, we're saying they
17 should be unchanged in FY2014.

18 There are other things going on in the
19 environment, like the sequester, that reduce rates. To the
20 extent that the sequester reduces the rate below the level
21 that prevails in fiscal year 2013, it would be inconsistent
22 with the MedPAC recommendation. It's Congress' prerogative

1 to do that, but our recommendation is that the prevailing
2 rates be held constant through fiscal 2014.

3 So we're not saying, just to pound the point one
4 more time, eliminate the update and go ahead and take the
5 sequester and we're okay with the net result of that. We're
6 saying the rate should be held constant at the now
7 prevailing levels for hospice and other providers.

8 So it's time to vote on the draft recommendation.
9 All in favor of the recommendation, please raise your hand?

10 [Show of hands.]

11 MR. HACKBARTH: Opposed?

12 [No response.]

13 MR. HACKBARTH: Abstentions?

14 [No response.]

15 MR. HACKBARTH: Okay. Thank you, Kim

16 [Pause.]

17 MR. HACKBARTH: And our final session is on the
18 status of Part D.

19 MS. SUZUKI: Good morning. In this presentation,
20 I'll provide a status update on Part D with a focus on
21 access and cost and how Part D program is working for the
22 enrollees.

1 And before I start, I wanted to thank Katelyn
2 Smalley for her work on this project.

3 Here's a quick overview of the Part D program.
4 Spending for Part D totalled about \$60 billion in 2011. In
5 2012, over 30 million beneficiaries were enrolled in Part D,
6 and Part D enrollees filled, on average, four prescriptions
7 at \$230 per enrollee per month in 2010. In 2013, over 1,000
8 stand-alone PDPs were available nationwide, along with over
9 1,600 MA-PDs.

10 Here's a quick overview of how this presentation
11 will proceed. I'll first discuss Medicare beneficiaries'
12 access to prescription drugs. We'll cover topics such as
13 Part D enrollment and plan offerings and take a closer look
14 at ten percent of the beneficiaries who do not have
15 creditable coverage and discuss recent trend in plan
16 offerings that use tiered pharmacy networks. Next, we'll
17 look at costs of the program with a focus on the use of
18 generics and how that has affected Part D prices. Finally,
19 I'll report some findings from our analysis of voluntary
20 plan switching by Part D enrollees.

21 In general, Medicare beneficiaries seem to have
22 good access to prescription drugs. All individuals have

1 access to many Part D plan options and many continue to
2 receive drug coverage through former employers. Survey
3 indicates that beneficiaries enrolled in Part D are
4 generally satisfied with the Part D program and with their
5 plans.

6 In 2012, about 65 percent of beneficiaries were
7 enrolled in Part D plans and an additional nine percent had
8 coverage through employer plans that receive Medicare's
9 retiree drug subsidy. Some beneficiaries receive their drug
10 coverage through other sources of creditable coverage, such
11 as the Veterans Affairs and TRICARE and Federal Employees
12 Health Benefit Plans. Although we do not have data for
13 2012, a subset of beneficiaries likely have no drug coverage
14 or coverage less generous than Part D.

15 There hasn't been a dramatic shift in the Part D
16 enrollment patterns from year to year. In 2012, about 63
17 percent of Part D enrollees were in stand-alone PDPs and the
18 rest were in MA-PD plans. As in previous years, most LIS
19 enrollees continued to be enrolled in PDPs. A larger share
20 of MA-PD enrollees have enhanced benefits, such as coverage
21 in the gap.

22 In 2013, about the same number of plans are

1 available as in 2012. There are between 23 and 38 stand-
2 alone PDPs available, depending on the region. And the
3 typical county has five to ten MA-PD plans.

4 In 2013, more PDPs are offering a coverage in the
5 gap compared to 2012. The extent of the gap coverage varies
6 from plan to plan, with some plans providing coverage for
7 only a few generics and others providing coverage for both
8 generics and brands.

9 Although having some coverage in the gap may
10 provide important protection, particularly for people with
11 high drug spending, this will become less important over
12 time as the coverage gap is gradually phased out.

13 In 2013, beneficiaries will pay a cost sharing
14 that is slightly less than 50 percent for brand name drugs
15 and 79 percent coinsurance for generic drugs, which is a
16 reduction from 86 percent last year.

17 This pie chart shows the drug coverage for all
18 Medicare beneficiaries. According to data released by CMS,
19 in 2010, about 60 percent of beneficiaries were in Part D.
20 Fourteen percent were in plans that received their RDS. And
21 another 17 percent had other creditable coverage. The
22 remaining ten percent either did not have drug coverage or

1 had coverage less generous than Part D's benefit. Although
2 the composition of the sources of creditable coverage has
3 changed somewhat since the program began, the ten percent
4 without creditable coverage has been pretty much unchanged.

5 Since 2012 data are not available, we looked at
6 2010 Medicare Current Beneficiary Survey data on coverage
7 and access to prescription drugs to better understand this
8 group of beneficiaries. We found that not everyone in that
9 ten percent went without drug coverage in 2010. Four in ten
10 indicated that they had some drug coverage. The remaining
11 did not report having had any drug coverage. When asked why
12 they did not enroll in the Part D program, slightly over
13 half reported that they did not take enough medications to
14 need such coverage or they would not benefit from enrolling
15 in Part D. A small number of individuals reported cost as
16 one of the reasons for not enrolling in Part D.

17 Beneficiaries with no creditable coverage differ
18 in many respects from those enrolled in Part D. For
19 example, they tended to be younger, have higher income, and
20 have somewhat more education, on average, compared with Part
21 D enrollees. They also tended to be healthier, with 26
22 percent reporting being in excellent health compared with 13

1 percent reporting being in excellent health among Part D
2 enrollees.

3 So we just saw the plan availability hasn't
4 changed much for 2013, but there are some changes in plan
5 features. One relatively new trend we're seeing is the use
6 of tiered pharmacy networks that classified some pharmacies
7 as preferred and others as non-preferred. In 2012, six
8 stand-alone PDPs have both preferred and non-preferred
9 pharmacies in their networks and used differential cost
10 sharing. Enrollment in these six plans accounted for about
11 12.5 percent of the total PDP enrollment. The share of
12 pharmacies classified as preferred pharmacies varied across
13 plans, from about eight percent for Humana Walmart Preferred
14 plan to about 30 percent for BlueMedicare plan in Florida.
15 Most had cost sharing differentials between preferred and
16 non-preferred pharmacies that range from \$5 to \$10 for
17 generics and up to a 19 percentage point difference for
18 brand name drugs. At least five plans had announced
19 addition of preferred pharmacies for 2013 at the time this
20 analysis was conducted.

21 One reason we're keeping an eye on this trend is
22 because this could have an effect on beneficiaries' access

1 to medications. Plans must meet a network adequacy
2 requirement that CMS has established to ensure
3 beneficiaries' access to pharmacies. For plans with tiered
4 pharmacy networks, since both preferred and non-preferred
5 pharmacies are considered to be in network, a plan could
6 meet the network adequacy requirement by having only non-
7 preferred pharmacies in some areas.

8 Although CMS rule allows tiered networks only if
9 the cost sharing is not so significant as to discourage
10 enrollees in certain areas from enrolling in that plan, it
11 appears that plans have interpreted this rule in different
12 ways, with some plans charging 60 percent coinsurance in
13 non-preferred pharmacies for certain brand name drugs while
14 charging 40 percent coinsurance in preferred pharmacies.
15 Other plans have no difference in coinsurance for brand name
16 drugs or a difference of a few dollars.

17 Another concern is whether enrollees were aware of
18 plans' use of tiered pharmacy networks. The impact of cost
19 sharing differentials between preferred and non-preferred
20 pharmacies could be significant, particularly if
21 beneficiaries were unaware or did not understand the
22 distinction.

1 Although the population currently affected by the
2 tiered pharmacy network is relatively small, many more could
3 be affected in the coming years. Access and cost
4 implications of tiered pharmacy networks are not yet known
5 and we will continue to monitor the plans' use of tiered
6 pharmacy networks and the effects on beneficiaries' access
7 to medications.

8 Cost is another aspect of the program that we
9 closely monitor. This chart shows the year-to-year changes
10 in the average bids from plan sponsors. As you can see, the
11 bids have fluctuated over the years. The national average
12 bid for 2013 is about the same as it was for 2012, but there
13 are some notable changes in the expected costs of the
14 individual components, as you can see from comparing the
15 last two bars to the right.

16 The direct subsidy portion, which is in green, is
17 a much smaller portion compared to 2012, decreasing by over
18 nine percent between 2012 and 2013. On the other hand, the
19 reinsurance portion, which is the orange piece, is expected
20 to grow by about 14 percent between 2012 and 2013. The
21 higher growth in the reinsurance component of the bid may,
22 in part, be due to the expectation that the gradual phase-

1 out of the coverage gap will result in higher reinsurance
2 costs.

3 The base beneficiaries' premium will be \$31 in
4 2013, which is about the same as in 2012. Higher-income
5 beneficiaries pay a surcharge calculated based on income,
6 similar to the income-related premium under Part B.

7 The average plan bid we just saw reflects plans'
8 expectations about what it would cost to provide basic
9 coverage for a beneficiary with average health. Here, we're
10 looking at the actual program spending. Payments for low-
11 income subsidy continues to be the single largest component
12 of Part D spending. Spending for this subsidy has grown by
13 36 percent cumulatively between 2007 and 2012. Payments for
14 individual reinsurance has grown the fastest between 2007
15 and 2012, with a cumulative growth of 84 percent. This is
16 the subsidy that covers most of the cash costs for
17 beneficiaries who have very high drug spending.

18 In our analysis of the Part D data last year, we
19 found that people with spending high enough to reach the
20 catastrophic phase of the benefit filled more prescriptions,
21 on average, and the cost of each prescription tended to be
22 higher because more of them were for brand name drugs. We

1 also found that over 80 percent of the people with high drug
2 spending received the low-income subsidy. These findings
3 led us to recommend that the Congress give the Secretary the
4 authority to provide stronger financial incentives for
5 beneficiaries who receive the low-income subsidy to use
6 lower-cost generics when they're available.

7 Finally, I wanted to quickly note that spending
8 for the retiree drug subsidy, which is at the bottom, in
9 green, has been decreasing over the years, and this reflects
10 the drop in the number of people who receive their coverage
11 through former employers who receive the subsidy. This
12 trend may have been accelerated by the changes made in PPACA
13 that no longer allows employers to deduct prescription drug
14 expenses that are covered by this subsidy.

15 One way plans manage their drug costs is to
16 structure their formularies to encourage their enrollees to
17 use generics in place of their brand counterparts. The use
18 of generic drugs has been increasing over the years. Based
19 on our analysis of the Part D data, the overall average
20 generic dispensing rate, or GDR, has increased from 61
21 percent in 2007 to 74 percent in 2010. During this period,
22 some of the most popular brand name drugs have lost patent,

1 which has increased the opportunity for generic
2 substitution.

3 As you can see from the table, GDR varies across
4 different groups of beneficiaries. On average, people
5 enrolled in MA-PDs are more likely to use generics, with
6 GDRs for MA-PD enrollees consistently exceeding the GDRs for
7 PDP enrollees by about five percentage points. GDRs for LIS
8 enrollees, on average, are lower than for non-LIS enrollees,
9 and the difference has grown from about two percentage
10 points in 2007 to five percentage points in 2010. Multiple
11 factors, such as differences in health status and prescriber
12 behaviors, as well as financial incentives, likely
13 contribute to differences in GDRs among groups of
14 beneficiaries. Our recommendation last year attempts to
15 address the financial incentives for LIS enrollees while
16 being mindful of the clinical appropriateness.

17 One way to see how the use of generic drugs have
18 resulted in lower costs for the Part D program and its
19 enrollees is to look at average drug prices. Overall, Part
20 D drug prices based on the individual drug products -- that
21 is the red line at the top -- rose 23 percent between
22 January of 2006 and December of 2010. However, when the

1 generic substitution is taken into account -- that's the
2 yellow line at the bottom -- prices rose by only two percent
3 over the same period. Here, the shift in volume from brand
4 name drugs to their generic equivalents resulted in dramatic
5 differences. We see that with generic substitution, prices
6 remained mostly stable during this period. This chart also
7 suggests that prices for brand name drugs have been growing
8 rapidly over this period.

9 The last topic I'll discuss is related to Part D's
10 competitive design. Part D uses competing private plans to
11 deliver prescription drug benefits. Medicare's payments to
12 plans are based on bids submitted by plan sponsors, and
13 plans compete for enrollees based on their premiums,
14 formularies, quality of services, and network of pharmacies.
15 The idea was for competition among plans to provide strong
16 incentives for plan sponsors to manage drug use and keep the
17 spending growth in check. Part D enrollees choose a plan
18 that provides access to drugs they need at the premiums and
19 cost sharing they are willing to pay, and their willingness
20 to reevaluate their plan choices from time to time is
21 important in keeping plans' incentives for controlling costs
22 while providing attractive benefit packages.

1 One way to see whether Part D enrollees reevaluate
2 their plan choices from time to time is to look at whether
3 they are changing plans voluntarily, meaning that those
4 changes in plans are not due to factors such as a plan
5 exiting from a market or CMS's reassignment for plans that
6 lose their benchmark status. According to CMS's analysis,
7 during the first few years of the program, only about six
8 percent of non-LIS enrollees switched plans voluntarily each
9 year. This rate is similar to the rate of switching
10 observed among FEHBP enrollees. Analysis of more recent
11 data suggest that a larger share of enrollees are
12 voluntarily switching plans.

13 In 2010, nearly 14 percent of non-LIS enrollees
14 voluntarily switched plans. We found that younger
15 enrollees, who are ages between 65 and 69, were more likely
16 to switch plans, compared to older enrollees. We also found
17 that whites were more likely to switch plans than non-
18 whites. Most people who changed plans tended to choose the
19 same type of plans, with 90 percent of MA-PD enrollees
20 choosing another MA-PD and about 80 percent of PDP enrollees
21 choosing another PDP. The results were similar for 2011.

22 So to summarize, we found that beneficiaries

1 appear to have good access to prescription drugs. Plan
2 offerings remained stable between 2012 and 2013. We are
3 seeing an increase in use of tiered pharmacy networks. In
4 terms of costs, low-income subsidy continues to be the
5 single largest component of Part D spending, and reinsurance
6 continues to grow rapidly. An increase in use of generic
7 drugs have kept the Part D prices stable. And we are seeing
8 that more Part D enrollees may be voluntarily switching
9 plans than during the first few years of the Part D program.

10 That concludes my presentation.

11 MR. HACKBARTH: Okay. Thank you, Shinobu.

12 Jack, do you want to lead off.

13 DR. HOADLEY: Sure. Thanks, Shinobu. This is a
14 great analysis raising a lot of, I think, really important
15 issues and hitting a lot of the issues that I think are
16 really worth doing. Let me comment on four of the areas
17 that you talked about.

18 The first one you raised was the set of people,
19 the ten percent with no creditable coverage, and I think
20 it's really good that we're taking a look at that because
21 it's a real puzzle, I think, and it's clear from your data
22 that there's a subset of those that are voluntary, rational

1 choosers of having no coverage. We don't know how well
2 they've researched it, but certainly their drug use suggests
3 that it may be a perfectly sensible decision for them to
4 forego this coverage and that there are probably some others
5 where that's not the truth.

6 The one thing that I got to thinking about was
7 you're basing this obviously on the only available source of
8 data which we have right now, which is the MCBS, and if
9 there are some people that are really kind of missing out
10 and just kind of don't even really know Part D is there,
11 they may also be the kinds of people that a survey is going
12 to tend to miss. I sometimes call them the off-the-grid
13 types that are just not attentive to what's going on. I
14 don't know any way to get at that, but we should think about
15 that and whether there's part of that ten percent that just
16 aren't even showing up in the survey.

17 Also, continuing, and I think the way you
18 presented it kind of allows for this, but thinking about
19 where the distribution of those people is rather bimodal, I
20 mean, it really may be these two very different groups, the
21 rational choosers and the kind of missing the availability.

22 The second issue was the preferred pharmacy. I

1 think this is clearly a trend in the program and I think
2 plans probably -- they would say -- their term would be
3 they're innovating and trying to come up with a way to
4 target use, get better bargains through negotiating with
5 preferred pharmacies, and that's all fine. I think the
6 issues, and you allude to a number of these, are very real.
7 If people don't understand the choices they're getting into.
8 The fact that network adequacy can be based on the entire
9 network, not just on the preferred pharmacies means -- and I
10 know when I've looked at it, it does seem clear that people
11 who are picking these plans may be people for whom there's
12 no preferred pharmacy very close to them and they may or may
13 not understand that CMS has made some improvements in the
14 plan finder to help on that point.

15 But I think the fact that they do that, and yet
16 the copay calculation, they do actuarial equivalents, is
17 based on the preferred pharmacy rates. So we're saying, on
18 the one hand, network adequacy is based on all pharmacies,
19 but the actuarial equivalents for the copay structure you
20 design is only based on the preferred pharmacies, may be an
21 inconsistency there and something we should think about
22 whether there's a policy issue there.

1 The third one that I wanted to talk about was the
2 reinsurance, and you point out very clearly that that's the
3 growing piece of the program. And I think, also, and I know
4 you've looked at this in the past, as well, is the extent to
5 which reinsurance needs to be changed possibly in some way.
6 I mean, reinsurance means that a plan, when a particular
7 beneficiary is a high spender, over the catastrophic
8 threshold, 80 percent of that cost is being picked up by the
9 Federal Government, five percent by the enrollee, only 15
10 percent exposure by the plans. Is that enough exposure to
11 the plans to kind of get the incentives set the way we'd
12 like to see them? It was designed, in part, to make sure
13 plans were encouraged to enter the program. That's clearly
14 not an issue at this point.

15 Are we at a point where we ought to change that
16 ratio and reduce the amount of reinsurance? That doesn't
17 change the subsidy, because there's a direct trade-off
18 between the reinsurance and the direct plan payment, so
19 those all still add up to that 75, 74.5 percent Federal
20 subsidy. But thinking about how we might want to rejigger
21 that, I think, is something that we might want to take a
22 look at.

1 And then, last, on the plan switching, as you
2 know, we've talked about this. This is something I think is
3 very important and I'm doing some research on this, as well,
4 and so I'm really glad to start to see these kinds of
5 calculations made. The one caveat that I would put out
6 there is we're sort of relying on the six percent CMS
7 reported result as being kind of where things might have
8 been at the beginning and it may turn out that that's based
9 on other data sources and really isn't a good reflection of
10 what. So characterizing this as a trend towards more
11 switching over time may turn out not to be accurate if we
12 look at what's going on in the earlier years through the
13 kind of data.

14 And then the only other addendum I would put,
15 among things that you didn't mention in the presentation,
16 but you did in the paper, is the exception and appeals, and
17 I know there's some intent to look more at that, and I think
18 that's a really important area and I do encourage more of a
19 look at that area.

20 MR. GRADISON: Thank you. From a beneficiary's
21 point of view, I understand the excellent comparisons you've
22 given us with regard to preferred or non-preferred

1 pharmacies, but I don't believe you mentioned, nor do I
2 remember seeing any data, on where mail order fits into this
3 from a point of view of its availability or its pricing
4 attractiveness or unattractiveness as compared with the
5 pharmacies.

6 MS. SUZUKI: So we've looked at the utilization.
7 I don't actually have the percent of plans and the cost
8 sharing amounts that apply to mail order. But my
9 understanding is that there's a level playing field between
10 mail order and the retail pharmacy cost sharing so they
11 could not use a preferred cost sharing for mail order
12 pharmacies. That's one.

13 And when we look at the utilization, we have not
14 seen a lot of use of mail order pharmacies in general in
15 Part D. My recollection is, maybe in the single percentage
16 points.

17 MR. GRADISON: Thank you.

18 DR. COOMBS: I was interested in the bar graph
19 that actually has the proportion of low-income subsidy.
20 First of all, I'd like to say, a great report, and I saw
21 Jack in there as a reference. I was very impressed.

22 Is there some kind of projection, because this is

1 a big quagmire in terms of how you get costs under control
2 with this specific entity, which it doesn't sound like we
3 have no -- we don't have a strategy to kind of rein it in.
4 So is there some kind of projection as to where we're going
5 with the LIS portion of this?

6 DR. MARK MILLER: Could you give us another pass
7 at the question? I'm not sure I followed it.

8 DR. COOMBS: So if you had a projection
9 strategically of how big this component would be, what would
10 you do to kind of limit the impact of that in terms of --
11 because it seems like this is the -- you know, this is the
12 36 percent on the graph, and it seems to grow at a rate
13 that's in excess of any of the other components. And so if
14 we were to say five to ten years this would continue this
15 kind of growth, is there some kind of intervention that we
16 could have to control this piece?

17 DR. MARK MILLER: Okay. Unless Shinobu would
18 really like to take this question, I mean, just a couple of
19 quick things.

20 One thing we are going to put some focus on, as
21 Jack just said, the reinsurance is growing fairly fast, and
22 so we are going to look at that.

1 On the LIS, I would say no, I don't think we have
2 looked at this and said we think the projected component
3 should be a specific percent, a priori, as it were. But we
4 have seen some rapid growth here, and at least one of the
5 things we've focused on is the difference in the generic use
6 rates and have tried to propose some structural changes in
7 the benefit that might influence that. But I will say
8 overall, at least speaking for myself, I haven't thought
9 about, well, should this be a particular number, and I would
10 definitely defer to anyone else who wanted to comment on it.

11 MR. HACKBARTH: To what extent is that growth a
12 function of more people qualifying for the low-income
13 subsidy as opposed to faster rate of growth for each low-
14 income eligible?

15 MS. SUZUKI: So we looked up PMPM spending for
16 2007 to 2010, and in terms of gross spending, LIS enrollees,
17 their spending is growing much faster than non-LIS
18 enrollees. And --

19 MR. HACKBARTH: On a per enrollee basis?

20 MS. SUZUKI: On a per enrollee basis. So given
21 the LIS population itself hasn't grown very much since the
22 program began, I think a lot of it may be on the PMPM

1 portion.

2 MR. HACKBARTH: Okay. And then within that, one
3 portion that we have looked at is the higher use of brand-
4 name drugs among the LIS population.

5 MS. SUZUKI: Mm-hmm.

6 DR. COOMBS: So maybe something like what Bill was
7 saying in terms of being able to go outside the loop of cost
8 escalation, a mail-order arrangement might be something that
9 would get some targeted -- a lowering of the cost.

10 MR. HACKBARTH: Yeah. As Shinobu indicated in her
11 presentation, we did recommend a couple years ago that the
12 Secretary reward more strongly LIS enrollees for using
13 generic drugs as opposed to brand names.

14 DR. MARK MILLER: And one of the surprises there -
15 - and make sure I get this right, Shinobu -- was not so much
16 that they were using vastly different drugs that didn't have
17 generic substitutes, for many of the same drugs that the
18 non-LIS, they were just using brand-name versions of that.

19 I think I mangled that, but I hopefully got it.

20 MS. SUZUKI: I think that's correct. And another
21 thing I would point out is low-income cost-sharing subsidy
22 portion picks up the co-insurance or co-pays that people

1 face at the counter. So it's also a function of the prices
2 that are growing, too.

3 DR. COOMBS: So are there local things that might
4 be happening at the pharmacy in terms of preferential
5 prescription for, you know, things that might not be on the
6 formulary in certain places? Would that enter into this
7 equation in terms of costs per beneficiary going up out of
8 proportion to the other group?

9 DR. MARK MILLER: Why don't we get back to you
10 [off microphone]?

11 MS. SUZUKI: Yes.

12 DR. BAICKER: The chapter was chock full of really
13 interesting data that raised a lot of questions. I just
14 want to focus on different things.

15 One, on Slide 13, I think, I was very interested
16 in the price trends, and I have two questions about that.
17 One is I was not entirely clear from the chapter what data
18 we have on prices actually paid net of rebates versus before
19 rebates and how the price information that we're seeing here
20 reflects actual transaction prices versus pre-rebate prices
21 that may map very differently to net prices.

22 And the second question on this is when we look at

1 substitution, the very flat price trend, once substitution
2 to generics is taken into account, does that also take into
3 account substitution across branded drugs? Or is this
4 holding that constant and just looking at branded versus
5 generic? Because you would also imagine that as part of the
6 design, the competitive design where insurers are
7 negotiating with pharmaceutical manufacturers, they should
8 be -- people should be substituting towards the drugs on
9 formulary where the insurers have negotiated the better
10 prices. So those are two questions on this, and then I have
11 a separate question on reinsurance.

12 MS. SUZUKI: Okay. So on the prices that are
13 used, this is the prices that are paid at the retail
14 pharmacy. We have no rebate data. And on the calculation -
15 - so this is volume weighted. And so the way the top line -
16 - top red line, is at the individual NDC level, and the
17 bottom line is more of a chemical equivalent price, so
18 brand-generic combined. I guess brand-to-brand substitution
19 is reflected in both cases to the extent that the volume
20 weights account for that.

21 DR. BAICKER: So both of these are volume
22 weighted.

1 MS. SUZUKI: Mm-hmm.

2 DR. BAICKER: Okay. And then going back to the
3 rebate question, in the absence of line-item rebate data,
4 which I know doesn't exist, is there any sense of the
5 overall magnitude of rebates and how that's changing over
6 time? Because it would be good to know whether these trends
7 reflect anything real in the aggregate, even if not in the
8 detailed drug-by-drug level, or we just have no idea what
9 the net transaction prices are.

10 MS. SUZUKI: I think we have the aggregate --
11 trustees report aggregate rebate information, and I don't
12 have the exact number, so let me get back to you on that.

13 DR. BAICKER: I think that would be helpful in
14 understanding at least on the aggregate level how we should
15 decompose changes into prices versus volume.

16 And then going to the question of reinsurance, I
17 at least hadn't thought carefully until you pointed it out
18 in the chapter about the interaction between filling in the
19 doughnut hole and reinsurance costs. And I suspect that
20 that was not a very salient point in the debate about
21 thinking about filling in the doughnut hole is the extent to
22 which that falls on individuals versus insurers versus

1 manufacturers versus the program. And I wasn't entirely
2 clear about which of the manufacturers' rebates got
3 eventually passed through into reinsurance versus the change
4 in the generic co-payments in filling in that, got
5 eventually passed through into reinsurance. And I had been
6 thinking about this primarily from the patient's out-of-
7 pocket perspective. But that's clearly not the input into
8 the reinsurance component as you highlighted. So how do all
9 of those separate components of the filling in the doughnut
10 hole pass through into program costs for reinsurance?

11 MS. SUZUKI: So there are a couple things that go
12 in different directions. I think the big change is the 50
13 percent manufacturer discount essentially reducing by half
14 beneficiaries' out-of-pocket. But the manufacturer discount
15 portion actually counts towards your out-of-pocket limit, so
16 you pay less out-of-pocket and get to the catastrophic phase
17 more quickly.

18 But generics drugs are cheaper, on average, and
19 you do have some reduction in cost sharing also taking
20 place, so those were the two things. And then I think
21 during the ten-year phase-in of the -- or closing of the
22 hole, the threshold is lower, so that puts more people in

1 the catastrophic phase more quickly than they would have
2 otherwise.

3 DR. MARK MILLER: Shinobu aren't you glad you
4 wrote that e-mail?

5 [Laughter.]

6 DR. MARK MILLER: This [off microphone]
7 internally, but it does raise a question that I want to put
8 a marker down, at least with you and Jack and anybody else.
9 When we re-examined that reinsurance thing, it does, in fact
10 -- you know, Jack's point about the percentage of subsidy
11 remains the same, but it also raises a question of what will
12 the plans' behavior be? Will they pass that through to the
13 premium? And I think we have to think through some of this
14 transaction in thinking about it.

15 DR. REDBERG: Thanks for a very informative
16 report. I had sort of two comments, anecdotes, and a
17 question. One was on the 10 percent who don't have credible
18 -- I mean, my mom is 86, and she does not have any Part D
19 coverage, mainly because she's in good health and she's on
20 one generic prescription for hypertension, and yet at the
21 time we did the calculations, and there was no way it was
22 going to be worthwhile for her. And perhaps there are

1 others in that good health category even in the older group.

2 The other is related to the -- because it's
3 clearly a really important issue, the generics and brand
4 name, and there's a lot of potential for people to be
5 switched to generic drugs with no difference in quality and
6 much difference in cost. The cost differences are huge.
7 And we know, you know, there are a lot -- we have direct-to-
8 consumer advertising for drugs in the U.S., and most of the
9 direct-to-consumer advertising is, of course, for brand-name
10 drugs, and often when there are generics available, and very
11 similar. I would just note in the Choosing Wisely campaign
12 that the ABIM Foundation launched, which is about to launch,
13 I think, 17 more specialty societies, but the original
14 primary care top five that we published in the Archives of
15 Internal Medicine like a year and a half ago, one of the top
16 five -- and, actually, the one that had the biggest cost
17 implications -- was to use generic statins whenever
18 possible, which is almost always, instead of brand-name
19 statins.

20 And just a little plug again, but we just ran --
21 and I'll send it to you; that's what I just tried to do --
22 in the January 7th issue of JAMA Internal Medicine a series

1 of articles on why people are still using brand names
2 instead of generic drugs. Harlan Krumholz's group estimated
3 that at least \$20 billion are being spent on brand-name
4 drugs when there are clear generics available for a number
5 of different reasons, including brand names when the exact
6 drug is available in generic but the brand name is protected
7 because it's an (S) enantiomer of the generic version that's
8 out there, and they're all very highly marketed, and they
9 tend to be statins, proton pump inhibitors, and things like
10 that, that are common and direct-to-consumer advertised.

11 And I think there's also a misperception among
12 physicians. When my daughter had that eye injury and she
13 was on a bunch of eyedrops, we had this very confusing
14 evening in the pharmacy because her pressure was still high
15 so the fellow, the glaucoma fellow, had given us another
16 prescription, and the pharmacy refused to fill it because he
17 said we had it. And I said, "Well, she just gave it to us."
18 It turned out it was the brand name of the generic she was
19 already on, and so he called the glaucoma fellow, and she
20 said, "No. This one's much better." And it was the exact
21 same drug. And so I talked to some ophthalmology
22 colleagues, and they said it's a very common perception,

1 particularly among the younger doctors, and it is, he told
2 me, increased by the marketing of these that they tell them
3 brand names are better, and so there's no data.

4 So I think there's a lot of room, clearly some
5 outside of this Commission, that we can do in educating
6 doctors and patients and certainly tiering reimbursement to
7 incentivize that education that generics are equivalent to
8 brand name. We did not fill that brand-name prescription.

9 Now my question is on Slide 16. On the non-LIS
10 enrollees that voluntarily switched plans, do you know the
11 reasons? Is that generally because there's a drug not
12 available that they want? Or what is their usual reason for
13 switching plans?

14 MS. SUZUKI: So the analysis was done looking at
15 their enrollment patterns. It doesn't really get to why
16 people are switching. But I think in talking to SHIP
17 counselors we've heard that people sometimes find that their
18 premiums are going up, so they try to find a plan that has
19 lower premiums. Other cases are that their drugs were not
20 covered by their plan, so they were trying to find a plan
21 that would cover their drug. So I think it could be, you
22 know, varied.

1 We did in our preliminary analysis find that
2 people who do switch may be switching to maximize coverage,
3 so maybe they're taking a little more drugs after the
4 switch, for example.

5 DR. BAICKER: I don't know if you have the data to
6 replicate some of the outside research that suggests that
7 there's money on the table for the people who don't switch
8 and that the people who do switch are likely to pay less
9 out-of-pocket after the switch and that the magnitude is
10 enough to make it surprising that other people aren't
11 switching more.

12 DR. MARK MILLER: We talked a little bit about
13 this a little bit, too -- right -- and I'm trying to now
14 recover. We were talking among ourselves whether we could
15 focus in on whether the premium was lower after the switch.
16 She has raised the out-of-pocket overall --

17 DR. BAICKER: But yeah, premium plus out-of-
18 pocket, total.

19 DR. MARK MILLER: I caught what you said. Where
20 were we? Because we were talking about this I think
21 yesterday, or a couple days ago, I guess.

22 MS. SUZUKI: We've looked at out-of-pocket, and on

1 average, it tended to be lower for switchers afterwards
2 compared to non-switchers.

3 DR. HOADLEY: But there is some evidence from some
4 of the other literature that people will switch to, you
5 know, plans without deductibles or things that aren't
6 necessarily advantageous to their situation. So they're
7 swayed sometimes by factors that look good but don't
8 necessarily lower out-of-pocket costs. So my guess is
9 you'll see a mix on that variable.

10 DR. NERENZ: Just one question about the employer
11 role in this. On page 27 of the chapter, there's a statement
12 that employers no longer offering drug coverage to their
13 employees typically move Medicare-eligible members to Part
14 D, which would suggest sort of an up trend in the employer
15 contribution. But then on Slide 11, if you can go there,
16 you have an arrow in the lower right drawing our attention
17 to a decrease. So tell us a little more what this story is.
18 It looks like employers are ceasing to do two things:
19 either they're doing less direct drug coverage and also,
20 apparently, less input into Part D. And I'm just not sure
21 how to read the implications, including the question of if
22 that's true, then what happens next? Where do people go?

1 MS. SUZUKI: So the retiree drug subsidy that's
2 shown on the graph, the green part, is the payment from
3 Medicare to employers who provide drug subsidy, and the law
4 says Medicare will cover a portion of their spending on
5 providing this coverage to their retirees. And what I'm
6 saying in the text is that more employers are deciding not
7 to provide this retiree coverage, which reduces the number
8 of people we're paying subsidy for under this program.

9 DR. NERENZ: Okay, okay. All right. I'm sorry.
10 I perhaps misinterpreted. But then now the second question:
11 When that happens, then what happens next? Do those people
12 just pay more out-of-pocket? Or does it shift largely to
13 either the low-income subsidy or the direct subsidy? Do we
14 know about just where that -- who picks that up? Or do
15 people just then go out of Part D entirely?

16 MS. SUZUKI: So I don't have a complete analysis
17 to figure out where these people are ending up. Some of the
18 anecdotal evidence is that employers who are dropping the
19 coverage will move their retirees to Part D. So they enroll
20 in Part D plans, or the plan itself becomes a Part D plan.
21 So they're actually now covered by the direct subsidy, the
22 other portion of the spending, rather than the retiree drug

1 subsidy.

2 DR. MARK MILLER: At least one thing I would say
3 is I don't think either what we hear or if you kind of
4 connect the dots across a bunch of slides, we think these
5 people are moving to having no coverage. We think they're
6 moving to D. But when she said that, you had a reaction
7 like that something didn't make sense to you. So pick up
8 there. Does that not make sense?

9 DR. NERENZ: Well, I guess now I'm still --
10 because I -- the way I originally read the text I think is
11 consistent with the last thing you said. But then as you
12 offered the first response to my question, I thought we were
13 talking about a change within D, that people were in D and
14 now they're in D in a different way with a less employer
15 contribution. So I will confess that I'm still somewhat
16 confused about being out of D and into D versus being in D
17 with or without an employer contribution.

18 MS. SUZUKI: So maybe I --

19 MR. HACKBARTH: Let me just take a piece of it.
20 So when a person is covered by an employer plan and the
21 employer is receiving the employer subsidy on this graph, do
22 we consider that person to be in Part D or outside Part D?

1 I think that's part of --

2 DR. NERENZ: Right, because I just assumed that
3 all these graphics and everything were about D.

4 MR. HACKBARTH: Were just different varieties of
5 Part D, yeah.

6 DR. HOADLEY: Yeah. I mean, that's part of the
7 complication. I mean, they're in Part D in the sense that
8 the subsidy operates as part of Part D. And when the
9 actuary does the global calculations, that's counted as Part
10 D. But when we get inside the part of Part D we can look at
11 as Part D plans, they're not in there. But one of the
12 things that happens is when these people -- when these
13 employers stop providing their direct coverage, they may
14 subsidize people going into a Part D plan, they're going to
15 move --

16 MR. HACKBARTH: Some other variety, yeah.

17 DR. HOADLEY: -- parts of the bars on our graphs,
18 but the employer may still say active in the program.

19 DR. MARK MILLER: I think using his framework just
20 for a second [off microphone] move from one kind of Part D
21 to a different kind of Part D.

22 MR. HACKBARTH: And we've got different data. So

1 if they're in the employer subsidy piece of Part D, what I
2 hear Jack saying is that's a little bit of a data hole for
3 us; whereas, if they move into a Part D plan that's
4 receiving a direct subsidy, we've got a different set of
5 data sources.

6 DR. NERENZ: Thank you. I was confused, because
7 it's confusing, and now I'm less confused.

8 [Laughter.]

9 DR. NERENZ: Then the only last point, the green-
10 shaded part of this, does that include both of these
11 flavors, let's call it, of employer subsidy, either direct
12 or to people who are in a Part D plan?

13 MS. SUZUKI: So once they move into a Part D plan,
14 then they're in the gray part, the direct subsidy part.

15 MR. HACKBARTH: And they would be there -- even if
16 the employer is helping to subsidize that, they would still
17 be counted as part of the direct subsidy pool.

18 MS. SUZUKI: Right.

19 DR. NERENZ: All right. Okay. I think I've got
20 it.

21 DR. MARK MILLER: Just another [off microphone]
22 may be whether the dollar travels to a plan or whether the

1 dollar travels to an employer. Does that help you at all?

2 DR. NERENZ: No, no, this is complicated. I'm
3 just trying to track it.

4 MR. BUTLER: So this, I think, on balance people
5 would say a pretty popular program that has worked maybe
6 better than people thought, although it's expensive.

7 Now, having said that, I'd try to remind ourselves
8 what is our legislatively mandated role here. We obviously
9 are required by legislation to comment on updates for the
10 fee-for-service silos that we just did. We also respond to
11 specific congressionally mandated reports like ambulance.

12 Here we're giving a status report. Is this
13 because we are required to give an annual, quote, status
14 report? Or is --

15 DR. MARK MILLER: I don't have the legislative
16 language in front of me. I went through this a few years
17 ago. The expectation of the legislative language is that we
18 report on this, and my recollection -- and I may not have
19 the language exactly right -- make recommendations as
20 appropriate. And so we aren't -- because there's no
21 administered update, we don't make an update recommendation.
22 But, for example, last year we made recommendations on LIS

1 on cost sharing.

2 MR. HACKBARTH: Yes, so think of it as sort of
3 analogous to MA, and so we don't make update recommendations
4 because of the pricing mechanism used, but we make other
5 types of policy recommendations.

6 MR. BUTLER: And that's kind of fluid or up to us
7 to some extent how boldly we want to take on recommendations
8 which more typically show up in the June rather than the
9 March report, right?

10 DR. MARK MILLER: Except that if, again -- and I
11 haven't looked at the legislative language recently. I am
12 pretty sure we are asked to report on this in the March
13 report, which is why we do this and do it in this particular
14 way.

15 MR. BUTLER: Okay. So what strikes me at the end
16 of the second day here is, you know, this is our first -- I
17 think the first discussion of drugs, Part D, this year. Is
18 that right? You know, for a \$60 billion program that --
19 it's an interesting one because at four prescriptions per
20 month, it is the most broadly, widely used Medicare benefit
21 there is, just in terms of number and encounters. And it's
22 interesting how much time we spend on talking about

1 integrating the silos and across post-acute and things like
2 that, and the use, the under- and overuse of drugs is so
3 integral to all this, everything from, you know, readmission
4 rates are affected by drugs and yet we don't -- I know staff
5 have limited time, but we really don't look at this as, you
6 know, a key factor and impacting the entire continuum.

7 MR. HACKBARTH: One of the differences, of course,
8 is here the choice was made to delegate responsibility for
9 management of the drugs and the pricing and the formularies
10 to private entities as opposed to doing that through the
11 government insurance program. So we've got a large number
12 of private people who have assumed both that responsibility
13 and the associated financial risk.

14 MR. BUTLER: Right. I understand that. But then
15 we also should be thinking about -- I wonder what the
16 outcomes are for the -- for not just the financial risk
17 they're assuming, but, you know, are some of these doing a
18 better job in impacting other aspects of the health outcomes
19 of -- it's a very complicated thing to do. But what I find
20 is both the amount of time we spend on it, given the impact
21 it has on health, is pretty limited. And let me just say a
22 couple other things, and then I'll let you respond to the

1 overall issue.

2 It also is frustrating that, as you look at the --
3 as a source of savings, it looks ripe. Yet it is not a --
4 you know, in that SGR list of offsets, which we haven't
5 vetted, the single biggest opportunity was in drug. Yet,
6 you know, you sit there and you say what is our
7 responsibility in, say, moving that one ahead as an
8 opportunity because it's not in our legislative mandate, yet
9 it is something that's just begging to be, you know,
10 addressed. It just seems we can't quite figure out how this
11 integrates maybe with some of the other activity that we've
12 discussed and formally acted upon -- in my own mind, anyway.

13 MR. HACKBARTH: I don't see it as our legislative
14 mandate is constrained on Part D or on Medicare Advantage in
15 particular. I do think there is a fundamental difference in
16 terms of what I said earlier, that we have private entities
17 that have assumed responsibility and financial risk for
18 managing; whereas, other parts of the Medicare program --
19 it's only the government insurer that's focused on that, and
20 so I think it's maybe appropriate for us to focus somewhat
21 more heavily on those issues.

22 But I think we've got a broad license to recommend

1 changes in Part D that we think can further enhance the
2 competition, save money, as with our recommendation on the
3 LIS cost sharing, or potentially, you know, changing the
4 rebates for the dual eligibles. I don't feel our mandate is
5 constrained.

6 DR. MARK MILLER: And what I would add is a couple
7 things. One, I've been trying to get Shinobu to work
8 through weekends now for, you know, a long period of time,
9 and so I appreciate this comment --

10 [Laughter.]

11 DR. MARK MILLER: -- because I can bring some
12 additional pressure to her. But, also, I've been sitting
13 here looking ahead to March and April, and we have on the
14 March agenda some research that we've had going in the
15 background on the effect of drugs on A/B, you know, so kind
16 of the connection, and our expectation is to bring that
17 forward in March, I believe. I don't always like to promise
18 that, but that's on our -- so we have been thinking about
19 this a bit.

20 I think the reinsurance point does kind of get at,
21 hmm, maybe the risk is not spread fairly and we should be
22 revisiting it and maybe an opportunity.

1 And then to your point on the rebates, you're
2 right about that. It's a bit hard to unpack and come at it
3 because we're not able to get -- that's proprietary data.
4 It doesn't break down to the individual drugs. But it
5 doesn't mean we shouldn't be paying attention to it. I
6 think you're right about that.

7 MR. BUTLER: I understand -- last comment -- the
8 risk being passed along to these plans, and so it does maybe
9 put pressure on drug companies. And I have a lot of
10 admiration for drug companies, but it's one of the few
11 sectors that just has this -- you talk about fee-for-service
12 incentives and the more the better. It is so embedded in
13 their business model and still present in our hallways that
14 it just like -- you know, how do you get everybody's skin in
15 the game working in the same direction? There's a lot of
16 momentum against that still in this particular site and
17 services.

18 MR. HACKBARTH: As always, Peter, I really welcome
19 the way you think about things. You step back and look at
20 the bigger picture, and let me use that as the platform for
21 raising a question.

22 So back in the very early stages of Part D, in

1 fact, even before the legislation, one of the policy
2 questions that sometimes was discussed is what will be the
3 effect of having two separate insurance pockets for drug
4 coverage versus medical services in separate Part D plans as
5 opposed to Medicare Advantage where you integrate both the
6 drug coverage and the medical coverage. And thinking about
7 it just in an abstract way, you might wonder whether the
8 incentives are right.

9 If you're running a Part D plan, you want to keep
10 the drug costs low, and you may make choices to keep the
11 drug costs low even if by raising drug costs you could have
12 reduced medical costs. You're not worried about medical
13 costs. You don't have financial responsibility for those.

14 In MA, the two responsibilities are integrated,
15 and so the incentives are right to substitute drug spending
16 for medical spending with separate insurance pools. They
17 are not necessarily correct. Now we have a number of years
18 of experience with Part D. Do the data allow us to shed any
19 light on whether that fear was justified or not? Can we
20 look at MA-PD spending patterns compared to free-standing
21 plans' spending patterns and see whether those distorted
22 incentives are coming into play.

1 MS. SUZUKI: And I would say that's a little
2 difficult to look at at this point without claims for Part
3 C's medical use. We do see some differences in patterns of
4 drug use between MA-PDs and PDPs. For example, we often
5 mention the generic use rate, even for a given therapeutic
6 class. Oftentimes MA-PD plans tend to -- or MA-PD enrollees
7 tend to use more generics compared to PDP enrollees. There
8 may be some differences in the classes of drugs that are
9 used, but it is difficult to distinguish between whether
10 that's a clinically appropriate difference because of the
11 differences in health status or not. Those are sort of
12 typical things.

13 DR. CHERNEW: I think this conversation is going
14 in the exact right way, so I'm going to try and say
15 something in responding to this discussion and then a few
16 things that I otherwise would have said.

17 We've been looking at this a little bit, and I do
18 think there are some differences between MA-PD and PDP
19 formularies, so you can look at the formularies. One thing
20 to understand, there's a lot of companies have both MA-PD
21 and PDP plans, and they will sometimes use the same basic
22 formularies across the different ones. So my

1 characterization is I think there are differences. I don't
2 think the differences are so enormous.

3 I think it is useful to note that the CBO recently
4 changed their assumptions about Part D spending to a credit
5 and offset, so greater Part D spending or, more correctly,
6 greater drug spending would be given some offset in the non-
7 drug area. But it's not one for one. You still spend more
8 money. You just don't spend as much more because of the
9 extra drugs.

10 I do think this use of drugs is important because
11 often this whole discussion is done as if it's all a cost,
12 where a lot of times there is a lot of quality for many of
13 these drugs. Some of them there's a gain clearly because of
14 financial savings -- again, not 100 percent offset, but you
15 could reduce hospitalizations. But, frankly, it's good not
16 to have a heart attack apart from going to the hospital
17 because you had a heart attack. So --

18 DR. MARK MILLER: I'm sorry. What was that? [off
19 microphone]

20 DR. CHERNEW: It's good not to have a heart
21 attack. I don't know if I said that loud enough for the
22 mic. That's the one quote I want.

1 MR. HACKBARTH: It's a bold statement [off
2 microphone].

3 DR. CHERNEW: Yeah, exactly. It's a bold,
4 politically complicated thing. We should have fewer heart
5 attacks. But we should have fewer heart attacks even if we
6 didn't save a lot of money because having fewer heart
7 attacks, it's a good thing not to have fewer heart attacks.
8 And so a lot of these drugs do very good clinical things,
9 and a lot of the discussion, though, recognizes -- and many
10 of these discussions is -- that said, we don't always
11 purchase them in the most efficient way for a bunch of
12 reasons. I take the presentation -- and maybe I didn't read
13 the tone right or didn't hear the presentation right -- as
14 saying that for the most part, the Part D program is pretty
15 successful in this delegation to private firms. There's a
16 lot of substitution that they do for the generics. The
17 prices when you do the appropriate generic substitutions are
18 relatively stable. Costs aren't soaring. Whether that's
19 due to the structure of the program or the, you know,
20 expiration of patents is a separate controversial thing.

21 There's not a lot of switching, which I don't at
22 the face of it take as a bad sign. I mean, in a perfectly

1 competitive market, you could have everybody choosing and
2 being happy with their choice. That said, I think there is
3 some growing evidence that people don't make the right
4 choices. They choose plans that are too expensive for them
5 relative to the drugs that they're using or would expect to
6 use.

7 So I think that there are a lot of interesting
8 questions about how people choose. My general sense is that
9 most -- that the program is basically working well, that
10 health care -- that spending growth on drugs is slower than
11 almost all forecasting. The CBO is lowering their
12 projections of drug spending. OACT is lowering their
13 projections of drug spending over time. There's a lot of
14 evidence that the drugs are doing good things both
15 clinically and non-clinically. But within that general
16 positive view, there's a lot of areas of serious concern
17 about people buying drugs inefficiently, joining plans that
18 were inefficient, subsidies that discourage efficient
19 purchasing of various things.

20 So I do think there's a lot of work we can do, but
21 generally I think it's within the construct of a basic
22 program that is relatively well functioning.

1 I don't know if that's your tone, but that was the
2 tone that I took from the chapter and from the presentation.
3 So if that's the wrong tone, that would be good to know.

4 MR. HACKBARTH: I think your tone is a reasonable
5 one. I think it is generally a successful program, but
6 still lots of issues to be addressed.

7 Let me just add one more to that while I'm
8 thinking of it, and then we need to complete the rest of the
9 round.

10 I remember back in the early years of the program
11 when John Bertko from Humana was a member of the Commission
12 and an ardent proponent of Part D. John used to say one of
13 his concerns for the future was the ability of the plans to
14 negotiate about sole-source drugs, the price of sole-source
15 drugs. And if sole-source drugs, the price of them grew
16 rapidly and the utilization of them grew for clinical
17 reasons, that that could be a real challenge. If there's
18 any way that we can disaggregate data and bring information
19 to bear on that question, I think that would also be useful.

20 MS. SUZUKI: So --

21 MR. HACKBARTH: Why don't you go ahead, Shinobu,
22 and then let Rita --

1 MS. SUZUKI: Last year when we looked at the high-
2 cost population, we found that the majority of them had high
3 spending because they were using just lots of drugs, rather
4 than the high-cost biologics and those kinds of things.
5 That's from 2009 data. So we can continue to monitor this
6 trend to see whether the single-source drugs are driving the
7 trend.

8 DR. REDBERG: I just wanted to comment that, of
9 course, it is good not to have a heart attack, and it's a
10 brilliant --

11 DR. CHERNEW: [off microphone].

12 [Laughter.]

13 DR. REDBERG: We never covered that in my
14 cardiology training.

15 [Laughter.]

16 DR. REDBERG: But I'm learning a lot. But that
17 there are also -- and some drugs certainly can avoid
18 hospitalizations. But as Shinobu just mentioned, there's
19 just an increased number of drugs in general, and a lot of
20 them are actually bad for you and are causing a lot of
21 problems. And we know in our seniors, you know, people are
22 on many more drugs on average than they were 10, 15 years

1 ago, and maybe if you just look at the last few years,
2 you're not going to see differences.

3 We published a study about a year ago on older
4 people where they just arbitrarily stopped five drugs in
5 each of these patients in a randomized trial, and the group
6 that had their drugs arbitrarily stopped did better and
7 actually lived longer than the group of older people that
8 did not. I mean, we know that there are a lot more
9 interactions and adverse effects when people are on more
10 than five drugs, and lots of our Medicare beneficiaries are
11 now on more than five drugs. And so while certainly some of
12 these drugs are beneficial, make people feel better and
13 avoid hospitalizations, a lot of them are also doing the
14 opposite, and that we really could be doing better.

15 DR. CHERNEW: That's almost an A/B medical primary
16 care, primary medical home kind of question as opposed to a
17 Part D. In other words, the drugs are being prescribed by
18 somebody.

19 MR. HACKBARTH: Okay. We are raising some
20 interesting issues, but we are running behind so we need to
21 move ahead and get through our final round.

22 DR. DEAN: I would certainly just reinforce what

1 Rita just said about the number of drugs has escalated, and
2 the dilemma from a primary care physician's point of view is
3 that, as patients move around from doctor to doctor, each
4 one adds a drug, they come back to me and very often I don't
5 know exactly why that was started. I really don't think it
6 probably is necessary. On the other hand, I'm very uneasy
7 about stopping it because I -- and so the indications for
8 stopping drugs are very difficult sometimes. You know, it's
9 beyond the scope of this discussion, but it's an important
10 issue.

11 I guess I would just raise one other point that
12 Jack mentioned, the preferred pharmacies, and I think I've
13 mentioned this before, that we do need to keep the pressure
14 on the insurance companies because, you know, we've had
15 companies come into our area and sell policies, and then we
16 find -- or then the beneficiary finds out they don't have
17 any approved pharmacy, and the nearest approved pharmacy is
18 50 miles away, and it's happened a lot. And, you know,
19 amazingly, people in my area put up with that. I don't
20 think they should, but they do. So I think just trying to
21 make sure that there's fair marketing is important.

22 DR. HALL: Shinobu, could you just look at page 13

1 again, the graph of the use of generics. Just the rising
2 trajectory in the red line, is that largely just biologics
3 that are making that go up? The use of biologics, which are
4 more expensive and not generic?

5 MS. SUZUKI: I wouldn't say it's primarily
6 biologics, given that it's volume-weighted. So the
7 utilization also drives how much of the weight is put on.
8 But they do grow much -- some of the biologics do grow much
9 faster than this 23 percent. But other brand name drugs
10 also have grown.

11 DR. HALL: I mean, the time course from 2006 going
12 up is just -- correlates perfectly with the introduction of
13 a lot of generics -- or biologics that are now being touted
14 for a lot of chronic illnesses of older adults. And --
15 pardon?

16 DR. BAICKER: [Off microphone.]

17 DR. HALL: Prices. Oh, I see. That's prices. So
18 that would -- but if there were more biologics being used,
19 it would come in there.

20 Didn't we also talk about, at one of our previous
21 meetings, that among either high-cost recipients or -- I'm
22 not sure what the context was -- that there was a tendency

1 to use brand names rather than generics? What population
2 specifically was that?

3 MS. SUZUKI: So we looked at people enter into the
4 catastrophic phase, high-cost beneficiaries, which the
5 majority of them were low-income subsidy recipients.

6 DR. HALL: Right.

7 MS. SUZUKI: And when we looked at their drug
8 utilization, they tended to use more brands compared to non-
9 LIS enrollees.

10 DR. HALL: Right, and one of the notions there was
11 that they're probably not making that choice personally,
12 that that's a choice being made somewhere in the delivery
13 system for them.

14 MS. SUZUKI: And it could be -- the prescribing
15 behavior, it could be their health status.

16 DR. HALL: Right.

17 MS. SUZUKI: When we talk to beneficiaries, among
18 non-LIS enrollees, we often heard how they've asked their
19 physicians to switch their prescriptions to generics to
20 lower their cost sharing, and so there is a role for
21 beneficiaries to play, too, as well as for other players.

22 DR. HALL: Okay. Thank you.

1 MS. UCCELLO: Just a couple of things. Like Kate,
2 I am really interested in understanding more about these
3 switchers and whether the switchers are choosing the best
4 way, the best plan for them, and if the non-switchers are
5 also correct in non-switching, and understanding more about
6 what part of the plan components are driving their
7 decisions. Are they over-emphasizing premiums? Are they
8 incorporating not just premiums but also the cost sharing
9 and also the benefits that are covered? So thinking through
10 all of those things.

11 And I would also suggest that we look at this not
12 only for Part D, but also for MA plans, especially as we
13 move forward on looking at competitively priced
14 contributions -- CPC. I think that's important, and I would
15 expect a little difference between how well people do under
16 Part D choosing as opposed to MA plans, because Part D
17 drugs, drugs in general, are going to be probably more
18 predictable than medical care for people. So I think
19 looking at both of those could be good.

20 As an actuary, I have to also note that if
21 everybody chooses perfectly, if all beneficiaries are
22 choosing the best plan for them, that's going to be raising

1 the costs for all the plans. That doesn't mean I don't
2 think people should be choosing appropriately. I want that
3 on the record. I want people choosing appropriately. But I
4 think this just illustrates how do we strike the right
5 balance between plan choice, flexibility, and
6 standardization and costs and how all of those are
7 interrelated. I think we just need to remind ourselves of
8 that.

9 Also, in terms of Jack's -- I think made a good
10 point about how network adequacy may be determined
11 differently than actuarial equivalents, and I'll just say
12 that we've had to think about this, as well, for actuarial
13 value under the ACA medal tier plans and how to incorporate
14 tiered networks into that. And I would be happy to,
15 offline, talk to you more about that, if this is something
16 you want to pursue.

17 DR. NAYLOR: Great report. Just three brief
18 comments.

19 One is to build on earlier conversations about,
20 and I don't know if it's here or if it's elsewhere, but the
21 context for medications and what we're witnessing in terms
22 of use of medications for Medicare beneficiaries. We're

1 witnessing in our studies reduced costs, more use of
2 generic, but many, many more drugs. And so I think that
3 trying to place this and its impact on A, B, and D would be
4 really helpful.

5 On the issue -- and you've done this. You
6 throughout have talked about the effects of the Affordable
7 Care Act, but I'm just wondering if there might be even a
8 chart that would talk -- summarize those provisions and
9 potential impact on Part D going forward, so as we expect
10 these changes and continued growth of reinsurance or
11 employers, et cetera.

12 And, finally, the quality section. It's good to
13 see that in 2013, we're going to place more attention on
14 medication safety and on appropriate use of medications and
15 interactions and side effects, et cetera, but it's hard for
16 me to know and understand how 18 CMS measures align with 49
17 MA measures in this star system. I wasn't quite clear how
18 it all gives you a robust assessment. So I don't know if it
19 does give us a robust assessment of key quality indicators.
20 And certainly, continuing to monitor what's happening in
21 different groups, especially low-income, in terms of quality
22 performance, I think, is important. So thank you.

1 MR. GEORGE MILLER: Yeah. Excellent report, and I
2 enjoyed both the context of the chapter and certainly the
3 discussion around the table.

4 I, too, like Mary just indicated, would love to
5 just see the impact on A, B, and D, just from a policy
6 standpoint.

7 I want to reflect on what Rita said, and the part
8 about her daughter, that she is a cardiologist and
9 physician. She asks questions. She had to push that issue
10 even further to get the right decision, and I'm concerned
11 about a large segment of the population may not have that
12 knowledge base, first of all, to ask those questions, and
13 then, secondly, have the fortitude to keep asking to get the
14 right decision, and what impact that may have.

15 And then Tom brought a very interesting point up
16 about the distance, especially in the rural areas, from a
17 preferred provider to not-preferred. So on Slide 8, do we
18 know, or have we done a study to know the location of and
19 distances from preferred providers to communities,
20 particularly in the rural communities, to see if that is a
21 benefit -- or a hindrance, I should say, if they're not
22 located -- have we looked at that type of distribution and

1 segregation? I guess "segregation" is not the correct word,
2 but stratification is the best word. Yeah.

3 MS. SUZUKI: So we have not looked at the data to
4 see whether this preferred/non-preferred has had an effect
5 on, say, rural areas.

6 MR. GEORGE MILLER: Right. Right.

7 MS. SUZUKI: And we will continue to monitor this,
8 and as more people are affected, I think we'll look more
9 closely into this.

10 DR. MARK MILLER: Shinobu, I don't know, a year,
11 two years ago, didn't we also have a --

12 MS. SUZUKI: Right. When we looked at the
13 pharmacy access, we did not find that rural areas had less
14 access to prescription drugs, generally, but that was --

15 MR. GEORGE MILLER: But I guess it would depend on
16 how you defined access. I mean, if it's 50 miles away, as
17 Tom's example, that's access, but is that access?

18 DR. MARK MILLER: Just a couple of things.
19 There's what we did in the rural report. But then, before
20 that, wasn't there a contractor report about how the
21 networks are kind of working out in --

22 MS. SUZUKI: So I have to get back to you on that.

1 DR. MARK MILLER: I didn't mean to put you on the
2 line.

3 MR. GEORGE MILLER: You'll be working weekends.

4 DR. MARK MILLER: Yeah. We'll come back to you on
5 this point. We did look at this a little bit. But you were
6 still correct that there's a new wrinkle developing out
7 there and we need to stay focused on that.

8 MS. SUZUKI: Right. Our study, I believe, was
9 before this trend had begun.

10 MR. GEORGE MILLER: Okay. Thank you.

11 MR. KUHN: Two questions or points to raise here.
12 One has to do, like Jack and Kate, I was interested in the
13 reinsurance issue. I think, like anybody, I was struck that
14 it went up 24 percent between 2010 and 2011, so I think that
15 ought to get people's attention.

16 They both explored some of the notions there, but
17 the one that struck me, as a little bit more refinement, was
18 the new incentives now for this decade as we move to get rid
19 of the doughnut hole or the benefit gap. There are a number
20 of incentives to not only get people to enter that gap
21 sooner, but to accelerate them through and get them out so
22 that they can take advantage of the reinsurance opportunity.

1 The attachment point language that's in the ACA and some
2 other things accelerate that.

3 But the one issue that I'm really interested in is
4 this 50 percent discount now on brand name drugs that are
5 there. And so the discount as well as the drug price count
6 towards the out-of-pocket, so again, part of the accelerator
7 that's through there. So are we starting to see now that if
8 people are choosing brand name drugs when they go in the gap
9 in order to accelerate them through, are they staying on
10 those drugs when they come out or are they substituting back
11 to the generics, and is that impacting what's going on, as
12 well? And if not, over a decade, we could see some real
13 behavior change in terms of movement of people starting on
14 generics, then in the brand names, and then staying on brand
15 names.

16 So I was intrigued by Jack's point about plan
17 exposure and would that be an incentive, then, for the plans
18 to move people back to the generic, or are there other
19 incentives, if we think that that phenomena is really
20 occurring. And so that's just something I'm really
21 interested in, seeing if the data shows that, and we can
22 understand, are we starting on generics, moving to brand

1 name to get through the gap, and then what happens after
2 that. It would be interesting to see.

3 The other thing I was kind of struck by the
4 information was the fact that 77 percent of the LIS
5 beneficiaries are in PDP plans only and not in MA-PDP, and
6 I'm just struck by that because I think that's a population
7 that would do very well by the care coordination that's out
8 there.

9 And so kind of a little bit like Craig talked
10 about yesterday, and I really liked his conversation about
11 how do we ultimately get the data to begin to compare fee-
12 for-service with MA in the future, is there a way we can
13 start to collect data that kind of begins to look at the
14 beneficiary cost side of all this? So if you think about
15 those that are in fee-for-service, you have the fee-for-
16 service cost. Many of them are buying Medigap policies.
17 They've got the Part B premium. And we all know that that
18 first-dollar coverage is probably incenting towards higher
19 utilization in terms of services out there. Is there a way
20 to look at the beneficiary cost that those that chose MA or
21 an MA-PDP compared to what goes on on the other side if they
22 do a la carte and they do fee-for-service and Medigap and

1 then a PDP plan and try to get some of that evidence and
2 some of that information so we can have a better informed
3 consumer as part of the process, as well?

4 Just something that I was struck when I saw that
5 LIS data, because that just seems just so peculiar. That's
6 a population that would benefit more from that care
7 coordination and they're not reaping the full benefits of
8 the program.

9 DR. SAMITT: So, thanks for a great report. You
10 have a very hard job. It was great to see more detail.

11 So I want to jump right to where Peter was,
12 because I agree that I don't quite feel we're spending
13 enough time on discussion about drugs. I think in the world
14 of value, one of the first places we look for opportunities
15 is in drug expenditures because the opportunity is so vast.

16 As I read the chapter and heard the presentation
17 today, I am really struck by, even in the setting of
18 transfer of risk, the degree of tremendous opportunity that
19 still exists. I mean, to think about \$5 billion related to
20 opportunities in generic substitutions alone, not to mention
21 all the things that other Commissioners have referenced
22 regarding polypharmacy or step therapy or other things that

1 are really in the prescriber's control, I just -- I wonder,
2 the degree to which these Part D plans are an arm's length -
3 - have an arm's-length relationship from the providers. You
4 know, I would have imagined, given the transfer of risk,
5 that they would focus much more on working with the
6 physicians, working with others to really influence a very
7 dramatic change in prescribing.

8 So I think there's a wealth of things that we
9 should be talking about here and really figuring out how we
10 further improve the quality of and reduce the cost of the
11 pharmacy benefit, because I sent that even though the Part D
12 program is very effective, that we've only just scratched
13 the surface.

14 MR. HACKBARTH: One of the issues that the idea
15 that it would make sense for the plans, the Part D plans, to
16 work more closely with clinicians really makes a lot of
17 sense to me. And I try to connect that with what I've heard
18 so often from doctors. One of their frustrations is dealing
19 with multiple plans, each of which has its own distinctive
20 formulary, and the complexity involved in that clinician-
21 plan interaction. And if there's some way that we could
22 help facilitate those interactions, make them less

1 complicated, there might be more opportunity for that
2 collaboration.

3 DR. SAMITT: I think they are complicated but my
4 perspective are the themes are still the same. So if our
5 focus is on generic prescribing, our focus is on
6 polypharmacy, our focus is on step therapy, it really
7 doesn't matter so much what the formulary looks like. The
8 principles are still the same.

9 I think the other thing is with the continued
10 evolution of electronic health records and the automation of
11 even programming formularies into EHRs for some of the
12 physicians, it makes some of the complexity a bit diminished
13 in the world of technology.

14 So I would hope that we can overcome those
15 barriers.

16 DR. NAYLOR: I think a related concept here is the
17 investment of the Medicare program, \$62 billion in Part D,
18 and what we know about the lack of adherence to meds even
19 when we make those expenditures. It's extraordinary.

20 And so to the extent that we could think in ways
21 that Peter and Craig have talked about, which is the kinds
22 of policies that also promote what we know about getting

1 people engaged to want to take these meds to prevent that
2 heart attack is really critical.

3 MR. HACKBARTH: Okay, Shinobu, you gave us lots of
4 food for thought and we gave you lots of work to do. That's
5 a fair trade.

6 So we are now finished our sessions. We will have
7 a brief public comment period.

8 Let me just say a word about the ground rules.
9 Please begin by introducing yourself and your organization
10 and limit your comments to two minutes, please. When the
11 red light comes back on, that signifies the end of your
12 time.

13 Thank you.

14 MS. CARLSON: I'll be brief.

15 I'm Eileen Carlson from the American Nurses
16 Association.

17 Many patients and families are thrown into crisis
18 mode when a triggering acute care event or episode happens,
19 regardless of the patient's previous underlying condition,
20 because as a culture we don't deal very well with death.

21 And I think MedPAC, the Commission, could really
22 do a great service to patients by encouraging or developing

1 policies that streamline the choices, provide educational
2 materials, et cetera. I mean, a lot of families have --
3 they've got emotional issues. There's a ticking clock.
4 It's sort of like being thrown in Grand Central Station and
5 you have five minutes to get to your train and buy your
6 ticket.

7 Providers are not encouraged or really paid for
8 appropriate end-of-life counseling. And sometimes there are
9 issues as to which providers are the appropriate one to do
10 that counseling in and of itself.

11 So anything that MedPAC can do to incentivize and
12 encourage appropriate choices and really engage the patients
13 and provide educational resources would be wonderful.

14 And then, with respect to Part D, the non-
15 integration between the delivery of care and the actual
16 drugs is so strange in some circumstances that -- as you may
17 or may not be aware -- some patients actually have to go to
18 a pharmacy, purchase a vaccine, and bring it to their
19 provider which is not a good thing, as you can imagine.

20 MR. HACKBARTH: Okay, we're adjourned.

21 [Whereupon, at 11:46 a.m., the meeting was
22 adjourned.]