MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, March 8, 2012
9:45 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
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WILLIAM J. HALL, MD
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GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD

AGENDA PAGE

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

MR. HACKBARTH: Good morning. Welcome to the people in the audience. We have, I think, a very interesting and important set of topics today. We are going to lead off with two subjects of longstanding interest to the Commission -- bundling post-acute care services and care coordination -- and then after lunch we will turn to three mandated reports from the Congress on outpatient therapy, Medicare benefit design -- actually, that one is not a mandated report, I guess -- and then rural beneficiary report, rural health care report. And when we talk about the benefit design issue, we will also discuss some draft recommendations for the Congress.

So as I say, we lead off with bundling for post-acute care services and, Craig, lead off.

MR. LISK: All right. Good morning. Carol and I will be talking about bundling today with a focus on bundling of post-acute care services. We will discuss many of the issues that need to be considered in developing and designing a bundled payment that includes post-acute care services.

So why are we examining bundling again? Well, the

policy world has moved forward since the Commission made its recommendations on bundling in 2008 where we recommended that the Secretary create a voluntary pilot program to test the feasibility of bundling around hospitalization episodes.

For example, PPACA included a provision for a couple of different bundling pilots, and the CMS Innovation Center has just launched its own effort to pilot test different bundling models which we will discuss a little later in this presentation.

The private sector has also had some bundling efforts such as the Geisinger health system's ProvenCare model and the PROMETHEUS model which sets budgets for episodes of care.

In addition, the results of the post-acute care demonstration and its use of the CARE Tool have finally been released, and this may provide a major step forward in helping to risk adjust for patient PAC service needs which is important if we want to bundle these services.

Bundling also provides an another strategy apart from ACOs to help manage spending while increasing the value of care.

So what do we mean by bundling? Well, in bundling

we provide a single payment for an array of services. Bundles are, in fact, used under current Medicare fee-for service system where we pay fixed rate for 60 days of home health care, or a single payment for a hospital admission, or a day of SNF care, but these bundles within a provider silo.

Bundles, however, can be defined more broadly by combining services across settings such as: hospital and physician services during a hospital stay, as has been done with the ACE demo which we discussed in your paper; it also could include the services provided for some time period after discharge from the hospital.

Conceptually simplifying these points for you, we can look at this figure to show you how we can combine services around a hospital stay.

Under current policy we have separate payments for hospitals, physicians -- for each of these things in the top part of the figure: PAC providers, physician services, and other services such as outpatient care.

We potentially can bundle the hospital and physician services together, and if readmissions are included, we have a readmission warranty policy. You can

also bundle together the post-discharge services shown in red into a single bundle, and readmissions could also be part of that piece as well. Carol will talk a little more about some of the issues in dealing with readmissions in bundling.

Finally, you can combine all this together into a single hospital and post-acute care bundle that includes readmissions.

So why bundle? In the paper we talk about some of the problems with fee-for-service reimbursement and how bundling has the potential to overcome some of fee-for-service.

Bundling should discourage volume of services within a bundle, although you need to be careful about not creating more bundles.

Bundling should encourage a more efficient use of resources, and because you are paying for services across silos, it should encourage more coordination of care across settings.

All this could lead to improved quality of care and reduced program spending. There are many issues, though, that need to be considered in designing a bundled

payment which Carol will discuss, and there are some potential downsides such as potential incentives for underprovision of services so quality and outcome metrics will need to be part of the mix.

So why focus on PAC services such as SNF, home health care, and inpatient rehabilitation services as part of the bundle? Well, first, PAC services account for a substantial portion of program spending for many conditions.

Moreover, current patterns of post-acute care spending may not reflect efficient care. As we discuss in the paper, the PAC setting used can greatly affect total episode spending. But placements are not always based on the what may be most clinically appropriate.

This slide, for example, shows that PAC provider services account for a substantial share of 30-day spending for many conditions, if we look at the episode. PAC services here are shown in red. So the PAC Services account for a substantial share of this spending. PAC spending in many cases on average is more than the cost of the inpatient admission.

We also see substantial variation in PAC spending within condition for the same severity of patient. For hip

and femur patients, we see almost a twofold difference between the 25th and 75th percentile in PAC spending, and for heart failure we see a fourfold difference.

Note that some of this variation within types may be due to other risk factors, but if we look nationally by markets from our Medicare spending variations report, we see substantial geographic variation in PAC spending, with a twofold difference in PAC spending between the 10th and 90th percentile geographic markets and an eightfold difference between the markets at the lowest and highest end.

This wide variation is services use and spending provides opportunities for program saving if higher spending areas can be moved more towards national norms.

The final issue I want to discuss today before we move on to Carol is the CMS bundling initiative which is being launched by the CMS Innovation Center. The initiative is pilot testing four different models of bundling which I have summarized on this slide, and it is in your paper.

Two of these initiatives, Models 2 and 3, include post-acute care services, Model 2 combined with the hospital services and Model 3 just focuses on the services of the post-acute care side -- for discharges to a post-acute care

provider.

Applications for Model 1 are currently being reviewed by CMS, and the other three models' applications are due in May.

These bundling initiatives are discussed in more detail in your paper, and we'd be happy to answer any questions you may have on them during your discussion.

So with that, I will leave it to Carol to discuss the bundling design issues.

DR. CARTER: Okay. There are several design issues that we are going to talk about. The first is the scop of the service and whether separate bundles for hospital and PAC services or should there be one combined bundle, and which one of those designs makes sense. Included in that decision will be how to consider readmissions. Another design issue is the time period covered by the bundle, and last is how to establish payments for the bundle.

The first decision is the scope and whether there should be separate bundles for hospital and PAC or one combined one. Each one has its pros and cons. Payments are likely to be accurate for separate bundles than with a

combined bundle. This is because a combined payment needs to estimate both who is using PAC and the cost; whereas, with separate bundles you are only trying to estimate the cost of each separate bundle.

The decision about a separate or combined bundle should be shaped by whether or not PAC services typically follow a hospital stay and how different the spending is with and without PAC.

On the left, you can see for select conditions that the share of beneficiaries using PAC services varies from 40 percent for beneficiaries with COPD to 87 percent of those hospitalized for hip replacement.

On the right, we have taken one condition, and that is stroke, severity level 4. And you can see the difference in spending between PAC users and beneficiaries who do not use PAC. The average 30-day spending for stroke patients was about twice as high for those who used PAC services compared to patients who did not, and spending after the hospital discharge was about 10 times higher.

The spending difference between non-users and users is typical of many other conditions. Payments based on the average of these two will end up being too high for

episodes that do not include PAC and too low for those that do.

Another advantage of separate bundles is that patient selection would be minimized because the payments would be more accurate. In addition, decisions about PAC use are more likely to be made based on clinical and not financial reasons. However, if a PAC bundle is triggered by the use of a PAC setting, then the selection of the setting has already been made, and there will be less opportunity for savings. To encourage that the most clinically appropriate setting is used, a third entity could be paid the PAC bundle and then it could decide on the setting. One downside of separate bundles is that if the hospital and PAC entities are not actually independent, then separate bundles could result in more PAC bundles than are necessary and could lower the savings opportunities.

With combined bundles, there are strong incentives to coordinate care to prevent more costly service use down the road, such as avoidable rehospitalizations, and to control PAC use. However, by aligning all providers' interests, a combined payment may put beneficiaries at more risk for underprovision of care and not getting the services

that they need.

Related to the scope of service is how to handle readmissions. Although readmissions occur in the minority of cases, they are costly when they do. The first option is to include readmissions in the bundle and then build some portion of those costs into the payment. If there are separate bundles for the hospital and the PAC services, policymakers will need to decide whether both the hospital and the PAC entities would be at risk for readmissions and how to apportion the costs of them.

For example, hospitals could be at risk for readmissions that occur within a few days, to discourage premature discharges and poor transitions between those settings, and PAC providers could be at risk for readmissions that occur after this point.

Alternatively, readmissions could be paid for separately -- again, maybe at a discounted rate -- but discouraged by extending readmission policies across PAC providers, similar to the readmission policy that was recommended this March for SNFs.

Another design issue is the time frame of the bundle. There are many permutations of the time period, but

we're going to simplify this discussion for now.

One option is a short period, say one that parallels the 30-day hospital readmission penalty. A shorter period of time would limit liability for PAC care but would exclude a sizable share of PAC use. For example, one-third of SNF stays are longer than 30 days, and the average home health user has two 60-day episodes.

Longer periods, such as 90 days, would include most PAC services in the bundle. The larger bundle would give providers more flexibility to consider the mix of services they furnish to keep their costs below the larger bundled payment. It also would accommodate the variation across beneficiaries in the time that they need to achieve similar outcomes.

In terms of setting the payment, Medicare should establish payments based on care needs not the site of service. The recent PAC demo results suggest that a common case-mix system for routine and therapy costs could be established across inpatient sites. Policymakers will need to consider how much of current practice patterns to incorporate into the rate. We know that current PAC spending does not represent a good benchmark because

Medicare margins are high in some sectors and services are not necessarily furnished in the most clinically appropriate setting or in the right amount. Given that some growth in spending in some sectors is unrelated to care needs, it would be possible to lower service use without harming quality. At the same time, payments need to adequate so that providers do not have an incentive to stint on services or select sites that do not meet a patient's care needs.

Turning to the payment method, policymakers may want to think about using different methods to pay for different types of conditions as a way to match the degree of risk associated with each. Conditions vary in whether quality is hard to measure, care needs are less clear, and best practices and guidelines are available. Fully prospective rates could be used for conditions where the need for the hospitalization is clear, and there are well-established clinical guidelines and outcome measures to detect stinting. Hip replacement might be a good example of this.

Conversely, methods that blend cost basis and a prospective rate could be used for medically complex patients, where quality measures are less well developed,

care needs are hard to predict, and there is disagreement about best practice. And here we are thinking about conditions that straddle inpatient and LTCHs and some of the medically complex patients that end up in LTCHs.

In terms of risk adjustment, this is obviously key to ensuring that payments do not encourage patient selection or stinting. Risk adjustment also allows for fair comparisons to be made across providers. Although the intention of any risk adjustment is to establish accurate payment, to date no method, including those currently used on the fee-for-service and MA plans, is perfect and some selection is probably unavoidable. Our work suggests that risk adjustment based only on the information from the hospital stay will not be sufficient to risk adjust payments. We have work underway to incorporate a beneficiary's history of comorbidities and their functional status at admission to a PAC setting into the risk adjustment.

We will also in bundling need to consider how to gauge performance across many dimensions, including spending, patient outcomes, clinical quality, and the patient experience. Given the incentives to increase

bundles, CMS may want to monitor and consider admission policies to penalize entities with high admission rates. To counter the incentive to stint, pay-for-performance policies or inlier policies for very short or low-cost episodes could be adopted. Using some form of cost basis or fee-for-service in a blended kind of way would also dampen incentives to stint on services.

One issue to address also is that entities accepting a bundled payment will need to be able to bear the financial risk of potentially large losses. The paper mentions possible ways to protect against potentially large losses.

Another issue is the balance between having a large network to retain beneficiary choice among providers and a tighter one to manage and coordinate their care. Ideally, bundled payments would prompt partnerships with high-quality, low-cost providers that coordinate beneficiary care. But networks could include poor-quality providers or require beneficiaries' families to travel longer distances. Although beneficiaries can still choose their provider, the network would try to influence the decisions that are made about where they seek care.

Our next steps are to refine the risk adjustment methods and then develop a data set so we can examine different bundling options. We plan to look at the variation in spending to consider the payment amounts and to model alternative payment amounts including one price across all institutional PAC settings.

We would like to hear your thoughts about what additional analyses would help you consider the scope of the bundle, the time frames, the level of payments, or the payment method. And we would like to know if there are designs you think would be most fruitful, or if there are some that should be excluded from our work.

With that, we look forward to your discussion.

DR. MARK MILLER: I'll just take a second here. Glenn was asking me to try and pull some of this together.

A couple of things to keep in mind. We made this recommendation a few years ago, and I know for myself and Glenn, we have always had this view that you don't just say, "Somebody should go do something," and then kind of let them take all of the responsibility. We continue to try and do work to support CMS' efforts or to advise the Congress on directions that CMS should take. And so we've been doing

work on this in the back room right along.

So, you know, why don't we just sort of let the demonstrations go? And there are a few reasons why you might want to re-engage on this front. One very clear one is risk adjustment. When you start to put things together with the hospital or even to put things around the post-acute care setting, different factors begin to come into play. Functionality comes to mind right off the top, and there is some intellectual technology out there, but there is not a lot.

Now, the CARE Tool has just recently shown up, so that might be a direction. But, meanwhile, these guys have been working with people outside of MedPAC to look at risk adjustment. And this is something that could help the demonstration. This is something that could also help if you wanted to go in some different directions than the demonstration.

You could consider some of the comments and points that you make here as advising CMS in how they think about the demonstration. For example, one of the last issues that Carol touched on was the notion of sort of freedom of choice and steering. You can think of risk a couple ways from a

provider's point of view. Do I have to take anybody that presents themselves to me even if they do not take my advice, they do not go to the first setting that I suggest they go to? The data suggests that decision is pretty critical.

On the other hand, you could think of a design that says, well, if you accept my advice, then I accept the risk. If I don't accept the advice, then the risk is played differently. And that's something that you could think about within the context of the demonstration or outside of it.

There's also a couple of other issues that I think are why we should be talking about this. When we talk about post-acute care bundles, you could think about it as everything, meaning everything that happens to the patient after they leave the hospital -- institutional, home health, physician, whatever the case may be. But the other way you could think about it as a first steps is to think about it as the institutional providers, where you might be able to get your arms around that faster than the broader bundle, and as a stepping stone in some of the conversation you were having about how do you move from one point to another. The

Commission has raised this issue of normalizing prices across settings, so you could use some of this research to begin to take those steps to pave the way to a bundled payment.

A couple of last things I will mention that I think, you know, we are uniquely -- or have some critical mass on is: What do you do with readmissions? Are they in the bundle or do you kind of keep them separately as a penalty? We have now introduced this hybrid idea. There are some things where you pay a bundle. Are there others where you have maybe costs and a fixed payment? And then while it was not discussed here, we are also looking at some private sector data to see what the patterns and the levels are because that will become very critical to setting the right price if we think that the current patterns are distorted by fee-for-service.

So maybe that was too much information, but I'm trying to give you a couple of places that we could weigh in on.

MR. HACKBARTH: Okay. Thanks, Mark. That's helpful.

As usual, we will do two rounds, a round of

clarifying questions and then a second round of deeper questions and comments. Bill, would you be willing to kick off the clarifying questions?

DR. HALL: Sure. I have some more substantive comments when we come back to the second round, but can I just raise sort of an issue in terms of vocabulary? We are using the term "stinting" a lot. Could you define that for me in this context?

DR. CARTER: We refer to sort of the underprovision of services, so that would be given a patient's care needs, a patient isn't getting that level of service.

DR. HALL: And the motivation being?

DR. CARTER: From a provider's perspective would be to save money.

DR. HALL: So if I may say, I think that might be somewhat of an oversimplification of what the problem really is in terms of choosing between post-acute care services. I wanted to put that as a bookmark, and I will come back in the second round on that.

DR. NAYLOR: Yes, I was wondering, on the additional analyses, thinking about this longer term to 90

days, whether or not we have the capacity on Table 3 to take the information that you provided about what showed variations in the post-acute spending, to show what it would look like over 90 days. And so now it's this spending plus 30 days, and one way to think about how to get to higher value is to look at what are we seeing in terms of differences. And in that, I'm wondering if it's possible to clarify where readmission takes place.

So for some people, we know if they're hospitalized, they go home, there's no post-acute referrals. For others -- and we know sometimes we don't target the right people for those referrals. And for others, they go home and they receive these post-acute services and then are readmitted. So where readmission, which is also a significant -- spending is highly variable in readmissions. So having an understanding of whether it's taking place in the episode, if you use that language, because there's -- when post-acute services are taking place, or if it follows, people who don't get it and then are readmitted and then get post-acute services, I think that longer 90-day look would be helpful. I don't know if it's possible.

DR. CARTER: We do plan on looking at the spending

within 90 days as an example of a longer bundle than 30 days. And, Craig, I am going to ask you, my guess is we have data of readmission, so we can look at where during the episode -- or certainly keeping our hands on the readmission -- the costs associated with the readmission, we know the date, so we can look at that, if that's something you're interested in.

MR. LISK: The readmission is more likely to occur earlier on. It goes down like a distribution like this, and that's true for the people who are admitted home without post-acute care and for the people who have post-acute care. However, the people who use post-acute care tend to be sicker and tend to be more likely to be readmitted because they are sicker on average.

DR. NAYLOR: Two last questions. Are these the only bundling models that we should be looking at, meaning these are the four options CMS -- I mean, can you think about bundling as hospital, ED, back to home, and a bundled payment for, you know, a care delivery innovation that creates a different scenario? Or should we be limiting our attention to these four that are presented?

MR. HACKBARTH: So you're raising the question of

-- some people have talked about bundling on the ambulatory side alone that doesn't involve any inpatient admission, and you're raising whether that's something we should --

DR. NAYLOR: Or people that go to the emergency room who could immediately go back home with more --

MR. HACKBARTH: Never admitted.

DR. NAYLOR: And never get admitted. So I'm wondering, are we to, you know -- is the conversation now about the models as CMS has presented them, or should we think alternatively as well?

DR. MARK MILLER: I would answer that question and say that is very much the point, is whether these are the models, and I think they are ones we would -- there are variants that we would suggest being looked at, even in the post-acute and hospital world.

To your other question, I would keep in mind we are going to talk about care coordination in a primary care acute type of setting momentarily -- or in a session or two, and so that conversation can come up there, too. And also, there is some other work that Nancy and Anne Mutti are working on. You've seen bits and pieces of it, but it's still going on in the background, where we're looking at the

experience of the patient before they go to the hospital. Are they using a lot of emergency room? What is the admitting patterns for this community? And there may be some opportunity there to have that discussion in that work, which is not on the agenda for today, but it's definitely in the mix.

MR. HACKBARTH: Clarifying questions?

MR. BUTLER: I could ask a lot, because there are a lot of interesting things, but I'll try to use one slide to focus on a couple questions that will help my own thinking about the issues, Slide 7.

It seems that most of the data in most of the slides and the written material we've got almost says there are two basic populations. One is cardiovascular disease that has all these complexities and variation in terms of what the post-acute care may involve, and it is not just variations in the risk but variations in the options, and the variation is much greater for that population than, say, for basically an orthopedic population. And I know there are many more groups than that, but everything we keep showing is kind of cardiovascular disease versus kind of orthopedics.

Now, within the hip and -- I assume that a good percentage of this are joint replacements, but you could have a fracture from a fall --

MR. LISK: This one is actually hip and femur procedures that result from trauma, so this would be falls. Some of them will be getting hip replacements. Some will be getting other things done in terms of this group here.

MR. BUTLER: Okay. So then maybe go back to Slide 8 that shows the -- no, what's the one that has the joint procedures on it? What I want to get at is within the joint procedures, there's one where we've already kind of addressed some things through, whether it's the 60 percent or 75 percent rule on IRFs and so forth. You don't have any data that shows the components of the post-acute care for what I would view as a fairly homogeneous set of activities or diagnoses without as much variation on risk around which you could have a prospective rate that includes the hospital piece and all the rest.

So I would like to see what the components -- what has happened to the components of post-acute care, for example, for the most homogeneous cases we have and what that might look like if we proceed at that, as one end of

the spectrum, because I would think that we probably would say, for some things, there are prospective rates. They ought to include the hospital business. And others, maybe, we would leave just to the post-acute care bundling, with or without home health. So I'm trying to get at those kinds of understandings of the populations.

MR. HACKBARTH: So further -- one potential example would be the hip and knee replacements. Are there others that sort of leap out from the data where there's relatively limited variation?

MR. LISK: Hip and knee replacements have very limited -- have much less variation than anything else, and hip and femur procedures related to trauma and stuff also don't, although there may be a broader mix of patients who are in that population. So there may be some other confounding factors in that population. But for this group, it's over -- it's about 90 percent of the people who are using post-acute care afterwards. It's very high --

MR. BUTLER: Yes. Your data says, interestingly -- you point out -- or the others, there's only 30 percent that -- well, the number that even use post-acute versus doesn't is very dramatic. But for that population, you're

right, it's almost 90 percent use it. So we ought to be able to understand that one better than some others.

MR. HACKBARTH: So it is the orthopedic-related --

MR. LISK: I think, actually, the orthopedic. So if you talked about spinal fusion and stuff, it probably might be a similar type of situation --

MR. HACKBARTH: Yes --

MR. LISK: -- and some things like that. So the orthopedics may be a good candidate. You know, when you think about stroke, there's a lot of use for that. But right now, what we have is a diagnosis from the hospital and that's where you need the functional stuff and stuff maybe from the care tool to really decide what their care needs are, and then stroke might be a candidate. But given just hospital diagnosis information, it's probably not sufficient.

MR. HACKBARTH: Yes.

MR. LISK: But you see quite a bit of variation there.

DR. MARK MILLER: I just want to tease out maybe the significance of your comment, or the direction that you're giving in the sense that you're saying. You might --

just confirm or deny -- you might see that a way to sort through this is to say less variation, more variation, and then you would build bundles accordingly. Like less variation, you can capture more bigger. More variation, maybe you do have to think about some segmentation. Is that what you are saying?

MR. BUTLER: I would pair that, also, with who is driving the care model, because in the orthopedics, I can see working with the orthopods and saying, you know what? Let's do the whole package. And you know what? On the post-acute, forgot not only the IRFs and the SNFs, but let's just do a home health package and we really could cut the cost down if we just assembled this whole thing together.

So part of it is kind of the cultural piece, too, not just the homogeneity. But we've got a team that actually could deliver on that bundle. I can envision who would be at the table and make it happen.

DR. CHERNEW: This is a simpler version of, I think, some of the things Peter was getting at. How do these overlap with each other? Do we have to worry about overlapping at all? Are there people that have hip and femur procedure and then they have a, you know, heart

failure admission at the same time?

MR. LISK: No. In this one -- I mean, the readmission might be for heart failure, but in this, in what we're showing you here, these don't overlap.

DR. CHERNEW: And I guess so my question, then -- another way to ask my clarifying question is, did you have to exclude a lot of people when you got rid of all the potential overlaps?

MR. LISK: Well, actually, I'm sorry. I should say that they may have some other post-hospital treatment that is for another condition that is not related to this. So we didn't use the ETG software to, let's say, just pick up what's related for this. This is just saying what's happened. But we didn't -- in terms of defining episodes, we had to have a clean break for defining a new episode for what would be a heart failure episode, for instance.

DR. MARK MILLER: So it's a time defined --

MR. LISK: It's time defined --

DR. MARK MILLER: -- and it's not related to the service, or related to the condition defined.

DR. CHERNEW: If you had a hip and femur procedure and you're going out for some period of time, as you were

discussing, and then you have a stroke within the window of time, you could have, at least in my mind, some overlap. That could be two observations that are just treated separately, or you could exclude the person where that happens, or maybe it just doesn't happen all that much --

MR. LISK: I mean, that would end up being a readmission -- counted as a readmission expense.

DR. MARK MILLER: [Off microphone.] In this case.

MR. LISK: In this data.

DR. CARTER: But they would be categorized in one bucket and it's based on what they were hospitalized for, right.

DR. CHERNEW: And a new one doesn't start for the new thing. So a readmission is never an index on a new thing.

DR. MARK MILLER: [Off microphone.] In this data.

DR. CHERNEW: No, I understand. That just was --

MR. ARMSTRONG: Just a couple of things. Actually, building on the line of thinking Peter was pursuing, it really raises the question -- I mean, there's a lot of reasons for variation, and I think in your analysis, you just look at variation and don't distinguish between

variation because different patients have different clinical issues versus variation that is unwarranted by the clinical issues but is really geographic or for other reasons. So we just treat variation generically as a variation, is that correct?

MR. LISK: Yes.

DR. CARTER: But the data have been risk -- they've been risk adjusted, at least here, for severity level. And the geographic differences in the area, that's been taken out. But, you're right. There's still a lot of variation.

MR. ARMSTRONG: So this may be the second round, but if we're looking at different bundling options driven by the degree of variation, we have to just be careful because the degree of variation is part of what we're trying to solve for, and so we just have to kind of think that through.

We make a good case for why this is important, and I don't want to belabor it too much, but could you just remind me of our total $500-and-some billion annual spend, how much of it is on post-acute services, just generally?

MR. HACKBARTH: All of them combined?

MR. CHRISTMAN: [Off microphone.] It's about $51 billion across, and that includes both parts of home health, including --

MR. ARMSTRONG: Okay. So it's ten percent or so of the total annual Medicare spend. I don't need to be more --

DR. MARK MILLER: Wait a second. Wait. Fifty billion was what, Evan?

MR. CHRISTMAN: [Off microphone.] That's all -- your home health --

DR. MARK MILLER: [Off microphone.] Post-acute care facilities --

MR. CHRISTMAN: [Off microphone.] Right --

DR. MARK MILLER: -- facilities, and we'll get you an answer to this question.

MR. ARMSTRONG: Okay.

DR. MARK MILLER: But the other thing to keep in mind here, you may be capturing more than those services in these bundles. It is a question, ultimately, how you want to design it, but you could be capturing the physician service provided after, you know, in 30 days and all the rest of it. So that question -- the answer to that question

depends on what you mean by what you want to count in there. But we'll give you an answer to it.

MR. ARMSTRONG: I know --

DR. CARTER: The other thing I wanted to add was something like a third of beneficiaries who are hospitalized go on to use PAC, so the PAC spending that Evan was talking about is going to include something like two-thirds of home health use isn't preceded by a hospitalization. So that's a broader measure of -- it's not post-acute because there's no acute, if you get what I mean.

MR. ARMSTRONG: I just -- you know, we know what the margins are. We know the variation. We know the cost of the disconnects and so forth. But it just seems the case for why this would be a priority for us could also be made by how much of an impact on the overall spend will these kinds of policy changes impact us.

And then, finally, to what degree do we look at the experience in Medicare Advantage plans around how they manage the transitions and the kind -- because they have many of the choices and are doing a lot of these things. Have we been able to study that at all to see what that --

MR. HACKBARTH: This is where Bruce raises his

question about when are we going to get encounter data from Medicare Advantage plans --

DR. CARTER: Well, that was what I was going to say --

MR. HACKBARTH: -- so we can evaluate that.

DR. STUART: [Off microphone.]

DR. CARTER: But what Mark mentioned was we are in the process of -- I mean, we have acquired some encounter data from MA plans and we'll be looking at the kind of variation and site selection that they make. But mostly, we've been limited by the lack of encounter data.

DR. BORMAN: I have two. First, as we look -- and this slide is particularly -- we're pulling -- and this relates to some of the questions over there -- this is basically by a DRG, so that stroke is the discharge DRG?

MR. LISK: Yes.

DR. BORMAN: Okay, so that -- but it includes stroke with or without comorbidities or complications? So it would be -- there is some diversity within there --

MR. LISK: Oh, yes. No --

DR. BORMAN: -- so that, for example --

MR. LISK: -- this is --

DR. BORMAN: -- the stroke with complications, one might think, would be more likely to be a PAC user, right?

MR. LISK: Right. The tendency is --

DR. BORMAN: Or a particular type of PAC user.

MR. LISK: You can go to this slide here between what the spending is for the stroke with and without --

DR. BORMAN: Right. But, I mean, just even setting the severity of the stroke itself aside, this is also, the with or without complications and with or without comorbidities is where you're going to pick up some of these alternative things like the congestive heart failure that manifests during the stroke recovery or something like that. So this is a pretty big group, and it may be that as we look at more specific interventions or targets or whatever, you may have to break this down to just the pure stroke, if you will, versus the patient who developed complications or something in order to make it a meaningful understanding experience. So that's one.

And then my second clarifying point would be, because I think I've heard -- I've not understood this well -- when you talk about -- when we talk about home health in this analysis, are we talking about home health as covered

by Part A and Part B home health coverage, or are we talking -- so it is. It's the totality of home health care.

MR. GRADISON: At a later stage in your work, I'd be interested in what may be somewhat speculative, but what may be the impact, if any, of this kind of bundling on whether the hospital, which I assume would get the money, is negotiating with an independent organization or with some entity which they control themselves, or to be more specific, the extent to which bundling might encourage the acquisition or merger of hospitals and some of these post-acute organizations perhaps beyond what we have right now.

I'm not sure whether it's a good thing or a bad thing. I'm just interested in what that -- and the reason I raise it is because there are questions that arise with regard to the ACO concept as to whether it is encouraging further mergers and raising perhaps, arguably, conflicts with some of the anti-trust concerns that have been raised in the past.

MR. HACKBARTH: So let me address that one, Bill. So to me, that's a policy decision, whether the money should go to the hospital or some other entity as opposed to a foregone conclusion, okay.

DR. MARK MILLER: And in some of these ways you can conceive of these models is you keep a fee-for-service -- even keep a fee-for-service framework. You're sort of conceptually saying the bundle is this much. You continue with the fee-for-service, withhold some dollars, and then say, if you don't hit the target of the bundle, then you don't get those dollars back. You could almost think of them that way, as well. And I'm correct that some of the CMS demonstrations proceed that way. So that's a $64,000 question that you guys can comment on.

MR. LISK: Yes. That's how the pilot -- that's how the model two and model three --

DR. MARK MILLER: Right.

MR. LISK: -- include the post-acute care, are being done.

DR. MARK MILLER: Right.

MR. HACKBARTH: Ron.

DR. CASTELLANOS: First of all, great presentation.

Carol, in your discussion earlier, you said the use of PACs was usually based on clinical grounds, and I agree with you. I think it should be. There's been a

significant discussion with Peter starting in on the variation, and as some of the material that you sent out, you described significant variation in PAC use across geographic areas and you said areas of low service use also had a low PAC usage. So we do know, in general, there is a significant variation, and that's concerning to me.

But maybe I'm drilling down a little bit too much. Maybe this is one and a half. But could you put Slide 17 on? Peter kind of brought up the 60 -- yes, that's a good one. Peter brought up the 60 percent rule with the hip replacement and the inpatient rehab, and I think it's really clearly cut cuts and it's made appropriate clinical decisions where that patient qualifies for that setting or a different setting.

You know, this fully prospective statement, we clearly have quality measures. We do have care needs. And we have best practices that are known. I find it disturbing that in some of the more complex things, we do have best practices. Why aren't they being implemented? We do know about care needs. Why aren't they being implemented? And we do know about quality.

So I'm going to get back on my bandwagon about

appropriateness, and I think in the orthopedic groups, as Peter suggested, they've done a great job. They've looked at their patients. They've looked at what needs were there. They made appropriate decisions. And I think if we use that, I think we can think about that also in some of these more medically complex cases.

DR. STUART: I'm not going to say anything about MA encounter data.

[Laughter.]

DR. STUART: There are lots of -- I think the common theme that we're talking about is -- it really is variability and what variability actually encompasses, and this is a particularly good slide for that. The one we had before on 12 was also good.

But I think in terms of the way in which the Commission decides to put its resources, which I think is the point that Mark was talking about, also is really relevant to -- this issue is really relevant to that. So when I look at that green side, I'm thinking, well, this is an area in which you probably would want to think about a prospective payment system that included all of post-acute care, whether it was formal care or informal care. In other

words, why would you pull out therapy services, outpatient therapy services, from outpatient therapy that's provided in a home health circumstance where you have high -- where you have fairly tight clinical guidelines?

And I think it gets back to a point that Mary was talking about, is that are we really focused on formal acute services or are we focused on this whole shebang that happens after an inpatient discharge. And I think that becomes important in terms of where we -- well, again, the resources that are devoted by MedPAC.

My question really comes back, I think, to whether, in fact, we have examined predictors of any type of post-acute care following discharge. And in those cases where you can predict well based upon patient characteristics, whether somebody ends up in formal acute care, then we can talk about which one they go to, but whether they end up in formal acute care or not, those are the kinds of cases where you would want to think about a broader basis of -- or perhaps a narrower basis -- of payment, but where you really can't predict formal care. You're on the left-hand side over here on this slide. Maybe those are the ones that you put off. But there is some

clear low-hanging fruit in terms of being able to predict who gets formal care. My guess is -- have you got a list of conditions in terms of where you can and can't predict formal acute care -- formal post-acute care?

DR. CARTER: Well, we're just getting our data back and that is one of the things we'll be looking at, is sort of what's the variation in PAC use.

I want to caution us to something Glenn said before, which is when you look at your ability to predict, we're usually comparing it to current practice patterns, and I think we're going to have to accept a lower level of explanatory power because we wouldn't want to predict, in certain cases, current practice patterns.

The SNFs, when Evan was showing us how good the models were in predicting SNF therapy use, I mean, that looks worse, but it's because we know from our own analysis that the therapy provision in that setting isn't always related to the care needs. So I just caution us in terms of good prediction is going to vary a little bit when we're talking about PAC --

MR. HACKBARTH: You know, I think Scott captured my uncertainty about how to think about this. On the one

hand, if there's little variation at one level, oh, this is easier to do and there's less risk and all of that. On the other hand, there's also less opportunity. It's where there's a lot of variation, which at least in some instances may not be in accord with appropriate clinical practices. That's where you want to -- the change to occur. And if you limit yourself only to the things where, oh, everybody's doing the right thing all the time anyhow, there is little gain from doing this. And I haven't sorted out in my own mind how to balance those two things. I have this ambivalence.

Were you finished, Bruce?

DR. STUART: Yes.

MR. HACKBARTH: George.

MR. GEORGE MILLER: Yes, thank you. On Slide 13, just the question comes to my mind, and that is if you were able to discern -- if there was any difference if you segmented rural populations and the distance played, any distance as we look at this bundling option, or did you just look at aggregate and total, if there's any impact if there's a rural community and where the folks had to travel distance and would a rural bundle play a difference, or

would it be looked at differently from a rural perspective. And I don't know if you slice it that way. We just may have done it accurately. But because of the geographic variations, I wonder if that has an impact. I know Tom always talks about the few home care companies in his territory, and would that also have the impact. So home care may be a better post-acute setting, but because there's not that many, then they may choose a different one. My question is, have we looked at that, and has that had an impact in --

DR. MARK MILLER: At this point, we're just getting --

MR. GEORGE MILLER: Just getting started --

DR. MARK MILLER: -- kind of the assembled data and looking at it at the aggregate level.

MR. GEORGE MILLER: Okay.

DR. MARK MILLER: We can certainly look at that as we go along.

DR. CARTER: And there has been research done that looks at when -- what setting has been used, and sometimes it is predicted by proximity --

MR. GEORGE MILLER: Proximity, right.

DR. CARTER: -- and ownership, and so some of your comments play into that.

MR. GEORGE MILLER: Okay.

MS. BEHROOZI: Thanks. Can you turn to Slide 9, please. So at the risk of asking simply the $64,000 question that can't be answered or subsumes all of the answers to all of the questions, in model number two, I think I understand how the payment rate, which is a negotiated target price, works with the payment to provider, which is the fee-for-service with reconciliation to the target. I think that's pretty clear.

What I don't understand is how they calculate the minimum discount of two to three percent. Discount off of what?

MR. LISK: That's really what we're talking about in terms of the negotiated target price has to have at least a two to three percent savings.

MS. BEHROOZI: Off of what?

MR. LISK: Off of --

MR. HACKBARTH: Current fee-for-service --

MR. LISK: -- current fee-for-service spending.

MS. BEHROOZI: For what, though, because if --

MR. LISK: Their historical pattern.

MR. HACKBARTH: For that provider.

DR. CARTER: These are case type negotiated rates.

MS. BEHROOZI: [Off microphone.] For that provider?

MR. HACKBARTH: Yes.

DR. CARTER: For that provider.

MR. LISK: For that provider.

MS. BEHROOZI: For that provider for that risk adjusted DRG?

MR. LISK: Yes.

MS. BEHROOZI: Okay.

DR. BAICKER: So my question really follows up on Bruce's in trying to think about whether we would prefer to bundle PAC with hospital or not. In some sense, we want to know how predictable use of PAC is versus not, and how predictable it is based on things that we think are clinically appropriate versus current use patterns that might not be so clinically appropriate, and that's obviously a much harder thing to quantify, but I wonder, do you have a sense of how predictable use of PAC is at all ex ante, and then which variables are driving it? Are they things that

we think are relatively immutable, like age and, you know, diagnoses that were made based on previous years ATCs or whatever, or are they things that we think -- are the things that are most predictive things that we think are subject to the patterns of overuse or underuse that we might not want to bake into the new payment model?

MR. LISK: I think some of the information is stuff we don't necessarily know in terms of where that's where the carrots could come into play and what we're trying to do with some of our work using some other methods to get at that. You know, you can also think about things we don't know. What the patient's situation is at home is probably a major factor there, too. If they have a caregiver at home and what their capabilities are might determine whether they can go home or not. And there are other factors that go in in terms of their functional status. Are they ready? Can they safely be discharged home or not?

Just going by what we have presented you in the past and just what is the discharge diagnosis and that's probably not sufficient. That's where we need some more information. That's what we're working on to hopefully get some other information that might help with that.

MR. KUHN: Maybe two or three quick questions about the CMS pilots or demos that they're looking at right now, just so I've got a better understanding of how they're kind of grappling with some of these issues.

We have the issue of low-volume providers, potentially more risk, maybe potential for larger losses with that category of providers. How have they thought through that one? And are they making any kind of adjustments for the low-volume providers?

MR. LISK: This is right now -- the effort on the bundling initiative is voluntary, so it's what that provider proposes. If they're a small provider and want to participate, that's that.

Now, you know, in some sense, because it's a payment to a target and the discounts are -- savings are potentially small, there's probably not a lot of risk for small providers given how they formed this demonstration for the pilot at this point.

MR. KUHN: Thank you. The second question: Technically, how are they managing the issue on readmissions? You know, because we have the PPACA provision for readmissions, and then you might have a readmission in

the pilot, so you don't want to be in a situation of double jeopardy. So how are they kind of reconciling that, or have they talked much about that yet?

DR. CARTER: My understanding is both the HAC policy and the readmission policy will remain in effect for the providers that are awarded to go forward, but I can get back to you on that. But that's my understanding.

MR. KUHN: So they could be facing double jeopardy presumably on that.

MR. LISK: But they may decide to do other conditions because the readmission policy is only covering three conditions right now.

MR. KUHN: Right. And the final thing I was curious about, a little bit what Mark talked about at the beginning, and that had to do with the issue of kind of freedom of choice for the patients out there, and kind of, as Mark said, kind of where does the patient head first and how do they kind of get either steered or moved through the system, because you don't want to undermine the incentives in the structure of what the providers have in order to be able to go to high-value providers, either low-cost, high-quality providers. But if they can move around to others

out there where they don't have an opportunity to kind of engage them in a way that's most effective, how is CMS thinking about that so far in terms of the freedom of choice notion or kind of more restrictive bundles in terms of the providers that kind of come together to manage that population?

DR. CARTER: We've talked with CMS about that, and what they described as -- they expect any of these models for providers to be partnering and working with entities; even if you're not getting a bundle for all of the services, they expect partnering to go on. And they expect that a beneficiary will be explained the advantages of going to a provider that's part of the network.

The requirement that a beneficiary would get a complete list of their options would still be in place, and so beneficiaries would have the freedom to elect -- I'm using "preferred" not in a formal sense, but, you know, somebody that they are partnering with, or not. But they don't -- I think what I understood from what they were saying is they expect providers to do some steering -- and I don't mean that in a negative way, but they're going to be working with providers who they think are doing a good

thing. And yet beneficiaries will have the choice to pick a provider that isn't one of those.

MR. KUHN: So, again, kind of reflecting a little about -- as Mark kind of teed up some additional things to think about, if the beneficiary does not accept the provider that they recommend, the providers -- whoever is taking the bundle is still at risk. They are still at risk for that out there, instead of decoupling that accepted risk that's out there. Thank you.

DR. MARK MILLER: [off microphone] currently constructed. That's right.

MR. HACKBARTH: Just one other question about the pilots. So they are referred to as "pilots" in the text, which signifies to me that the Secretary has been granted the authority to extend these nationwide if the actuary signs off at the end that a pilot has reduced costs without hurting quality. Am I correct in that? I know that was true of some of the --

DR. CARTER: I always heard them described as kind of initiatives, and they are three-year periods with the option of maybe two more years at the end. I haven't read discussion of sort of scaling up.

MR. HACKBARTH: Could we check on that?

DR. CARTER: Yep.

MR. HACKBARTH: Because I know some of the provisions for CMMI in PPACA provided for the Secretary to have the authority to extend with OACT certification. Others did not, and I can't remember where this particular one fell. Do you remember?

DR. BERENSON: I don't know in this case, but that is the distinction between a pilot and a demo, is that the pilot -- that's why Medicare health support was a pilot, and it failed, but I think that's right, but it would be good to clarify.

I have two Round 1 questions. If you could go to Slide 17, I just want to make sure I understand what you are saying and not saying about hip replacement in terms of why it's a good candidate for fully prospective. All of those bullets -- quality measures available, care needs clear, best practice known -- I assume you're referring to what happens when somebody has a hip replacement, that there are standards. And then, Craig, when you said there's not a lot of variation with these orthopedic procedures, it's for those who have a procedure, how they are treated. You're

not saying there's not a lot of variation in who gets a hip replacement, are you?

MR. LISK: No.

DR. BERENSON: All right. That will set up my Round 2, but I'll deal with that in Round 2.

The next one is on Slide 9. I just want to understand a little more the bottom, which is gain sharing with physicians allowed. We now in general -- as I understand it, the OIG has some restrictions on gain sharing and the circumstances under which it might be contemplated and permitted. When you say gain sharing is permitted, is it in these pilots it's permitted only and because we think that we're meeting the OIG's concerns within the pilots? And I guess more generally what is the need for gain sharing if, in fact, you have got a bundled payment that already the physicians have a stake in getting a share of savings?

MR. LISK: In terms of how the payments are designed, they have to -- the people who apply have to -- the places that apply have to determine how they're going to share any savings that come about. In part, that's part of the gain sharing. In Model 1, for instance, it's just current hospital payment rates, and you're asking -- it's

basically saying if you want to participate, you can get a -- - you are allowed to have gain sharing as long as you don't accept -- as long as you accept a lower PPS rate.

DR. BERENSON: So basically they can -- we're basically permitting hospitals to even use their own revenues --

MR. LISK: Yes.

DR. BERENSON: -- to potentially sweeten the pie for physicians.

MR. LISK: Yes.

DR. BERENSON: That's what we're permitting in these --

MR. LISK: Yes. They have to lay it out in their proposal, though, so they're going to have a proposal. So what they're going to do, they have to lay it out in their proposal to CMS, and that's going to be reviewed. So it's not going to be -- you know, they don't know what the type of gain-sharing arrangement is going to be.

MR. HACKBARTH: On that issue of gain sharing, for the next discussion it would be helpful, for me at least, to get a reminder about what the current law is on gain sharing. My vague recollection is that, you know, it's

still prohibited by statute, but OIG has defined some limited conditions under which it can be done, if you, you know, file basically with OIG and say this is what we plan to do? Is that right, Ariel?

MR. WINTER: They've issued advisory opinions that cover just the specific arrangements that they've been asked to give an opinion on. But those opinions only apply to those specific arrangements. There is broader authority --

MR. HACKBARTH: If you want assurance, you need to file for another advisory opinion from OIG.

MR. WINTER: Right. Outside of this pilot situation, outside of the ACO situation. Under the pilots, they may have been given -- the Secretary may be given broad authority to allow gain sharing.

MR. HACKBARTH: That's my recollection.

Okay, Round 2.

DR. HALL: Well, this is really an important discussion. Coming out of Round 1, I have sort of two themes I'd just like to mention briefly, hopefully briefly. One, are there methods to satisfy our angst that we may not be capturing all of the confounding variables, even with current risk adjustments, that allow us to make these sort

of blanket statements about use of post-acute care services and the variability?

One would be, just as an example, there's such -- I have to put my clinical hat on for a minute. There are just vast differences between the 65-year-old who gets a hip replacement and a 75-year-old who falls down the stairs and needs to have a fracture fixed. It's Mars and Venus.

So one of the things we might want to do as we look at this is to put a little age stratification into these graphs, and I would suggest maybe take age 75 as a cutoff -- not a cutoff but a division point. And I think what we might find is that in that 65-year-old population, there would be much less variability in application of services, and that even a lot of the medical conditions would look a lot more like hip fractures, just from my own experience. One thing you learn if you care for old people for a long period of time, if nothing else, is to become very humble about prognostication once somebody comes into the hospital. The options are you are going to send them home and they're going to live forever, or you'll put them on advance directives and do nothing. I mean, it's that broad. So that's one way to get at it.

Another might be there are systems around the country, I think lots of them, that have what we might call "bundle lite" already, systems that are an acute-care hospital, they may even own a brand, all the variations of post-acute care that exist. They have their own home health care agency. They might have an affiliation, a financial affiliation with a chronic hospital, rehab services, and SNF. And I bet you that some of these would serve as good role models of how people have approached this even before we move into it. Some of these things may have already been approached by innovative health care systems, but I don't know where those are.

The other I guess I would say is sort of to interject what I think are some of the decisions that are involved when anybody who is involved in acute care wants to decide on post-acute care options, okay? One approach would be to say, well, there's enlightened self-interest. The hospital wants to have low lengths of stay to gain share, stint, the value of the DRG payment.

More often than not, I think, if you look into this, the decision as to which of the various options that we now bundled as post-acute care is a bit of a crap shoot.

It kind of depends on what's available.

In New York State, for example, home health care services in upstate New York, you'd be lucky to get somebody in one day a week; whereas, New York City you might get seven days, 24 hours. That's how it works out.

It may be that the nursing homes -- the SNFs that you use happen to be full up, although usually that's not the case for Medicare patients. It's only afterwards that that comes in. It's very difficult sometimes to place people in rehab. So sometimes, quite frankly, if there is to be some -- if you want to call it "gaming," but whatever it is, is to try and do the best you can with the available options at that particular point in time. And I don't know how we get at that, but I just wanted to add that as, I think, something we have to be very cognizant of.

That's all.

MR. HACKBARTH: Those are good points. They also for me raise a question about if you were to go down this path for some definition of a bundle, how are the rates set? So if you have a provider-specific rate or a rate that's partially provider-specific, you may start to capture some of those local differences in available resources. If you

were to move to the other end of the continuum and have, you know, all national rates with only adjustment for wage differences, then you would obviously not be capturing that. So that's another policy variable to be considered.

DR. DEAN: I would echo what Bill just said. This is really an important discussion. This is clearly an area there has been a lot of concern about rapidly rising costs and how do we deal with that. And I find the whole bundling approach very appealing rather than the alternative, which is some sort of regulatory approach, which is just almost impossible to come up with anything that is both doable in any kind of an efficient way and also gets to where we want to get to.

So I think this is exactly the right direction to go. Obviously it's not easy, but I think beyond that, as we work through these pilots, we really need to make sure that -- and hopefully that's already built into them, but that we get a much better understanding of what each of these services really actually contribute to the improvement of patients and so forth.

We've operated, I think, for a long time on the idea, well, if people get home health services, that will

keep them out of the hospital. I just saw some very disturbing data that came from several different places, actually some data that looked at utilization of home health services, and you couple that with some separate data -- I think it was from Commonwealth -- that looked at admissions for ambulatory-sensitive conditions and readmissions, and they were high in all three areas. And if these post-acute services do what we all assume that they should be doing, those other two things ought to be low. And they were also at the highest end of the spectrum.

So we clearly have some major misuse of these services, and the question is how to get at that, and I think hopefully these pilots will help us to understand what -- and so I think it's really important that we get -- that we measure outcomes from these bundles and how much did patients improve, and I think the readmission stuff is really important, and it needs to be included so that we really can understand what exactly did these services continue -- I mean, so we need to look at things like readmission and functional status and all that stuff so we really know, in fact, are beneficiaries benefitting.

DR. NAYLOR: So this is a great report. It

highlights the complexity of the issue, but I think it also highlights the huge opportunity that a payment model with the right delivery model could get us to. So just a couple of things.

Intuitively, with the data that you have, it seems like Model 2 that says let's put it all in may give us the best opportunity to get to higher value. But I think being open to what might be other models -- I mean, one way bundling could potentially work -- and we don't think about it in this context -- is maybe to help shorten lengths of stay, to get people earlier to really high-quality post-acute services where in a length of stay they may not be as at risk for some of the negative sequelae or questions from hospitalization.

So I would really like us to know how, if we targeted that 10 percent of the population that consumes 30 percent of the spending, that medically complex -- you know, I totally agree with Bill. Hip fracture is a hip fracture for one population, but for an 85-year-old, they are medically complex. And when they come in with those falls, et cetera, it's an entirely different game.

So I think here is an opportunity to really think

about a population that even though we don't have all of the answers on that left side, is where maybe we have the best opportunity to effect change. And even with that, you know, hip fractures, they could be readmitted with heart failure, et cetera. But there is a great chance to prevent that readmission for infection, for heart failure. So I think that's a group that I would focus on.

I think in terms of risk adjustment we do know who -- we don't know necessarily who should -- in post-acute care from current data, but we do know from data who's at risk for poor outcomes. And so thinking about targeting that population who needs a whole range of services over an episode of acute illness is good.

Variation, I think obviously we need to -- this is a really good opportunity to prevent the variation in care and trajectories that I think look -- I like the fact that the quality domains have been identified, and I know we have a long term to get to the measures, and I would really emphasize how it is that we could use this, not to focus on 30-day readmissions but longer-term value, 90 days.

MR. BUTLER: I have four points.

The first is related to what I said in Round 1,

and that is, how to frame this. And, Glenn, you started to put words in my mouth I think that were pretty accurate, but I think if you looked at one axis as the -- not the variation, as Scott was pointing out, in the services delivered, but the variation in clinical condition, the best you could measure it. And another axis would be at one end a fully prospective payment that included everything, from hospital care -- that's one end. And then the other end is kind of you got to have all kinds of outliers and other protections, something like that. And then if you could say, okay, where are the dollar opportunities within there, you begin to plot where you want to make your mark.

By the way, I think we're still using -- we're almost to the 30th anniversary of prospective payment, and I'm still waiting to get paid ahead of time. I thought that's what it meant.

[Laughter.]

MR. BUTLER: The second point, which is just not to forget, we've loosely referred to risk adjustment. It is very important. It's mentioned in the narrative. And then it will bring up IME and DSH and all those other things that you have to think about and not complicate this with, so

that's just a sidebar comment.

The third is there's a lot of interest in bundling in providers I know, a lot of participation in CMMI, a lot of enthusiasm for this. But I'm going to trump probably a little bit of what Bob would say in that ACO level is really -- and above, is really still where the action is. That's the ultimate, because I can say, Boy, our stroke team does amazing things for strokes, and the more strokes we have, the more we celebrate our market share, and they take care of the acute, but are they really preventing stroke? You know, I can see how they can really work on the post-acute side, but -- and also I'm certainly on the "Do you really need the joint replacement to begin with?" kinds of questions is still where a lot of the money is. And so I still think that this is in the end an incredibly important analytical tool, an incredibly important way to actually manage the care, but I am still less optimistic as it ultimately being the payment mechanism that's going to be our salvation.

And, finally, a little bit more controversial, but I'm not sure where hospice is in this. We don't call it a post-acute service, yet it is, and often is, and it's very

much a human dimension. It reminds me that this just isn't about payment. It's about how do we help people navigate when, frankly, hospitals and doctors often kind of wash their hands of a patient after they've left the institution. We still are not too good at figuring out how to really add the human touch of navigating through this system. And we have to think about who's really going to do this, because that in the end was what the beneficiary wants in addition to obviously having cost-effective and great outcomes.

DR. MARK MILLER: Will you guys remind me of the data set that we build as the hospice? That's one of the blocks that can be put in or out?

MR. LISK: Yes, it can.

DR. MARK MILLER: There's a lot going on here, so we didn't burden you further with here's the structure of the data set, and you can kind of pull elements in and out of it. As you have your discussions, we'll try and back in behind that.

MR. BUTLER: I just didn't want to get the death panel thing in there.

[Laughter.]

DR. MARK MILLER: And, you know, we almost got out

of this comment without anyone saying --

MR. BUTLER: I know. I couldn't help myself.

DR. MARK MILLER: You know you're --

[Laughter.]

MR. HACKBARTH: It's up to me to take charge here.

I think -- I know when we get around to Bob we'll hear more about this issue of whether bundling around an admission, wherever you define it, is on the critical path to delivery system reform. I would invite other Commissioners to address that issue as well as we go around.

Mike, Round 2.

DR. CHERNEW: So first let me say the patient orientation surrounding this I think is a fundamental paradigm shift that we should encourage, celebrate, laud, take to lunch, whatever it is. It's just -- I can't emphasize the importance of beginning to think about this as a patient-oriented kind of thing, just conceptually apart from any of the details.

The second thing I'd say is we're not going to get this perfect, but our bar is to do better than fee-for-service, and fee-for-service stinks, so you don't to have to run faster than the bear. You have to run faster than the

guy you're with to run away from the bear, right? And so we just have to do better than fee-for-service. And we spend half our meetings sitting around talking about how fee-for-service has made this horrible. This has got to be better than that despite all the flaws, and we could go around and I'll say a few things in a minute, but we're not going to do worse, in my opinion, in general, than fee-for-service, particularly in this general area.

One thing that I would like to emphasize as sort of a little wonkier is we don't need to predict it at a person level right. We need to predict sort facility averages right. So facilities aren't going to get it right, but what I'd really like to see is not how much of the variation of the individual level stuff. I would like to know how big a mean is there, so if stroke patients get 80 percent post-acute care, so that's fine, but I don't -- what I really care about is: Is that at a facility level averaging from 10 percent to 100 percent, or is that averaging from, you know, 75 percent to 85 percent? And what is talking about that? Because if we get the mean right, the whole point of bundling is you don't have to get it right for everyone. There will be patients in a bundled

model that the providers lose money on and patients that they make money on. You do have to worry about the incentives to skimp on some and select on others. So there's aspects of that that matter. But we don't have this high hurdle of being able to predict the exact right payment for the exact right person in all the settings.

MR. HACKBARTH: Can I just pick up on that? Going back to when we did prospective payment for inpatient hospital services, of course, this was one of the central issues, and the basic idea is just what Mike describes. It doesn't have to be right for every individual patient. There's an averaging process that goes on.

So the question that occurs to me when I heard Bill Hall's comments is: Is there a way analytically to look at whether post-acute care is different from inpatient in the likely effectiveness of that averaging process? Are there analytic tools, analytic measures that we can use to assess whether this is a different sort of problem or not?

DR. CHERNEW: That requires more thought. I'm not prepared to answer that question. I hope that was rhetorical.

[Laughter.]

DR. CHERNEW: Kate will answer it. You've got ten people, Kate.

I do think the big issue is really it's a selection, though. So, in other words, it's not -- you know, if you can really pick -- it's not just you get the average right, but if it's really under the control of the providers, you have to worry a lot about that and risk adjustment and stuff, and I think that is really actually a big deal.

The other implementation thing that I think is mildly problematic in this -- which incidentally I love this -- is that there's going to be these issues of overlapping bundles, how it fits in with other initiatives. That's why I actually am where Peter is. I think an ACO-type model is much better because it is much less complex to deal with all of the nuances that will occur on the ground when you try and expand this beyond some select areas, and you're going to have to build these micromanagerial rules about periods of time and when it ends and when it does this and how you switch over to that and if you have this care then you're no longer in it. I just find that really challenging.

So I tend to like the ACO sort of orientation, but

I do think, incidentally, underneath the ACO you would see some of these types of bundled payments develop, and I think this is still better than fee-for-service. But my overall sense, at least of the question on the table, is I advocate broad bundles in terms of inclusive services; I advocate relatively long bundles to capture as much of the care. But, of course, when you have these overlapping bundles, the problem with -- you know, there's going to be some sweet spot there that I've have to think through or have others think through with a more clinical sense of what that is. But I think the more we can get into the brew, the better it is.

MR. HACKBARTH: Even among people who believe that -- and I'm one of those -- there's still the question of, well, what if not everybody is ready to do the ACO? As a policy matter, do we need to provide a path that involves smaller steps that people might feel more comfortable taking?

DR. CHERNEW: I think this is a plus [off microphone].

MR. HACKBARTH: Yeah.

MR. ARMSTRONG: So just a few points. They're a

little redundant, but I want to make them, and I'll make them quickly.

First, I agree that this is important, we should go forward. The approach you're taking to the different models I don't have any comment that hasn't been made about that.

I think we can't overstate, though, that this isn't just about the financial implications and the margins and so forth. This is also about individuals who are in skilled nursing facilities or other facilities like this who are simply not getting taken care of as well as they should be, and that discoordination of care and the way that payment doesn't reinforce this organized approach is our beneficiaries aren't getting what they deserve through this, and let's not forget that.

The second point, I agree with what has been said, the broader the bundle, the better. I don't really know -- I'm interested in hearing Bob's comment or perhaps this is a dialogue for MedPAC going forward as to how this -- it is better than fee-for-service, but how does this contribute ultimately to where we would imagine payment reform going? I think it's a step in that direction. MA is the ultimate

bundle, as far as I'm concerned, and even that's just a silo. That's just Medicare. But I think you have to take steps to get there.

Third, it has been raised, but this whole issue around patient choice, I think through the whole ACO dialogue, we were not firm enough about the fact that patients need to be in a relationship with care systems, and that will limit choice, and it won't work if we don't confront that. And I think we're a little light on that issue so far and that somehow we're going to have to speak to that.

Then, finally, Peter's comments allude to this frequently, but this implies a kind of organization in our care delivery systems. It's just so dramatically different from the way in which different providers are working together today. There's an infrastructure behind that. There's a whole lot that this payment policy just presumes will get built, and that, too, I think we just need to speak a little bit more specifically to.

DR. BORMAN: First, if I could just ask a question or confirm my understanding. This would not capture patients that had ambulatory surgery center procedures

because they weren't admitted, correct? But it certainly is conceivable that, given how much has migrated to the ambulatory surgical world, a block of those patients, perhaps inappropriately selected for that venue to start with -- who knows? --- but indeed also had required some PAC services. So at some point in the analysis, you may want to see if you can figure out is there a group there and are they different or are they the same, whatever, because I just worry a little bit that we could be missing something important by not thinking about that piece of it.

Obviously, if they got admitted for some major complication, then they would fall into whatever of these groups they got admitted for. But I'm just saying there's a whole -- you know, now doing total joints and a variety of procedures that are pretty high volume, you know, is moving to truly an ambulatory structure, and so I would just think there might be some data there worth capturing.

My second thing would be I think what we're -- there are a couple of pieces here. There's who should get post-acute care, and I think that's kind of a clinical decision, by and large. But what I think we can do is say who does get it, which you're doing a nice job of coming at,

and presumably that can feed back on the appropriateness piece, as Ron gets to, to put pressure on those that should define who benefits from it, let's get there, to exert that pressure.

Then the other piece is what kind of PAC should be available to whom, to the beneficiaries, I think clearly is the work of the Commission, and in a very broad way, I would say that at the end of the day we want to be outcomes-driven -- that is, for a patient with stroke with, you know, some categorization of deficit that enters this, what would we want to see come out of that? What's the minimum threshold that we want to come out of that? And then measure performance against that. Those become the quality metrics and kind of not worry quite so much about did they get it in a SNF, did they get it with home health, whatever. Really, if we start trying to press this to be outcomes-driven, I think it gets us down the road more toward where we want to be over the longer haul and is less -- because we're never going to resolve all these geographic and market variation pieces, or at least not for a very long period of time until the ideal system is in place everywhere, or whatever. So I think to live within that, we absolutely need to be

outcomes-driven.

I'm reminded of Nick Wolter telling us all the time to focus on where the money is, and I would suggest that as we look for data that we really should focus on, it should be about the top ten or whatever conditions that precipitate, see where the commonality is across the different settings, and if stroke is being cared for everywhere as the first place out of the box, see if there's some message there around building a bundle; whereas, if there's exclusively things that almost always go to SNF or always go to home health, then maybe there's kind of less of something to waste time and precious staff energy on.

And then the other thing might be to more crisply define the demographics that might get you into one or the other thing, that is, my guess would be just given the nature of the Medicare population, this is going to be biased to female gender and to older age groups. But there are things that we need to know about that aren't just sort of co-driven by that, something about -- and you've already identified the geography piece as almost a piece unto itself. But I think knowing the top conditions and then the nature of the top people, if you will, then maybe that would

help us come toward defining outcomes.

Then the other thing I'm struck about in sort of thinking about former Commissioners is home health -- there are many wonderful things that are achieved by home health services, but I think to paraphrase maybe some of Bill Scanlon's comments in the past, home health is almost like a benefit looking for a definition. It's just such a broad possibility of services, and we struggle with that here, and that's going to argue that it's going to be harder to keep in this mix if we're trying for a very global definition.

I think as has been alluded to, a lot of this is about the choice that's made by a patient and/or patient's families at the time of discharge. And we can sit here and, you know, think about, well, they should be choosing by quality or this, that, or the other thing, and the likelihood is that within a couple of days -- within a day or two of discharge, all of a sudden, you know, somebody -- the physicians decide, oops, they're getting pretty close to discharge, and somebody has got to pull together a plan of resources and so forth in a fairly big hurry and do the coverage investigations and whatever, and all of a sudden a family or a patient is confronted with, you know, your

doctor recommends that you go to an X kind of situation, and here's the ones around here, and very quickly your decision gets made on not necessarily great rationales that would be made other than in the heat of battle.

So I think the practical import of that is that, consistent with some of the work that Joan and others have done for us about health literacy and about decisionmaking, we should be reminded in whatever chapter comes out of this about just sort of the impact of health literacy and decisionmaking generally, and that it would apply to this potentially pressured circumstance also.

And then, finally, that wherever the Commission gets to on this in the end, the recommendations should, I think, work toward directing us to where we want to be. But, Glenn, as you point out, some steps along the road rather than just leapfrogging the interim period, which we may think may be five years but practice would suggest that it may be a good bit longer than that.

MR. HACKBARTH: I also think of Nick Wolter often in this regard, and as Karen said, Nick often said, you know, go where the money is. But he also often said go after the low-hanging fruit, which is an expression that

somebody else used. And I think there was some wisdom in that. He would say don't define the problem so that it's so big it's going to take you forever wrestling with it, and you're inevitably going to come up with an unsatisfactory result or maybe no result at all. There are some easy things to do, do them quickly, and then move on and keep the process moving ahead.

MR. GRADISON: I am all for what we're doing here, but I approach this with a considerable amount of skepticism because I'm far from clear whether it's leading to where we really need eventually to be. Let me be a little more specific.

The way this is set up -- and I'd say the same thing about ACOs - is that if they are totally successful and we save 3 or 4 percent, we will say, "Success." That's not going to save this program. It barely takes care of the normal experience in the past of one year's excess inflation. It just raises the line a little -- drops the line just a little bit, but it doesn't really fundamentally change anything.

So I would hope as we think this through a little bit further that we have a little more discussion maybe than

we've had so far about what might this best be designed to lead to.

In that connection, I understand why we focus on the orthopedic, certain orthopedic procedures and a lot of other things, that in the case of a lot of other things it's not so clear whether this would work. But to limit this to just the ones where we're reasonably sure what the clinical appropriate next place is once you leave the hospital kind of begs the question. If we can't figure out how to apply this in some conceptual way elsewhere, okay, it's low-hanging fruit, but I don't see that it really leads anywhere.

One final point and I guess it relates to what I just said. In the case of an ACO, I haven't heard an explanation that satisfies me yet as to how or why the ACO should be held responsible when the patient can go anywhere. The ACO is being held responsible for a case where the patient may not even know they're part of the ACO, which is a little weird to me, to be frank. And I think in this situation, the parallel is very direct. You're going to leave the hospital, and you should be going to a SNF, fine. Here's a list of the SNFs. We recommend the one that we own

or the one we're affiliated with or the one that we think is the best one in town. But then the hospital is going to be responsible for some bundle of payment when they have no power at all to influence the price as well as the quality of that referral? There's something in that I -- if somebody could explain that to me over lunch.

Thank you.

MR. HACKBARTH: Bill, on the ACO issue, since this pre-dated your being on the Commission, I think the single biggest issue that we took with both the CMS proposed regulation and the final regulation was on this issue of this being invisible from the beneficiaries' perspective. And we strongly urged that they engage beneficiaries in making choices and even consider the possibility of beneficiaries' sharing in the savings from that choice as opposed to all the savings going to either the government or the providers. But, obviously, CMS saw it differently and went a different path.

DR. CASTELLANOS: There's a lot of good discussion, and I appreciate everybody's comments.

I kind of like what Mike and Scott said about a continuum of care and getting away from these silos,

because, you know, a PAC is a silo. Yes, we're talking about payment, but if you really think about it, it's really a silo, and we're really getting away from a small silo to a bigger silo.

I like the idea of some form of care system being responsible for providing care. I really like that, whether it's an ACO or what it is, I really like that, where you have a continuity -- you have care and some continuation or continuum of care.

Bill, you started out with stinting, and I thought you were going somewhere else, but you did talk a little bit about stinting. PACs stint. They stint all the time. If you're sick and you have to go to the hospital and the hospital has to take care of you whether you have insurance or not, whether you have Medicare or not, whether you're dual eligible, Peter, you're stuck with taking care of that patient to the best of your abilities. But try to get this person into a PAC, it's going to be very difficult. They have the ability to say, "No, I don't want to take this person. He takes too much care. It's going to be too expensive."

So there is some stinting there, and I don't know

how we can avoid that. I can only tell you, if you have Medicaid in my community, you're not going to find any PAC that's going to take care of that patient. Often what happens is the hospital takes the patient to get it out of the DRG and puts it in their PAC.

So there's a lot of stinting going on, and I'm not sure how to avoid that. But I think it needs to be recognized. And I'm sure some of the industry people here will defend it, but it happens.

Thank you.

DR. STUART: I think this is in a way an example of kind of buyer's remorse. We've had this idea that bundling actually is going to help us out on theoretic grounds, and we realize that it's kind of a stepping stone between, you know, bigger bundles. But the more we learn about it, the more we have concerns about where it's going to go. And when we bring in the patient-centered idea about being good for a particular patient, we're going away from what Mike had to say about as long as you're there on average, then as far as the financial incentives, you're okay, and then it's up to the individual organization that is accepting the payment to do whatever it does.

One thing that I would note about this is that if you don't know what the range of variation is around the mean that you're establishing -- and you're not going to know with some of these things because they're going to have selection effects, they're going to have all kinds of other things, they're going to influence whether you get into the nursing home or not. You probably also want to think about some of the long-term monitoring issues that come about that you really want to pay attention to up front. And I didn't see any discussion at this point about how you monitor whether these things are actually working. And I think that's particularly important. Karen was talking about health literacy as an issue. You know, that's not in the payment system. You don't know whether people are going to be able to take care of themselves or not.

The other point that I'd like to note -- and this is a big deal in the literature on skilled nursing facilities in particular, but for other types of long-term care as well, and that is the issue about the ability of caregivers to provide services that would either substitute for or complement other kinds of long-term care services, and we just don't have that information in terms of how

that's going to affect these bundles.

So where are we going to get that kind of information? Well, we've got this whole information technology initiative going forward in terms of these information systems, both at the facility level as well as at the individual practice level, and it strikes me that if you were to have an electronic record of the discharge planning process in facilities, at least that would offer an opportunity for some monitoring and gathering information in terms of where people actually are -- what the reasonable alternatives are for the channeling of services for both formal post-acute care as well as release to caregivers at home.

MR. GEORGE MILLER: Thank you. This has been a very rich and very helpful discussion for me, and for Peter, in honor of the 30-year anniversary of PPS, I propose we change the name to "Please Pay Us Something."

[Laughter.]

MR. GEORGE MILLER: But, again, I think bundling is the right track, and I think this is an opportunity -- I think Karen said it, and I had it in my notes -- that we should follow the money, and Karen reminded us of what Nick

would always say. And I think this is an opportunity for us, with the right bundling, to create bundles that guy us where we want quality of care and patient outcomes to go and use that possibly as a lever.

I think it was Mary or Peter who mentioned about hospice and/or palliative care. There are times when palliative care may be appropriate. We create a bundle that would end up with palliative care, that also, I think, could help us derive the type of outcome and really, as Bill talked about, lower the real cost. I mean, if you want to follow the money, lower the cost. And that may be a way to do so.

Also, as you have heard me talk about before, I'm wondering if this is an opportunity for us to at least address and make sure that all patients get the same level of care to deal with health care disparities by appropriately bundling are.

But, conversely, on the other side, I wonder as we look at this, where does the patient have responsibility? We often recommend that a patient as an example needs to fill a script for blood pressure medicine and they can't afford it, they are making a decision between eating, rent,

and the prescription. So we get them back in our system because they can't afford that, and so I don't know if bundling has an opportunity to deal with that issue, but it's something we should at least think about.

I also wonder if psych data are in these numbers. I know we often have patients that have heart failure, and that leads to depression, although it's not necessarily post-acute, but is that quantified in this data? Do we look at that as a post-acute care issue? I'm just raising that as a question.

Then, finally, I think this is an opportunity with bundling also to redirect care with primary care physicians as well to direct the appropriate care if we really want to make a significant sea change involving the primary care as a major focus of bundling care. I could see a system, just thinking out loud, where you get a different payment stream if you start with a primary care physician versus if you started with a cardiologist -- I'm not picking on cardiologists. I don't want any letters. But using that as an example, and that may be a way that we could really change the sea change --

MR. HACKBARTH: In a minute we're going to start

talking about care coordination.

MR. GEORGE MILLER: Yes, I know.

MR. HACKBARTH: These two topics --

MR. GEORGE MILLER: -- can intertwine.

MR. HACKBARTH: -- overlap with one another.

MR. GEORGE MILLER: All right. Thank you

MS. BEHROOZI: So, a lot of important issues about how to address variability, variability of patient needs, and I think a lot of, as people have said, a lot of the important focus that the Commission can put on it, that the staff can spend important time on, is on risk adjustment. And, of course, what we want to really get at is practice variability, and I really liked what Peter said, actually, in the first round about -- not so much about the predictability of what's needed, but who's in control of the decisions about how the patient should get treated, and the more you know where that control is and that there, in fact, is control by the provider, that that presents opportunities.

Just in that whole area of practice variability, I just wonder about the places where there are no LTCHs, right, no LTCHs for providers or for people, too, and what

we have talked about in some of the prior post-acute care work is that a lot of those people who might otherwise be in LTCHs probably are in home care, which is sort of way down at the other end of the intensity level, or they may be in SNFs or they may be staying longer in hospitals, maybe kind of bringing some of that back into this analysis, because to the extent that that stands there as one of those institutional areas but it doesn't exist everywhere, I wonder what we can learn from that.

But, anyway, so all of those things need to be examined and reconciled and whatever to make a really robust system. But going back to the Nick Wolter approach, the little, whatever, adage that I had written down, not low-hanging fruit, was don't let the perfect be the enemy of the good.

And when I look at -- that's kind of why I asked the question about model two or model four. It's the same thing. As a payer, if I could get two to three percent off of what I paid that provider last year -- instead of five percent more, you know, instead of a trend factor of an additional seven percent, if I could get, like, a net ten percent reduction from what I would have expected to pay

this year, I'd say this is money on the table. Great. Grab it. You don't need to fix all that other stuff before moving to some of these areas that clearly aren't designed to reduce geographic variation, right, if you're just going based on what that particular provider did before. It's not really necessarily going to produce tremendous corrections in what might be practice patterns that are excessive in terms of the amount of treatment or whatever. But it's a great start and it puts providers, I think, on the track to thinking about how to come in at those targets.

But, having said all of that, I think that, again, the important work that the -- the important additional work that the Commission can do is on then protecting the patients against the providers making purely economic choices, and people have used the term stinting, and I think Ron's, actually, description of the many different forms of stinting is a very important one. So I think we really do need to be sure that we are offering policy levers to protect patients and the quality of care they receive. But otherwise, go for that two to three percent right now.

DR. BAICKER: I agree that the move towards bigger bundles is better, and all else equal, we want to

incorporate a longer period of time and a greater number of entities and that the real challenge comes in as -- both with the stinting but also with the selection of patients and that seems like a bigger problem when you're trying to contract across separately operating entities, that the selection is going to play a much more destabilizing role when there's nobody who can internalize the spillovers to other downstream entities.

And that's part of why I was asking, in particular, about the predictability of future PAC needs, and if the hospital knows well which patients are going to go on to PACs or which ones should go on to PACs, that's a different story from if it's less predictable ahead of time. And if you can get it right on average and it's not so predictable post-risk adjustment -- obviously, the risk adjustment is key -- then it seems like it works even better than if the risk adjustment is inadequate or it's particularly predictable and, thus, amenable to the kind of selection that would lead to patients not having access to the providers that we want them to.

MR. HACKBARTH: But wouldn't those two go hand-in hand? if it is predictable, then isn't it amenable to risk

adjustment?

DR. BAICKER: Yes. So the question is -- well, there are two factors that go into the predictability. There's the stuff that we observe in our risk adjustors and then there's potentially other stuff that the providers observe. Right. So how good a job do our risk adjustors do in predicting what they can see, and I love the bear analogy. We don't need to do perfect risk adjustment. We just need to do risk adjustment that's as valid or as good as anybody else can do.

MR. HACKBARTH: Right.

DR. BAICKER: And so is there a divide in what they observe versus what shows up in the claims or whatever we're using.

DR. DEAN: Just a quick comment on risk adjustment. There was a very interesting article just a couple of months ago in the Annals of Internal Medicine about complexity, and they took a group of primary care doctors and asked them to identify which of their patients were complex, and then they ran those same patients through the usual risk adjustment. There was very poor correlation.

So I think it just says how difficult this is, and

it had to do with -- you know, somebody brought up the issue of mental health issues, a whole lot of social, depression, all those things. Our ability to risk adjust is good, but it is way short of perfect.

MR. KUHN: Three points. The first one, on this issue of risk adjustment and kind of the averaging process that I think Mike and Glenn and many others have talked about, you know, I understand and I agree with it, the concept that's out there. I just want to make sure that we think about low-volume providers, because if this bundling is going to be scalable, we have to make sure that we don't leave anybody behind in the process. So I think that would be on our "to do" list as we go forward.

The second issue, in terms of variation, a lot of people have spoken to that and I agree with all the comments that have been said. There's a real opportunity to get at some big wins early, hopefully looking at where the greatest variation and where there's an opportunity to really kind of incent some change that we think is appropriate, that we can move faster on than before, kind of a little bit what Mitra was saying. Where are the big gains we can get and get them early as part of this process.

And then the third thing that we've all kind of -- many of us have talked about, but I think it's pretty important to come back to it, and that is how are we going to establish the baseline when we believe the utilization might be high in certain post-acute care areas, particularly in some of the therapy services. And I think establishing that baseline is absolutely going to be essential and trying to get that as accurate, or at least have a methodology that we can defend going forward on that would be very helpful.

DR. BERENSON: Happily, some people have started articulating some of my concerns. First, let me say I am happy this pilot is going on. One is there are a lot of very smart people who think it's an important improvement, so I think we will want to test that and see what we learn. And under one scenario that I'll lay out in a few moments, I actually think it could compliment more fundamental payment and organizational delivery reform.

But I've got major concerns about both some of the issues around episode-based payment and then particular concerns about bundled episode-based payment. One -- and we haven't talked about it much except Mike sort of brought it up in round one, is operationally, it is very difficult. I

mean, if you just take the typical scenarios of what happens to patients after a hospital discharge, let's say they go to a PAC and then there's an ER visit and there's potentially another hospitalization, you can deal with an episode payment to, say, the hospital, which says that they're going to be responsible for a readmission, but are all the doctors who see the patients for other purposes, are they part of the bundle? Are they outside of the bundle? Does it create a new bundle? But sometimes there's no new bundle. It was just we ruled out a pulmonary embolism and there is no new -- - it's just very complicated stuff.

I would point to the Health Affairs article that looked at PROMETHEUS, which they've been trying to do this for years, and it pointed to lots of operational issues. So even if conceptually it makes sense, I think it's actually more complicated than capitation or global payment to actually implement episode-based payments.

My second and major concern goes to the issue of the incentive for volume increase, and that's why I asked the question in round one about what we did or didn't know about hip surgery. A major driver of health care spending is inappropriate services. I've seen a recent literature

review which actually it turns out the literature is mostly concentrated in particular cardiac and orthopedic and a few other procedures. But we've just got the recent information, the COURAGE trial, which pretty well has documented that medical management of chronic stable angina is as effective as stent placement. In a world of shared decision making, some patients might select the stent. But clearly, there hasn't been any real change in the incident of stent payment, which about 30 percent of stents are placed for chronic stable angina.

We have a fee-for-service engine driving inappropriate services, and so let me just go to the data in the material you sent us. One center in the ASIS demo [phonetic] saw a 28 percent increase in volume for cardiology services and a 31 percent increase for orthopedic procedures. Now, I like the notion that CMS might do some admissions policies, but how do we interpret that? On the one hand, it could be what they're doing is people are moving from other institutions to this high-value, high-quality place and the total number of procedures in the community are not increasing, we've had a shift. But I would suspect that at least part of this is consistent with

the notion of a medical arms race that Hal Luft and Jamie Robinson defined about 20 years ago, which is non-price competition, basically competition to attract patients based on the latest and greatest of new technology, in some cases giving people what they don't need. There's also operationally developed service line competition, is how it gets called.

And so we might save two or three percent, Mitra, on the cost within the bundle, and you might be losing ten or 15 percent for inappropriate services. And so we can say -- and I think this is right -- that we have those incentives currently in fee-for-service so we're at least not making it worse. I'm not so sure of that. You put all these parties together, particularly the doctors and the hospitals together in a service line focus factory and I'm not sure we wouldn't have higher volume than we have in the baseline. I don't know that, but I don't think in any case it solves the current problem that we have in fee-for-service. It sort of institutionalizes it. So we might be kidding ourselves with -- I mean, looking at this data, I'd be real concerned that CMS is actually losing money in the ASIS demo [phonetic] despite saving two or three percent on

each case.

In the first -- another point I'd want to make is around another concern that we don't give -- haven't given much attention to, and Bill and Mark and Glenn had a very brief conversation about it in round one, which are sort of the business issues. If I'm a home health agency, how do I develop a business plan and a budget if my cash flow is going to a different entity? Now, it's possible you can sort of have the payments flow through, but sort of by definition, some other entity -- and I assume for practical purposes it's going to be the new hospital and not new entities we're going to be creating -- is in control of steerage.

So now we have given my, if I'm a home health agency, virtually all of my potential revenue is actually in the hands of a hospital and that, for better or for worse, that creates a whole different set of relationships. And I would distinguish an ACO in which there are contractual business relationships amongst the parties where they work these things out from just having these relationships based around payment. I'm not sure how the market would respond to that, but I think we would want to really try to

understand those bundled relationships, sort of the business aspects of those bundled relationships. How would it actually happen?

That's why I've thought for a long time that rather than actually having to bundle the payment to hospitals and doctors and in dealing with the, in many cases, the relationship issues between doctors and hospitals in many communities, just be more liberal on your use of gain sharing and the bulk of at least the payment to hospitals and doctors for a hospitalization is the hospital's money. If we want them to cooperate and use joint purchasing to get lower price appliances, et cetera, do gain sharing and not have to deal with the complexity of actually giving the doctors' money to the hospital.

So in any case, I don't know exactly where I would come out on this, but I don't think we've explored those very practical, how would the market respond to a complete different cash flow situation.

And so the last point I'd want to make, and this is what some of the other Commissioners have addressed, is does this get us on the path to where we want to go, or as I would say, is it potentially a cul-de-sac where we would go

in and never get out and spend a lot of time. So I guess it was Mike saying it can't be worse than what we've got, it might be better, but there's a lot of opportunity costs if we really spend a lot of effort going to something that might be marginally better.

Here's the scenario in which I think it could fit into a long-term strategy. If we actually had ACOs that were paid global payment or some combination of global payment with some fee-for-service sort of a partial capitation, but something where they're really taking risk, and it was based on physician organizations, and they were controlling referrals to the hospital, appropriateness, then having a bundled episode -- or having an episode, broader episodes, including the readmission, et cetera, would be a better payment vehicle for them to be reimbursing the hospitals than a DRG that stops at the discharge. We have a mechanism for controlling appropriateness.

If, in fact, we don't have physician-based ACOs, then I think we've got a problem of that a bundled payment in and of itself doesn't do anything to address the fee-for-service incentive to generate lots of inappropriate services and I don't think it gets us -- it doesn't move enough away

from fee-for-service that it's worth it.

And under, I guess it was Carol laid out the possibility of having complementary payment systems. There would be some services that would meet criteria for a bundled episode payment, but then all sorts of other services wouldn't. So we're going to have another payment system to administer simultaneously, and what is that? If we have 15 or 20 or 25 percent of care flowing through bundles, I'm not sure -- we still have to address the other 75 or 80 percent and I don't know how, short of -- it's conceivable that maybe you're better off than you are now, but I could imagine us not being much better off than we are now.

So those would be my concerns about this. I would reiterate that I think -- and I support the fact that this is happening. I think we will learn a lot, which will have some potential application, or maybe that some of these models actually -- it may be -- well, here's what I would urge strongly, is that CMS would actually explicitly think about the issue of appropriateness, and if Carol is right that there might be some strategies around admissions policies and things like that, that should really be part of

the pilots, to try to address this issue. So at the end of the day, I would want to know whether this institution that has a 30 percent increase in volume is at the cost of some other provider or is at the cost of Medicare.

MR. HACKBARTH: So, for me, I have no regrets, to use Bruce's expression, no buyer's remorse about the pilots that are now being established. I think that -- I thought it was a good thing before, I think it's a good thing now.

On the question of is this ultimately going to be a critical piece of the transition that we hope to make towards more organized and efficient, higher quality care delivery, on that, I'm less sure. I believe in global payment. I don't see global payment happening now or anytime soon. You know, when I look at the details of these bundling pilots or proposals and all the difficult issues you need to work through, the blood drains from my face. But I remember well going through in detail the ACO stuff and more than once thought, oh, my God, there's got to be a better way than this. We are just in the weeds. We are so tangled in this ACO regulation that we've lost sight of what the objective is here. And ended up with an approach that, as I said earlier, I think is fundamentally compromised by

not engaging the patients and making choices.

And so none of these options is going to be a clean, simple fast track to the destination that at least I want to go to. There's going to be complexity in every direction and struggles in every direction.

But I agree with George. This was a rich and very helpful discussion and we'll digest it and come back with some thoughts about how to proceed.

Now that we are enormously behind schedule, we'll turn to care coordination, and I suspect have some of the same issues arise. Maybe the second time through we can do it in a faster, more streamlined way.

Thank you, Carol and Craig, for your work on this.

Whenever you're ready, Kate.

MS. BLONIARZ: Good morning. Throughout the Commission's work on a variety of different issues, you have expressed concern that gaps exist in care coordination in fee-for-service Medicare and that beneficiaries are undersupported in transitioning between settings and across providers, accessing medical information and supports when they need them, and may receive conflicting information about how to manage their illness because providers are not

communicating effectively about managing the beneficiary's care.

This lack of effective care coordination in fee-for-service is particularly concerning because Medicare beneficiaries are more likely to have multiple chronic and acute conditions requiring systematic coordination. And when the care is not coordinated, the risk of an adverse health event increases.

Today the presentation will discuss indicators of poor care coordination in fee-for-service, discuss different care coordination models, and evidence to date from some Medicare demonstrations. Then I'll discuss challenges in applying care coordination models to fee-for-service Medicare and outline some possible next steps. This work benefitted from the assistance of Kelly Miller, Kim Newman, and John Richardson.

There are many indications that care coordination in fee-for-service Medicare is poor.

First, providers request repeated histories and often do not have access to medical records from other providers, meaning that the beneficiary is the sole source of information about their prior care.

Second, adverse drug events occur with some frequency among the Medicare population, resulting both from contraindicated medications as well as under- and overuse of appropriate medications.

Third, transitions between settings and across providers are poor, particularly discharges from hospitals to a community setting, where a beneficiary must learn new tools of self-care and how to recognize dangerous complications.

And, fourth, beneficiaries may use an emergency department or hospital for non-urgent illnesses or an acute exacerbation of an illness, that could have been managed in the community because their care was not well coordinated in the ambulatory setting or they were unable to access appropriate medical care in a timely way.

Now that I've laid out the evidence around gaps in care coordination, this slide presents a framework that you could use in thinking about future work in this area.

Incentives for care coordination could result from a number of different policies, ranging from narrow policies to broad ones as you move down the slide.

At the narrowest end or the top box are changes to

the fee schedule to direct resources towards care coordination. Examples could include expanding codes for transitional care or establishing additional codes for taking care of patients with chronic conditions.

The next box, moving down the page, are policies that would establish a dedicated payment for care management, including a per-member per-month payment to coordinate care for a group of beneficiaries, or a payment for a transitional care intervention for patients getting discharged from the hospital.

Then, next on the continuum are policies that pay for outcomes resulting from good or bad care coordination. One example is the policy to reduce Medicare payment to hospitals with excess readmissions.

And, finally, in the broadest category are payment reform models that make the provider responsible for delivering a certain quality of care at a fixed level of spending, with wide leeway on how to do so. These include accountable care organizations, bundling, or capitation.

While this presentation is generally focused on policies in the second category, your discussion could pivot off of all four.

So within that second category of care coordination policies, this slide has the types of models that entail a specific care management function and establish a payment for them, and I'm going to just cover these quickly in the interest of time.

First are practice transformation models so that medical practices can improve the delivery of coordinated care. These include the medical home model or the chronic care model.

The second group are embedded care manager models, where care managers are trained in care coordination processes and then located (or embedded) within a medical practice.

The third group are interventions to facilitate transitions across settings, following a beneficiary from the hospital through their first medical appointment and for a specific time period beyond.

The fourth group are external care manager models, where the care managers operate outside of the medical practice.

I want to spend a little bit of time talking about care coordination over the life cycle as well as how the

principles of palliative care fit into this.

Many of the care coordination models focus on beneficiary-centered, goal-focused care that facilitates access to social and medical supports. This includes eliciting the beneficiary's preferences about their care and making sure their care plan reflects those preferences.

And they emphasize making sure the beneficiary knows how to manage their symptoms, understands their illness and care options, and is able to successfully communicate with their medical staff to get the information they need.

These principles are very much in line with palliative care, which, in addition to emphasizing beneficiary-centered care, also emphasizes symptom management or goal-focused care -- for example, minimizing pain, reducing side effects, or maintaining a certain level of mobility.

Palliative care can be appropriate for beneficiaries at advanced stages of both curable and non-curable diseases, such as beneficiaries with treatable cancers that cause significant pain, beneficiaries struggling to manage a complex drug regimen, or

beneficiaries with serious illnesses and many complications.

As a beneficiary moves through different stages of their disease progression, beneficiary-centered palliative care may become more important in the overall framework of their care, bringing together both care coordination and palliative care principles.

There's a lot of evidence out in the literature about the efficacy of care coordination models discussed on Slide 5, and this slide presents information about Medicare's experience with care coordination models.

Medicare has conducted three large-scale, multi-year demonstrations of care manager models of the type we have been discussing. In these demonstrations, CMS paid an care management fee to providers, disease management organizations, or other groups to coordinate care for Medicare beneficiaries with chronic diseases. In total, there were 29 programs among the three demonstrations.

The last two columns on the slide has the reported outcomes from the evaluation of the demonstrations, and generally, the results were quite modest. Overall, the programs did not make significant improvement in clinical process or outcomes measures. And out of all 29 programs,

only one program significantly reduced Medicare expenditures enough to recoup the cost of the intervention.

You might here see a disconnect between Medicare's experience testing care coordination models and experiences in the private sector or evidence in the literature. So this slides discusses some of the challenges and the reasons that evidence in one setting may not be applicable to fee-for-service Medicare.

First, interventions will have to work in different places and different settings. Some of the Medicare demonstrations were not prescriptive about the type or design of the intervention, recognizing that a model may work in some areas and not in others.

Second, identifying beneficiaries for whom care coordination is cost effective and who would recoup significant benefit is challenging. The Medicare demonstrations were generally most likely to be cost-effective if they targeted beneficiaries with spending about twice as high as the average. However, the evidence on poor coordination leads in a different direction -- to beneficiaries with very high Medicare spending and a significant disease burden. These findings may suggest that

a range of different care coordination approaches is appropriate depending on the disease burden of the beneficiary.

Third, models of care coordination that rely on significant patient engagement may not work well in populations facing dementia or other cognitive challenges, so they may need to be modified.

And, fourth, ensuring that beneficiaries remain in the model or connected to the care manager is a particular challenge for Medicare because the beneficiary can seek care from any willing provider.

With the evidence to date from the Medicare demonstrations and the other models of care coordination described on Slide 5, there are three elements that appear to be key.

First, managing transitions, reconciling medications, and otherwise facilitating a beneficiary's discharge from one setting to another is a key part in nearly all of the models. Beneficiaries face a special vulnerability at these points, and it is particularly acute for older people.

Second, establishing both robust information

technology that is interoperable with other systems as well as process changes to facilitate communication across settings and providers is another important component.

And, third, the models that have shown the most promise had significant communication between the care manager and the beneficiary's direct medical staff. This last point does not mean that the medical practice staff have to do the care management activities themselves. Some models embed a care manager in the medical practice, and other models have the care manager attend the doctor's appointments with the beneficiary.

So now I will turn to some upcoming activities. The Center for Medicare and Medicaid Innovation, or CMMI, was established to test models of care that have the potential to reduce costs and improve quality. CMMI, as you know, has undertaken a wide range of projects, and four are directly germane to this discussion: the Independence at Home demo; the Community-based Care Transitions program, which is part of the Partnership for Patients; three projects testing the medical home model; and the Health Care Innovation Challenge. In the interest of time I am not going to go through these but can answer questions.

So to bring it back to the framework I laid out at the beginning of the presentation, there are also broad ways of incentivizing care coordination in fee-for-service Medicare. These types of approaches implicate a wide range of the Commission's work, including readmissions, bundling, and ACOs, as well as your work on different models of care for dual eligibles.

For example, one path is to focus attention on reforming the payment system to change the incentives more broadly. Under a bundled payment or ACO, if the return on investment for care coordination is positive, then there's a direct financial incentive for providers to invest in it.

Another path is to pursue using payment policy to reward positive outcomes resulting from coordinated care, such a low hospital readmissions, or penalizing negative outcomes resulting from fragmented care, such as high avoidable emergency department visits.

The Commission could also pursue more narrowly targeted policies for care coordination of the kinds we have been discussing.

First, the fee schedule could be changed to more fully capture care coordination activities. We haven't

talked about this in the presentation although there is more information in your briefing materials.

The second option is to establish a dedicated care management payment, such as a per-member per-month payment for a medical practice, like in the medical home model, or to an external care manager.

The third option is to define a specific set of activities that facilitate good transitions between settings and to establish a payment policy around them.

And, finally, the authority given to CMMI to test models of care could provide more evidence on how best to improve care coordination in fee-for-service. CMMI is planning to implement a rapid cycle evaluation strategy, which could mean that the results would be available in a more timely way than some of the prior Medicare demonstrations. On the other hand, the results to date from the Medicare demonstrations have been modest.

With that, I'll close and can take questions.

MR. HACKBARTH: Mary, why don't we start with you this time? Clarifying questions.

DR. NAYLOR: Just clarifying. All of the investment of Medicare in the multiple Medicare

demonstrations over time and, indeed, much of the investments in private or NIH-supported models would really raise questions about the value of care coordination. I'm wondering how you -- have we looked at what we can learn that's underneath all of those demos? I mean, have we had a chance to interact with the people that are conducting the demos or leading these models that have overall shown limited positive impact?

MS. BLONIARZ: So a couple of papers have looked at kind of the synthesis of all of the demos overall, and so there's a lot of information about -- there was a paper that Dave Bott and colleagues at CMS did in 2009 and then a more recent one that Lyle Nelson at CBO did where they looked at, you know, okay, so overall there's limited evidence, but certain facets of certain models seem to be promising, and it was things like interfacing with the medical staff and, you know, the intensity of contact between the care manager and the beneficiary. And so they've done some work to try to tease that out, and we can look into that more as well.

MR. HACKBARTH: Could you put up Slide 7 for a second, the one with the summary? In the care management for high-cost beneficiaries, one was significant savings.

Was that the Mass General?

MS. BLONIARZ: It was.

MR. HACKBARTH: To me that's sort of an interesting illustration. All I know about the Mass General project is what I heard one day at a meeting, and I was impressed at what seemed to be very significant effects. You would think Mass General, this is about as improbable a place to get really positive results, as you could imagine, given the historical culture of the organization. Yet they were able to make it work by engaging some really smart people in doing the work, and they had strong institutional support.

And so, you know, when I look at these and, you know, no result, no effect, no effect, no effect, you know, the immediate impulse is to be discouraged by it. But I think that the real focus should be on those that succeeded, and then the process of how do we teach those lessons to other places as opposed to just saying, oh, care management for high-cost beneficiaries doesn't work because it only worked one place and the balance of the evidence is negative. I don't think that's the inference that we ought to draw here.

MR. KUHN: Just to kind of dig in a little deeper on those demos to get a sense, did any of the data or any of the studies show if there was a particular disease or particular patient that performed better in these kind of care coordinations? For example, did heart failure or diabetes or a CKD patient, you know, to delay the onset of full-blown renal failure, any sense of the types of patients that might have done better?

MS. BLONIARZ: So some of the -- each of the demonstrations had specific groups that it was targeting. Some were condition specific and some were just, you know, you had to have a hospitalization the prior year. I think one thing that did seem to come out is that the demos were most -- the programs were most effective if they kind of had this band of beneficiaries who had higher-than-average spending but not spending that was so high that they were having many hospitalizations and very advanced disease burden.

And so I think that's where we're trying to say that maybe these types of models are most appropriate for that group that's kind of, you know, prior to crisis but, you know, kind of moving in that direction.

MR. KUHN: Okay, that's helpful. So it's basically those that have high spending but not the real train wrecks, is kind of what they're saying here.

And then the other question I had had to do with on some of the -- like the Medicare Health Support Demo, I know one of the problems with that one, as I recall, is that the data fees that they were able to get back on the patients, because of then it was the old fiscal intermediary system, it would be 60 days before they could get any data on a patient. So they might be trying to intervene with someone, and all of a sudden they find out 45 days later, oh, by the way, this person had an encounter at the ED, they had no idea, so how could they manage them. Or they were getting a new prescription from their physician, so they weren't getting Part D claims.

So how much better are the information systems to support almost real-time management of these patients on a go-forward basis?

MS. BLONIARZ: So there are two points I'd make on that. The first is that CMMI has put in a lot of effort to get claims data back to the providers more quickly, and I know this is a specific interest in the Pioneer ACO demo. I

think the other thing I would say -- and this is something Mark and I have talked about -- is that there's also a feeling that the providers should also have other ways of getting that information, whether it's establishing relationships with hospitals or other providers in the area, because reliance on claims information means that you're always going to be getting that information significantly after the hospitalization occurred. So there's just kind of two answers to that.

DR. MARK MILLER: My take is that as a result of some of the things that they learned from that demonstration, when they're thinking about actors in subsequent demonstrations, it was, What capacity do you have to know or touch the patient as things are going on? Because even in the private sector, you don't see the claim on the hospitalization until after the fact.

The other thing I'll say -- and I don't want to push this too hard because I can't remember precisely where I was getting this. I also thought there was some sense from that demonstration that they had -- even though they had very little success, that to the extent that they could show success, it was more likely for congestive heart

failure than it was, say, for diabetes. Those are some of the things that I remember some of the actors coming out of that were saying. But that's not science. That's what people were saying coming out of the demonstration.

DR. STUART: Just briefly on the IT and communication protocol, I think it's obvious that you have to have information in order to coordinate. But I think it's also dangerous to assume that if you have information you are going to coordinate, and particularly if you're going to coordinate to save money. There was a piece that just -- I haven't even had a chance to read it. I just saw the abstract of a paper that was just published in Health Affairs that showed that medical groups that had a high level of information systems actually were more likely -- the physicians were more likely to prescribe more laboratory tests and more high-cost imaging than physicians that didn't have those services.

So I think we have to be a little bit careful here in terms of what we can expect just from the information technology part.

DR. CASTELLANOS: Kate, good presentation. I know there has been a lot of work done in the medical community,

in various medical societies, I think CMS has done some work on this. In fact, I think Herb will tell you, when we were there, when I was with Herb at CMS, we discussed care coordination, and I know the RUC has done quite a bit.

You made reference in the footnotes to some codes. I'm just curious where we stand. I mean, there's been a lot of work done. Where do we stand with that?

MS. BLONIARZ: So I can speak to a couple things and then maybe Bob or Kevin would want to jump in, too.

In the physician fee schedule rule this year, there was -- a proposed physician fee schedule, CMS asked for, you know, input on care coordination and chronic care codes and things of that nature. And ultimately they decided not to make any changes because there's a bunch of ongoing work in this area. The Office of the Assistant Secretary for Planning and Evaluation is doing a study on kind of care coordination and the fee schedule, so that's ongoing. I know that the RUC also has a group that is focusing on care coordination, and I believe they have fed some suggestions to CMS.

Those are the things I can speak to, and maybe Bob wants to speak to some others.

DR. BERENSON: Yes, which is, I mean, the RUC is actively engaged in this issue. In reading what they have submitted to CMS, I guess I would observe that some of what they've suggested are very discrete, concrete activities, like anticoagulation management, which in my view lend themselves to CPT coding pretty well.

Another area that I think -- I forget if it's in theirs, but I know others have proposed it -- is a very targeted definition of physician activities related to a patient discharged from the hospital related to communication with the hospitalist, medication reconciliation, a very concrete, definable thing.

I had some more concerns in the area of just opening up fee-for-service reimbursement for phone calls and related communication. I'm not sure you can capture in a fee-for-service system some of that activity.

But to your basic question, the RUC is very active and has been pretty constructive in providing some advice in this area. I think a lot of people think that you can't do everything in a fee-for-service construct that you want to do to promote care coordination.

DR. CASTELLANOS: Good. Thank you.

DR. HAYES: The only other thing I would add to that would be that Kate's right, there is a lot of interest at CMS in trying to promote primary care more generally and care coordination in particular. And there's an openness to ideas such as those that would come from this technical evaluation panel that's been convened by the Assistant Secretary for Planning and Evaluation. So it's just kind of an ongoing process and one that we'll have to keep an eye on.

MR. HACKBARTH: Didn't the RUC also do a build-up of how you might set a capitation payment for the medical home demos as well?

DR. BERENSON: Well, the initial medical home demo that never happened.

MR. HACKBARTH: Right.

DR. BERENSON: They did have a set of specific recommendations.

MR. GRADISON: Thank you. Kate, a quick naive question. You say here some care coordination programs in the Medicare demonstrations dropped out midway. I'm curious how many -- well, not exactly how many, but were there a lot. And then, why? Why did they drop out?

MS. BLONIARZ: So there were a fair number of them, and I can get you the specifics. But, generally, especially for the demonstrations where the fees were at risk, they did not see it as being financially viable once we were getting information on avoidable hospitalizations. You know, some programs actually increased spending as compared with the comparison group, and so I think there was a financial decision for a lot of them.

I know Georgetown also dropped out early, I think, in one of the demos because it was unable to recruit a sufficient patient panel to make it worth their while to run the program.

DR. BORMAN: I guess I'm a little struck in this conversation about how coordination of care is starting to remind me of the terms "accountable care organization," "medical home," in that for as many people as there are in the room, there's probably 2x times that understanding of what the terminology is. And I guess if we're going to specifically address this in some fashion, I think perhaps one of the things we have to do early on is sort of identify what we're trying to come at. And just from a fair number of years of being pretty close to the CPT process, I can

tell you that the gazillion of proposals to come and fragment this and the most incredible number of codes that you can sort of bundle up remind me of the things that you can bundle up -- not to pick on any one in particular, but complex spine surgery.

So I really have some concern about what we're doing here because is this for every phone call, or whatever. Just because I might be someone who chooses not to go to the hospital anymore, why should I get extra money for having to find out what happened to my patient in the hospital? I guess I have a little bit of, you know, ethical angst about that.

So I think as we go down this road, I'd just like to clarify what it is that we as a Commission are considering, or is our role to say coordination of care can mean all these many things, and here appear to be the ones, based on the data, where there may be areas of high value, low-hanging fruit, you know, achievable savings. I'm struggling a little bit with where we want to go.

MR. HACKBARTH: My short answer would be it would be the latter. There are a lot of things that fly under this banner of care coordination, and I think a way that we

can help is sort of go through that and say these look particularly productive to us and these might not be on the path.

DR. NAYLOR: So I would build on Karen's comment. I do think that there's a really important need for clarity around what these words mean, and a lot of work has been done in this area. McDowell did a major report for ARHQ and distinguishes care coordination from transitional care. And they're not the same thing. So I think a really important starting point is just this language around the concept.

I also think that there's been a huge amount of work done understanding the needs of people along a continuum. So a lot of emphasis on which models have been effective for whom at what point in time that help to promote downstream, or is it upstream, better self-care to prevent longer-term outcomes versus those that have been really effective, and that's in the areas around most vulnerable transitions at most vulnerable times and getting a short-term impact, et cetera.

So there are systematic reviews that I think would help us to understand what are the core components of effective interventions at which point in time along these

trajectories. And I think, you know, they constantly clarify -- you know, one of the things about the Medicare demo is -- many of them is that they didn't start with what we knew about what's the best approach, evidence, et cetera.

So often they recast some ideas that we maybe shouldn't have gone to. But that's the past. And I think what we know now is that it's multi-dimensional. Nurses have been seen in the most effective interventions as being central and hubs. And, you know, so we have a sense of who are the players that need to be working here and what are the core components that we should be supporting.

So I think this is a really important path. It's not simple. And yet, I think there is a critical opportunity along the entire trajectory of the beneficiaries that we're serving to get to higher value through the right kind of investments.

The policies. I think, you know, looking at how do we promote the processes that are evidence-based and work along with creating the accountable systems that say, We're paying for performance, I think the combination of the two makes sense in advancing this field very, very quickly.

DR. DEAN: This has been an area that I've been

concerned about for a long time. I would certainly support what Bob and Karen said, that I think the idea of trying to set up a separate payment for coordination of care is just the wrong direction. It's too hard -- and fee-for-service, yeah.

And I would hark back to the comment I made before. I thought this article that talked about a primary care provider's view of who is complex compared to what the standard measures show us is complex, and they didn't correlate, and I think most of us who have been on the front line can think of, you know, any number of patients. And yet, we need to be sure that the coordination gets to the people that really are the complex patients, and they're not real well identified by our current measures. That's me.

So I think that argues that we have to build these payments into some kind of global payment. I mean, I realize, you know, how you define that is a huge issue, but a separate fee-for-service payment just sets up another set of providers that may or may not be contributing much, and I think that's the problem with some of these demos.

And I guess that would lead to the second point, is that for these things to be effective, I feel really

strongly they've got to be closely integrated with the care-givers. It can't be a separate outside agency. I just remembered an amusing thing with one of the first special needs -- what am I trying to say -- payment programs, and one old fellow came in and he says, Oh, yeah, they sent me this book that I was supposed to read, but I just threw it away. And it's got to be part of the overall payment system.

Finally, I would really argue that the transfer of information is just so important. We've put a lot of emphasis on the importance, especially in the rural context, of the value and the need for people or us, as rural providers, to make sure that the information about the patient gets sent to the referral center. We've put almost no emphasis on the reverse.

And we have to sometimes -- it's like pulling teeth sometimes to get the information for the transition back. When they come back to us, they will be on a bunch of drugs, we really don't know why, and a whole list. I can give you a whole list of unpleasant scenarios.

But I think we know that those transitions are important. That's where things fall apart often and we've got to emphasize that the need for information transfer has

to go every time there's a transition. It isn't just in the acute situation.

DR. HALL: Well, when you can't find any positive studies after a number of people have done something, it probably means that because of publication bias, that for every one negative study that's published, there are probably a hundred that never see the light of day because nobody wanted to report negative data.

So some people describe folly as doing the same thing over and over again and expecting a different result. But I think this is such an important topic and is so central to any kind of health care reform that we can't give it up, even in the face of these negative studies.

I think one variable that's still out there right now, and it's at various stages at various parts of the country, is sort of the acceptance and utility of the electronic medical record. You would think that it would be a no-brainer that something like medication reconciliation between being out of the hospital, in the hospital, in another care venue, at home, would be a piece of cake.

In point of fact, what's proving to happen in many parts of the country, even with the standard packages that

are available, it's required huge amounts of time and the error level is very, very high, and the only way people have been able to get through that is to put in huge numbers of people hours.

So we're at the very kind of cusp of a major change in having information around. So we need to sort of, I think, see whether in systems that have really successfully and maturely accepted electronic health records for the entire system of care, if they're doing a little bit better, and there certainly are some examples, but not a whole lot yet.

DR. BERENSON: I much appreciate the work and this is real important and I hope we continue. You found the Randy Brown piece and cited it, but I actually would like to give it a little more emphasis. There is a -- sort of the headline is that the CMS demos didn't work. Underneath the headline, people like Randy Brown, who's at Mathematica and knows as much about these demos as any single human, wrote a paper a few years ago in which in the middle of the failed demos there were successful interventions and successful components of effective programs.

The three that he identified as worthy of emphasis

are transitional care interventions, what Mary knows all about; self-management education interventions, and I didn't think he gave -- was that in your chapter? I'm not sure.

DR. NAYLOR: I didn't talk about that.

DR. BERENSON: Kate Lorig's approach based in Stanford about basically teaching patients self-management skills. And then number three is what he calls coordinated care interventions, but basically this, instead of disease management, telephonic disease management, and is focusing on patients with particular chronic conditions at high risk for hospitalization and having a central role for the practice in that activity, with the ultimate role being to base the support, whether it's often an advance practice nurse actually being in the physician's practice, that those three across the failed demonstrations have great promise for success.

He goes on to say one other, I think, important thing, which is that in definitions of medical homes, rather than having everything, including the kitchen sink -- he didn't use those terms, I'm using those terms -- everybody's idea of what a medical home should be, go where the evidence says.

We have three interventions that work. If you add sort of the traditional pillars of primary care around access and comprehensiveness, et cetera, you would have a much simpler and probably much more powerful definition of advanced primary care or medical homes than, in my view, what we've got now.

And so I think that's the point I wanted to make, is that these are not necessarily failed demonstrations. They ultimately would need to be revised and targeted to achieve.

And then I wanted to address Karen's point, which I think is an important one, about, well, our primary care doc is going to not go to the hospital and no longer be doing what they were doing, but still get additional payments. I have some sympathy with that point of view. In fact, I co-authored a couple of articles on payment models for medical homes, and one of them was to actually reduce the fee-for-service component of payment to primary care, put a larger piece of it into a care management fee, consistent with the notion that real good care management, care coordination, is not based in office visits, but there should be some more freed up money for physicians to not

only be communicating more often with their patients, but with other physicians, with social service agencies, et cetera.

And so, even if you don't increase the payment -- and separately I think we should be increasing the payment, but that's a separate discussion -- it's changing the distribution of how the payment occurs. I would point to the Netherlands and to Denmark as two countries that now have that as the payment model for primary care, about a third of it coming -- a third to 40 percent coming in the form of a monthly care management fee, and the rest of it coming as fee-for-service.

And so not only does the relative generosity of the payment count, in which we can agree or disagree with each other, but sort of the division of the payment from fee-for-service to a sort of monthly payment, I think, is also important to free up some opportunity for the practices to behave differently, essentially.

DR. BAICKER: I think the dual emphasis on the quality outcomes and the financial outcomes is important because we have a natural tendency to want these things to save money, and it seems like they should save money if

you're reducing duplicated tests, if you're improving hand-offs and reducing readmissions and all of that.

But I wouldn't want that to be the main benchmark by which we evaluate success because here's a case where we could potentially improve quality at a low, but positive cost. And that would be a good thing. And so, obviously you want to watch both metrics, but I don't want the rhetoric that this is a failure if it's not cost savings to enter in too much.

MS. BEHROOZI: I'm so glad you said that because it occurred to me that like if there was some new treatment that came on the market, we don't yet do least costly alternative or whatever, right? We don't judge whether this is going to be cost-neutral or cost-saving. We pay for it because we presume, or whatever, the way things are now, it's presumed that it will improve health outcomes.

And, Kate, I thought one of the really wonderful things about this paper was that you were so compassionate in describing the impact on individuals of the lack of care coordination, and there is so much opportunity for improvement of their lives, not necessarily all measured in outcomes like avoidable hospitalizations that cost X

dollars, but in being less confused, being less frightened, being less terrified to go home when they don't understand their instructions.

I think that was just a real strength of the paper, and I agree with Kate that that drives in the direction of not -- it's not like bundled payments where it's all about the payment, you know. This is really about care, it's really about treatment.

Clearly we care about the sustain ability of the program and we don't want to open up a whole Pandora's Box of additional spending that isn't tied to better outcomes. So we absolutely should be looking for outcomes. And yeah, the intuitive thing that this improves -- or money is better spent this way, I think we should also be looking for that for that result.

One thing I want to say, a little bit coming off of Bob's comment about freeing up money, you know, not having it be so tied to the sort of high-level provider, whether it's a physician or a physician extender, advance practice nurse, or physician assistant, you talk a lot in the paper and in the discussion we talk about care managers.

But something that's being discussed out there a

lot, and maybe Scott has something to say about this -- I'm not sure if you're there yet -- is community health workers, people who are not professionals at all, maybe don't even have a background in health care, who really extend the ability of physicians, of clinics, you know, and FQHCs and PCMHs, they're looking a lot to people who can make a decent living doing this, but they're not going to get paid doctors or other advance practice professional rates to do so. But there's no room for them in the fee schedule now.

So I think that that does argue in favor of, you know, what people are trying to do out there. It argues in favor of additional payments. I think it's taken into account in the FQHC structure and maybe we need to look at its availability a little broader.

MR. GEORGE MILLER: Yes. Both Mitra and Kate teed up my very limited comment because I agree with Mitra. I thought the chapter was very good on dealing with the compassion and what a difference care management can make in a beneficiary's life.

And although it wasn't the goal of the chapter, and I certainly understand that, but I certainly would like to see that translated to my -- my passion about health care

disparities and how care coordination can deal with that issue.

And this may not be the appropriate place, but at some point in time, care management can make that difference and we should have that as a measurement tool, especially in large communities where there may be significant health disparities in communities. So I just wanted to add that point.

DR. STUART: Just very briefly I want to follow up on a point that Bob made about these failed demonstrations. And we want to make sure that the information we take away from this is not that the organizations themselves necessarily failed to achieve their outcomes.

The other part of this is the place -- the role of CMS in terms of setting these things up, and this is just anecdotal, but I know of at least two of the contractors on the Medicare Health Support side were very, very critical of CMS in terms of their ability to identify patients for enrollment, and also in terms of getting information back in a timely manner to the organizations so that they could act upon it.

Now, I don't want to go there. I don't know how

serious that is, but I think the point being that with this new set of demonstrations that the Innovation Center is going through, I think it's going to be really important to understand right now whether they're set up in a way so that they could at least avoid those two major problems that were apparently an issue with the Health Support demos.

DR. CASTELLANOS: I think this is a terribly important thing and I think there's a significant benefit that we can do to the Medicare system with cost savings. There's just no question that we can prevent excessive tests, et cetera, et cetera. We can increase quality, but we also can do something that we really need to do, is to help the beneficiary. In the real world, this is a significant problem.

Can we go to Slide 9? I think it answers a lot of the questions. We already talked about managing transitions. IT and communication, I think, Bruce, you've mentioned that. We need to improve that.

Interface with the direct medical team. The person that does this does not have to be a physician and probably shouldn't be a physician. I know in primary care, Tom, 40 percent of what you guys do is uncompensated, but

it's terribly important to the patient and to the delivery system.

I would like to talk -- I think you need somebody in the system, and when Mary talked about PACE, one of the most important persons on her team, and it is a team, it was the bus driver because he noticed there was problems. And we need that in the office or in a clinic.

I was part of one of those demonstration projects where they had an external person, and, you know, that person interfaced between the patient and the medical care team, and we never really got any feedback from them. And I kept telling them, You need to talk to us, you need to let us know what's going on. Well, that's not our role. Our role is just to talk to the patient.

And nobody wants to talk about money, and I agree. I don't think this belongs in fee-for-service, but there are two parts of fee-for-service where we have this now, and I was wondering if you have any experience. I know they pay for this with hospice and they pay for this for home health. Has it been beneficial? Is it a positive or negative? I think we need some feedback on that.

I don't have any feedback, for sure, and I'm not

sure how you get that. But to get somebody into the office as an advance practitioner or a nurse practitioner, or whatever, they play a vital role and that person needs to be compensated and there needs to be some part of the bundle or some part of something where this service is recognized and valued and paid for.

DR. MARK MILLER: Can I just ask one thing really quick? I just want to clarify. When you said it's paid for in hospice and home health, you were saying the physician gets compensated for developing the plan of care? Is that what you were referring to or were you referring to something else?

DR. CASTELLANOS: I'm really not -- yes. In fee-for-service, it is the physician. They get some compensation, but it's part of a team. I want to know how successful that care management is for home health, how successful it is with hospice, not just to pay the physician, but we're already --

DR. MARK MILLER: I see. I got you.

MR. HACKBARTH: Right. I have to scrutinize at least once a meeting.

MR. ARMSTRONG: So first I would just say, I would

agree with many of the points, that this is a very important, interesting topic. I look forward to the work that we'll be doing on this. I'm glad we're doing this. I have to say that if there are no positive results from these studies, why am I doing every single one of them in the organization that I work for?

And I guess part of -- so I'm looking for you answering that question for me. But I think first, this is not something that you buy. This is a feature of a system that's working well.

And I think the other key that I hope we can really push forward as we go through this is that these interventions really represent a portfolio of different tools that we have. Our key is to apply the right intervention to the right patient.

And so, I don't know how that affects the impact of the study, but it seems that the competency we're trying to build in our care delivery system is not care coordination, as defined by these different interventions that we're trying to evaluate, but actually it's connecting a patient and their individual care needs to the right intervention.

I think that's the best explanation that I could offer for why literally every one of these different ideas that we've studied and have proven not to show results when they're analyzed in the way that we do are interventions that are an important part of how we run our system.

Just briefly, one other point I want to make is that I think part of why it works, too, is that as you note in the report that care coordination interventions really have to be placed in the context of a lot of other features that make good systems work well.

Information technology has been mentioned. I really agree with the fact that care coordination needs to be grounded in care teams. This is part of clinical decision-making that is very difficult to do from a call center in the Midwest somewhere.

And another feature of a care delivery system that we have begun to believe really works with respect to care coordination is to Mitra's point, and that is that even the health care system, as we think about it, is too narrowly defined. Most of the health that our populations achieve is a function of who they hang out with and who their friends are, what church they go to, and to the degree health care

systems in this coordination of care is finding ways of recognizing that it's far beyond doctors' offices and it's into the community that's having a real impact on overall population health needs to extend.

Actually, the final point I would make is that, I think we have to acknowledge, as we look for ways of advancing within fee-for-service some of these ideas in ways that will really get a result, that one of the hardest practical issues is that Medicare is only a small part of most practices.

And that we're talking about changing clinical practices and the way we work, it's very difficult for practices or hospitals or others to do when it's only a subset, a relatively small subset of the patients that need them. So I think we can't not acknowledge that as well.

DR. CHERNEW: So, the first thing I'd like to say is despite the complaints about how CMS operationalizes some of these demonstrations, I think the evidence from the private sector is actually not stunningly optimistic as well. With that said, different things will work in different groups. In Seattle, I think they work great, but other places I'm not so sure.

So you have different groups that may be able to implement them in ways, different approaches that will work, and again, it's going to be constellation of activities that matter. So it's very hard to go through this thing and say, Oh, if you just had this, it would work. It's this whole constellation set of things.

My general view, because I'm an economist, is that the financial incentives are a prerequisite to having those things work, but they're by no means sufficient to make them all work. And so we have the sort of financial system that would support it.

I'm pretty strongly opposed to the idea of building some extra payment modifier into the fee-for-service system. I think that's moving in the wrong way. I think it's going to add a whole lot of administrative and regulatory burdens. And what I would say to groups that turn out to be very good at these types of activities, they should try and migrate to new settings, to the extent they can, or they will be rewarded for doing all of that stuff.

And I think just think it's remarkably hard to move to a paradigm. It's almost the opposite of what I said before. We were thinking about things in a patient sort of

concentric way. I think that's sort of a better way of thinking about it than moving to a paradigm where we figure out everything you've done and then figure out exactly how to reward it, because then you're going to have to figure out, What's the cost for it? What happens if it was done by these types of people in this setting? What if you did two of the activities instead of just one of the activities?

You know, if you have a separate person call, you know, all these questions about how to micro manage this fee-for-service system seems to philosophically move in the exact wrong direction. And frankly, and maybe it's just because we've been sitting here for a while I'm mildly grumpy, I think some of this is just to try and cover the fact that we're under-paying certain providers for providing really important things and we're trying to find some big justification to give them more for all the various things they do, when a better approach would be to just pay them more adequately in the first place. Of course, by more adequately, in my mind, I mean in a more integrated and bundled way, but at least at a minimum to give them more adequate payment instead of looking for other ways to find all the literal things they did to bolster their

reimbursement.

So I think moving away -- I just would not go down the let's have a new set of codes for these new set of activities --

MR. BUTLER: So to make my point, I will coordinate the points of four Commissioners, but try to do it efficiently. Bill, you mentioned early on the similarities to pediatrics. In my simple mind, I think the closer you are to death, the closer you are to birth, the more often you contact and need the doctor and the more often there is somebody in between that can handle the issue, even though ultimately you need the physician to sign the order or move the patient. But it's that in-between person, closer to the time of birth or closer to the time of death that needs the coordination.

And, Mary, your point is the nurse is often the most effective, not the only, but the most effective one to do that is part of this. And then, Tom, your point is whatever you do, don't put it out in a warehouse and a third party because ultimately it does, in our system, require the physician. And then Bob's fourth point is really, it still is about an expanded recognition in importance of a primary

care model, and with an aging, fragile, elderly population, this is more important than ever and we'd better make sure that the payment, however we do it, supports that kind of environment.

So that's -- I kind of threaded it together. And I would say, we have a contract with a payer in pay-for-performance that paid us reasonably well based on the number of NCQA-designated medical homes we could put in place. And guess what? We did that far more rapidly than we would have otherwise and have them up and running and they're effective.

I'm not sure that that is the path to go if we don't have the science to say that that works, but if you paired something like that with -- by the way, you also have to participate in some risk-sharing direction that we're going on Medicare so that you're kind of both supporting the revised delivery system, and we'll give you a little kicker to get something going.

Maybe there is a way to kind of thread the payment incentives in the short run as well as the primary care payment model in the longer run to support this.

MR. HACKBARTH: Okay. Again, a good discussion.

And, Kate, appreciate your work on this and I look forward to hearing more in the future.

So now we'll have our public comment period before adjourning for lunch.

So let me just remind you of the rules, which I think you know. Please limit your comments to no more than two minutes. Begin by identifying yourself and your organization, and when the red light comes back on, that signifies the end of your time.

MS. CONROY: Great. Thank you. My name is Joanne Conroy, and I am here from the Association of American Medical Colleges representing teaching hospitals and health systems.

We'd like to comment on the great discussion on bundling. We are applying as a facilitator-convener with 22 academic medical centers, so I have been eating, drinking, sleeping bundling for the last four months.

Number one, we do appreciate the fact that you recognize that IME, DME, and DSH payments as special payments should be considered separately. But I want to talk a little bit about risk adjustment.

We have spent a lot of time considering how the

risk adjustment could be modified, and we've made a couple observations.

Number one, there are certain disease-specific severity adjusters that could be included, and we're planning on doing that on our application to CMMI.

Another thing is that transfer patients, patients that travel from remote locations, we know not only are they more expensive but they're more complex. And how do we really adjust for those?

But I think more broadly there are other ways to actually mitigate risk, and it's not just on the risk adjustment. It's really in the definition of the bundle and what's in and what's not in the bundle. And that allows people to understand really what they need to manage around, number one; but, number two, figuring out what that balance is between mitigating risk and including enough services in that bundle so you actually can re-engineer and improve care. And all of our members are focusing on care transitions. They're focusing on how they integrate care coordination in order to achieve this.

Thank you.

MS. CARLSON: Hi. I'm Eileen Carlson from the

American Nurses Association. I wasn't going to say anything about coordination of care, but now I feel like I have to.

We are part of some of the people in the RUC process who are grappling with this horrible issue of how to figure out how to pay providers who are now delivering coordination of care services. Some physicians doing it themselves who have said that, "If I actually got money for this, I could actually hire a registered nurse or somebody else to do this for me."

I think there is great recognition of the value of this service. One of -- and I'm not an expert on the data, but one of my initial concerns is the value of care coordination is primarily in the prevention of complications. And one of the concerns that I would have is -- and maybe, Bob, you're aware of what the data actually s how -- how do you demonstrate that a complication has been prevented?

You know, one of the Commissioners mentioned the importance of baselines, and I would just hope that the data really drills down to looking at whether or not the true value of care coordination has been demonstrated. And we'd also appreciate any wisdom you all can provide in this area.

Thank you.

MR. COHEN: Hi. I'm Rob Cohen. I also wasn't going to say anything, but as long as you're talking about care coordination, I thought I would mention, just following upon Commissioner Miller's point about disparities, we recently had an article published in Health Affairs that showed a tremendous impact. When we segregated our population into the white and the non-white population, we showed that overall we made a strong difference in increasing the use of physician services, reducing hospitalization, readmissions, you know, outpatient services, all the hospital services. And, importantly, we really brought together the white and the non-white populations on fee-for-service, the usage rate, the much lower physician services, much higher hospital services on the fee-for-service side; whereas, in our population they pretty much came together. So I thought that showed a nice value of care coordination and an impact on disparities.

MR. HACKBARTH: Okay. We will adjourn for lunch and reconvene at 2 o'clock.

[Whereupon, at 12:57 p.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.

AFTERNOON SESSION [2:00 P.M.]

MR. HACKBARTH: Would everybody take their seats, please? Okay, Adaeze, whenever you're ready you can start.

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

The mandate requires MedPAC to come up with recommendations on how to reform the payment system under Part B to better reflect individual acuity, condition, and therapy needs of the patient. The law also requires MedPAC to evaluate how therapy services are managed in the private sector. The mandated report is due on June 15, 2013.

Today we will begin with an overview of outpatient therapy services in Medicare. I will describe the Medicare benefit, including therapy types and providers; present findings on spending across the different therapy types; discuss therapy caps; exceptions to the caps, the renewal of which requires Congressional action every year; and present some policy concerns the Commission may begin to discuss.

Outpatient therapy services should improve and

restore function after an illness or injury. Covered services in each of these categories include evaluation and an intervention plan under the scope of each practice area.

There are three distinct services that comprise outpatient therapy: physical therapy, which focuses on treatments to restore or improve function; occupational therapy, which focuses on independence in performing activities of daily living such as bathing; and speech language pathology, which focuses on assisting patients with communication and swallowing.

Now, under the Medicare benefit, conditions for services to be provided must include the following: a verifiable need for outpatient therapy services; a treatment plan which must include at a minimum, diagnosis, long-term treatment goals; the type, amount, duration, and frequency of therapy services; the beneficiary must also be under the care of a physician or a non-physician practitioner who certifies the plan of care; and outpatient therapy services are identified by one of the designated HCPC codes and paid the physician fee schedule rate regardless of the site of care.

Therapy services may be furnished by the providers

listed on the slide including physical therapists, occupational therapists, and speech and language pathologists. Qualified PT and OT assistants must be supervised. Aides, athletic trainers, chiropractors, and nurses cannot bill Medicare for therapy services.

So a bit about spending. Medicare spent a total of 5.3 billion dollars on outpatient therapy in 2009: 73 percent of total spending was on physical therapy while 20 percent and 7 percent were for occupational and speech-language pathology, respectively. About 4.5 million beneficiaries used outpatient therapy services, and overall, per beneficiary spending on all therapy was $1,165.

Not shown here but in your mailing materials, beneficiaries who receive outpatient therapy tend to be a bit older, there are more women, and more dual eligibles than the general Medicare population.

In Medicare, outpatient therapy services are provided in ten different settings, split between facilities such as outpatient rehab facilities, and private practice settings such as physical therapist's private practice.

Medicare Part B covers ambulatory patients, but services may also be furnished to an inpatient of a hospital

or a nursing home who requires these services but has exhausted or is ineligible for benefit days under Medicare Part A.

This chart shows the breakout of spending from some of the larger billing sites in 2009. Spending varied significantly across sites. Nursing facilities accounted for about 35 percent of total spending, physical therapists in private practice accounted for about 29 percent. And hospital outpatient departments and outpatient rehab facilities accounted for 15 percent and 11 percent, respectively.

Medicare has experienced significant growth in outpatient therapy services. Across all settings, total spending has grown by 23 percent or by an average annual rate of 4 percent over five years. But while the average annual growth rates over five years appear modest, one year growth rates are more stark. From 2008 to 2009 -- that's the last column on this slide -- spending in nursing facilities grew by 21 percent. So it remains unclear what is driving the growth rates in nursing facilities, but this is one of the issues we plan to examine. In all facilities, spending grew by 10 percent. Among private practices, the

largest, physical therapists, grew by 13 percent from 2008 to 2009, and for all providers, total spending increased by about 11 percent from 2008 to 2009.

Here we show spending per therapy user on outpatient therapy services among high- and low-spending counties. The national average, remember, is $1,165.

Mean per user spending among the top 1 percent of counties is $2,072, while it is $496 among the lowest-spending counties. The average user in Miami-Dade County used almost $4,500 in outpatient therapy services in 2009, almost four times the national average and almost $2000 higher than the next-highest-spending county, Kings County New York, in Brooklyn. The top-spending counties are concentrated in southern states like Texas, Florida, and Louisiana, while the lowest-spending counties are concentrated in the Midwestern states of Minnesota and Iowa.

On this chart, we show per user spending (in green) and the share of fee-for-service beneficiaries who use therapy (in yellow) over five years. In that period, the share of users has remained relatively constant, at around 14 percent, while per user spending has grown over the same time frame. One possible explanation is that the

volume of therapy services per user has increased while the number of users has remained relatively constant.

The Medicare outpatient therapy benefit includes annual caps on per beneficiary spending. The caps reflect an effort to control spending on therapy services given the absence of functional status and diagnosis information, or clear information on services beneficiaries receive. The adoption of therapy caps raised concerns about restricted access to services, and so this led to an exceptions process around the caps which I'll discuss in a moment.

The caps were introduced in 1997, suspended twice, but they have been in place since 2006. There are two cap limits: one for physical therapy and speech pathology combined, and another for occupational therapy. Therapy caps are adjusted annually for inflation, and for the 2012 spending year, the cap is $1,880.

A couple of points about the caps:

Therapy caps are not wage adjusted and, therefore, do not reflect the differences in cost of services across regions.

Second, until later this year, therapy caps have not applied to services received in HOPDs. So beneficiaries

who incur services up to the limit in other settings could simply go and obtain more services in hospital outpatient departments if they chose to do so. HOPDs will be included under the cap under current law from October to December of this year, three months.

Now, as I just mentioned, given the concern that caps could impede access to therapy services, an exceptions process was adopted in 2006, and this allows Medicare beneficiaries to receive services above the cap limits in non-hospital settings. These exceptions are indicated on the claim with a KX modifier, which is an attestation by the therapist that services incurred above the cap limits are medically necessary and documented in the medical record. The list of conditions beneficiaries could have to qualify for an exception is broad, and the exceptions process has made therapy caps essentially an ineffective tool to control costs. The exceptions process expires every year and requires legislative action to be extended every year. It has been extended until December 31, 2012.

Now, a significant share of therapy beneficiaries benefitted from the caps exceptions process. In 2009, about 23 percent of users exceeded the physical therapy/speech

pathology cap, and 29 percent of occupational therapy users exceeded that cap. The mean spending for users who exceeded the caps was significantly higher than the national average.

Now we switch to some of the concerns about payment policy in outpatient therapy.

Medicare spends over $5 billion a year on outpatient therapy, and there are no clear diagnosis codes that yield meaningful information about the condition or acuity of the beneficiaries. Most of the diagnosis codes used in therapy are non-specific codes such as lumbago or low-back pain. The most commonly used code is a V- code, V57.1 for "other non-specific physical therapy," which is a description of the service rather than a diagnosis.

Of the 75 or so HCPC/CPT codes used for outpatient therapy in 2009, the top six codes displayed on this table account for almost 80 percent of total spending. The top 20 codes account for about 98 percent of all spending, which leaves about 55 therapy codes that are either infrequently used or not used at all.

The codes are not always very descriptive and are sometimes difficult to distinguish from one another. In addition, most service codes used by therapists are billed

in 15-minute increments which can only represent the volume of units rather than the intensity of the service provided.

Given that there are no patient assessment tools in wide use among therapists, poor diagnosis codes make it difficult to determine therapy needs, the severity, and complexity of the patients.

Poor diagnosis codes could also pose challenges for Medicare's ability determine the conditions and acuity of beneficiaries who seek therapy and the ability to determine standards and clearly define the benefit.

Outpatient therapy service codes could also be improved to better reflect services patients receive, and the intensity of each service, ideally over an episode rather than in 15-minute increments.

In addition to poor diagnosis and service codes, there are no functional status measures for outpatient therapy beneficiaries at baseline or functional improvement at discharge. There are some instruments available for physical therapy and speech-language pathology, but they do not appear to be in wide use. It is, therefore, difficult to determine the progress patients make once therapy is initiated. Two CARE tools for outpatient therapy delivered

in community and facility settings are currently under study by CMS, but we are a few years away from any results.

Here are some issues the Commission could discuss to address some of the reforms called for in the mandate.

The first group reflects major systems reform such as data on patients' functional status and long-term improvements in service codes and diagnosis.

Changing the payment system is also a long term effort if we think about paying by episodes or in greater bundles. We would need much better data than we have today, particularly patient assessment information, to determine severity and thereby classify patients by therapy need and risk.

The second category reflects issues around coding that could be addressed in the short term. Towards that end, we could discuss potentially requiring that all submitted claims have clear and specific diagnosis codes, and not use non-specific V codes as a primary diagnosis in order to be reimbursed.

The Commission could also discuss requiring more information about the need to exceed therapy caps. This could involve refining the modifier that goes on the claim

which currently yields no information about the necessity for more therapy.

The third category here reflects other program integrity issues the Commission may choose to discuss. One is as a way to gain better control of outpatient therapy benefit while data are collected and the payment system is refined. So until this year, HOPDs have not been included under the therapy cap, but the new law will include them under the cap starting in October through December this year. So the Commission could discuss making this more permanent.

Next, we could consider edits that target high utilization geographic areas or individual providers for additional scrutiny.

Next is physician attestation, and just as a quick reminder, the physician has to order outpatient therapy services before beneficiaries can receive them. The Commission could consider whether there should be a stronger reminder on the document that they sign to ensure that services are absolutely medically necessary.

Next, the list of conditions on the exceptions list is very broad and includes common conditions among

beneficiaries. The Commission could discuss whether there are opportunities to tighten that list.

We could also discuss whether the annual increases to therapy caps should be linked to improved diagnosis coding, collecting functional status measures, or some other specified target.

Finally, in the near future, we plan to conduct an evaluation of benefit management policies used in the private sector, and plan to present those findings later this year.

With that, I'll turn it over to Glenn.

MR. HACKBARTH: Would you put up Slide 9 for a second? I need help in understanding the payment in nursing facilities. For patients that are in a SNF under the Part A benefit, the therapy is paid for under the SNF payment system, a point we have often discussed in the Commission.

Under what circumstances is therapy paid for under Part B? I'm having difficulty understanding that.

DR. AKAMIGBO: So if a patient -- so the SNF benefit is a Part A designation, and if a patient is in a skilled nursing facility paid under Part A, if that Part A benefit expires and they flip to Part B, outpatient therapy

services received while they're under Part B would be covered on the Part B side.

MR. HACKBARTH: If, for example, the Medicare beneficiary is a long-term resident of a nursing home, then all the therapy they get is going to be the Part B benefit that we're talking about here.

DR. AKAMIGBO: Yes.

MR. HACKBARTH: But so long as they're on a Part A-covered SNF stay, it's exclusive through the Part A.

DR. AKAMIGBO: Yes.

MR. HACKBARTH: Okay. I just wanted to make sure.

MS. BEHROOZI: A minor point. I thought there was a reference in the paper to therapy being available after an inpatient or SNF stay. Is that a requirement? Could it be that someone is just at home and is prescribed therapy?

DR. AKAMIGBO: Oh, yeah. You can be prescribed physical therapy and get it as a community admit, if you will. So you can walk into a nursing facility that has sort of, you know, a therapy setting and get therapy from home.

MS. BEHROOZI: One other question. It's actually on your last slide where you suggest one of the improvements in management of the benefit, the physician attestation of

medical necessity when ordering therapy. Can you explain a little how that would differ from the physician or nurse practitioner certifying the plan of care and, you know, whatever the current requirements are, how that would differ?

DR. AKAMIGBO: Yeah, Mark likes this. This is the physician attestation.

[Laughter.]

DR. MARK MILLER: [off microphone] numerous times about not characterizing my views.

[Laughter.]

DR. AKAMIGBO: This basically would be a stronger statement that says if you order -- so this is at the front end, not just certifying the plan. You know, once you prescribe therapy, the physician attestation question, once you prescribe therapy, a strong statement where the physician signs reminding them that this needs to be absolutely medically necessary, basically to get at overuse or fraud, yes, at the front end.

DR. MARK MILLER: Just to go through some of this, for those of you who have been through some of -- you know, have some of these scars, you know, put yourself in mind of

the hospice conversations we had where you have this benefit churning, you want to get a better sense of really how to design a payment system, but you're lacking all the tools of that. And some of your mind has to move over in the short term to almost program integrity things to try and manage it while you build a better house or, you know, what the case may be.

We're in that mode here, and the Congress is very much tell us about the perfect system, and I think where we're going to be -- they're going to be frustrated is we're going to say you might be able to build a better system, but here's everything you're lacking to do it. And so I think we have to also think about some other tools to put in their hands to manage things in the short term.

On this, there's a couple ways you can think about this particular concept. We're just trying to get your minds working in a couple of directions.

One is very much what Adaeze said, the notion that you put on the form, when you sign this, you're saying it's medically necessary and you, just to remind you, are liable if, in fact, it turns out that's not the case.

The second thing you can think of is whether upon

recertification you kind of require it to come back and how frequently you require it to come back through the physician, because that's really the only control point. After that, it's in the therapist's hands, and it's less clear, you know, where...

MR. GEORGE MILLER: Yes, just to follow up on that point, looking at this Slide 20, it would seem to me that our overarching goal is to improve care, and I guess my question is along the same lines: Are these the elements we need to assure that we improve care to the beneficiary? And I understand some of the other things that you want to happen just as Mark just described, but the ultimate goal, I would think, that we need to assess if the beneficiary is getting the optimal care, and this is the best setting.

So my clarifying question would be: Are these all the right tools that help us achieve that ultimate goal or some of these issues are really around payment and/or, as Mark just described, to make sure that we certify? But because the physician certifies that the care is necessarily needed doesn't still mean that that patient gets the optimum care. And we don't have a way to measure that in what I've read.

DR. MARK MILLER: Agreed. And here's the other way to think about it: Put your mind in the discussion that we had of the CARE tool in post-acute care, just for simplicity, institutional settings and having a tool that says I'm going to assess your needs at the beginning of your stay, I'm going to then assess your functional status, let's say, at the end of your process. In a perfect world, what you would have here is also a tool like that that's useful in all settings for all patients that says these are your needs, this is what we think you need, you go through a process, and it turns out that now you are more functional, you can walk from Point A to Point B or whatever it is. But that is what is not available right now, and we can talk more about that, but that's -- then at least you'd have some way of measuring what you think they need and then what happened to them at the end of the process.

DR. STUART: Didn't we hear that CMS is actually testing to see whether the CARE system would work for outpatient therapy?

DR. AKAMIGBO: Yeah, so there are several CARE tools. The CARE tool that I think Evan discussed, the results from that, is from a different one that applied to

institutional PAC settings. For outpatient therapy, there are two different tools currently under study for therapy. So they're quite different.

DR. STUART: But not the CARE tool that we heard about this morning.

DR. AKAMIGBO: Unfortunately, yeah, they have the same name, but they're different.

DR. STUART: But I do have a question, trying to bring this together. Do we have a sense of -- and this follows up on Mitra -- the volume of these services that might be considered post-acute care, such as those that are provided 30 days after an inpatient hospitalization?

DR. AKAMIGBO: That's something we need to study using more current data. The data from several years ago showed that not a lot of -- a small minority of them, of outpatient therapy services, were received immediately following a hospitalization. But I can't say definitively what the trend is, but it has not been large.

DR. STUART: Right, okay. It was just a thought that if we're thinking about PAC services more broadly, this is something, because of its difficulty in terms of trying to define what it is, I would think would be part of that

conversation as well.

DR. CASTELLANOS: You mentioned the caps on HOPD was stopped in October to December. I thought you said that we needed to do something to make sure it's extended?

DR. AKAMIGBO: No. The caps -- so services received in HOPDs have not traditionally been under the cap.

DR. CASTELLANOS: Right.

DR. AKAMIGBO: But current law basically they will start -- so services received in HOPDs will start to count under the caps starting in October, but the law expires in December.

DR. CASTELLANOS: Right.

DR. AKAMIGBO: So in that ten-month extension, you've got this three-month --

DR. CASTELLANOS: So we're going to have it for three months, but then it expires.

DR. AKAMIGBO: Right.

DR. CASTELLANOS: So if we're going to do something, we should make a recommendation that we extend the cap.

DR. MARK MILLER: It is one of the things you could choose to do, and I think she's just trying to

highlight that's a thing --

DR. CASTELLANOS: That's what I'm trying --

DR. MARK MILLER: -- you could do.

DR. CASTELLANOS: That's why I picked that up.

Second, can you go to Slide 16? The ICD-9 codes are very non-specific. Now, we're soon to have ICD-10 codes. Are you familiar with those with physical therapy? And are they more specific?

DR. AKAMIGBO: I can't say how they sort of expand or refine the current ICD-9 version with respect to physical therapy codes. And I say that also knowing that the implementation of ICD-10 has been delayed again. But it's another sort of piece of the puzzle, but I don't know, I can't say specifically what it does to the therapy diagnoses, the usual therapy diagnoses.

DR. CASTELLANOS: Okay. Those codes are expanded in every other field. I'm not sure what they are --

DR. AKAMIGBO: For therapy, right.

DR. CASTELLANOS: And we're still on clarification, right? Slide 11, please.

MR. HACKBARTH: Yes.

DR. CASTELLANOS: And this is really for Mike's

benefit. Mike, I do not live in Miami-Dade. I want to clarify that. Okay?

[Laughter.]

DR. CASTELLANOS: I really don't. There's so much infectious problems there that I don't even travel there. Thank you.

[Laughter.]

MR. GRADISON: I guess it's just an observation. I realize how the numbers can work out with the exception process, but to get to $4,400 where you have a cap that's a very small fraction of that, you'd have to have almost -- I mean, I don't see everybody, but you'd have to have a very high proportion of those who receive these services get an exception and then come in and be using whatever, three or four times whatever the cap is, I can understand why there might be some CMS focus on what's going on down there.

DR. MARK MILLER: And I think the reason that we're putting things like this up -- and, again, for those of you who have gone through some of the battles, you'll remember that we've also looked at things like this for home health and DME and that type of thing. And so you could imagine policies that run along these lines.

Just to be very direct about it, a number like that, it may not be that patients are receiving $4,000 of services. It may be just IDs are being billed, you know, over -- but you could imagine -- and there was just some things in the press on this recently, and that's -- you do it. That's one of the ways you can do it. But then you can look at some of the other places, and there's probably a fair amount of utilization. But you could imagine screening criteria that the Commission could come forward and say I think there's some screening criteria, and any provider or any area of the country where this pattern is expressing itself should be prior authorization, medical review, something. You could begin to make statements like that, and I think that's the point of showing those numbers.

MR. GRADISON: What struck me, just in reading the news articles about that, $375 million or thereabouts of contested payments, it wasn't just the amount, it's how many years it covered, how long it took, frankly, to get somebody's attention.

MR. HACKBARTH: Let me just pick up on Bill's question because I was confused about this. So if the cap is $1,800 per beneficiary -- I assume that's per use,

beneficiary using the service.

DR. AKAMIGBO: Yes. For 2009, the cap was $1,840, but, yes, per beneficiary.

DR. MARK MILLER: Aren't there two caps?

DR. AKAMIGBO: Well, each cap was $1,840, so PT and speech and language pathology is a combined cap.

MR. HACKBARTH: Oh, okay. I was reading it as they were combined $1,800. So it's actually $3,600 or $3,700.

DR. AKAMIGBO: Yeah.

MR. HACKBARTH: But still, that's less than $4,400.

DR. MARK MILLER: But --

MR. HACKBARTH: But we're not even supposed to be paying over the $3,700.

DR. MARK MILLER: No, but remember, then there's an exceptions process, and if you put a code on the bill, a KX code, if you put a KX code, then you can go above the cap.

DR. AKAMIGBO: Yes.

DR. MARK MILLER: And how much scrutiny and what is required to get that code is yet another question.

DR. BORMAN: Just a couple of questions. One would be the diagnosis category or diagnosis codes that allow the exception were determined in a national coverage process rather than these are not done at a carrier coverage process.

DR. AKAMIGBO: You mean the conditions on the exceptions list?

DR. BORMAN: Yes.

DR. AKAMIGBO: Yes, they're determined nationally.

DR. BORMAN: So that's a program, not done at each state or regional carrier

DR. AKAMIGBO: No, no. Yes.

DR. BORMAN: So they're uniform.

DR. AKAMIGBO: Yeah.

DR. BORMAN: The second thing would be, if I understood you correctly, these claims will be paid with only a V-code as a diagnostic code.

DR. AKAMIGBO: Yes.

DR. BORMAN: That's pretty inconsistent with most of the rest of the program, at least to my understanding. So that's certainly -- I think it would be helpful to understand why that is so. I mean, it seems odd and

inappropriate, but before we sort of slam that, probably we should say is there some history we should know about why that's the case.

And then the other thing I would ask is, you know, the ICD codes do seem to be relatively non-specific. Rather than saying is ICD-10 going to fix it, are there more specific codes, for example, within ICD that could be used yet these other ones will be accepted? Because one could envision that one of the options might be requiring -- shortening the list to get ones that do go out to a fifth digit of specificity, which would be as high as you could get in ICD-9.

And then my final question would be related to you have some material in the chapter that professionals delivering these services have within themselves some lack of clarity about what these things really describe, and, for example, the overlap, I think, between the exercises and the activities, for example, that you discuss in the mailed materials or the website materials. Do we know if the professional groups have tried to bring forward improvements in that coding structure because there is a whole parallel CPT process for other than services delivered by physicians,

and one might think that if there is this fuzziness about this, that there is clearly a pathway to get better. So is there work going on on that that could lead to greater specificity and give us better data over the long haul? So those would be maybe some things to find out if we don't know.

DR. AKAMIGBO: So we know that some of the professional groups have -- there are ongoing discussions. I think that they definitely recognize that there's some specificity issues around the therapy service codes. How far along they are in that discussion I couldn't say, and we'll keep trying to find out. But there have been talks, certainly, around those issues.

DR. BORMAN: I think the folks at the CPT Editorial Panel offices would know are there things in the pipeline that are underway, and then the coordinating committee for ICD would probably know, you know, are there things in process, because it's one thing if we recognize there's a problem and we're sort of en route to fixing it as opposed to there's this problem but kind of all we're doing is wringing our hands about it.

MR. ARMSTRONG: Part of why we're focusing on this

is the increasing cost to the program for a five-year period from 2004 to 2009, but in particular, it was the last year inflation rate in certain areas. Do we know anything about what has happened since 2009? Do we have any information that would tell us that that was a really particularly unique year or that was the beginning of a spectacular increase in trends?

DR. MARK MILLER: Yes, Adaeze was running this down in anticipation of this question. We started to move things quickly because of Congress' -- the other reason we're looking at this is because we've been asked to. And there has been a general slowdown in utilization broadly, as we've discussed in the physician world. Adaeze, when we talked about this, I remember the number was 7 percent between 2009 and 2010.

DR. AKAMIGBO: Overall growth, yes. 2009 was impressive in the growth rate, but 2010 has also been quite healthy.

DR. MARK MILLER: And this is in a context where utilization in a lot of other areas had slowed down significantly. So this seems like there's still a healthy clip. Of course, we could come -- that's the latest we

have. We could show up here 2011 data and there might be yet another shift.

The other thing which Adaeze points out when we talk internally is, as you look across those settings, there's radically different growth rates. Some are actually declining, and others are growing astronomically.

MR. ARMSTRONG: Right.

DR. MARK MILLER: And we don't exactly understand all that.

MR. ARMSTRONG: I ask partly because different interventions will deal with the overall trend versus the huge variation in different geographic markets. I think I'm more concerned about the huge variation in geographic markets than I am the overall trend. But without any of the outcomes data, you don't know if the increase in overall trend is good or bad, to be frank.

My last question would be: We talk about concerns when we look at that geographic variation with overspending in high-cost markets. Is there any information we have about whether our beneficiaries are not as healthy as they could be in those underspending markets? Is that something we should be concerned about?

DR. AKAMIGBO: Well, that's sort of a natural first question. What's different about the patients or the beneficiaries in certain markets, depending on spending? And it was really hard to get at that, with these really poor, opaque diagnoses that you have through claims. And given that claims are really all we have, it's hard to figure out. And there's no functional status information for Medicare. But it's absolutely the first-order question, but we haven't -- yeah.

DR. CHERNEW: There are sort of two contradictory senses I have from the presentation, and I'm not sure which is right what I think about it, although I have a guess. Part of this leads you to believe that, in fact, the indications are really vague, you don't know, even physicians don't know, it's just kind of -- no one's sure when these things are indicated. So there's a lot of uncertainty about the merits of this in a whole bunch of different cases. And then there's another part of it, like the attestation part, where we're asking people to say, yes, I attest this is necessary.

So should I think about this as something where, if I got a bunch of people around there would be some

agreement, yes, this is necessary, no, it's not, we could think about that? Or should I think about this as an area where there's so much play about what the clinical indications are and what's coded and who deserves or who doesn't deserve it that it's virtually impossible to know sort of what's right or wrong? There's two different ways of thinking about the services compared to some of these other things.

MR. HACKBARTH: Do any of the physicians want to respond to that?

DR. BORMAN: Well, I think it's hard to say that therapy will absolutely not benefit someone, if that helps to answer the question. In any given patient, they might get some improvement, and so part of the question would be, you know, do they get enough improvement to justify the service? Is there ever a patient for whom you can say, absolutely, PT, OT, speech-language, whatever, will not do this person one bit of good?

DR. CHERNEW: But if I were to say, alternatively, you know, Karen, certify that this person needs this, is your reaction, all right, I'm really going to think about this and decide? Or is your reaction something like how the

heck should we know?

DR. BORMAN: Well, I think that you picture that the environment in which this comes in is your stack of paperwork for the day on which you're signing off on a whole variety of things. And so the amount of time that you invest in that and the data that you really have on which to make that judgment are both pretty poor.

MR. HACKBARTH: So in the context of physician attestation of home health, I think Tom was in the "what the heck" school of thought. You know, how am I supposed to know exactly how much home health this person needs? There aren't well-defined clinical standards. I don't mean to put words in your mouth, Tom, but that's my recollection.

DR. DEAN: They're exactly the right words. I will say some more about attestation -- [off microphone] -- I think it's really important, and I think it's a mess the way it is now.

DR. BORMAN: I think, Mike, maybe there are some clear things. If I'm an orthopedic surgeon and I'm doing a total knee, then it's pretty clean about what -- and this patient has this degree of motion, you know, that's very clean. But once you start to get outside of that,

particularly in these some really fuzzy things, low back pain, whatever, we're in "what the heck."

DR. DEAN: I completely agree with what Karen said.

MR. BUTLER: One, in the text that you gave us, the hospital utilization has been flat since 2004, and yet that has been an area that has not been subjected to caps. Do you have any thoughts about why? Is it just the lucrative --

DR. AKAMIGBO: I had thoughts, yeah.

MR. BUTLER: -- nature of the non-hospital business? Or is there --

DR. AKAMIGBO: No, so we looked at -- because I had the same question. There has generally been a shift among practitioners away from hospitals or under physicians into private practice, and you see that with the latest group of therapists, speech-language pathologists to get their independent -- who can bill Medicare independently as of 2009. That was the first year.

But beyond that, when you look at the distribution of payments from first percentile to the 100th percentile, and you separate it by including HOPDs and excluding HOPDs,

you find that the HOPD spending tends to be front-loaded, or at least at the lower end of the spectrum. And I think the only -- the one explanation that I could offer -- and I can certainly track this down a little bit more -- is that they basically get outpatient therapy either immediately following some acute incident, and they get little of it, and it ends there. Well, that's really the only plausible thing that I could come up with. But I can chase that down a little bit more, but I think the practitioners, not focusing on hospital or under physician and moving more towards independent practice, is one of the major drivers.

MR. HACKBARTH: So, Adaeze, here again I need some help understanding about the intersection of different payment systems. In the hospital outpatient department, we've got the outpatient PPS system, and then here we have outpatient therapy paid under Part B. How do those two fit? I assume that there are codes in the outpatient PPS system for therapy. Or am I wrong on that?

DR. AKAMIGBO: Is Dan here?

MR. WINTER: I'll take that. Actually, therapy services, they receive the same payment rate regardless of the setting under Part B. So there's not -- I believe

they're actually not considered part of the outpatient PPS. If they're provided in an outpatient department, they're paid the same rate they would be paid in a physician's office or in a nursing home under -- you know, not under a Part A stay.

MR. HACKBARTH: Okay, so there's --

MR. WINTER: Those rates are set under the physician fee schedule using that rate-setting methodology.

MR. HACKBARTH: So we already have an example of equal payment --

MR. WINTER: And there's no extra facility --

MR. HACKBARTH: -- for a hospital and physician office.

DR. MARK MILLER: That's actually one of the things that we were saying inside the office. Here is a case where it's paid the same everywhere, but nobody has any idea exactly what it is and how much and all the rest of it.

[Laughter.]

DR. MARK MILLER: On the one hand. For the public, that's Ariel Winter, who is on the staff. He didn't just sort of step up and --

[Laughter.]

MR. BUTLER: He didn't take the oath, though.

MR. WINTER: As Karen pointed out, there is no extra facility fee when it's provided in a hospital as there is with other kinds of services.

MR. BUTLER: But I would have thought that if caps were at all effective, you would get some flight from those other settings back into the hospital where they were not subjected to a cap. So I wouldn't expect flat utilization because the beneficiary, how much the hospital gets paid versus the others, whether it's the same or not --

MR. HACKBARTH: If there was unmet need and people were bumping up against the caps, you would say, well, where can we go and get the needed additional therapy, and it would pop up in hospital. But --

DR. AKAMIGBO: So that hasn't been so much in play because of the exceptions process, so the HOPD as an escape route hasn't been really needed or necessary since wherever you are, you can --

MR. HACKBARTH: The caps aren't --

DR. AKAMIGBO: Yeah.

MR. BUTLER: Okay. So then my other question, totally unrelated, is it looks like about a third of the

spending is for physical therapy in skilled nursing facilities. I was trying to just cross-walk where the action is and where the dollars are and maybe where to a large extent the increases are. So what happens if that intersection seems to be important? It's partly a question, partly a comment. The question part is do we -- we know the service codes. We don't know the diagnoses of the patients that are sitting in the skilled nursing facilities that are getting these services, right? So they're strokes, it could be whatever. But is there anything about the characteristics of those patients that might be a little different than patients that are not in nursing homes that are getting the therapies?

DR. AKAMIGBO: So we can look at this a little bit more, but the diagnosis of the patients who get outpatient therapy in the nursing facility setting is not clearer than -- it's not any more clear than the diagnoses for the other patients.

DR. MARK MILLER: [off microphone] But --

DR. STUART: Part A, Part B [off microphone].

DR. AKAMIGBO: Oh, so I should probably give a little bit more information about that. So all the patients

or the beneficiaries who are getting outpatient therapy services from nursing facilities are not necessarily residents. Many of them are community walk-ins or people who come from somewhere else, get therapy, yeah. So they're not necessarily residents of the --

DR. STUART: Well, now I am really --

DR. MARK MILLER: Hold it. We can do a few things. We are able to array, however informative it will be, the differences in the diagnosis or services that are provided by setting. That is correct, right? So we can look at it, but it may turn out to be very uninformative.

Then what I would say on this last point is we might want to also parse and compare how many of them are dual and then how many of them are either resident or walk-in, because the other thing is that you can have some dual eligibles that are in that part --

MR. BUTLER: Of course, if they could walk in, they probably didn't need the therapy.

[Laughter.]

DR. MARK MILLER: And just for the record, that's two for you, Peter, today.

[Off-microphone discussion.]

DR. NAYLOR: Quickly, the person who is a recipient, must they have had an injury or illness to be -- when you look at the criteria about who can, it seems as if this notion of medical treatment is services are required because they need therapy and the treatment plan says that they can gain from the therapy.

So I'm wondering about, you know, this older population, largely dual eligible, who are at very high risk for falls. Could a therapy plan be in place to improve gait and balance and strength in order to prevent falls? I'm trying to figure out who is the recipient?

DR. AKAMIGBO: Yeah, I think -- and I'm just sort of going on. I think if the physician who prescribes therapy deems it necessary for that reason, then I -- obviously with a diagnosis to back it up and a plan of care in the medical record, then, yeah, it would be.

DR. NAYLOR: Thank you.

DR. MARK MILLER: I think we should looking at that a bit. It may be going on. I think your question is, you know, if one took a strict look at the rules and regulations, is that what it is for? Because I took your point as preventing falls.

DR. NAYLOR: Yeah, I think there's been a lot of evidence about the value of physical therapy in function, cognition, prevention of falls, which are a big cost to the Medicare program. So I'm just wondering, as we're looking at this, can we frame it in the context of who is being served currently, and so we think about --

DR. MARK MILLER: Right. And without any expression of, you know, judgment on the utility of it, I think the one thing we should check very clearly is whether it's allowable under current rules. It may very well be going on, since it's hard to tell, and then we can certainly express it any way you collectively want to look at it.

DR. DEAN: I was going to say, I have ordered it numerous times for that very purpose, but whether it was legal or not, I don't know.

[Laughter.]

DR. MARK MILLER: There is a transcript here.

MR. GEORGE MILLER: Your attorney just spoke for you.

[Laughter.]

DR. DEAN: Oh, okay. We better change the subject.

Back to Slide 11, just out of interest, if you look at that right-hand column, Olmstead, Minnesota, is where the Mayo Clinic is located, just for your interest, which is, I think, an interesting observation.

The one question I had, I have always been told by our physical therapists, especially with patients on our swing bed program, that in order for them to continue to qualify, the therapist had to document that they were progressing, and as soon as they hit a plateau, then they no longer qualified.

Now, is that -- I mean, you said there's no functional measures or -- can you clarify that?

DR. AKAMIGBO: It could be that it's for non-Medicare. I don't know if they're all --

DR. DEAN: No, this is all Medicare.

DR. AKAMIGBO: All Medicare.

DR. DEAN: That's all that we do.

DR. AKAMIGBO: Well, it's not data that is currently available to the Medicare program at this point. So it could be that that documentation basically stays in the medical record in the different clinics, but it's not something CMS has available to them.

DR. DEAN: Really? Okay, because it always seemed to me to be a very logical requirement, that as long as they were improving, the therapy was justified. And as soon as they hit the plateau, then it wasn't.

But, on the other hand, you know, I work in a fairly conservative institution, which is also losing money.

DR. HALL: I assume from the Round Robin here that you think that the bump in 2009 may have had something to do with the independent billing provision. Is that correct, or am I wrong on that? The therapists could bill independently of anybody else?

DR. AKAMIGBO: No, that didn't start -- that only started for speech-language pathologists in 2009.

DR. HALL: In '09.

DR. AKAMIGBO: Yeah.

DR. HALL: Because there's no biological explanation for this, and so one would think that it must have something to do with some kind of an awareness or incentivization for things to change. Sometimes that can be that a new procedure comes along, a new gizmo or toy that people use. Or it could be a professional association that puts a very concerted effort to get their members to be more

cognizant of the unmet needs of a population. I think that's probably where we're going to see this.

But even if it turned out that it was a one-time aberration, I guess the major issue that still begs to be addressed is: Is there some way to kind of rationalize the payment system, whether it is in coding, changes in coding, or whether, as difficult as it is, we ought to look for more stringent outcome measures? And I agree with Karen that, you know, it's like my mother said about cod liver oil: "It's good for you. Don't argue with me." It is. Look how long I've lived.

But I think there are some areas where you can -- indeed, most of these forms that, incidentally, most of us fill out well after the service has been provided, right? Like electrocardiograms. I think that the idea that the therapy should stop when there is no change is always there. The same person who's doing it is making that observation, so you could argue that that's a problem.

But the sort of things that Mary mentioned, this is used in nursing homes, it's generally for a very defined reason. It's not just because they're growing old, but it has to do with a fear of falling or inability to achieve

enough level of independence so they can walk to the bathroom or something that's actually quite concrete. So I wouldn't despair if this is -- if we're being asked to add something that is perceived as a problem, there may well be some solutions, I think.

DR. MARK MILLER: Just to your point on independent, you were saying, Adaeze, the speech and language pathology change was in 2009, and the spending there went from about $1 million to $8 million.

DR. AKAMIGBO: In 2010.

DR. MARK MILLER: In one year. And her numbers were all 2009, so this wasn't in that number. But to your point, in 2010 there was a big jump. And I guess what Glenn was saying when I mentioned that to him is it sort of raises this question of oversight versus a new opportunity and exactly how you --

DR. HALL: Right, right.

DR. MARK MILLER: -- get an eightfold increase, if that's right, in one year. That's kind of the question.

DR. BERENSON: True, I guess. On Slide 16, where -- actually I've compared 16 with 17. With 16, the first five conditions here represent 15 percent -- I'm discarding

one because it's non-specific. We know about 15 percent of diagnoses. In 17, the first five HCPC codes were up to 75 percent of services provided.

I guess what I'm interested in, have you looked to see if there's any way to sort of aggregate all of the different diagnoses so we actually can get some picture of what percentage is for back problems and what percentage is for gait or some meaningful categories so we can figure out how to hone in? In Round 2 I'm going to make a couple of other comments about honing in. Is that something you've looked at or can you look at it?

DR. AKAMIGBO: I can, yes.

DR. BERENSON: I was surprised at how small a percent -- we're already -- at the fifth condition we're only down to 3 percent of diagnoses, so I'm wondering if we could do that.

My second one would go to this difficult issue of figuring out if -- Ron, to use the word again, "appropriate," where therapy is appropriate. Have there been attempts by the administrative contractors or the OIG to do medical review looking at medical records and seeing if medical records provide information that one can use? I

mean, I think my suspicion is that in the area of physical therapy it's pretty difficult that there will be a loose diagnosis and therapy is indicated and probably not a lot, but do you know if there have been attempts to do that?

DR. AKAMIGBO: I don't know about attempts to look at medical records specifically by the OIG. They did do -- they put out a study in December 2010 based on claims, looking at aberrant patterns by geographic area and some potential ways to begin to get a handle on that. But I don't remember -- I don't think they looked at medical records.

The MACs in the past couple of years where you've seen a major sort of either fraud issue and some of the Southern states have -- I believe when they developed edits to get at some of their billing concerns looked at lot at claims data, but, again, medical records specifically I'm not -- I'm not remembering anyone looking at those.

DR. BERENSON: Because it is, I think reasonably common practice where you see sort of a billing pattern of concern, you just do medical review, look at medical records and see if there's documentation for what's being claimed. And I assume in some cases there would be evidence that the

service wasn't provided. But my hypothesis is that, in fact, in many cases or most cases, the service is provided and the information in the medical record really doesn't help very much, but it would be interesting to know if any of the contractors actually have experience in that area, if there's a way to get that.

MR. HACKBARTH: Adaeze, part of our charge from the Congress is to look at what private payers do. Because this is so new, you haven't had a chance to really begin that part of the work yet. Is that right?

DR. AKAMIGBO: Not in earnest, no.

MR. HACKBARTH: Yeah, okay. Herb, Round 2?

MR. KUHN: One question before I -- I'd like to go up to Slide 20, if I could for a moment. I want to maybe add another category for us to look at. But before I get to that, I just want to ask a question about the CARE tool.

I went back and re-read the information that you shared with us, and you make an interesting observation here that, based on conversations with therapists and people who are actually doing the work, and others, CMS is having a difficult time getting individuals to sign up to help evaluate the tool that's out there. And, you know, maybe

this is an uninformed observation, but it seems to me if that's kind of the problem that they're seeing with this CARE tool now -- and we know that the facility CARE tool that RTI published a report on last month took seven years to get done, if they're having trouble with this particular tool getting therapists to even help demo it early on, that ought to be a good signal that maybe they -- instead of forcing that one through, trying to put a square peg in a round hole, and then three years later find out, oh, we got to go back and start again, it will be the end of the decade before we see a CARE tool on this thing.

So, you know, again, maybe an uninformed comment, but to me that's a signal that hopefully they get it right the first time, because I would hate to lose valuable time on the development of this CARE tool.

Anyway, the point I want to make on this one, you've got three areas that we could look at, but let me add a fourth. All these look at really kind of the payment system, but as there has been some conversations around here in Round 1, it seems to me that we could begin to talk a little bit more about the benefit itself and to better define the benefit that's out there. And what I would

suggest that we might want to do is like we did in the home infusion report, do a bit of a literature search here to kind of better understand the science behind this benefit, where the real value of the benefit is, to the extent that we can understand the science, if it tells us anything. And even to take a bit of a stretch here -- and I'm not saying this is where I think we ought to go, but I think it's worth a policy consideration -- if the science is suspect in this area, instead of making broad recommendations, we could say, well, hey, CMS, why don't you do a national coverage determination on outpatient therapy and have them take a look at that and see if that might be an option -- yes, Bob's laughing. Yeah, it's bold, but I think it's something we might want to add to the menu of things to at least consider. So just an option out there to think about.

MR. HACKBARTH: It's 3 o'clock, and so we're running behind. So as we go through Round 2, I'd urge people to be as concise as possible.

MS. BEHROOZI: Okay, really quickly, the thing that looked really great up there was, you know, putting it into episodes until we learned that it's really not connected to other treatments a lot of the time, so it sort

of goes back to more what Glenn said about global cap, which then, you know, it should be part of the whole comprehensive way you take care of a patient, as Mary said, can be preventive, right?

So then, yeah, that leads to looking at what the private sector does, whether it's MA plans or commercial insurers. We do visit limits with prior authorization for time beyond that, so that's somewhat related to the caps except that limits also kind of goes a little more to what the therapy is that's being received and requires a little bit more information, which I think is a really important point being made here, it requires much more information in the coding and the nature of the diagnosis and the nature of the patient and what the reason for the therapy is and, yeah, the fraud.

I do live in Brooklyn. I can't get away from whatever the infection is that's going on there, except that it is in a very small part of Brooklyn, and there's a lot of home health abuse there, too, and I don't live near there. But I can tell you that while Brooklyn and Queens counties appear on that list of high utilization, the Bronx doesn't, and I can't say that Brooklyn looks demographic or health

status-wise a whole lot different than the Bronx, certainly not better than the Bronx. So, you know, I can't emphasize enough the Secretary's authority and all the other tools that we could use to go after the fraud.

DR. MARK MILLER: One real quick thing. I know there's time. When you get that extra information, who and how do you get it?

MS. BEHROOZI: [off microphone].

DR. MARK MILLER: I'm sorry. We can talk [off microphone].

MR. HACKBARTH: George, Round 2?

MR. GEORGE MILLER: Concise.

DR. STUART: I was looking in the chapter about this drop-in business that apparently nursing homes are developing, and I couldn't find it. How do you determine whether a beneficiary is receiving therapy in a nursing home if that person is not a resident?

DR. AKAMIGBO: I went back and looked at some of the large post-acute companies, Kindred, for instance, you read their 10Ks, it's an explicit -- sorry.

DR. MARK MILLER: I think his question is more narrow. Don't we just get it through the provider ID? Is

that how you --

DR. AKAMIGBO: Maybe I misunderstand the question. Go ahead.

DR. MARK MILLER: Is that what you're asking?

DR. STUART: Yeah. Is it the provider ID?

DR. MARK MILLER: Yes.

MR. HACKBARTH: How do we know the location?

DR. AKAMIGBO: That's pretty clear from claims, the provider ID and the -- we can tell with claims the billing site for each of these.

DR. CASTELLANOS: Consistent with our previous feelings of paying the same over the same site of service, I would like to permanently include services from HOPD under the therapy caps. It expires December, and I would like to make some recommendation that it's continued.

DR. BORMAN: The one thing that the fuzziness about both the diagnostic classification scheme and the service provision scheme suggests here is that maybe those are two criteria that cry out for a benefit management approach to this. I think what we're circling around is that there's enough "what the heck" in this that it does go down to the level of the individual in the record. And it

seems to me those would be the kinds of circumstances in which a benefit manager probably has the greatest value by virtue of being to engage at the individual level.

MR. HACKBARTH: And based on what Mitra described, that's sort of what you're doing. There's a certain amount that's automatically approved, if you will, and then when you go beyond that, there's got to be specific authorization, including document of the reason.

MS. BEHROOZI: Yeah. When you say automatically, it's still got to be justified by the diagnosis.

MR. HACKBARTH: Yeah.

MS. BEHROOZI: I think we require more than Medicare probably does.

DR. MARK MILLER: Yeah, we'll be curious about that.

MR. HACKBARTH: Round 2.

DR. CHERNEW: First I'll say that despite the banter, I think these actually really are very important services that we have to make sure beneficiaries have access to. And that said, my biggest concern is that as we move forward and examine these options, that we carefully weigh the administrative burden and other complexities of trying

to get the darn thing right, because I think with this much vagueness between outright fraud and stunning need, you know, there's a wide range in there that's going to be hard to get right away, and we have to think about the cost and the burden associated with that.

MR. BUTLER: I'm afraid what I might say, but I'll try to -- okay. I agree with this is a good list to work off of. The one thing that troubles me a little bit is where the patient fits into it, and based on personal experience and a number of incidences, the lack of or willingness of engagement, where does the -- you know, sometimes it's prescribed, and the patient -- you know, I've seen such cases, you've got to be kidding, they're not ready to do that. So I don't know how you get -- and it's not one of those things that you cost share on, but I'm not sure where that becomes a criteria, patients' willingness to engage in the therapy. It's a vague concept, but I think a lot of the utilization -- not a lot -- some may be without the engagement of the patient. It's not worth it, yet it's still prescribed.

MR. HACKBARTH: And I assume that the cost-sharing requirements are the same as for all Part B services,

subject to the deductible and 20 percent co-insurance.

DR. NAYLOR: Just to echo many of the comments, but I think this issue about the CARE tool is really important and wonder -- I honestly had conceptualized it as a tool that carried across multiple systems and functional status as a core measure in the PAC part of it. So I'm wondering if we can't come to some recommendation around how critically important it is that we have a tool that goes with the patient across these settings and that enables the kind of measurement of functional status and other core domains going forward.

DR. DEAN: Yeah, I wanted to say a few words about the whole attestation thing. It really is a concern. Karen outlined that. For the first certification, it often times is reasonably clear-cut. Certainly if it's somebody that I see in the office and recommend physical therapy, I'm certainly perfectly willing to take responsibility for the legitimacy of that order.

The ones that really are a problem are the recertifications, and we get a lot of them, and, unfortunately, I get a fair number of forms, some of which are legible and some of which are not, and that they want to

continue this, and it may well be somebody I haven't seen for a while, and do I go through all the rigmarole of bringing them back in, trying to figure out if they're progressing or not, or whatever? Or do I just sign the thing? And, like Karen says, it comes at the end of the day in the stack of the papers. And so, you know, you more often than not just sign it.

It seems to me that, you know, one thought that crossed my mind, why does it have to be a physician attestation? I would think the therapist attestation ought to be considered. I mean, they need to be able to take some responsibility that they really are showing some improvement and their documentation should verify that, it seems to me.

MR. HACKBARTH: So could I just ask a clarifying question about your first point, Tom?

DR. DEAN: Go ahead.

MR. HACKBARTH: You said there's a difference between the initial certification and recertification. Is the challenging part of the recertification the fact that often you don't have the patient in front of you? Or is it because there's something inherently different about the recertification, even if the patient is there, you know, how

much improvement have they made, or do they have potential to continue to improve? So is it just the lack of a face-to-face that makes it --

DR. DEAN: I would say they are almost never there for the recertification. All I get is the form.

MR. HACKBARTH: Right, and that's what makes it really tough, is the lack of patient contact at that point.

DR. DEAN: Yeah. And, certainly, some better measure -- "measure" isn't the right word, but diagnoses, some more precise diagnoses, and some measure of functional change. I mean, for instance, with speech therapy it's going to be really tough for me to decide, you know, what their progress is, have they reached a plateau, what are the prospects that they are going to continue to improve, those are judgments that I really don't feel qualified at all to make. I mean, the therapists are the ones that generally make that and I think appropriately make that judgment. And if that's the case, then it seems to me they should be the ones doing the attestation. So I don't know.

DR. BERENSON: I like Slide 20. I think this whole -- you're getting a good handle on this whole issue sort of as an overview, and I like the work that you've laid

out.

I think sort of consistent with Mike's notion of not making this more difficult than maybe it would be, I wonder if we can hone in a little bit. And my own experience with practice is that the indications for speech therapy -- and I agree, the continuation of speech therapy, I don't know, but identifying that there's a problem that would benefit from speech therapy, and I would say occupational therapy is much more straightforward than physical therapy where I sort of agree with Karen that everybody could benefit -- in fact, having sat here all day, I could --

[Laughter.]

DR. BERENSON: I could benefit from physical therapy.

I also note that on your data on Slide 7, by my calculation, 87 percent of the users of therapy are using physical therapy and 73 percent of the spending is in physical therapy. I'm wondering if we could hone in on physical therapy. I have one suggestion which may be to test my hypothesis. Whereas in Slide 11 you've done spending per therapy user, I'm wondering if we could also

erase spending per beneficiary and break it down by the three categories of therapy and see if there is a difference in the variation across the country with my hypothesis being that speech therapy, there won't be nearly the same variations in use and spending that there would be in physical therapy with occupational somewhere in the middle but closer to speech. If it turns out that the variation is really in physical therapy, maybe we don't have to worry too much about what's going on with speech and occupational, which isn't where the spending is anyway, and we could really try to hone in on how do we verify the need for physical therapy, which is tough. But it might permit us to focus a little more.

MR. HACKBARTH: Okay, thank you, Adaeze. Good start on this.

Let's see. Our next topic is reforming Medicare's benefit design. Whenever you're ready, Julie.

DR. LEE: Good afternoon. In today's presentation, we'll summarize our discussions to date on reforming Medicare's benefit design. First, we began with the policy goals; then we deal with the key design issues in changing the fee-for-service benefit, and go over the

illustrative benefit package from January's meeting, including a surcharge on supplementary insurance. Finally, we conclude with the Chairman's draft recommendation.

The Commission has been considering ways to reform the traditional Medicare benefit for several years to give beneficiaries better protection against the high out-of-pocket spending and to create the incentives for beneficiaries to make informed decisions about the use of care.

The Commission has been also particularly concerned about the potential impact of such changes on low-income beneficiaries and those in poor health. The Commission's discussions on potential changes in the fee-for-service benefit have focused on three key design elements.

First, an out-of-pocket maximum would protect beneficiaries from the financial risk of very high Medicare costs. The current fee-for-service benefit does not have such a limit on cost-sharing, and each year a small percentage of Medicare beneficiaries incur a very high level of costs. But without additional changes in the benefit, an out-of-pocket cap would increase the program spending.

A combined deductible for Part A and Part B services would be more intuitive and simple than the two separate deductibles that exist under the current benefit. In general, a deductible is mainly used to reduce the cost of other aspects of the benefit package such as the premiums, co-payments, and co-insurance.

For some beneficiaries, a deductible would be financially burdensome, but their overall costs might be lower if a deductible can buy down the premium and cost-sharing. The Commission has expressed a preference for co-payments rather than co-insurance for Medicare services because they are more predictable for beneficiaries.

Co-payments, which are set dollar amounts known in advance, would be easier to understand, compare, and respond to. Therefore, they could be used more effectively in creating incentive support beneficiaries to make better informed decisions about their use of care.

As we noted previously, a small percentage of beneficiaries incur very high cost-sharing each year. Therefore, an out-of-pocket maximum would lower their cost-sharing, but a larger percentage of beneficiaries would reach the out-of-pocket maximum at some point over time.

This slide compares the beneficiaries' hospitalization and spending over one year versus four years.

For example, in 2009, 19 percent of full year fee-for-service beneficiaries had at least one hospitalization; whereas, 46 percent did from 2006 to 2009. Similarly, 6 percent of full year fee-for-service beneficiaries had $5,000 or more in cost-sharing liability in 2009; whereas, 13 percent had at least one year of $5,000 or more in cost-sharing liability over four years.

In general, an out-of-pocket maximum would be valuable to the beneficiary in two ways. First, it will protect those who actually reach catastrophic levels of Medicare costs. And second, even those beneficiaries who don't reach the maximum level still would lower the risk of paying very high cost-sharing liability and for risk-averse beneficiaries that lower risk and uncertainty would be valuable.

We want to point out here that there's no one perfect or correct combination of design elements. We can trade off various levels of cost-sharing amounts and different definitions of the services to which they are applied. But a budgetary target for the new benefit design

will limit the set of feasible design combinations.

So the key question is, given the trade-offs between the design elements, can we find a combination that represents a reasonable compromise between competing policy goals within the budgetary target?

As we state at the beginning of the presentation, one of the policy objectives for reforming the fee-for-service benefit is to create the incentives to discourage the use of lower value services. As we have discussed over the past several years, beneficiaries tend to respond to higher cost-sharing by reducing both the effective and the ineffective care. This behavior is particularly worrisome for low-income beneficiaries and those in poor health.

Within the fee-for-service environment, however, change in cost-sharing may be the only policy tool available. Unfortunately, first dollar coverage provided by many supplemental plans effectively eliminates any price signals that might exist in Medicare's cost-sharing requirements.

The Commission has considered two approaches to mitigate the effects of first dollar coverage. Under the regulatory approach, we looked at different policy options

that restricted what supplemental insurance can and cannot do. At that time, the Commission expressed a strong preference for imposing a surcharge on supplemental insurance rather than regulating supplemental benefits.

So instead of restricting how supplemental coverage can fill in Medicare's cost-sharing, the surcharge would make the insurer pay for at least some of the added costs imposed on Medicare of having such comprehensive coverage.

There are two main effects of a surcharge on supplemental policies. First, it would provide the revenues to help recoup some of the additional Medicare spending associated with the supplemental coverage. Second, as the insurers pass along the surcharge by raising premiums, it may provide the incentives for beneficiaries to switch or drop supplemental insurance.

Here's an illustrative benefit package that shows some trade-offs between some design elements. If you recall, this is the beneficiary-neutral package from January. Under this package, average beneficiary cost-sharing liability would be about the same as under current law. We want to emphasize that this is for illustration

only, and the Commission is not endorsing this specific benefit package. It represents only one example of the many possible solutions to that design problem that we discussed earlier.

You are already familiar with this package, so let me highlight just a few elements. The illustrative package has a $5,000 out-of-pocket maximum and a combined deductible of $500 for Part A and Part B services. The co-payment on hospital is $750 per stay and it has different co-payments for primary care and specialist visits.

This slide summarizes the relative change in annual Medicare program spending under the illustrative benefit package from the previous slide, combined with a 20 percent surcharge. Before we look at the numbers, we want to repeat that this is only a one-year snapshot of relative changes and it is not a score. The table also lists our modeling assumptions which are discussed in your mailing materials.

So remember that the illustrative benefit package held beneficiary cost-sharing liability roughly equal to current law that resulted in an increase of program spending by about 1 percent. That's mainly due to the catastrophic

protection for high-cost beneficiaries.

In addition, the 20 percent surcharge on supplemental insurance generated revenue offsets of about 1.5 percent. On net, the change in program spending was about 0.5 percent in savings, that is adding plus 1 percent and minus 1.5 percent equals minus 0.5 percent.

This chart you have seen before. It shows the results of simulating changes in out-of-pocket spending and supplemental premiums for 2009 if the illustrative benefit package had been in place. So let's start with the first bar on the left, which corresponds to the illustrative package without the surcharge.

At the bottom part of the bar, 9 percent of beneficiaries had their out-of-pocket spending go down by $250 or more under the new benefit. On the other hand, at the top, a little over 20 percent of beneficiaries had their out-of-pocket spending go up by $250 or more. Mostly these are the beneficiaries who are spending more out-of-pocket due to their deductible. But for 70 percent of beneficiaries in the middle part of the bar, their out-of-pocket spending basically remained unchanged.

Now, the second bar on the right shows the

distributional effect with a 20 percent surcharge on supplemental coverage. We made a very simplistic assumption that a 20 percent surcharge would mean that beneficiaries' annual expenses will be $420 higher for those with Medigap, and $200 higher for those with retiree benefits, even before we consider any changes in their cost-sharing liability.

You can see the effects of the surcharge reflected in this chart where we see a noticeably bigger change compared to the bar on the left. Looking at the top part of the bar, we now see that 70 percent of beneficiaries had their total out-of-pocket spending go up by $250 or more; whereas, 7 percent of beneficiaries had a decrease, about $250 or more. But the relative magnitude of the increase was smaller than that of the decrease. As a result, the average change in out-of-pocket spending was about $220 to $240 per year.

Here are some additional issues important to restructuring the Medicare benefit. First, with the new benefit applied to all beneficiaries or only new beneficiaries, as mentioned in the previous slide or earlier slide, a combined deductible is problematic for those enrolled in either Part A or Part B only. This issue would

need to be resolved in implementing the new benefit.

Moreover, if there's a shift in the distribution between Part A and Part B spending under the new benefit, Part B premiums would be affected. We haven't discussed this effect, but such a change in Part B premiums would be included in the CBO score as a change in offsetting receipts to the program.

Here is the Chairman's draft recommendation. It reads: The Congress should direct the Secretary to develop a new fee-for-service benefit design that includes an out-of-pocket maximum, a combined deductible for Part A and Part B services, co-payments that may vary by type of service and provider, Secretarial authority to alter cost-sharing based on the evidence of the value of services.

And we want to make two quick points here. First, the Secretarial authority to alter cost-sharing can mean either increasing or decreasing cost-sharing based on utilization and clinical evidence. And second point, we would like to clarify that in making such changes in cost-sharing, the Secretary would determine that they would not compromise the quality and the Office of the Actuary would certify that they would not increase program costs. The

second point is not yet in the paper, but will be included in the next draft.

So now returning to the draft recommendation, the last two bullet points read: No change in beneficiaries' aggregate cost-sharing liability, a surcharge on supplemental insurance. The draft recommendation may have the following effects: For the Medicare program, spending would depend on the levels of the cost-sharing and surcharge specified in the ultimate benefit package.

Under the new benefit and surcharge, most beneficiaries would pay slightly more on average for their Medicare and supplemental benefits, but an out-of-pocket maximum would provide protection against the very high spending and also reduce the risk and uncertainty of potentially very high spending. If the individual's cost-sharing were to go up, he or she is likely to reduce both the effective and ineffective care and some beneficiaries may experience worse health because of it.

Finally, those beneficiaries with supplemental insurance would pay the surcharge if they decide to keep their coverage. For Medigap plans, the surcharge would increase their premiums and some beneficiaries might drop

their Medigap or move to Medicare Advantage in response to the Medicare benefit change and higher Medigap premiums. The effects on employers offering retiree benefits are quite uncertain and will depend on various factors.

That concludes our presentation and we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Julie. Well done. Let me ask a couple questions on Page 9. So in your modeling of this, you excluded dual eligibles. Could you just say a little bit about why and whether that might buy us the results one way or the other?

DR. LEE: So our simplifying assumption was that whatever happens to the fee-for-service benefit, the Medicaid will wrap around the cost-sharing of the changed benefit in the same way that they do now.

MR. HACKBARTH: And then on the bottom part of the page, the modeling uses the 20 percent surcharge. Could you just say a little bit more about why 20 percent as opposed to some other number?

DR. MARK MILLER: Probably not.

MR. HACKBARTH: That's fair enough.

DR. MARK MILLER: I mean, just to give you a sense

of a few things about this, if you look at the added costs that wrap around policies impose on the program, you actually end up with a larger number than 20 percent. I think some of our thinking was to have a placeholder number to kind of focus people's attention. The other thing about this is the surcharge, if the premium is higher because the benefit package is larger, then you're paying 20 percent of a larger number versus 20 percent of a lower number.

But this is just a placeholder. This number could be higher, smaller, whatever the case may be. But the one empirical point is, is the actual cost imposed is much higher than 20 percent.

MR. HACKBARTH: And then also in the surcharge, so this surcharge, of course, applies to individually purchased supplemental coverage. It would also apply to employer-sponsored insurance for retirees?

DR. LEE: That's correct.

MR. HACKBARTH: But it would not apply to Medicare Advantage plans on the basis that the Medicare Advantage plan is responsible for the full cost. So their structure of what we would think of as supplemental benefits, they fully bear the cost of that monthly?

DR. LEE: Yes. We think of it as within the Medicare Advantage program.

MR. HACKBARTH: Right, right. And then on Page 10 in the bar chart on benefit changes with surcharge, as I recall our discussion at the last meeting, our working assumption, after consulting with actuaries, was that the surcharge, at least in the short-run, would not dramatically alter purchasing behavior of supplemental coverage, the type of supplemental coverage purchased. And so, this sort of assumes static levels of supplemental coverage. Is that right?

DR. LEE: That's correct. At least the actuaries that we consulted, among the current beneficiaries who have supplemental coverage, the switching was going to be relatively small. So for this particular chart, we have assumed static.

MR. HACKBARTH: Okay. And then my last one is on Page 12 with the wording of the draft recommendation. Since this is my draft recommendation, this should have occurred to me before, but it did not. So the wording is, the Congress should direct the Secretary.

It just occurred to me that some people -- that

could be construed in different ways. One potential interpretation of that is, we think this should be done and the details should be developed through a thoughtful process by the Secretary, and we have an illustrative package. So that's one interpretation.

The other interpretation is that this is a mandated study from the Congress to the Secretary of HHS. This is just something we think should be studied, because there's no further action beyond the Secretary working on it. I offered the draft recommendation with the first interpretation in mind. I didn't think of this as a mandated study to the Department. And we may want to think, for the final version, about how to modify the words to make that clear.

DR. MARK MILLER: And just so you know, we understood that that's your intent and that was what we meant when we wrote it, but I do see the ambiguity and we'll get that right.

MR. HACKBARTH: Okay. So let's move. Bruce, you look like you're primed for clarifying questions.

DR. STUART: Actually, I do have a clarifying question and it's on Slide 5. Glenn asked the question

about excluding duals. Can I assume that duals are excluded from this analysis?

DR. LEE: They are actually included, but they had to have been involved for the full four years.

DR. STUART: Harrumph. If you're a dual eligible, then you would not have any liability for these services. So I'm not sure what that would mean. If duals are included and duals are generally more expensive, then that suggests to me that less than 6 percent of the non-duals are going to have liabilities of 5,000 or greater.

DR. LEE: Actually, I think I would need to clarify the semantics, so the duals would have a cost-sharing liability, but they might not have out-of-pocket spending if Medicaid isn't paying for their liability. So this one is just showing the liability under Medicare.

DR. STUART: I'm not sure I understand that.

DR. MARK MILLER: The dual has liability. Somebody else pays it so they don't incur the out-of-pocket. So I think what she's saying is, this is a calculation of the liability.

DR. STUART: Well, in many cases, there is no liability because Medicaid pays at a lower rate and it's

just simply wiped off the -- you know, it's an accounting --

MS. BEHROOZI: Non-Medicare only.

MR. HACKBARTH: Yeah.

DR. STUART: Well, that was one question, a clarifying question, and so I would just suggest that we think about that, because I think that the message that I took away from this is that if people have a liability, then they're expected to pay for it.

But that leads to the other question and that is, do we have any sense of people who actually have the personal liability that would not be duals in that range of 5,000 or more who actually pay the liability? Because if we look at the income distribution of the Medicare population and we take out the duals and we look at that big bolus of people that have incomes between 100 and 200 percent of the poverty level, they're not going to be paying $10,000 out-of-pocket. They just simply don't have it.

And so, one of the factors here that I'm wondering whether you've had a chance to think about, is whether this is helping institutions with their bad debts or is it actually reducing the true financial obligations of beneficiaries.

MR. HACKBARTH: Is there any way to get at that question?

DR. LEE: In terms of bad debt, we actually would not know that from the claims data. One thing that I will just kind of raise is that even though the income and savings or people's assets are correlated, in some cases, people are using their savings. That's another source of their financial resources.

DR. STUART: Is that an assumption or do you know that?

DR. LEE: There are some studies that indicate that, suggest that. Now, I actually cannot say to what extent that we can generalize that.

DR. STUART: But there is information on assets in the MCBS, in the income and asset supplementation that you might be able to address this question. And, in fact, there's a question in that INA supplement about whether you have medical liability.

DR. MARK MILLER: And maybe you'll talk about this the second time through. I mean, notwithstanding the ability to quantify it, I think one of your statements stands, which is in some instances, what we're doing is

probably helping the institution because the beneficiary doesn't, in the end, end up paying that, although it can be, you know, there's peace of mind and that type of thing because they can be continued to be pursued for it, at least at some level.

And so, yeah, maybe the second time around you might, if there's some significance that that would lead you in a different direction, speak to it.

MR. HACKBARTH: George, clarifying questions?

MR. GEORGE MILLER: Just a quick one about demographically, do we know if this would have an adverse impact financially on inner-city or those who may have lower economic status? I think you've already covered dual eligibles. Have we broken this down by demographic information, race, in any way?

DR. LEE: This particular slide or the more general?

MR. GEORGE MILLER: The more general information, but this slide as well. Do we have a disproportionate impact just demographically?

DR. LEE: Demographic information as to age, sex, race.

MR. GEORGE MILLER: Okay.

DR. LEE: That information we can get.

MR. GEORGE MILLER: Okay.

DR. LEE: Income would not be, although we have used the Part D LIS status as an indicator, and I don't believe we have actually seen anything that's disproportionately.

MR. GEORGE MILLER: Disproportionately?

DR. LEE: Yeah.

MR. GEORGE MILLER: Okay. Yeah, I'd like to see that. Thank you.

DR. BAICKER: Two quick clarifying questions on the assumptions in Slide 9. So for supplemental coverage, you're assuming that the premiums stay the same except for the surcharge when you layer that on? I would have thought that premiums would change because the liability that the plan faces is changing because of the changing Medicare benefit.

DR. LEE: But overall, we held to the cost-sharing liability about the same, so we introduced out-of-pocket maximum, but we raised the cost-sharing on other parts, like home health. So the kind of aggregate remained about the

same.

DR. BAICKER: And that plays out the same? It's changing the composition in a way that's neutral to the Medigap policy because their coverage is the same across those different dimensions that you've changed?

DR. LEE: Yes, the kind of average we held it roughly the same.

DR. BAICKER: And then in terms of the behavioral assumptions, you're building in some elasticity based on the price. Is that only applying to people who don't have Medigap coverage? Because the people with Medigap coverage are still not seeing a price change, so you're getting very little behavioral change because it's only a few people?

DR. LEE: That's correct. So we applied the behavioral assumption to how -- you know, there have been changes in the cost-sharing liability. It works through their supplemental, so it changes whatever the change in out-of-pocket spending that comes out, and that's the number to which the behavior was applied. So it's the -- your supplemental status changes or not changes your out-of-pocket even though that Medicare benefit might have changed, and your behavior is a function of what you are paying out-

of-pocket.

DR. BAICKER: And then the last question under the assumptions, is the only change in Medigap policies that you're modeling is that a small share of people drop in response to the increased share -- in response to the excise tax or whatever --

MR. HACKBARTH: Surcharge.

DR. BAICKER: Surcharge, surcharge -- there are no taxes here -- in response to surcharge, but not the form of insurance coverage. So the plans all still look the same?

DR. LEE: That's correct.

DR. BAICKER: It's just some people don't take them out. Okay, thank you.

MS. BEHROOZI: Sorry. I thought of a question that I had when I was reading the paper. You do a chart of the Medigap policy, the standard policies and what they cover. K and L include more cost-sharing and then have the out-of-pocket cap a little bit later on, I guess, than some of the other ones do.

I know you've talked about this before. In what proportion do people who choose Medigap policies choose K and L? Are they down at the lower end or do people prefer

those?

DR. HARRISON: K and L are not popular. I think it's a total of less than 1 percent of policies. The newer N has become popular, though.

DR. BERENSON: Yeah, a couple are clarifying. Could you go to Slide 10, please? I just want to make sure I understand. The note says that you're not including beneficiaries enrolled in Medicare Advantage in Medicaid. You are including those without any supplemental insurance. So they would be in the second group, benefit changes with surcharge. They presumably wouldn't be affected by adding a surcharge because they don't have it. So they're included in that calculation?

DR. LEE: That's correct. So for that group, between the two bars, their underlying data would be the same.

DR. BERENSON: So I just want to pursue so I understand. First Glenn asked and then Kate followed up. The advice you've gotten from actuaries, was it that the surcharge, they wouldn't be willing to estimate with the 20 percent surcharge that there would be any choice changes, or was it that with this whole benefit package change, they

would not be able to estimate how many people might drop getting supplemental insurance in the first place, or both? Would you clarify that for me?

DR. LEE: So their kind of opinion was that people who currently have a supplemental insurance, they like having that coverage. So their decision is going to be sticky because they're already starting with the state of having that insurance. So whether the benefit, the basic benefit has changed or that the price of their supplemental benefit has changed, it's relative how they are comparing the benefit -- the advantage of having the supplemental insurance versus the cost of having that insurance.

But it's at least among the current beneficiaries with the supplemental coverage, that will be not very sensitive. Now, they did also, I think, believe that if you are starting out at age 65 trying to decide whether to get supplemental coverage or not, then that decision probably is going to be different.

DR. BERENSON: Have you tried to quantitate for, let's say, the low user, the average user, and the high user? If somebody who has Medigap insurance today dropped it, what the net would be on their out-of-pocket spending?

DR. LEE: The short answer is that we have not. The -- yes, I'll end there.

DR. BERENSON: I guess if I were -- I'm not an actuary happily, but I'd want to know the degree to which the amount of benefit -- I mean, I'm assuming there would be some net benefit if you're no longer paying very high premiums and relatively high premiums and you're going to avoid the surcharge that's going to be applied.

At the same time you have more direct out-of-pocket spending for co-insurance, and now you have out-of-pocket protection for catastrophic expenses, that the net is going to be a positive. I think it might be helpful to sort of see how much we're talking about for different kinds of beneficiaries, to at least challenge the actuaries to, you really don't think people would make a different selection with this kind of savings?

If it turned out it was 38 cents, then maybe that's one thing. If it was in the hundreds of dollars, one might be in a better position to assess whether their judgment sort of has credibility. Does that make any sense?

DR. LEE: Yes. So I think one simple way of looking at the kind of a comparison that a beneficiary could

make, and this is just only in terms of what an expected benefit would be, is if you are paying $2,000 a year for Medigap coverage, that means if you don't have it, that's $2,000 in cost-sharing liability under Medicare that you could actually use those premiums for.

$2,000 in cost-sharing liability, that implies more than $10,000 into Medicare or spending for Medicare services. That's quite a high number. One thing that actuaries did point out is that with out-of-pocket maximum at $5,000, that is statistically, it's good protection. But for some people, 5,000 is still too high and they want to protect, or maybe at 2,000 or at a lower level.

So supplemental coverage, the extra protection they are providing for 5,000 -- between 5,000 and 2,000, or some lower number, that still might be valuable to them and that might be one of the reasons why they might still consider it.

MR. HACKBARTH: I'm just glad Cori wasn't here to hear your hurtful comments about actuaries.

MR. GRADISON: Julie, this is a comment more on me than on actuaries.

MR. HACKBARTH: Bill?

MR. GRADISON: Could you remind me, Julie, what happens with beneficiary responsibility for preventive services?

DR. LEE: The idea is that they will be carved out of the cost-sharing.

MR. GRADISON: Do we have to specifically say that in a statement that says -- do we have to specifically mention that in this or would the provisions of the ACA cover that already? I don't know.

DR. MARK MILLER: We can discuss this.

DR. HARRISON: I think that would be contemplated in the Secretarial discretion to raise and lower co-payments by the type of service.

DR. HALL: But I thought we had sort of made the principle that it doesn't make a lot of sense to allow people to not take advantage of preventive services, that the cost is --

DR. HARRISON: We sort of assumed that preventive services would not have cost-sharing.

DR. DEAN: Does the calculations of what beneficiaries would end up paying, does that include Part B premiums? Because, I mean, do you have any projections to

what would happen with Part B premiums, because it seems like if the incentive is to use less low-valued care, those possibly could go down. On the other hand, if the benefit package changes, they might not. I mean, is there any projection about that?

DR. LEE: So this one of the items that we included on other issues because we have not actually included what the change in Part B premiums would be. Now, with cost-sharing changes, that's going to have an effect on Part B or Part A service use, and for Part B services, if it goes down, in our modeling of the illustrative package, it did slightly.

Then the 25 percent of the Part B costs will be smaller, so that the Part B premiums would decrease. But it's going to change and it will be -- even though we have not included it in our analysis, a score would include that.

DR. DEAN: I just wondered if that would offset any of these other costs, but I realize it's a lot of speculation.

MR. BUTLER: So you've really done a great job, in my mind, of taking a whole set of complex things and I can, I think, even understand them. So congratulations. Slide

9, to show you how well I understand them, maybe we shouldn't call it tax or surcharge. You're really only paying a portion of what the downstream impact on Medicare spending is. Something like that is what it's about.

And I understand from the chapter the individual is, on average, going to pay about $420 more a year, the surcharge estimate for the average premium.

DR. LEE: For Medigap.

MR. BUTLER: For the Medigap policy? In other words, they will have out-of-pocket an additional 420 for their supplemental insurance, right? Now, the 20 percent Mark already said, he's not sure how he came up with it or you came up with it.

DR. MARK MILLER: Careful now.

MR. BUTLER: But this is you. You're fair game. I'm really nervous now. I assume one of the things is budget neutrality and kind of what makes sense and what might be bearable, and that's why I was thinking about the 420. But then I was also trying to think of, if you were to have Cori here, what is the actuarial number that you would charge?

And you also say in the chapter it's a little over

8,000, on average, for the 90 percent that have Medigap, and it's about 5,800 a year for those that do not, although that does not have the risk adjustment in it, but you have a $3,200 a year, if they were exactly the same populations -- I'm jumping ahead -- you'd be paying for 420 of the $3,200 gap from an actuarial standpoint. Is that right?

DR. LEE: So the difference that is in the chapter is not adjusting for risk.

MR. BUTLER: Right.

DR. LEE: And the people who have just Medicare only, they tend to be younger and, you know, so that there are risk differences there.

MR. BUTLER: Less than 3,200. I don't know how much less, but I assume that the 420 is less than the actuary -- I'm just trying to get a sense. Is the 420 still a lot less than the actuarial -- than the impact on the strength of spending?

DR. LEE: Yes. So the conventional or the rule of thumb that the number that people use for the difference between people just with Medicare and people with supplemental or first dollar coverage adjusting for risk is about 25 percent higher spending. So if you kind of apply

that to a much smaller base of Medigap premiums, it is -- the number is much higher than 20 percent.

MR. BUTLER: So it's probably covering less than half of the actual impact?

DR. LEE: Yes.

MR. BUTLER: Okay.

DR. MARK MILLER: That's correct.

MR. BUTLER: I'm trying to get it in my mind. So this isn't such a bad -- I'm trying to get the high-level message in my mind how I would sell this. And so, you're still not paying for the full impact of what the supplemental insurance is actually creating downstream? Okay.

DR. CHERNEW: I have a question about the out-of-pocket max. is constructed so that if there was low-value services used by people that had serious illness, so they're going to pay their out-of-pocket max, there would be no way to charge or use any financial incentive to discourage use of that service once they hit it?

DR. LEE: In our modeling, we have not made any -

DR. CHERNEW: I understand, but in the policy -- the way that this is applied, if there was a service that we

thought was low-value, but it was used for people that had some other serious ailment, whatever it was, so they're -- the other cost-sharing range, it would work the same as catastrophic in Part D works this way, which is no matter what you think you have in your cost-sharing requirements in Part D to discourage low-value use, if you're sick enough that you hit the catastrophic cap, there's no more cost-sharing no matter what it is. Is that the way this is envisioned?

DR. MARK MILLER: Yeah, let me draw a distinction between modeling and policy and then what D does, and some of the D folks, make sure that they're paying attention here. So the way this was modeled is, when you hit the catastrophic cap, you have no more liability. That's it. Okay? And, of course, you're saying, but that's not what I want to talk about. I want to talk about the policy. I'm with you.

And on the policy, as I understand D, when you hit the cap, it's not that you're relieved of all liability. What happens is the beneficiary still has a 5 percent liability. The plan, I think, has 20 or 15, somewhere in there. I'm getting some nods, but I can't tell the

difference between a 15 and a 20 percent nod. I'm getting a 15.

And then the program takes the rest of it over. If you could think of some kind of wrinkle like that in here, but you almost had even a more precise one, which is, can I go in and go after a specific low-volume service.

DR. CHERNEW: Low-value.

DR. MARK MILLER: Sorry. I'm sorry. I mean value.

DR. CHERNEW: I think your answer is, that hasn't while you were thinking about it, but that's open for discussion.

DR. MARK MILLER: Absolutely. You could design the policy like D and say, the beneficiary still has a 5 percent liability. You have to think about the distributional impacts that get set, all the rest of it. But yeah, D has that sliver that the beneficiary still is beholding for.

MR. ARMSTRONG: Just for the record, I admire actuaries and thanks to them, I can ask stupid questions like the one I'm about to ask, and that is, so this is a little bit broader. I mean, a lot of this, 3 percent seems

like a small impact from some of these changes, but I just trust that that analysis was done right.

But stepping back half a step, I assume we are assuming through all of this work that we're really just focusing on the impact of the -- on the beneficiaries and the cost to the Medicare program of making these benefits available. But what kind of assumption are we making about the overall expense trends based on the net of these benefit design changes? Are we assuming that there's no impact on that? Or is that really part of this analysis?

MR. HACKBARTH: There is a net fiscal effect of minus 1.5 percent when you take into account the increased outlays from the beneficiary-neutral policy, benefit redesign with the offsetting effect of the 20 percent surcharge. The net effect of those two is the 1.5 percent reduction in Medicare outlays.

MR. ARMSTRONG: That's exactly what I wanted to hear. That's kind of what I was counting on. But we keep talking --

DR. MARK MILLER: Can I just pin a fact down? The net effect is minus 1.5 or 0.5.

MR. HACKBARTH: Oh, I'm sorry. You're right. I'm

sorry.

DR. MARK MILLER: You have to do the arithmetic and the way I would have answered Scott's question is, what this does is, is it says off of baseline. You're at half a point less, but I don't think we're making any assumptions about changing the growth trajectory. So in a sense, if this is what the line looked like, it's a half a point lower as you net those two numbers out. Right?

DR. LEE: It is just the one year. We just took a snapshot of what this new benefit would mean in terms of how people's spending changed.

MR. ARMSTRONG: Okay. So I think that does answer my question and on Round 2 I'll make it --

MR. HACKBARTH: Okay. Karen, clarifying questions? Bill?

MR. GRADISON: I just want to make sure I understand this. So I'm picking up from Bruce's point, which is, as I understood it, focused on the impact on very low-income beneficiaries of the cap, of the $5,000 or whatever. The bottom line, I think I can support this, but my understanding is that there could be a fair number of people whose income is just above the poverty line,

therefore not dual eligibles, that are going to get hit as part of the 68 percent who are in the plus $250 to $999 a year.

And I just think if we go into this, we ought to do it with our eyes open because there are going to be a lot of low-income folks that aren't going to think this is a very good idea. I kind of like it because I think it does correct a defect in the program, but on that point, I'd just like to think a little bit more about it.

And I've worked with accountants and actuaries for a long time and I never could quite it get clear which way it was. Some people said that accountants are people that are good with numbers, but don't have the personality to be actuaries. And others said it was the other way around.

DR. STUART: Let's see. Where do we go with this? I'm worried politically. I'm on Page 10 right here. I'm worried politically about the right hand bar because if you do the -- there are a couple ways you can do the math. If I split that 24 percent into half, gain a little half, lose a little, I still end up with about 80 percent of the population worse off. And some of them are worse off by a lot. And it's not just the 68 percent.

That 2 percent at the top actually worries me. And that sounds like just a tiny number of people, but we've got a program that has almost 50 million people, and that means about a million people are going to be facing higher annual costs, higher than $1,000, and that's really big.

The other thing when I put this in trying to figure out how we should go about modifying this program, I really do think that there are two pieces here. I'd like to see them separated. And the first piece is, what do we do about the current benefit design? Forget about supplementation at this point. Let's just make this more rational, which is the left-hand column.

And that left-hand column, to me, makes a lot of sense, although to be honest, I'm a little worried about the 1 percent at the very top, but that's not my major issue. The way I would look at this on the left-hand column is to say, that is budget neutrality as we have applied it on the reimbursement side.

In other words, what we're trying to do is to come up with a policy that some people are going to win, some people are going to lose, but on net, there's not going to be any greater or lesser outlay for the program.

MR. HACKBARTH: Just to be clear, the left-hand column is not budget neutral. It results in an increase in program outlays of about 1 percent.

DR. STUART: Of 1 percent. Okay, all right. Well, that's a good point because that kind of makes my point. I mean, that increases it 1 percent and the other column decreases it 1.5 percent. So I guess what I would think would be, let's have one that is truly budget neutral and then let's think about supplementation and its implicit subsidy of the Medicare, current Medicare beneficiaries in the Medicare program. That's been around for, you know, that's been around since year one.

That's an important issue, but to me it's a different issue. And one can think about that issue in saying, Okay, for the long term sustainability of the program, let's phase out this subsidy and let's phase it out, as we've talked about other kinds of payment reforms that affect providers. So it wouldn't be just the 1.5 percent cut. It would be the whole shebang, whatever that happens to be. But it would be put in in phases over time, because I think that's really a different question than changing the current budget, than changing the current

benefit structure.

And if you had the two together, I think you might have a better chance of actually having Congress look at it favorably because, frankly, making 80 percent worse off, I think, is politically--you know, it's just not going to fly. I just think that's going to be a very --

MR. HACKBARTH: So that's a useful way of framing the issue. So the left-hand column that results in a one percent increase in outlays, we looked at both versions. We looked at making it a program neutral restructuring, or a beneficiary neutral restructuring. This is the beneficiary neutral version. And the reason that we went to that was because of the significantly higher deductible that was required to make the program neutral model work. Now, in fairness, there are different ways you can do it. You can greatly increase the catastrophic limit or increase the deductible. Julie, help me out. If you kept the catastrophic constant and tried to do it on a program neutral basis, the deductible had to increase by how much?

MS. LEE: So the program neutral package that we considered in January was the deductible was the 700 and it also had, you know, higher copays and I think SNF stays.

But mainly that it was the deductible that had to move noticeably.

MR. HACKBARTH: Yes. And so when we talked about that, there was some preference for keeping that deductible lower, the number as low as possible, as we opted for, therefore, the beneficiary neutral approach, but it cost the one percent.

DR. MARK MILLER: And the way I would think about this, Bruce, because I think there's kind of a difficult choice whichever way you go. I mean, if you say, okay, I want to build the left-hand side and I want to rationalize the benefit, and I'm using our terms, and I want to remain program neutral -- program neutral -- then you're taking the average liability for the beneficiary up. And so you will have increased cost sharing widely through that distribution and that bar will look very different. And the same problem that you run into of, wait a minute, the beneficiaries aren't going to like it, that's is going to occur there, as well. And the right-hand side, it's basically saying, you're putting the cost on an item, and I know that there are issues with income and poor, but you're putting on an item that's a choice for the beneficiary.

DR. STUART: I guess I'm thinking of it two ways. One, I think that if we go with the Chairman's recommendation, which includes a surcharge on benefits, on supplementation, then nobody is going to pay any attention to the left-hand column because we're going to be saying what we're really looking at is that right-hand column, or some variant of that. Everybody recognizes that this could be redone and would be redone.

I'm just afraid of giving a recommendation that might just be dead in the water and so that it won't be considered. So I'm actually in favor of changing the program so that that implicit subsidy, in fact, is recouped. But if it were done over time, then I think that it would be more likely to be considered as opposed to what it looks like here.

MR. HACKBARTH: Yes. So help me understand, Julie, the numbers here. We say that a 20 percent surcharge represents only a fraction of the downstream effects of the decision to buy supplemental coverage. What is that fraction?

MS. LEE: Umm -

MR. HACKBARTH: If we were to set the charge,

surcharge to offset the full downstream effect, how high would it be?

MS. LEE: I think one time we calculated what the back-of-the-envelope number was, so, like, 70 percent -

MR. HACKBARTH: Yes.

MS. LEE: -- so --

MR. HACKBARTH: So we're talking about a small first step in your phase-in to the full effect, and you're saying, oh, I can't even accept this, it's going to make this politically unacceptable, while you come in and say, well, this is the first of four steps, and that will be a political problem.

DR. STUART: [Off microphone.] I think there are two issues and I'm worried about putting them together.

MR. HACKBARTH: And you're absolutely right. There are two distinct issues here. There's no disagreement with that.

Any other points, Bruce, that you want to make? George. Mitra.

MS. BEHROOZI: So, I'll start with what I like. I really do appreciate in the evolution of this work that I really feel like you have listened to all of the commentary.

I feel like I've been heard. I really appreciate that. I think that you have not just looked at it, with all due respect to my dear economist friends -- can I pick on them now that the actuaries have been picked on? I know it's going to come around to lawyers eventually. It always does. Lawyers always, always --

[Off microphone discussion.]

MS. BEHROOZI: We'll get it in the end. But anyway, it's not just about the numbers. I feel like the emphasis has shifted more to look at the impact on people. So I really do appreciate the evolution of the work and of the recommendation, I think, that's come out of that work.

So would you mind putting on Slide 12, please. So what I like about the recommendation. An out-of-pocket maximum, I think, is fine. It's good. I'm not against it. I share Bruce's concern that it's not necessarily going to benefit that many beneficiaries, and I think I tried to get at this a little bit the last time we talked about it, you know, the ten percent of people who don't have any kind of supplemental coverage are the -- they're poorer, but they're also healthier. They're younger, so less than six percent of them are the ones who are likely to exceed the $5,000,

that whole thing. And they will more than likely go into the bad debt and charity pool. I don't think that's a good way for society to deal with coverage of health care costs. So it's a good thing. It's fine.

I'm going to skip over number two.

Copayments that may vary by the type of services and provider that allows for all the kinds of things that we're talking about in all the other discussions that we have. Secretarial authority to alter -- I would add, or eliminate cost sharing based on the evidence of the value of the services, because I think that goes to the point that Bill Hall raised earlier about, so what does that mean about preventive services, let's be explicit, and all of that.

MR. HACKBARTH: And that's what was intended, was to go all the way to zero if the Secretary deemed it.

MS. BEHROOZI: Great. No change in benefits -- in beneficiaries', I'm sorry, aggregate cost sharing liability. I'm going to come back to that in a minute because that, to me, relates to the second point. I'm sorry -- yes, the second point.

And then the last point, a surcharge on supplemental insurance. I came to that somewhat reluctantly

just because there is a lot of concern about the added cost brought on by supplemental insurance. I think that people like their supplemental insurance. They're not looking just for out-of-pocket -- I'm sorry, maximum spending, catastrophic coverage. There's a reference in the paper to auto insurance and the catastrophic coverage. Actually, I was talking about this with colleagues the other day and somebody said, yes, right. When you decide what kind of coverage you get on your car, of course, there's the insurance that covers collision and all that, but then you can also buy a maintenance contract and that's what people are looking for, it seems to me, in the Medigap policies that they're buying, right. So I don't think it's necessarily a bad thing. I think that's the value that people are looking for in their coverage, not just insurance coverage but health care coverage. It's a broader kind of a package.

But to the extent that that extra cost should be recouped and paid for differently, I would suggest that we don't necessarily need to recoup a percent and a half so that the net savings in this whole thing is a negative-point-five. Maybe we can look at balancing it out to more

of a zero. Twenty percent is a lot. I would suggest that we look at varying it by the value of the plan, by how much additional coverage there is.

And I also think that it would be good if we could say something -- there's a text box in the paper about a public plan -- oh, God, I almost said public option. I don't want to open that can of worms. A public Medigap plan that has a lot of apparent advantages, not least of which is to lower the load, the administrative cost, and allow for policy choices to be made that are consistent with the kinds of things that we're encouraging the Secretary to look at. So I would sort of put that a little more up front, maybe recommending that the Secretary study the viability, perhaps, of a publicly financed Medigap plan.

But then to the unified deductible, the combined deductible. And my big problem with that is that I just really don't agree with some of the premises, I think, that underlie it. I don't find it more intuitive or simple. You know, I talked with colleagues in the benefit design world and I say, yes, and so to pay for the out-of-pocket max they're talking about a combined deductible. They're, like, why? Why would you combine the deductible?

You know, they are different dollar amounts right now, the Part A and Part B deductibles, but there's a reference to them being relatively -- to bring them -- yes, they're relatively out of whack or whatever. But the thing is, relative to the benefit they're paying for, they're not so out of whack. And if you look at the benefit design, the potential benefit design that you've suggested, that relatively to have the same -- the one deductible for both hospital and, say, physician services, but then you're okay with charging a $750 copayment for a hospital stay but only a $20 copayment for a primary care doctor visit. So the person who's now paying $140 deductible until they get coverage for their doctor's visit would have to pay $360 more, which relatively is the value of 18 primary care doctor visits, or nine specialist doctor visits, just in our proposed alternate plan. But the deductible would be even less than the copay for one hospital stay.

I mean, I'm not trying to, like, say, okay, so it has to be this or it has to be that, but I don't think there is an intuitive logic to making it one deductible for both sets of services, both types of services.

MR. HACKBARTH: To help me understand, Mitra, if

we were to have two separate deductibles, holding everything else constant, and set them at a level so that all of the numbers balance out in terms of not increasing the cost of the package, would you prefer that relative to a single combined deductible of equal actuarial value?

MS. BEHROOZI: I think it's consistent to keep costs on the doctors' side lower, whether by deductible or by copayment, with everything else that's been said in the paper about cost barriers. You know, there's a phrase in there, mitigating the impact of first dollar payment, of first dollar coverage. Well, I would say mitigating the impact of cost barriers is essential. And everything that we have in here about bigger impact on lower-income people and, you know, that includes more minorities, we're going to exacerbate disparities by loading more costs onto the front end.

So that's where I get to the second-to-last point, no change in beneficiaries' aggregate cost-sharing liability. It's not about aggregate. That's what matters to the Medigap payer, perhaps. That's what matters to the Medicare program, perhaps. But to the individual beneficiary, it matters a lot where those costs come in, if

they're paying for it in a premium that's knowable and all that or if they're paying for it at the point of service, which will deter them from getting the service.

So the answer is, yes, I recognize that that means that you have to find the dollars elsewhere. I do think Julie's comment about how $5,000 is still a lot -- for the people who it's going to matter to, it's going to matter a lot. I don't know that maybe $10,000 isn't the right out-of-pocket maximum, especially if you take into consideration what Michael said about keeping some copayments on services beyond a certain point to drive behavior.

There are other ways to do it. I mean, Part D imposes doughnut hole later on. But that up front point of service, not letting somebody get to the doctor until they have paid for 18 visits' worth, basically -- I mean, you know, they don't go 18 times, but it's the value of 18 visits' worth in addition to what has already been the deductible, I don't think is enlightened benefit design. I don't think that makes it a better benefit, particularly for those ten percent with no additional coverage who are less likely to get to the hospital but more likely to need doctor services.

MR. HACKBARTH: So as we go through the rest of the second round, if people could react to some of the ideas that have already come up. Two in particular that I'd like people to react to are this idea of having two distinct deductibles and a lower deductible on the Part B services, again, assuming that it's all within a fiscal constraint, and we've got to make the numbers add up. Do people prefer that to a single combined deductible or not.

The other issue that I invite reaction to is on the idea of, well, let's structure the combination of the two, the surcharge and the benefit redesign, to net out at zero. And at the end, I'll explain why I didn't do that, but I invite people to react to that idea, as well.

DR. MARK MILLER: Can I just ask one thing? So just to understand what you are saying, Mitra, because I have to think about, when we go back, how to design this, if there's any place where we have to let off steam as a result of moving these deductibles, I also seem -- I don't want to put words in your mouth -- seem to hear you're saying, and if the catastrophic cap has to either go up or the beneficiary has to share some cost above that catastrophic cap like D, that's okay.

MS. BEHROOZI: I think that's a better thing. It's not my favorite thing. You know, I don't like cost sharing altogether. I like other forms of management. So it's a little hard for me to advocate for what I would suggest beneficiaries should be paying for more than, you know, is recommended. But, yes, I think the worst place to put it is right up front before any services are paid for, so someplace later, or spreading it across different silos in different ways, that kind of thing.

MR. HACKBARTH: And as you well know, Mitra, that's where the challenge here is, that changing deductibles have big dollar impacts, and so that means there need to be significant changes other places when you reduce them.

MS. BEHROOZI: I would just say, you know, the question earlier about do people choose K and L very much, no, people are willing to pay higher premiums for more comprehensive coverage. I'm not advocating that premiums go up, but I do think there is some evidence that people will choose to take on that total aggregate cost in a premium way rather than --

MR. HACKBARTH: Absolutely, and that's why we

reached the collective judgment that we would not interfere with that choice, but there needs to be -- at least some of the additional cost to the program and the taxpayer needs to be reflected, and that's the reason for the surcharge.

Kate.

DR. BAICKER: Okay. So first to react to the question about the separate versus unified deductibles, there's clearly an argument that the deductible poses a cost barrier and that you want to set the deductible at the appropriate level, and you're maybe arguing for the deductible to be smaller. The separate deductible, to me, seems like if you're going to have a car accident and say, you know, my insurance covers the motor with this deductible but the bumper with this deductible and you're getting hit from the front, in some ways, having those separate deductibles doesn't change much. It's the marginal cost sharing, where you're saying people are not going to go to the physician if the cost sharing is too high. That might suggest a lower deductible overall but then dialing up the cost sharing in a value-based way so that the marginal cost for the extra physician visit is relatively low compared to the marginal cost for the extra service of lower value.

Now, the question of whether people are willing to pay a deductible up front, there's a little bit of a disconnect there to me between saying people are willing to pay a $100 higher premium, but they're not willing to have a $100 lower premium and a $100 deductible for care where they're almost surely going to consume more than $100. That's really a marketing or psychological question. If everybody's consuming some health services, whether you call it a deductible or premium, in some sense, they're paying the same thing out of pocket with very high certainty. So I, in some sense, from an economics perspective, you're sort of neutral on that if you think everybody's going to be above that deductible. How it appeals to people is not really a question of economics.

That said, Slide 9 makes me very nervous, Figure 1, for I think -- or Slide 10 -- Slide 10, Figure 1 -- for slightly different reasons from Bruce. I really like the text box on the value of insurance. You know I'm all about the insurance value of insurance. In some ways, I worry that that text box leaves people with the impression that it's a rationale -- it's an apology for still having cost sharing despite the fact that people value insurance rather

than touting the fact that changing the benefit design in this way makes the Medicare benefit better. This means that imposing an out-of-pocket maximum provides people with something that they value highly and there's sort of no meat on that part in the text box.

And then that's what makes me nervous about mapping to a picture like this. Because people are risk averse, they're willing to trade off means for variance. And I know we can't say it like that. I know that. But you know what I mean.

Suppose, on average, everybody's costs went up by $5, but variance disappeared. People would be better off. And we're telling half that story. This picture is telling the means story but it's not telling the variance story. And so you're left with the impression that imposing an out-of-pocket maximum makes everybody worse off somehow and that can't be the story that we want to convey. So that makes me a little nervous about displaying things this way, is it makes it -- we're characterizing people's losses in a way that doesn't build in some of the gains that I think they're getting.

Now, the gains are actually undermined by the

existence of these first dollar Medigap policies that are basically filling in the value that people wish they could get out of Medicare and are willing to pay for in Medigap. So we know they value it. And it's not an efficient way to provide that kind of backstop. It comes with all of these costs that we've been talking about.

So then the fact that we're not getting any aggregate benefit out of the package that we're proposing, if you look at these graphs, is because of that first fact, that we're maybe not capturing the risk reduction that people are getting, but also the fact that because of the assumptions that are sort of necessary to make the model tractable at this point, we're also assuming away all of the gains and efficiency that we think we're going to get by replacing this Medigap inefficient backfilling of the failure of the basic Medicare benefit with a better Medicare benefit that would then have less of a bad Medigap wrap-around. We've assumed away the gains that we get from that shift by not really letting people switch to more efficient Medigap policies, by not allowing the types of Medigap policies that are offered to change in response to this.

We kind of assumed away all of the reasons for

doing this switch in the first place because we're moving from a world in which people have Medigap filling in the holes into a world in which there are fewer holes. That's kind of all the same if you thought they were equally efficient. We think that they're not, but we're not letting those gains come through in the behaviors that we're trying to promote.

That was very roundabout. I hope you get a sense of what I was getting at.

MR. HACKBARTH: So the bottom line is that, in a sense, these are sort of worst case, sort of, presentations of the impact, because, as you say, they assume away some of the desirable --

DR. BAICKER: All of the good stuff.

MR. HACKBARTH: -- impact.

DR. BAICKER: So there's two things. There's that and there's the absence of this other dimension that I realize is harder to quantify but that we're not talking about enough.

DR. MARK MILLER: I did follow what you said, and --

DR. BAICKER: Good for you.

[Laughter.]

DR. BAICKER: Tricky.

DR. MARK MILLER: No, I really do think I did -- I do think I followed it, and I think the -- all right. One thing that we did is a different slide, of which I have forgotten which one, but the one where we were trying to show the impacts over multiple years was one way to bring some information to that. You know, it may be only a couple of percent in the one year, but over four years, more people would be helped. So there was a bit of that.

I mean, I suppose on the key slide that has everybody hung up -- and it is the most conservative and we're also trying to be very clear about what people are walking into -- you know, the actuaries that we consulted were very adamant that, in the short run, people wouldn't change. I suppose we could try some kind of sensitivity, and I don't know how much evidence there is out there to vary something and say that picture could look like this. You know, the actuaries we consulted said no change in the short run, but over the long run, if X percent changed -- and this definitely goes to what Bob was saying -- but wait a minute. If the arithmetic looks like this, why wouldn't

people shift?

We could try to play around with something like that, or am I getting a look from you guys of, like, this guy is really killing me here.

DR. HARRISON: I might remember a few iterations ago, we had the same charts but instead we had the regulatory policy where you couldn't have Medigap. Well, that looked wonderful because you were taking away the value of insurance, which is invisible, and you were cashing it all out and so the benes looked like they were much better off. So there is an optical problem that we haven't solved yet.

DR. BAICKER: And the fact that people won't switch in the short run is surely true. But then if that's all you're willing to graph, what you're basically saying is, we've assumed that there's no movement along this thing that we said was the cause of the problem because everyone was responding to it. So I think that's what drives the disconnect, that if you're not willing to say that people will move in response to the change but you're attributing where they are to the preexisting incentives, then you've stacked the deck against being able to find the thing that

we think should definitely emerge over time, in which case it's not clear that that's a useful exercise. To assume a problem exists and then assume that the absence of the pathway that caused the problem doesn't fix the problem, you've doomed yourself.

MR. HACKBARTH: Kate, are you aware of any literature that we could use to try to construct a model that is different than the assumption the actuaries gave us of no change in the short run?

DR. BAICKER: Not from the Medigap literature. There's an older literature looking at the responsiveness of insurance purchase to copayments and to -- and to tax rates or -- not taxes -- the surcharges. I am so untrainable.

[Laughter.]

DR. BAICKER: That you could port over and there'd be all sorts of reasons to be hesitant about porting something from a commercially insured population over to a Medigap purchase. But in some sense, the assumptions that drove the initial discussion and then the assumptions that show up later are a little bit in conflict with each other. So you might just not want to do that exercise and try to do instead back-of-the-envelope calculations about what the

value of insurance protection is and how you would expect that to change. I don't know what the graphical answer is.

DR. MARK MILLER: [Off microphone.] I know we are getting jammed on time, but the other way maybe to bring these thoughts together is to think about what Bob said early on the first round, if I was following that, where maybe there is some arithmetic we can bring out of the model that the beneficiary distribution of the cost of the supplemental versus the change in the benefit and showing some of the arithmetic and least being able to say, you know, if these actuaries aren't right, this is what the kind of cost frontier that people are facing, and maybe more people would be willing to move with this kind of arithmetic facing them and maybe we can draw that out. Maybe we can also do some kind of sensitivity assumption to get to your point, because this is clearly vexing more than just you here.

The other thing I think you said that I don't want to lose track of -- and I want to have this discussion when we get back -- she's also kind of made this point off of Mitra's point of, you know, if I'm not willing to -- I don't want to face a deductible, why am I willing to pay the

premium for the Medigap, and there is definitely a logical -- - and I want to think about that more. So I don't want to lose that point. I wanted to say it out loud and make sure that we, after we get out of here, start talking about that.

Okay. I'm really sorry.

MR. HACKBARTH: Okay.

MR. KUHN: I don't think I have anything to add on the lower deductible. It's something I want to think about some more.

In terms of the net out to zero that you kind of mentioned earlier, that doesn't bother me. The narrow band that you have of the negative one and a half, I'm fine with that.

And generally, I think the draft recommendations -- - obviously, we're going to be doing some refinements here, it sounds like, as we go forward, but I think what you've laid out is a pretty good framework to continue the conversation.

DR. BERENSON: Well, first, I want to be able to say some of my best friends are actuaries, but I don't have any --

[Laughter.]

DR. BERENSON: But more seriously, picking up on what sort of Bruce got us into is the optics, and then Mitra's discussion of the deductible, and Kate, who I think I'm pretty much on board with how you said it, and I think I support what I said in round one, if Mark thinks he interpreted it right.

Two questions around -- could you go back to Number 10, the famous Number 10. In the second one, and I agree with Bruce, the optic of 80 percent of people worse off is a problem. How much of that is because of the combined deductible, I guess is my question. I assume -- well, you are moving a lot of people -- 80 percent of people who are not hospitalized are now paying a much higher deductible and 20 percent of people are getting some benefit. So is that a major factor for this, the fact that more people are worse off?

MS. LEE: For the one on the right, that went down to 70 percent --

DR. BERENSON: Right.

MS. LEE: -- increased out-of-pocket spending, that is actually the surcharge, because, you know, even before anything happens with your cost sharing, you have

$200 or $400 that has increased. The one on the left gives you a better sense of what that deductible is doing.

DR. BERENSON: Yes, and I misspoke. You're right. So the one on the left, with people being worse off, is that a major function of the combined deductible?

MS. LEE: If you do not have hospitalization and only Part B spending, that combined deductible, since it compares to $140, that is a significant factor.

DR. BERENSON: Okay. Well, I mean, in the handout you gave us, we only have, like, two sentences for why we think a combined deductible makes sense. It's intuitive and simple and it's easier to track. I think it would be good for us to try to articulate the benefits of a combined deductible. I'd be interested in Scott's view and others' about sort of the tradeoff. I think that's an important thing. I personally could go either way with it. I'd like to be convinced that the combined deductible does make sense and it does affect these distributions.

And I guess the second question I would have in terms of optics is can we do the calculations of both, of benefit changes only and benefit changes with surcharge, over a multi-year period, also? We can't do that -- you're

shaking your head -- to demonstrate what we want to demonstrate, that more people -- fewer people are negatively affected when you go out. We can't do that?

MR. HACKBARTH: You do have --

DR. HARRISON: In the future, we may have more years of data, but we really only have one year of data for this exercise.

MR. HACKBARTH: You can see the table, though --

DR. BERENSON: No, I saw the table, but that would be in terms -- again, I think I'm -- well, I don't think. I'm clearly with Kate that if we just lay out this by itself, it gives a very different picture of what it is that we're proposing and we do need to work a little bit. It's nice to have that other table around, but I think we've got to work on presentation here because I actually think we're in better shape than this table would suggest.

DR. HALL: Well, if we go back to the original objectives of this whole exercise, I think this plan addresses them. I mean, one thing we can't do is suggest change that makes people more responsible for health care decisions without causing some pain. No matter what plan we talk about, we're going to deal with that.

I think a single deductible rather than -- or combined deductible rather than pay me now, pay me later, is going to cause a lot of confusion. And so I agree with Bob that I think what we're talking about here is we have sort of a marketing problem rather than a fundamental problem of meeting the objectives that we started out with here.

DR. DEAN: I'm out of my element here. I don't really have strong feelings either way. It seems to me that Mitra's concerns about the combined deductible makes some sense, but I really don't have a good understanding of the implications of all of that, and how much we try to recover from a surcharge, also, I don't have a real clear sense of it.

MR. BUTLER: No strong feeling on the separate deductibles. I do think this 20 percent needs a little bit more rationale behind it rather than we're just trying to be a little bit better than budget neutral. So it'd be easier to say, if we were to be budget neutral to the program, this is the number and actuarially, given the downstream impact, this is what it would be if you really wanted to capture all of it and then let them make some judgment. It would be another way to frame it.

I do think we're losing a little bit of sight of maybe -- we're almost tinkering with something that is very important and it's going to enter a political context, as we talked about earlier in the day, that's going to have much bigger things, like are we going to start at age 65 or 67, or are we going to do this or are we going to do that. And, I think, let's not lose sight of the major points we're trying to make, and that is that the supplemental insurance really has a downstream impact on utilization. I don't think in health reform that was acknowledged at all because of the minimum basic packages for Medicaid expansion, some of these things, just, you know, not taking those kinds of things into consideration at all. So let's not lose sight of some of that point as well as the benefit redesign, that this doesn't make much sense, even though only ten percent of the people are really subjected to that, that don't have supplemental insurance. So those are my points.

DR. CHERNEW: So I agree with a lot that was said. A few basic points. The first one is that I don't think we should constrain in the recommendation there to be one single deductible. I actually think if you spent more time thinking about this, you'd realize for many cases, it's

crazy to have an inpatient deductible. There's no incentive effect. It's just a tax on people that get sick, right. Whereas the outpatient deductible has these remarkably complicated properties. On one hand, it discourages overuse. On the other hand, it discourages really appropriate use and you need to think about it more intelligently. We're not going to resolve all of that now, but I wouldn't constrain in our recommendation the Secretary to have a combined deductible. I think that's too limiting.

The second thing I would say is I have some real problems with aspects of the out-of-pocket max because I think there's a lot of low-value services that will be consumed above the out-of-pocket max, and I don't want to discuss that, but I recognize the risk issues and I think Kate was 100 percent correct on that.

But I would want to make sure that if you were a Medicare Advantage plan, you wouldn't be constrained, for example, not to charge some high cost sharing on some low-value services that really expensive people use. So within this fee-for-service world where there's not management, I think there's an appropriate risk thing.

In terms of the optics related to that, and again,

I agree completely with everything Kate said, and Mark, I think you gave the exact right answer, presenting this over a long period of time so that people understand that even if you're in the top two percent in one year, you could save a ton of money if you have a heart attack or if you have whatever it is. That's what has to be conveyed.

And I really would try -- I recognize the importance of not completely ignoring the politics, but I really would try to strive with starting out with what we think the most sort of efficient set-up is to the extent that we can get there, and then we kind of finagle how we can present it in a way that convinces people, as opposed to start with a premise of we need to make sure that more people are winners than losers and so we need to end up with a design that does this or does that. We're never going to get this perfect, obviously. And again, we have a low bar in the current system.

So I would focus on the two key deficiencies of the current system. The first one is that the supplemental insurance has a big distortion. That's what Peter said. The second one is there's way too much risk for people to bear. We don't do a good job of managing the risk in that

way. We don't think about the right behavioral responses.

The other thing I would say just in general, which is by way of just a huge compliment, is I believe employers are going to start cutting back on the subsidies that they pay for retiree health insurance, and a lot of times when we think about the world that people are going to be in when they face this market, we don't really fully understand the fact that a lot of people aren't really paying the premium. Someone is subsidizing the premium and stuff is going on. But when employers start dropping, which I think commonly they will, this is going to become a much, much bigger issue. So it requires, I think, a lot more thought.

So, essentially, the type of recommendations you have, I could always nitpick one way or another, but I think this is completely on the right track.

MR. HACKBARTH: So let me just ask Scott about the intersection of this with Medicare Advantage. One of the points Mike just made is he doesn't want to tie the hands of MA plans to have high cost sharing on low-value services even after a catastrophic limit. It used to be that there were no restrictions on plans' ability to have high cost sharing on services. Then there was a reaction to that and,

as I recall, there were some restrictions imposed by legislation/regulation. What do those restrictions now say?

DR. HARRISON: Right. Well, it used to be that you couldn't charge discriminatory cost sharing --

MR. HACKBARTH: Right.

DR. HARRISON: -- so you'd be discriminating against the sick. But now --

MR. HACKBARTH: And that was loosely interpreted.

DR. HARRISON: Right.

MR. HACKBARTH: So there were very -- was very high cost sharing in some MA plans on oncology services, for example --

DR. HARRISON: Right.

MR. HACKBARTH: -- and that was found consistent with non-discriminatory --

DR. HARRISON: Although it turns out that if you have low cost sharing on other things and have the Medicare level on some things, it's also considered high, but --

MR. HACKBARTH: Yes, right.

DR. HARRISON: But now they actually have out-of-pocket caps on all -- plans have to have an out-of-pocket cap, and it's somewhere just under $7,000, I think.

MR. HACKBARTH: And it's an absolute cap once the --

DR. HARRISON: It's an absolute cap, and if they have a lower-level cap, and I'm forgetting exactly where that is, somewhere around $5,000 -- it might even be a little lower -- then CMS doesn't look as hard at the cost sharing on individual services.

MR. HACKBARTH: Yes.

DR. HARRISON: So you'll see two clumps of where the caps are.

MR. HACKBARTH: Okay. Scott.

MR. ARMSTRONG: So, at this point, I'm probably amplifying a number of points that have already been made, but I'd like to do that briefly.

First, I think this work is fantastic. It doesn't have to be said, but it probably just should be said again. The importance to MedPAC in our role of complementing our provider payment work with this kind of work, I think, is really important.

I think it's long overdue. Generally, my view of this conversation, the recommendations, is we're being too conservative and too slow to make changes that are already

the standard in our industry and that -- and to a point several of you have made, I think we're seriously understating the value to our beneficiaries of some of the things that we're doing in here, like the out-of-pocket caps and some of the other things.

With respect to two different deductibles, I don't have a strong point of view on that, but I'm just not aware that that works anywhere else, and so I think it's good that we'll continue to talk about this, but I wouldn't have come into this discussion encouraging us to really do that.

The 20 percent surcharge on the supplemental plans, to me, is a very conservative approach to dealing with what we've acknowledged is a significant issue, and I think we're going down this path of a surcharge as opposed to some other regulatory change or elimination of the supplemental plans altogether and I don't remember -- I mean, I don't know what the right solution is, but the underlying problems created by the availability of the supplemental plans and their ability to mask the real problems we have with a core benefit, to me, are still only superficially addressed with a 20 percent surcharge on these plans.

And then, finally, I made this point earlier, but we look at the objectives that we've laid out for this work in general and we talk about reducing the beneficiaries' exposure, requiring cost sharing to discourage low-value services, being mindful of the impact on low-income beneficiaries. I really agree with all those things. But I think we also have to balance those with our other obligation and that is to be stewards for the overall cost trends for the Medicare program. I just -- I think we need to be a little more assertive about balancing the impact of these program changes on the overall expense trends and just recognize that -- or at least my view is we're being far too sensitive to the impact on the beneficiaries themselves in the absence of weighing that against this other goal.

DR. BORMAN: I do think this is one of the most important avenues or items we explored, and certainly in the time that I've been here, and you've really done strong work yet again at a staff level.

I think that this is -- there's so much that's good here, but I do think that there's a tremendous marketing burden, if you will, and marketing is not something that is intrinsic to Medicare, and I think that

will be a huge challenge. And I'm struck by some of the things that physicians are accused, for example, of always talking about changes in relative risk rather than absolute risk as we present interventions to patients.

This is somewhat the same in the beneficiary viewing this in terms of what happened to me this past year, what I know I paid, as opposed to what might happen to me and the fact that if it happens to me, it's 100 percent for me versus zero percent for me. This is going to take just an enormous amount of explaining and thinking about when your natural tendency, I think, as you age, is probably going to be to get more scared of the expense that you may face.

And so I think that we need to somewhere be pretty eloquent about the education and -- marketing maybe isn't the best term, but something, really the education and conveying that is going to be a huge piece of this if it's going to work the way that we want it to work and to meet all the laudable goals.

In terms of the specific piece about the deductible, I could go both ways on it except there's a piece I really like about the combined deductible in that it

makes no sense to me that we allow someone to be injured, if you will, for Part A when we believe that the services that they receive under Part B are of such value -- that so many of them are of such value and there's things that we want them to have. I mean, why would we want Part B to be voluntary, and essentially what this does is it converts it to involuntary, so that while politically the word "involuntary" probably is a death knell, if we can find some other word, I think there's really value to just getting -- to acknowledging -- that to say one piece of care, you've absolutely got to have without having that other piece, I think, is -- to fix that is probably a good outcome of having a combined deductible. Getting people to understand the arithmetic of it, I think, is a huge issue and, I think, will present challenges.

In terms, Glenn, of your specific question about discomfort with zeroing it out or whatever, I'm fine with that.

MR. GRADISON: Talk about deja vu, I was burned pretty badly, like a lot of people, as a member of Congress when this came up the last time. We remember it as Medicare Catastrophic but often forget that this legislation also

included for the first time a Medicare prescription drug benefit. What killed it was a relatively small proportion of high-income people were objecting to the income-related premium which they would have to pay and that sunk the whole thing. A handful of us stayed with it right to the end.

I support this. Consistency being the hobgoblin of little minds, I am trying to be consistent. But what does strike me about this as compared with the prior experience is that, here, the increase is actually not limited to people at the top at all, who will hardly notice the fact that they've got to pay 20 percent more on their Medigap policies, but a much larger percentage than was true then of people of far more modest means.

Finally, though, I recall one of my favorite members of Congress from years ago whose aphorism was, when in doubt, do right, and I think that's about where I end up on this.

DR. CASTELLANOS: Well, I'm going to be a little outspoken, as usual. Like Tom, I think I'm way out of my element, so I would like to be in my element, which is called the real world.

Scott, you say we're not very sensitive to the

impact -- we shouldn't be as sensitive to the impact on the beneficiary. I just remind you that the beneficiaries are the voters for Congress and Congress wants to do one thing. They want to get reelected. And when you have 80 percent of the people that are worse off, I don't think Congress is going to take this with a lump of sugar at all. I think we have a real, real issue there.

I think what this is going to do, it's going to cause you a lot more business because it's going to force everybody into MA. Why would you want to stay in fee-for-service? I think you want to go into MA, and I think we have to realize that's what's going to -- in my opinion, that's what's going to really happen.

I also have -- you know, Karen's point is extremely important. We need to have a better beneficiary and provider education on these options to at all get anywhere.

I guess another concern I have, and maybe it's really not a concern, but it's a concern, is that when we present -- if this is presented as it is now in the Chairman's draft recommendation to Congress, I just wonder what the real world is going to think of MedPAC's

credibility.

MR. HACKBARTH: So, there's a lot here that I could touch on, but let me just focus on one point because we're very late. You know, I think this is a controversial recommendation and I think the most controversial piece of it is the surcharge. And so the question is, people want comprehensive coverage, as evidenced by their decisions on purchasing supplemental plans, but they want first dollar coverage without the management of the care that goes with it in Medicare Advantage. So they want the cake and eat it, too, and the current arrangement allows people to shift the cost to the taxpayers and that's the policy problem. And people like that, but in the current fiscal situation, for my money, that's a situation that we can no longer tolerate.

And I think if people want first dollar coverage, they should be entitled to buy it, but they should see at least some portion of the additional cost that the taxpayers incur because of that. And then there are lots of different ways that you could think about whether it ought to be 20 percent or some different number. But for me, that's the bottom line. If you want the combination of open system, no management of care, and comprehensive coverage, you need to

see some of the cost of that choice.

The other alternative for the Congress is that as we face these increasingly severe fiscal pressures, the only way we can get that money is take it out of the providers. Beneficiaries, no, it's always too controversial to touch the beneficiaries. We'll just continue to take it out of the providers. And I think I'm all in favor of taking some out of the providers. We spend 90 percent of our time talking about the best ways to try to do that. But I think, at the end of the day, the beneficiaries are going to have to contribute some piece to it, and that's what brings me to this conclusion.

DR. MARK MILLER: The other thing I was going to add to that, after Kate's comment and Bob's and yours and some over there, maybe Mike, I mean, the other way you could almost express that right-hand column is how much the subsidy is now and then how much you're asking the beneficiary to pay of the subsidy, because you could express that as the people who are getting Medigap now. There's a subsidized portion of that and we're saying, okay, there's some charge against that now, and maybe reconfigure how we express that using that kind of a metric. So I'm just

trying to think about how to operationalize some of the things that you've been --

MR. HACKBARTH: And just one last thought. You know, one of the properties of the surcharge is that the payment, the amount the beneficiaries pay, will be directly related to the costs incurred in their area. Unlike the Part B premium, which is a flat national amount and the low-cost parts of the country are probably overpaying their fair share and the high-cost parts of the country are underpaying, this is a way to introduce some beneficiary contribution to the program that is directly related to the costs incurred in their parts of the country and also by the supplemental insurance coverage that they purchase. If they choose a more elaborate package, a richer package, they'll pay -- the 20 percent would be a higher dollar figure than if they choose a leaner version. And I think those properties are an important way to add -- if we're going to have some more costs for the beneficiary, I like those two features of the surcharge.

Okay. So we're not quite to the finish line on this. Obviously, we'll be back in touch and talking with people more about this in the next few weeks.

Thank you, Julie and Scott. Terrific work.

And now we will move to our last session of the day, which is the mandated report on rural health care.

DR. AKAMIGBO: Good afternoon. So this is the final presentation on the rural report which began in 2010. We've presented various components of the report in detail in prior meetings, and you have a draft of the report in your mailing materials. We will summarize the highlights today, and we look forward to any comments you may have for us before we submit the final report in June.

Before we start, we wanted to take a moment to thank David Glass and Joan Sokolovsky who've contributed immensely to the report, and our RAs – Matlin Gilman and Kelly Miller.

So this report, as mandated by the Patient Protection and Affordable Care Act, requires that we examine four issues. The first is access to care, which we discussed last February. Second is quality, which was discussed in October. Third is adequacy of rural payments, which was discussed in detail in each sector in December and summarized in January, for rural areas specifically. And the last issue was payment adjustments to rural payment

rates, which we discussed last September.

I will start with a summary of our findings on access to care. We have found, as others have, that there are fewer physicians per capita in rural areas, subspecialists are even more likely to concentrate in urban areas, and recruitment of physicians continues to be a serious challenge for many rural communities.

However, despite these differences, we showed back in February that access to care is relatively equal in both rural areas and urban areas as measured by volume of hospital services, physician visits and utilization of skilled nursing, home health and pharmacy services. So, equal volumes may be explained by the fact that rural beneficiaries get about 30 percent of their care in urban facilities.

So in some cases, rural residents may have to drive further distances to access care and average travel times were slightly longer for rural residents. While, on average, that difference in travel time was about 7 minutes higher, or longer, for rural residents, there is some variation about that average as evidenced by one finding that 41 percent of rural versus 25 percent of urban

residents drive for more than 30 minutes to access their care.

Our analysis of Medicare surveys confirmed that beneficiaries' satisfaction with their access in rural and urban areas were relatively equal. For example, among the very few beneficiaries who expressed concern with their access, the same share of rural and urban beneficiaries cited travel as the source of their concern.

So while we don't find significant differences in service use among rural and urban Medicare beneficiaries, we do find more pronounced differences by what region of the country beneficiaries live in. Here, we see that overall -- nationally, in bold there -- rural urban differences in service use is negligible, but when we look at regions of the country with high utilization rates per beneficiary, like Louisiana, we see higher rates for rural and urban areas, like Monroe. Low use areas like Wisconsin show the same rates for both rural areas and urban areas, like Madison. In some, access and use of services tend not to differ by very much, by rural-urban status, but there are differences by geographic region.

So given our findings on rural access to care, the

Commission has developed guiding principles to examine rural health care for Medicare beneficiaries. The principle for access posits that rural beneficiaries should have equitable access to services. Equity in access can be measured by volume of services, visits, prescriptions as well as beneficiaries' reports of their experience. And when we discuss equity in access, we recognize that some rural beneficiaries may drive longer distances than their urban counterparts.

The quality findings we presented in October 2011, which informed our principles, are summarized on this slide. Overall, we found that rural and urban quality, as measured in each setting, is similar in skilled nursing facilities, home health agencies and dialysis facilities.

On the other hand, hospital quality across rural and urban areas is mixed. First, readmission rates are roughly equal between urban and rural areas. Process measures, as reported on Hospital Compare, were generally worse for rural providers and tended to worsen as providers became smaller. Mortality rates are worse in rural areas. And while, on average, larger hospitals have lower mortality rates than smaller hospitals, hospital volume only partially

explains the gap between rural and urban providers. It could be that it is more difficult to achieve high performance scores when hospital clinical staff see certain patients less often and there are potentially different staffing levels and ratios in rural areas.

Now on to guiding principles for rural quality of care -- first, the quality of non-emergency care delivered in rural areas should be equal to that of urban areas. This reflects the reality that for non-emergency care, where there is a choice of whether to treat the patient locally or transport them to a larger urban facility, the rural facility should be held to the same standards as the urban facility. The small rural facility should be as good as the alternative site of care.

However, emergency care is different. There may be no alternative and small rural hospitals are obligated to treat those patients. In these emergency situations, our expectation for outcomes at small rural hospitals may not be as high as they are for larger facilities. Our expectations, therefore, should reflect the inherent limitations that exist in small rural hospitals compared to large urban hospitals.

Finally, most hospitals are currently evaluated on the care they provide to Medicare beneficiaries, and their performance is publically reported on Hospital Compare. However, critical access hospitals have been exempted from some quality reporting requirements.

And as the Commission has stated, providers should be evaluated on all the services they provide. This includes measures common among rural and urban providers as well as measures that are specific to rural providers such as timely communication of patient information after a transfer. The Commission's principle here emphasizes that evaluations should include measures common among rural and urban providers and measures that are more specific to rural providers.

So to allow equal access to information for all patients, all hospitals should be subject to public disclosure of their performance scores. This may improve accountability and hopefully improve the quality of care delivered in small facilities.

Jeff will now pick up with our findings and principles for payment adequacy and special payments.

DR. STENSLAND: As we discussed in January, rural

and urban payments are adequate for most sectors. In general, volumes of care, other indicators of access, profit margins are all similar in rural and urban areas and indicate adequacy of payments for physicians, home health agencies, skilled nursing facilities, hospices, IRFs and hospitals.

However, there is one area that needs further work, and that's dialysis. There's a new payment adjuster for dialysis facilities that started in 2011 that will increase payments for all low volume facilities including many rural facilities. While the low volume concept fits with the principles we will show you in this paper, there is some concern that the dialysis policy is not targeted to isolated facilities, and we'll be examining the issue in the fall of 2012 when the new data become available.

For hospitals, we find that payments are adequate relative to urban payments. However, this differs from the MedPAC's finding from the 2001 report, and I have a graphic here that will explain a little bit why it differs.

As you can see on this slide, rural Medicare margins for hospitals were far below urban margins from 2000 to 2002. And during this time I think there were two

problems that the Commission identified. One was that the payment rates were biased towards large urban providers, and the Commission recommended some changes. Second, small isolated providers that had suffered from low volumes, in part due to low population density and not due to any shortcomings of their own, were not getting the help that they needed, and the Commission also recommended a low volume adjustment which fits into the principles we've talked about here. And when those two policies were enacted, the gap between rural and urban margins started to close.

Then there was also a series of other adjustments that took place, and the gap not only closed, but now rural margins tend to be slightly above urban margins.

This slide shows a list of recently enacted payment adjusters for rural hospitals, and it starts at the top with a couple that MedPAC recommended. And I guess the main points from this slide are:

First, that there are many different adjustors. That's the one point.

The second is some of these adjusters and some of these changes were necessary for fairness and for access.

And I would say some of the fairness adjusters were the first two adjusters where we moved rural payments up toward the urban rates, their base payments, and some of the things that might be necessary for access may be a low volume adjuster for the isolated hospitals if we didn't have the critical access hospital program.

And third, as we discussed in the past meeting, some of these adjusters do not meet the principles the Commission has discussed and developed over the past year, and we'll turn now to those principles.

The first principle is that low volume adjustments should be targeted to isolated providers. It does not make sense to provide a low volume adjuster to two competing providers that are ten miles from each other.

Second, we want the amount of the adjustments to be empirically justified. With respect to low volume adjustments, the adjustment should be tied to the total volume of patients and not just Medicare volume. In addition, the low volume adjustment should not duplicate other adjustments as they currently do for some hospital payments.

Finally, it's important to think about incentives.

Different ways of payment carry different incentives. While all hospitals have some incentive to control costs due to receiving prospective payment from some payers, Medicare creates stronger incentives for cost control to the degree that its payment are prospective and reduces incentives for cost control to the degree that its payments are based on cost.

So that's the summary of the findings in the full report, which you've all received in your mailing materials, at least in draft form. We've tried to summarize the principles the commissioners developed over the past year, and now we'd like to hear your comments on the principles, the draft report and its finding, and any other guidance you have as we move forward to finalizing the report over the next month or so.

I now turn it back to Glenn.

MR. HACKBARTH: Thank you.

So as you might imagine, we've had lots of conversations about both the content of this report and how particular issues are framed and discussed. In the last week or 10 days, we've had multiple conversations with Tom and Herb about the report, and I think those conversations

have been very productive, and we're working towards a better product than we would have without them.

There have actually been some changes made that I don't even think are in the materials that were distributed for the meeting. So the briefing materials went out last Thursday or something, and even some modifications have been made since then. Again, I think they've been making the report better.

Two common themes, and I'm going to turn it over to Tom to lead off the clarifying round.

Two common themes in these conversations have been that the important part of the message is that the various changes that Jeff summarized, that have been made in the payments for rural providers, have done a lot of good things and helped a lot of institutions that otherwise would have had a very difficult time financially and may have closed with detrimental effects for the populations they serve. So that's an important message that should come through in the report.

The second theme is that we've talked a lot about averages, and by definition, there is always variation around the average and there are always exceptional cases

and circumstances. And we need to take care that in reporting about averages, people don't lose sight of the variation that exists around them.

In some instances, we try to enrich the discussion by doing subcategories of rural, and of course, as everybody well knows at this point, the label "rural" covers hugely different circumstances around the country. And so in many instances, we use various gradations of rural to try to get at some of that variation. But even after all of that, there are still exceptional circumstances that we need to be cognizant of.

Now to be fair, that's not just true when we talk about the rural label; that's also true when we talk about the urban label as well. It's just the nature of the issues that we deal with.

At the end of the day, you cannot have a sensible conversation about these things without talking about averages. You can't talk about every individual institution or adapt payment to every individual institution.

The only payment mechanism that is adapted to every institutional -- individual institution is cost reimbursement, which comes with its own problems, some of

which are discussed in the report. And among them are consequences that can be quite detrimental to Medicare beneficiaries. If we use cost reimbursement to prop up institutions that are really not a reasonable size and not able to do a good job for Medicare beneficiaries, that's a problem too.

So I'm afraid there's no way of talking about -- getting around talking about averages or using payment mechanisms that are often based on averages, but we do need to acknowledge that there is, of course, variation.

With that, Tom, let me turn it over to you. I think what I'm going to propose is since we've been over this topic I don't think we need to do a clarifying round. And why don't we just focus on going right to our round two comments and questions?

Tom.

DR. DEAN: I do have a couple of clarifying questions.

MR. HACKBARTH: Well, you're entitled to do that.

DR. DEAN: Okay.

MR. HACKBARTH: As opposed to going around two times, we'll just do once.

DR. DEAN: There were a couple of things in the report, that just I didn't quite see a long list of concerns, but that just didn't quite fit. One of them was the map on page 31 which is basically the counties where people had to drive a significant distance for pharmacy services, and it shows none of those counties in Wyoming, for instance. That just doesn't fit with my knowledge of what the geography of Wyoming is.

And also -- I mean, it's also Arizona, California, Washington, Oklahoma. These are very sparsely populated areas, and it just didn't fit.

DR. STENSLAND: Well, I guess the clarifying comment on this map is this was developed by Acumen, and they looked at the addresses of every beneficiary and every pharmacy, and looked at the different distances traveled.

And first, I'll say what they're not saying. They're not saying no one in Wyoming traveled more than 18 miles to get to the pharmacist.

What they are saying is that all the counties in Wyoming, for the people in that county, the average travel time was less than 18 miles. And that could mean that you would have maybe one town that would be here and most of the

people live in the town and very few people live out in the ranching area, or whatever else, and most of the people have less than an 18-mile drive. So that's, I think, why you see things like that in Wyoming.

And maybe in some other towns, like when I think of some of these counties that I've been to, like in northwestern South Dakota, you do have little towns around there -- what I would call grain elevator towns -- where maybe you're not big enough for McDonald's but you've got a grain elevator. And in those kinds of places, those people might be commuting into the main town and it might be more than 18 miles on an average for those people to go into the main town and county that happens to have that pharmacy, or to the next county over that has the pharmacy.

And we can show you maps where they -- and give those to you, where it has little dots for every person and where they're traveling to.

DR. DEAN: I guess -- I mean, I don't disagree with that. The question is: Does this map really represent what the real issues are or the real problem is?

So I mean, I don't know. I don't know what the answer is.

By the way, grain elevators are disappearing because they're inefficient and OSHA is insisting that they may be closed down, but that's probably not -- doesn't need to go into the report.

We'll keep it -- [laughing.]

The second issue, there was talk -- and I know some of this has already been changed -- about home health agencies and the profitability and so forth. But it was a concern, and I think you've heard me talk about this before, that provider-based home health agencies are not included. And the justification has always been that well, we can't really trust those cost reports because of hospital CFOs shifting cost and so on.

But they tell me that they have to fill out a separate cost report for their home health services. I mean, is that true?

DR. STENSLAND: That is true, but they take some of the hospital overhead and it goes onto the home health agency. So the question is: Is that really overhead allocation correct?

And I think part of the reason they might think it's not profitable anymore is now if you're a critical

access hospital you're getting cost-based reimbursement. And then, you have a home health agency that's getting paid prospective payment. If you take some of your costs away from the hospital and shift it, shift some of the overhead onto your home health agency, you're going to get less cost-based payment for your outpatient and inpatient services from Medicare because there's less cost to be allocated to those two services.

DR. DEAN: Okay. I mean, I'm certainly no accountant, but we've had several in my area where they've actually closed because they said they couldn't support the cost. And I don't think you would do that if you were worried just about accounting issues. So I don't know what the answer is, but I have some concerns about that explanation.

And I guess I'm particularly concerned because in South Dakota, as you've heard me say more than once, you know probably three-quarters or more of the home health agencies are provider-based. In fact, there's only about -- there's only two-quarters of the state where we have any free-standing facilities.

MR. HACKBARTH: Tom, there are two distinct points

here. One is that, for the reasons that Jeff described, it doesn't make sense to routinely report separately the costs of hospital-based home health agencies. It does not follow from that, that we're saying that every hospital home health agency is, in fact, profitable. Some of them may lose money.

And so, both things can be true. This isn't a good way to look at the profitability of the home health business, and not all of them are profitable.

It just, I guess, makes me uncomfortable; they don't even get included in the analysis, but -- you know.

MR. HACKBARTH: The effect would be to distort the analysis and make it a less clear picture of the financial performance, but that's not to deny that there are some that lose money.

DR. DEAN: Okay. The final one on the clarification issues, you talked about the hospital -- rural hospital margins being now better than urban although if you look at that graph, rural hospital margins were -2 in 2000 and they're still -2. The change is not in rural hospitals; it's what's happened to urban hospitals, which have been basically hammered by cuts. So I think it's a little -- it

isn't entirely accurate to say that.

You know, some of these programs clearly have helped rural hospitals, but to say that they have done well isn't exactly, I think, a good representation. I think the problem -- where the changes come -- is in urban hospitals. So I'm not sure that statement is really justified.

MR. HACKBARTH: You don't need to do it right now, but why don't you show us which statement that goes along with this graph you think is inaccurate?

DR. DEAN: Okay, we can do that later.

DR. MARK MILLER: The other thing is if you were to fold CAHs into it, it would look different because there are 1,300 hospitals that are paid on cost that are not in that picture, in an attempt to be fair, to show PPS to PPS. But if you're just showing urban and rural, there are 1,300 hospitals that aren't on that graph.

DR. DEAN: I'm not sure how that would -- I don't think we can say how it changed because at least the information I have is that roughly 40 percent of CAHs have negative bottom lines.

MR. HACKBARTH: Medicare -- they'll have positive Medicare margins, and these are all Medicare margins.

DR. DEAN: Okay. Well, again -- okay.

DR. MARK MILLER: [Off microphone.] In some ways, this chart could have looked much --

DR. DEAN: Yes, okay.

Okay, but on to the more general things, you know, there's a lot -- as critical as I've been about some of this, there's certainly a lot of good observations in this work, and I know that there's a lot of work that's been done. So I don't want to sound too critical or too negative.

On the other hand, I am really worried that there's a risk of misinterpretation for a number of the statements that are in here. And I think it's going to be read by a number of people that really aren't particularly familiar with these particular areas or these particular issues, or the unique problems that exist. And I think the problems are unique in some sense, not always. But I guess that's where my worry is.

You know, we -- I understand, Glenn, the issue of averages. I've complained about focusing on averages. And to some degree, we don't have any choice although I think whenever we do use an average it's also important to state

what the variation is and what the range is, and what the high and low numbers are, and that oftentimes did not show up in some of these numbers. So that's one concern I have.

I'm also concerned about the tone in a number of areas. And just to pick out one, there was a comment about independent pharmacy closure, and the statement, I think, in the report is something about most of the pharmacies that -- most of the independent pharmacies that closed were in communities where there was a competing pharmacy.

Over that period of time, there was about, I think you have 922 closures or something. And it's true; the majority of those were in communities where there was another pharmacy. On the other hand, 30 percent of those closures were in communities that did not have another pharmacy. So there actually were 30 percent of those that actually lost access to pharmacy service in their community.

I think -- and that wasn't mentioned, and I think that's -- 30 percent is enough that it needs to be mentioned because it tended to sort of -- I'm concerned that it tended to kind of gloss over something that is really a significant problem.

I don't have a solution for it, but I think there

is a problem there that wasn't really identified in the area.

Another concern I have is there were some places in the report where it wasn't really internally consistent. For instance, in the discussion about process measures, there was some really good analysis of the problems with using process measures to define quality -- the fact that in many cases they are poorly correlated with outcomes -- and yet, in other parts of the report we seem to put a lot of emphasis on process measures.

And I think we need to do -- we need to be consistent, that if we really don't quite trust these measures, then we shouldn't be overstating their effect in terms of the measurement.

On the issue of quality, this is a hard one. I probably am a little defensive. I've worked in these facilities for 30-plus years. And it's hard. I mean, these are complex issues, and the struggle between determining the drive that we all have. None of us want to defend poor care or sloppy care or incomplete care. At the same time, we're talking about small staffs, extremely broad ranges of responsibility.

And we don't want to be -- if we -- I think it came up earlier. If we let the perfect be the enemy of the good, we will end up doing damage, and I don't think anybody wants to do that. So understanding where the balance is, is really tough.

So I can't really -- I don't have an answer, but I think I don't -- on one hand, I don't want to support care that's inadequate. On the other hand, I don't want to say to overly criticize care for situations where there are barriers to quality that we don't really or certainly don't identify.

So I think it's a tough thing. It's something we struggle with. And like I say, I get uneasy about it, and I'm not sure what the answer is. But I think we need to be careful that we're not too quick to use some relatively simple parameters that may or may not really be fair to the situation.

DR. MARK MILLER: Can I say something before you go on to your next point?

DR. DEAN: Sure.

DR. MARK MILLER: On that one, what I thought the Commission came to because of the very things that you

pointed out in previous conversations and our own site visits -- the principle that the Commission came to is in the emergent situations you should expect a difference, and I feel like in some ways the Commission report tried to take your very point. And it's not a solution, but the point of the report is this should be recognized when you look at judge -- when you look at quality in a rural setting.

So there may be tonal statements that you want us to look at in the report, but the landing point was to try to absorb that very comment.

DR. DEAN: Yes, and there is -- you know. I'm not sure that it's as complete as it needs to be, but there was that in there.

I guess I will -- there's -- you know, I could go on, but I won't.

I guess I would -- one -- this one last point. I think the observation that there's more difference in regional variation than there is in rural/urban variation is a very important and extremely useful observation.

Having said that, I think we need to be careful that we don't just automatically assume, well, then everything is okay. I mean, Minnesota is oftentimes

identified as a low utilization state, and it is. But I know, talking to the folks in Minnesota, there are significant access problems in some of the remote parts of Minnesota. And so, they are very -- they're low utilization, but it's probably too low in some areas, and it's not uniform across the states.

So, you know. I don't know.

I think we probably are not using the right parameters to really break it down, but we do what we can, I guess. So, anyway.

MR. HACKBARTH: On the Minnesota issue, that's one that you've rightly pointed out before. Just so the other commissioners are aware of that, when we looked into that, we found that in fact what you were reporting was correct. The people in Minnesota said the primary problem is not Medicare payment being inadequate; it's there are a lot of other factors involved here as well.

DR. DEAN: It's a complex issue. I don't -- well, I'm not sure that's exactly what they say. That isn't exactly what they told, but I know. I know.

DR. MARK MILLER: I know.

DR. DEAN: We've had the discussion, but I-

DR. MARK MILLER: But I do want to say something else, rather than just dispute that point. When we're on the phone, they said, you guys aren't the problem. Medicaid has pulled out -- pulled back its rates and some counties had pulled back some funding, and that was the problem.

But nonetheless, what I also want you to know, and others to know, is we have also changed the document, which you don't have in front of you, to be very clear that these utilization levels; these aren't statements about them being the correct utilization levels and that even though you see this variation, in no way is this statement that that's the right level.

And so, we went -- based on your comments, we went in and made changes there as well because I think your fundamental point is I still think -- you speaking -- there may be people not getting the services that they need, and I think that's your main point.

DR. DEAN: Yes, and I think we had the discussion about we keep trying to struggle to figure out what the right level really is. And we don't -- we're not very -- we don't really know very well.

And I guess even if you accept the issue that

Medicare is not the problem, the reality is you've got significant areas where Medicare beneficiaries do not have access. So, whatever the problem is.

DR. BERENSON: Yes, I wanted to talk about two things. First, I like the report very much. I think you did -- I support the recommendations.

I wanted to raise one issue that -- I mean, I'll have some comments for editing, but I wanted to ask about one topic, which is the low volume adjustment. And it's a very compelling table you present in the paper: Low volume policy favors hospitals with larger non-Medicare shares. I'm wondering if you could even buttress that argument, but I need to know a little more of the data.

If, in fact, of the -- you have a column that says Private Payer and Other Discharges, what the mix is between private payers and Medicaid there. Because from the other work that you've done, and the Commission has done, I assume that a low-volume rural hospital for private payers either has a contract with pretty high rates because there's no competition, or they just are getting paid charges and there's no contract in place at all so that they're actually doing very well on the -- relatively well on the non-

Medicare side.

So disproportionately giving hospitals that have larger non-Medicare shares is even compounding. I mean, they have less of a compelling need unless they have a high proportion of Medicaid patients.

And so, I'm just wondering what we know about that and whether my reasoning makes sense, question one.

DR. STENSLAND: I don't have the Medicaid number, but from the AHA data we do have the profit margins and the private pay numbers. And they aren't huge. They're somewhere around -- everybody is like 30 percent. But nevertheless, if you have a lot of private pay, you're going to be doing better.

DR. BERENSON: I think you could even buttress the argument then because I think the way this has been constructed just is the wrong way, and I think you have a stronger argument to make.

The second one, I just wanted to briefly comment on Tom's concern about process versus outcome measures, and I actually am sympathetic to -- I mean, I thought the chapter starts getting into some very important issues around the emerging literature -- that process measures, at

least for hospitals, don't seem to predict outcomes very well. And it's worthy saying I hope we actually pursue that more fully outside of burying it in a rural report.

But it is the existing paradigm right now. I mean, Hospital Compare uses those measures. The value-based purchasing program at CMS is going to use those measures. There are some people who don't necessarily agree with sort of the direction of your argument, and which I think is basically right, and would still have a high priority on process measures.

So I don't -- I guess what I'm saying is I don't think this is the place for MedPAC to sort of take a strong statement and say we really don't think process measures are what we should be evaluating plans on. I mean performance on, in rural areas. The fact that there's also a problem on mortality rates, I think, suggests that there is a difference probably in quality.

So I guess there's probably a balance to find, which is that we need to follow this over time. But at least right now, it is reasonable to make some inferences based on the performance on process measures, if that makes any sense.

MR. KUHN: Let me first start by thanking Jeff and Adaeze for putting this report together and getting us to this point. You've done some terrific work here and thank you for that.

I also want to thank you for taking all the time to go out and visit a lot of rural areas across the country and also meeting with a lot of the various stakeholder groups that have come in to meet with you, to talk about this report. I suspect there will be many more to come in now that we've got a draft report, to talk to you about more details on that.

And then also, I want to thank Glenn and Mark for allowing me to bend their ear many times on this report. I know Tom, as well, and George have also done that. So thank you for your sensitivity and your efforts on this.

Like others, I'm going to have a lot of edits to share with you and will do that after this meeting, but let me just touch on some kind of major themes I have, or some highlights, in the three areas of the report -- the access, the quality and the payment.

First on the access, one of the findings in this report is that there are fewer local -- there are fewer

physicians in rural areas than urban areas, not a big news flash there. I think we've all known that for years, if not decades.

But what I think this report shows is that individuals who live in rural areas are getting basically equal access or levels of care that folks in the urban areas, and I think that is news.

But my takeaway from the report is that in order to achieve that both rural providers as well as rural Medicaid -- Medicare beneficiaries are having to work harder in order to access that care, and I think that is news. And I think that's important.

Now I think the real question for a lot of us is: Is that a sustainable model into the future?

I know I've asked a couple times in the past, and I think the data are hard to come by, but is there a way that we can kind of stratify physicians by age in rural areas versus urban areas so that we can kind of do a little bit of a look forward, to say okay, it's stable now, but look out with perhaps retirements in the future?

So that would be something still that would be, if that's possible, and if not, at least something that we can

talk about in the report a little bit more.

The other kind of takeaway on the access, to me, is kind of the underlying culture with rural populations that allows them to feel okay about their care even though they have to work harder to get access to it. And we see that in terms of the self-reported ADLs that are part of their -- as well as the CAP scores. So that too was kind of news to me, and fascinating, that they feel pretty good about their care that's out there and kind of what's going on.

But having said that, I think kind of going to Glenn's point of averages; I think in order to continue to sustain that, some of the special adjusters that are out there have done a lot to kind of stabilize the care that's out there.

So I think we have to be very careful and a little bit kind of what Tom was talking about in terms of the tone of the report, that people don't interpret some of these things incorrectly because it has created, I think, an interesting equilibrium out there. And so, I think there's got to be some caution here of how these things are described because I think we've reached, like I said, a good

equilibrium in rural care in terms of access.

Let me now kind of talk a little bit about, or share some thoughts on, the quality side. And there are the gaps in the process measures that are out there. And so, what I did is I went back and looked at the 2005 report, in June 2005, on critical access hospitals. MedPAC's report, that is. And it was interesting for me in that two things that were kind of pulled out in the report.

One is that critical access hospitals, and I suspect other rural hospitals, are very thinly staffed. So because of that, obviously, their ability to code as accurately as urban hospitals is probably -- was the case then, as acknowledged in that report, and probably still the case today, which could mean some of the differences that we're seeing in terms of some of those process measures but particularly the coding of the comorbidities and activities that are out there.

Plus, as you indicate, we have 1,300 critical access hospitals across this country and there's no incentive for them to code more accurately for all those comorbidities.

So I think some of the gaps that we're seeing

there and then the fact that we see in those self-reporting ADLs show two different stories. I think if we could talk about that a little bit more in the paper so folks have a better understanding of that, it might be something we could discuss more as we go forward.

Also, in the report, I think on page 39 you talk about mental health and the fact that there's not a lot of information on there. But I would just share this observation about mental health and what we're seeing in our State of Missouri, and I suspect in others out there.

There's kind of this bad joke among hospital executives, both urban and rural, but a lot more in rural. A lot of them have opened their new mental health unit. It's called their emergency department. People are being flooded in the EDs with behavioral health cases.

And I will tell you in rural areas it's particularly problematic because when you get someone in the emergency department with behavioral health issues and you have no place to transfer, particularly at critical access hospitals, I've heard of some critical access hospitals having to board someone for up to six or seven days. It's very disruptive when they're not in a position to manage

that.

And then, what we're seeing, of course, is for the ambulance crews to transport them when they do find a place, to move that patient. Generally, a lot of rural ambulance crews have a ring of a 50-mile radius. Some are going up to 250 miles, and now you're pulling that ambulance out of that community for the entire day as a result of that transfer. So that's an issue.

And I don't know if there's something we can add a little bit about those issues and maybe capture some of that in that ambulance report that's newly required, that's out there.

The final thing on the quality I would just mention is something that we talked about, I think at the last meeting, and Karen had some comments on this, but it has to do with kind of the mortality issues out there. Again, in that 2005 report, MedPAC at the time kind of speculated that one of the reasons you might have higher mortality in critical access hospitals in rural areas is the notion of people come home to die. They want to be close to family, friends. They want to be with local caregivers who they know and in a facility that they know that's out there.

Karen, at the same time, talked about that she sees some that come into the urban areas for that very reason.

And so, one of the things I would be curious about is: Are there some new data or new literature that says in 2005 MedPAC kind of made this assertion and then can we still make it today, or has something changed over the last 7 years that has got us?

So let me stop for that, if I can get you to answer that, and then I'll finish up here.

DR. STENSLAND: I think we said that in 2005, that this is a possibility. And as we go on with looking at this study and looking at more studies, it seems a little less probable.

And there are a couple reasons. One is that we looked at the spectrum of outcomes and volume, and we see this kind of clearly ticking up in your mortality as you go down in the size of the hospital. So for it to really hold true it would have to be that they're going only to the really small hospitals to die, and not the larger hospitals.

I think this is also something that has a -- another way to look at this would be looking at the critical

access hospitals, and we did see a little bit worse performance in the smaller critical access hospitals than the bigger critical access hospitals. So it would kind of have to be that they want to go to the smaller critical access hospitals with the fewer physicians but not the bigger critical access hospitals with the more physicians.

And then, this was also kind of a reoccurring theme that was connected into they don't have hospice maybe in some of these rural communities or they useless hospice in the rural communities. We wanted to see, well, maybe that maybe that is the situation. Maybe you're not -- you're going to the hospital to die rather than stay in the hospice.

And I think we have a couple of good data points on that. First, in the new -- that study by Joint and Ashish Jha, they included hospice as a discharge category as one of their control variables in their study, and they still saw that differential.

And then, when we ran back and ran our numbers to see, well, what happens if you put up the share of people in the county that are using hospice. And that is a smaller share in the more isolated areas, like 30-something percent

versus 40-something percent. And that didn't really affect that differential at all. It just didn't come up as significant in the regressions.

So this is kind of a long answer. Sorry.

The bottom line why I think why the hospice effect might not really turn out as big as we think it is has a lot to do with exactly how we're measuring mortality. And the way we're measuring mortality is did you die within -- not in the hospital but within 30 days after you were discharged.

So if someone goes to the rural hospital and they stay there for 30 days and then they die, or they stay there for 40 days because there's no hospice and they die in the hospital after 40 days, that counts as a mortality for the rural hospital.

If someone goes to the urban hospital, in there for 20 days and then they get discharged to hospice and they're in hospice for 20 days and they die, well, that counts as a mortality for the urban hospital.

So because we're counting the mortality on anybody who dies 30 days after discharge and the average hospice stay is only 17 days, I think it explains some of the reason

why we don't see the effect of whether using hospice or not really affecting the mortality rates and that relationship between size and mortality.

MR. KUHN: Thanks, Jeff. That information is helpful.

Like I said, MedPAC postulated on that notion back in 2005, and I think kind of drawing that information into a little bit more of a conversation of what we think the literature shows now, or what the data shows now, I think would be helpful to kind of close that gap.

Finally, on payment, a couple things here. One is on page 69 and 70 in here we kind of lay out that set of principles in payment -- you know, to preserve access, the isolated provider, the empirically justified and the control of costs. But on those pages, there's a chart that only lists the last three; that is, the isolated provider, the empirically justified and control costs. The preserving access is not part of that. And if there's a way we can complete that chart, to make sure all those things are captured as part of that process, I think would be helpful.

The other part on payment is cost base. And again, going back to the 2005 report, while it did

acknowledge that cost base is not as strong an incentive in terms of incentives to hold down -- as strong an incentive on payment. There, nevertheless, were incentives in cost base, and those are kind of absent in this report. So I think carrying that forward from 2005 to be consistent would be helpful.

And then, finally, we've talked quite a bit about the beneficiary co-payment section, and we still have a conversation on that.

One final thing there is that we don't kind of get to address this, but at least with the empirically justified conversation and others there are some assumptions that, ultimately, some facilities may merge or close as part of the process as we go forward. And if you look at some of the regulatory underpinnings out there right now with CMS, there are some regs recently in terms of what happens with mergers with critical access hospitals.

So if two that are close together want to merge, the one that closes in one community, it's hard to maintain any kind of services, outpatient services in that facility because of these regulations.

Likewise, if a hospital decides to give up its

cost status, or change and go back to PPS, at least currently, my understanding is CMS requires them to get a new provider number. So it makes it very difficult for them to kind of recapture their sole community or Medicare dependents.

So I'd like us to also talk about that if we are going to do some movement in this community in the future at least we ought to acknowledge that there are some regulatory barriers that make that very difficult, and some conversation about those would be helpful as well.

Thanks.

DR. MARK MILLER: Jeff, on one of his earlier points about the age of the physicians, we either did or are doing something with that? Can you just remind me?

DR. STENSLAND: Okay, I'll try to do these really quick.

With respect to the age, there are a lot of state-by state studies, some saying rurals are older, some saying rurals are not. I think there was a nice study by the people at WWAMI, who do a lot of work. That's in the University of Washington. They do a lot of workforce stuff. And I think the key statistic there -- and we'll put it in

the report -- is amongst primary care physicians in rural areas, 27 percent are above age 55, and in urban areas it's 25 percent are above age 55, on a national basis.

So everybody can kind of judge on their own, how big a magnitude they think that is and how big of a difference it is in the problem.

DR. MARK MILLER: And then on the regulatory stuff, you did take a look at it, and I remember the conversation. There is some drag there, and we would put -- go ahead.

DR. STENSLAND: Yes, we can address that, like if there are two people next to each other and they both have a necessary provider, if they actually are 35 miles away from anybody, then there's no problem.

But if there are two people next to each other and they both have necessary provider criteria, and there is still somebody, a third one, that's 15 miles away or something, then it might make sense to have some sort of regulatory waiver where if they set up a hospital that's in between these two they can move in between the two with a new hospital. That's one option.

The other option that does exist in current

regulation is you can have this one continue to be a critical access hospital and this one can be a rural health clinic because the rural health clinics have a waiver in that regulation so they can still be a rural health clinic and have that outpatient capability.

But I think if what you're saying is if they do decide to build a new hospital in between the two, which might make perfect sense, maybe there is a need for a new regulation that would make that allowable.

The other kind of background story is the one thing they probably wouldn't want to do is allow them to move closer to somebody else because when this was coming up and this critical access hospital was talking about moving, particularly, I remember talking to somebody in one place. And the PPS hospital was kind of mad that the critical access hospital was over here and they got their necessary provider designation. The PPS one is here, and the critical access hospital wanted to move its building over here because there are more people over here, and that is probably not such a good idea.

MS. BEHROOZI: I'll try to be brief. So I think you've done a really great job of putting out the facts and

not being -- and not just sort of reciting truisms that I think people -- I would have been willing to accept. You know. Old or sick or poor in rural areas, not so, the evidence shows.

I mean, I'm just looking at the paper. With respect to poverty, it's slightly lower rates of poverty in rural areas than urban residents after adjusting for the cost of living. I mean, all the facts have to be taken into account.

And there isn't a normative standard of what's the right amount of care, so you have to do relative. I get that. And so, you have to compare averages.

But I guess I'm sort of on the other side of the coin of Tom's concern about averages, and I've expressed this before, that taking every area that has 50,000 people or more, right -- that's the threshold -- and calling that urban really does not get at the variability, one of the points that Tom raised, doesn't get at the variability within urban.

Sorry, just a little off-track. Off the top of my head, I have a question about this. Does this reflect all payments like IME and DSH and that kind of stuff?

Like, off the top of my head, it seems to me we ought to include critical access hospitals in there too, and that will really show so-called urban and so-called rural hospitals. As you said the lines will be that much more different from each other.

I think that would be a fairer comparison, if all the adjustments -- I get those are PPS adjustments, but still, all the extra payments are in on the “urban” side. That’s where the major teaching hospitals and whatever are. I mean, I’m sure there is some DSH or whatever on the rural side.

So anyway, just back to the comparative thing, comparing rural to urban, you know a theme of mine is always about looking at socioeconomic status and disparities based on socioeconomic status and race. And a big concern of mine is that you have more variability, more heterogeneity in the urban group.

And just based on what it says in the paper about African-American and Hispanic concentrations in this so-called metropolitan urban side, I just think we’re not -- it’s not a -- a comparison that doesn’t really examine all the underlying problems of access within what we call urban.

There are lots of problems of access by poor people, by people of color, by people in inner cities, people in whatever suburban areas within adequate public transportation, but people are poor so they don't have their own cars. There's a lot of that going on under that 50,000 -- or above that 50,000-person threshold.

So, as I said before, it's a great thing that Medicare has addressed, or Congress has addressed, a lot of the issues for rural areas, but I think it's time to turn attention to whether it's urban areas. I don't mean to set it up as a competition, but maybe looking at access by lower socioeconomic status beneficiaries across wherever they live because if you have money you can get care no matter where you live.

MR. GEORGE MILLER: Yes, I also want to thank you for this report and certainly thank -- I did send comments in to Mark. I trust he got them last Thursday, concerning the report. I sent an email in late. Maybe?

DR. MARK MILLER: [Off microphone.] No.

MR. GEORGE MILLER: No, did not. All right.

DR. MARK MILLER: [Off microphone.] I've been all over, and I got all of this.

MR. GEORGE MILLER: Yes, I know. I know. You sent me an email.

DR. MARK MILLER: [Off microphone.] To be clear, I've been at work.

MR. GEORGE MILLER: Yes. I've had -- I'm in a rural area.

DR. MARK MILLER: [Off microphone.] Seriously, I didn't find --

MR. GEORGE MILLER: Okay, I'm in a rural area. Maybe my internet didn't get out. I'll go back and check because I sent about two pages.

Both Herb and Tom, we have been talking. They have commented on most of what I will cover. So I won't bore you with some of the same things except for one or two things.

In the report, I don't know if this has been changed, but it does say -- and I'll read it -- "There is room for improvement in rural hospital quality." I served on the joint commission. There's room for improvement in all quality.

So I'm not sure why that was picked out in that way and characterized that way. There's room for

improvement everywhere, and we won't dispute that.

The other issue that Tom brought up, about 30 percent of the pharmacies have been closed, is in my mind an astounding number and is compelling, and I think more attention certainly should be paid to that, that point. That's significant for those communities that have had that one pharmacy close in their community.

The other issue that Herb brought up that I think is important to highlight and just to take a second or two to talk about it is that the rural beneficiaries; they like their physician, their hospital and the care that they're receiving. And the point is that in the paper it talked about the fact that they're getting the same volume of services, as percentage-wise the access to services is there, but there are fewer providers. So as a result, being fewer providers, they're working harder and the beneficiaries certainly appreciate they're both working harder.

So that issue will have to be addressed at some point, as Herb mentioned.

The comment about the rural health care is often asserted as the rural populations are older, sicker and

poorer, but your literature said that was not true. But, your literature talked about the Medicare population.

The comment that was quoted, that rural populations are sicker and poorer -- the Medicare population may not be in those rural communities, but the overall population is sicker.

So in my mind, you're comparing apples with oranges because you first said they're not sicker, all rural populations, but then you quote the Medicare population in that community. So I think there's a difference there, and we certainly can take a look at that.

Also, the comment about slightly lower rates of poverty from urban residents after adjusting for the cost of living -- well, USDA released their new poverty index that says it's much higher nationally in rural areas. So I encourage you to at least look at data from the USDA to see and reconcile who's right. Rural poverty and urban poverty have been converging with the majority of the persistent poverty.

Now I agree with Mitra about the amount of disparities in urban areas, but still, there's rural poverty as well.

And then finally, on the tone of the report -- and I agree with Tom's comment about you get a staff that reads this in the tone. Without knowing all the intricacies and doing the talking, the background that you did in the report, they may read this report and get a different opinion. So I agree with the comments about the tone.

DR. CASTELLANOS: I think you did a great job. It's been fun to watch you go through this project. It's been educational to all of us, and I really think you did exactly what they asked you to do. They asked you to evaluate what's happening in the rural area.

We're all talking about comparing one to the other, but that's not what they asked you to do. They asked you to evaluate, and that's what you've done. You called. You said what was happening. You may have said it in comparison to something else, but I think you've done exactly what you should have done.

I think it's well studied. It's well written and very, very well structured. And I congratulate you for doing exactly what they asked you to do.

MR. GRADISON: In addition to joining in congratulating you, I have a request that as we get the next

version, somehow I'd like you to pinpoint the differences from this version. To be frank, I would have found it helpful with this version as well. I don't mean every word, but any substantive changes, because it's been a while since I've gone over it and there are 90 pages in this document. So I just think that at least for myself it would make it easier to do my job, if I had that crib sheet on the side.

Thank you.

DR. BORMAN: To me, the benefit redesign work and also working on this report have some similarities in that they've presented us some opportunities to really make some comments but offer some significant pitfalls that we've tried to -- you know, we've had to try and avoid. So I'm going to add enormous congratulations to you for the way that you've handled this and for what I perceive as a really balanced attempt to look at this.

I spent 25 years of my professional career at institutions that were sort of on the receiving end, really focal to being on the receiving end. And I, in that, am struck by the absolute tragedy of care that didn't get delivered to those people. On the other hand, I've been struck by the seeming ka-ching mentality of care that was

delivered in terms of tests done or things done when it was very clear from the get-go that that patient needed to be elsewhere soonest as they're best. And I don't mean just in the emergency situation.

So I think that there are -- no matter how you look at it, it is -- unfortunately, you can't always get it by the average out, but you can try and present both sides of the equation and try to achieve what is equivalence, given that there are constraints about what you can deliver with a thinner staff, with fewer resources, and whatever. And so, in my mind, you've done a really nice job of bringing what are the data out there.

The only suggestion I would have -- and it's pretty late in the game. I would just wonder if there's a place for saying that this is a mandated report and structured in this way, but we feel a responsibility as the Commission just about the sustainability and vision for the program in general, and that we have -- that's also been part of the lens through which we've looked at this and that we've had to consider our recommendations, first, what is appropriate to these populations and these facilities, but that we've also considered it in the context of the future

of the program for everyone.

And there may be some value to saying something like that. My feelings will not be hurt and my life will not end if that doesn't somehow appear in the report.

MR. ARMSTRONG: I would only -- if you're going to -- first compliment the work as others have done that.

If you are going to try to modify the tone a little bit, just the one additional point I would add is that we tend to under-represent the fact that actually in our rural communities there are solutions to some of the issues we're talking about that we, frankly, should be paying more attention to and applying to the urban communities. We seem to be sort of worried about assuring that in rural communities everything is up to our standards, but in fact, in many ways, it offers insight into how standards should be applied to some of the other markets.

DR. CHERNEW: So, admittedly, I did not read this with the same scrutiny or sensitivity or experience as some of my colleagues, but I have to say I didn't pick up on the tonal issues that have been discussed in the same way and maybe I'm more ignorant in that regard.

But I think the broad message; I think you did a

wonderful job. And the message that I took from it was that there are some really important and special issues that rural areas have, and I think you've discussed them.

Frankly, I read this, not knowing what other people do, as they weren't as serious as I otherwise might have thought they were. We could argue, I guess, about some of the data, but I thought it was at least reasonably convincing.

And I agree with what Mitra said, that other areas have special issues as well.

I think the real challenge here is to understand that when these issues arrive, to think about what Medicare's responsibility is. So there's a part of this where we run through a whole bunch of things and statistics, and blah, blah, blah. But even when you find a problem, it's not always clear what Medicare's issues are and whether the goal is that everything should be equal between the different places.

My general view is that they shouldn't be equal between the places necessarily, but they certainly have to be good enough in all places.

The sort of general concern I have, of course, is

what we would do when there are problems in this very cost-constrained world. And I guess a lot of people look to this and read this to think that well, if there's a problem in the rural areas relative to urban areas, we have to figure out how to give more to the rural areas.

And that may be true because I think there probably are certain places where there's access issues or not although I have to say in general -- let's take physician issues. One of the challenges might be that we're overly generous in maybe urban or other areas.

So it might not be we just equalize by giving more to rural. You know you could equalize in a lot of different ways, and we seem to be in a world where we're taking away, not in a world where we're giving.

So I'm not arguing we should take anything away from anybody in this comment. I'm just saying there's a tendency, or at least I perceive a tendency, to read reports to look for places where there's problems and figure out how to give more there.

And I think that it's going to end up -- you know all of the stuff we do is just sort of budget-neutral, this kind of view in what we're doing, and everything is going to

get really tough.

So I very much appreciate what you did, and I agree exactly with what Ron said. I think you did exactly what you were asked to do, and I think you did that well.

But the policy ramifications of what we should do where there are areas of problems -- and I do think there certainly are, as there are everywhere, as George said -- I'm just really not sure what the right overall solution would be.

And I don't think it's -- you know, it's not appealing to me to pick one area and say, oh, here's a problem; let's do this. I think it has to be more comprehensive across all the providers, all the areas, all the other stuff, which wasn't our charge.

MR. BUTLER: So my reading was that it was pretty objective, almost too objective in the sense that it didn't comment on both the values of the rural or values of urban. And I understand if you had a bias going in, how the wording would not maybe satisfy you or you would interpret it differently.

So I was going to really make Scott's point but even be more specific because I think we've heard in some

sessions, including from myself, some specific examples of where rural care may be done better.

Now I'm one who brought up tele-health, and it's reported on although it kind of just says well, they've got it but not all that much, where I can point to examples where I see how it's been very effectively used. As much as it's been anecdotal and I don't have the science, I think there are some superb examples how they've made great use of tele-health.

So maybe if you look back in some of the previous comments, and we not only say there are lessons to be learned, but maybe highlight three or four kinds of things that are worth further emphasizing. It just kind of sets a little different tone maybe, or a little more positive tone.

DR. NAYLOR: I thought it was an outstanding report, and I appreciate the depth of knowledge colleagues bring, but I really also thought it was a really balanced view.

And I didn't walk away with any sense other than this is a real celebration of MedPAC's investment, and others, over time, and we have a lot to, I think, be really proud of. The Commission does. I had no parts of it.

I also thought this process of establishing guiding principles and figuring out how a report evolves from that was really quite extraordinary. So the integrity of the process, I really think it's something to celebrate.

I also thought the focus on the major outcomes that we do know about -- mortality, where there are only very slight differences, and readmissions -- was a real acknowledgment of what has been accomplished.

And so, I don't have anything else to say other than congratulations and thank you for the introduction to new language about rural micropolitan, adjacent rural frontier. I really, honestly, had no understanding, and I really appreciate all that I've learned.

MR. HACKBARTH: So this is our last discussion of this report as a Commission. Bill, the only way you will see the next iteration if you sign up as a reviewer with Jim on your blue sheet.

MR. GRADISON: I already have.

MR. HACKBARTH: You already have, okay.

So that's where we are in this process.

Thank you, Adaeze and Jeff, for your heroic efforts on this report. You did a great job.

[Applause.]

MR. HACKBARTH: And also, thanks to Tom and Herb and George who have, in particular, spent a lot of time on this project. As I said at the outset, I think the final report will be better for their efforts.

So that's the end of our session today, save for the public comment period, for those intrepid people in the audience who have stayed to the very end.

And before you begin, sir, let me just quickly say what the ground rules are. Please begin by introducing yourself, your name and your organization. You will be limited to two minutes. When this red light comes back on, that signifies the end of your two minutes. And I would remind people that, of course, this is not your only or your best opportunity to provide input on the Commission's work. Use our website and, of course, continue to talk to staff, as people have in the past. Sir.

MR. MOORE: Great. Well, good afternoon. I'm Justin Moore, the Vice President of Public Policy at the American Physical Therapy Association and also a licensed physical therapist.

As you know, physical therapy allows individuals

to regain function and mobility to remain independent in their homes and communities. The value to improving this quality of life to Medicare beneficiaries is well supported in science and practice. Without physical therapy, Medicare beneficiaries would likely incur higher costs downstream due to patient loss in function, falls, and more intensive interventions or inpatient care.

The major concern of physical therapy is not so much that value of the service, which provides 14 percent of the beneficiaries' care at three percent of the cost. The concern is its variance and its volume.

We believe reform needs to be both immediate and in long term. Immediate reforms will begin this year. In addition to the legislation which mandated the report to MedPAC, it also took some necessary steps to better understand the benefit and to apply immediate reforms.

To understand the benefit, CMS will begin to collect data on functional status from the claims form beginning on January 1, 2013. To reform, CMS will begin to require medical manual review of all services that exceed 3,700 beginning on October 1 of this year.

Finally, APTA [phonetic] is developing a refined

payment system for the outpatient physical therapy services that would consolidate our code set and represent the severity of the patients we serve with the intensity of services needed. We found these consistent with a lot of the work that this Commission is doing and look forward to working with the Commission to continue their work in this area.

Thank you.

MR. CONLEY: Good evening. You've had a long day and I'll be very brief. I'm Jerry Conley and I'd like to speak as a physical therapist on behalf of three organizations, of private practice physical therapists across the country, over 4,000 of them; PTPN, which is a managed care rehabilitation network in 23 States; and Focus on Therapeutic Outcomes, which is a national outcomes database providing quality and functional status outcomes information to patients and to providers, clinicians, in all the States and in over 3,000 settings, both hospitals and other settings, as well.

I greatly appreciate the levity that you brought to the discussion around outpatient therapy, but I hope that, in seriousness, you will take Commission Mike's

comments to heart, and that is this is a critical benefit and it's very important to provide and restore function to the Medicare beneficiaries who are eligible for this function -- for this benefit.

There's a wide variety of conditions that physical therapists treat and treat effectively, not the least of which is ambulation. But the comment that if a person was able to walk into a skilled nursing facility to get Part B benefits means that they don't get them shows that there really needs to be, if less levity, then certainly more understanding of what physical therapy is and how it is provided and how it is accessed.

So there are a number of functional status outcomes organizations that measure function for patients and that provide information to the therapists and to the providers around the country. One of those is Focus on Therapeutic Outcomes, which has measures all over the place in all States, recognized by NQF, has provided information to CMS. Now, are these and others widely used across the nation? They are. Are they broadly used across Medicare? No. Are they required? No.

As Justin has just said, because of this latest

extension on SGR and the therapy cap exceptions process, CMS will be required to access and refine this exception process, accessing data collections information. MedPAC can enhance and refine and assist that by making a recommendation to CMS that this information should be functional status information. That would help with the recertification process, because you will know as a physician whether or not the patient has plateaued or has continued to improve. It will help driving the benefit toward more effectiveness and toward, more importantly, the quality of the care that is delivered.

So outcomes information, which can be available and is available, needs to be available and required through the Medicare program, and MedPAC can help by moving CMS more in that direction. It also will help the interpretation of whether this utilization -- one Commissioner said, well, we don't know whether this increase in utilization is a good increase or if the decrease is bad decrease. Outcomes information and functional status information will answer that question. So it will help cultivate and create the most and best use of the Medicare benefit with respect to outpatient therapy.

So the latest SGR extension does require that CMS grab that -- gather that collective, that functional status information, and I would urge CMS -- or MedPAC to urge CMS to make sure that that is functional status information and that that be required across all settings so that you can gather information as to where that benefit is used all across the PT benefit exposure.

Thank you very much.

MR. HACKBARTH: Okay. We are adjourned until, let's see, 8:00 a.m. tomorrow morning.

[Whereupon, at 6:23 p.m., the Commission was adjourned, to reconvene at 8:00 a.m. on Friday, March 9, 2012.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, March 9, 2012
8:00 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD

AGENDA PAGE

P R O C E E D I N G S [8:00 a.m.]

MR. HACKBARTH: Good morning. We have three important sessions this morning, the first on a mandated report on home infusion therapy, followed by a session on risk adjustment for Medicare Advantage, and then dual eligibles. Today we will be on time, I promise.

So who is leading? Kim.

MS. NEUMAN: Good morning. Today we are going to continue our discussions of home infusion for a congressionally requested report. I won't dwell on this slide, but I wanted to briefly remind you of the issues that the Congress has asked MedPAC to examine. Previously, we discussed the third and fourth bullets. Today we're going to discuss the remainder.

So this morning, we'll review Medicare coverage of home infusion, and then we'll focus on the cost of home infusion. As requested, we'll assess sources of data on the cost of home infusion that could be used to construct a payment system, and we'll assess the cost implications of broader home infusion coverage for Medicare. And then Joan will discuss design issues that could be considered if Congress wished to expand home infusion coverage.

Before we do that, we'd like to thank Kelly Miller and Evan Christman for their contributions to this work.

So you have seen this slide before. It summarizes Medicare's current coverage of home infusion. Medicare's coverage is spread across different payment silos. Coverage for the drugs is split between Part B and Part D. Part B covers roughly 30 drugs requiring a durable medical equipment pump. Part B also covers parenteral nutrition for patients with a permanent impairment and intravenous immune globulin, or IVIG, for patients with primary immune deficiency. Part D covers drugs not covered by Part B that are on the plan's formulary and that meet any plan prior authorization criteria.

If Part B covers the drugs, the supplies and the equipment are also covered, except for the case of IVIG. If Part D covers the drug, it does not cover supplies or equipment. Nurse visits as well as limited supplies are covered under the home health benefit if the beneficiary is homebound.

Now we will turn to cost. We were asked to assess sources of cost data that could be used to construct a payment system for home infusion. The data on the cost of

providing home infusion are limited. An industry-sponsored by Abt Associates estimated the per diem cost of home infusion, which they defined as all pharmacy costs except the cost of the drug itself and nurse visits.

This study has limitations that make it not well suited to rate setting. It is based on cost information from a limited number of pharmacy companies. Much of the cost information is obtained at the aggregate level, and the study had to make assumptions to extrapolate those aggregate costs to the drug level, so results would be sensitive to assumptions. We also have some concerns about what types of costs were and were not included, and we were not able to make a judgment about that.

In terms of other options for cost data, Medicare payment rates for other services might serve as a benchmark such as payment rates for nurse visits under the Medicare home health benefit or the DME fee schedule rate for infusion pumps and supplies, although caution would be needed here since the DME fee schedule pricing in general is thought to be high. Another option might be competitive bidding.

So next we are going to turn to the issue of the

cost implications of broader home infusion coverage for Medicare. It may seem intuitive that providing infusions in the home would be less costly than providing them in a skilled nursing facility or other settings. But it turns out that the cost implications for Medicare of broader home infusion coverage are complex and uncertain.

To look at this issue, we first reviewed the literature and then we did additional analysis. In terms of the literature, most studies are dated and do not examine the implications of home infusion from Medicare's perspective. The main finding in most studies is that a day of home infusion costs less than a day of inpatient hospital or SNF care.

There is one study that models the effect of a hypothetical Medicare home infusion benefit for antibiotics. The authors conclude that broader home infusion coverage for antibiotics would save Medicare money, but they include a sensitivity analysis that demonstrates that if they modified some of their assumptions, it would be a net cost rather than net savings.

So to look at this issue, we developed a conceptual framework of the various effects expanded home

infusion coverage could have on Medicare expenditure, and the overall effects depend on many factors.

First, it depends on what payment rates Medicare establishes for home infusion services and then how those rates compare to how much Medicare would pay for infusions in other settings.

So, for example, there is not likely to be significant inpatient hospital savings. That's because if broader home infusion coverage led to shorter hospital stays, Medicare payments to hospitals in most cases wouldn't change because Medicare makes a DRG payment.

There might, though, be savings on SNF care for some patients if there are beneficiaries who are candidates for home infusion but who enter SNFs because of the out-of-pocket costs associated with home infusion.

It is also possible that there could be savings from avoided home health episodes for some beneficiaries if the only reason they are receiving the Medicare home health benefit is for assistance with infusion services.

Now, compared to ambulatory settings like hospital outpatient departments or physician offices, home infusion might save or cost, and it would depend on many factors:

the payment rates established for home infusion, how much is paid for the drug in different settings, how frequently the drug is administered, are home nurse visits needed periodically or for every infusion, and would the patient receive separately paid nurse visits or nursing through the Medicare home health benefit.

So in addition to site-of-service shifts, we also would have to consider the potential for Medicare expenditure to increase due to a crowd-out effect and a woodwork effect.

Expanded Medicare coverage for home infusion would crowd out spending by other payers since some beneficiaries currently receive infusions in the home with supplies, equipment, and nursing paid for by employer supplements, Medicaid, or beneficiaries themselves. With expanded coverage, Medicare would pick up those costs instead.

There would also likely be a woodwork effect, meaning that expanded coverage of home infusion would likely result in more beneficiaries receiving intravenous drugs than otherwise would have been the case. For example, some individuals who might have been previously prescribed an oral drug might now get an IV drug, and this would likely

increase Medicare expenditures. And, finally, sort of the bottom line of whether Medicare saved or incurred additional costs overall would depend on the combined effect of all of these dynamics.

So where does all this leave us?

First, there are a couple of key points that come out of this. The cost implications of home infusion coverage for Medicare vary by drug and in some cases also by diagnosis. There is a better chance of savings for drugs where home infusion substitutes for SNF stays or possibly home health episodes. And the likelihood of savings is higher if a nurse's presence is only needed periodically and not for every infusion. And, of course, whether on not Medicare would save or incur additional expenditures would depend on the payment rates that were established for home infusion.

So to make this more concrete, we developed some illustrative scenarios of the potential cost implications of home infusion for two drugs where it seems there may be a possibility, although not a certainty, of savings. We did this for antibiotics covered by Part D and for IVIG covered by Part B for patients with primary immune deficiency.

To construct these scenarios, we had to make assumptions about how Medicare might pay for home infusion services, including assuming hypothetical payment rates for home infusion nursing, supplies, and equipment. We used several hypothetical rates to illustrate the financial effects of varying payment levels, and all of the scenarios were for illustrative purposes, not to suggest an actual payment structure or payment amount. The detailed tables are in your materials.

This next chart summarizes the results, and I'll walk through the antibiotics example. The IVIG example is very specific to that product and a particular diagnosis, so I'm not going to go through it, but we could discuss it on question.

So if we look at the antibiotics column, the first few rows show the potential effects on Medicare expenditures of shifting antibiotic infusions to the home from alternate settings. If antibiotic infusions shifted from SNFs to the home, there generally would be savings. How much savings, though, would depend on how many people are getting IV antibiotics in SNFs and how many of them would be capable of receiving that care in the home.

If antibiotic infusions shifted from hospital outpatient department to the home, it might save or cost Medicare money depending on the payment rates for home infusion, frequency of nurse visits, and other factors.

Also, with broader coverage of home infusion, there might be some avoided home health episodes, and whether this saves or costs depends on assumptions, but the savings possibilities would be greater if the infusion therapy occurred over a very short time frame, one that's shorter than the 60-day home health episode.

And then, as we discussed earlier, we would expect Medicare expenditures to increase due to a crowd-out effect and a woodwork effect. And the net of all of these various effects on Medicare expenditures is uncertain, and I know that's not necessarily satisfactory. It's uncertain for a couple reasons. It depends on how many beneficiaries are in each row of this table, and we don't generally have data to speak to that. It also depends on the amount of additional savings or costs per beneficiary in each row, which depends on the many factors we've discussed, including the payment rates that would be established for home infusion.

So now I'm going to turn it over to Joan who will

talk about potential policy options.

DR. SOKOLOVSKY: So we have come up with three potential options

The first option is actually to leave the current system in place. Medicare beneficiaries are accessing home infusion at an increasing rate under the current payment systems.

For example, Part D drug costs for home infusion drugs grew at an average annual rate of 47 percent between 2006 and 2009, and the number of beneficiaries receiving home infusion grew at an average of 21 percent per year during that time.

With respect to Medicare Part B-covered home infusion drugs, Medicare spending increased at an average rate of about 17 percent per year, and the number of beneficiaries grew at an average rate of 6 percent during this same 2006-09 period, despite the decline of the fee-for-service population during this time.

Alternatively, the Congress could decide to fill in some of the coverage gaps that we've identified, for example, providing nursing services for beneficiaries receiving IVIG with primary immune deficiency disease.

Thirdly, the Congress could design a demonstration project testing the effects of broader coverage for home infusion antibiotics. For either of these two options, as Kim emphasized, it would be necessary to take into account increased spending due to the crowd-out effect of current coverage sources and the potential woodwork effect.

Because Medicare home infusion coverage is divided among so many different payment silos, it's not surprising that coverage gaps exist. Remember, the extent of coverage depends on the prescribed drug, the patient diagnosis, and equipment needs. Congress could fill gaps on a limited basis, for example, covering nursing and related services for primary immune deficiency patients. This has the advantage of dealing with a small population with a specific diagnosis so could be more easily monitored. People with primary immune deficiency disease need IVIG on an ongoing basis. By statute, beneficiaries with this diagnosis can receive IVIG under Part B at home. However, nursing and related services are not covered. And, generally, a nurse must infuse IVIG directly into the patient's vein during each administration. Without coverage for nursing and related supplies, the patient may be unable to use this

benefit and may use the more expensive subcutaneous IG instead. Subcutaneous IG requires a pump that's paid for under DME, so the supplies in that case are covered. The expansion of coverage might increase Medicare costs, but we do have some ideas about ways to help offset this increase.

On the third option, Medicare could fill gaps more broadly, for example, covering supplies and equipment needed for IV antibiotics. However, managing this broad expansion within FFS would be difficult. The potential for a significant woodwork effect is high, so it could be costly.

A third option would be setting up a demonstration project to test the effects of expanded coverage for antibiotics under fee-for-service. It could allow us to evaluate whether a home infusion benefit for antibiotics improves quality and saves money compared to current options.

Recall that MA plans already have the ability to implement an integrated home infusion benefit and many do. Fee-for-service presents a much greater challenge. The demonstration would need management controls like prior authorization. CMS or its contractors could provide this oversight, but given the agency's limited resources, it

could be a challenge.

Perhaps the biggest challenge is determining an appropriate control group. One strategy might be to select demonstration areas and identify diagnoses that are associated with use of IV antibiotics. The evaluator could measure Medicare payments for episodes of care for all beneficiaries in the areas with these diagnoses, whether they have home infusion or not, and compare it to similar areas outside the demonstration. They could also look at changes over time. However, it may be difficult to disentangle the effects of the demonstration from other unrelated effects if infusions are a low-frequency event even for beneficiaries with these diagnoses or if they account for a small share of their overall expenditures. The evaluator would have to address other methodological issues as well.

Some of the design questions would include: Who would participate in this kind of demonstration? Since home infusion requires coordination among multiple providers, we can imagine partnerships among physicians, home infusion providers, and home health nurses, for one example.

What would the payment cover? It could cover

supplies, equipment, services, and nursing. If it includes drugs, it would involve another set of issues related to payment and coordination with the beneficiaries' Part D plan.

One of the more difficult issues would be how the payment is set. The most common method used in the private market is a separate payment for drugs and nursing and a per diem for supplies, equipment, and other services. The range in payments for the per diem is high, and current data are insufficient to determine a "right price" for Medicare, although Medicare provides some benchmarks, as Kim has shown you. Medicare could use competitive bidding to determine payment rates.

So now I want to briefly summarize what we've found on the issues that Congress asked us to look at. We were asked whether there was useful literature on the comparative costs of providing Medicare coverage for home infusion therapy. Although there is some literature on the costs of home infusion, it is old and does not take into account the costs of a home infusion program under fee-for-service Medicare. Based on our analyses, whether home infusion yields costs or savings depends on the settings

which beneficiaries would otherwise use, payment rates, how frequently the drug is infused, and how often home nursing visits are needed. Shifting beneficiaries from SNFs is likely to yield savings.

We were asked whether there were data sources that could be used to construct a payment method for Medicare. Data on the costs of home infusion services are very limited. We've had some frustration on this. Some Medicare payment rates might serve as benchmarks.

Are the payment methods used by private plans applicable to Medicare? As we noted before, the most common method used in the private sector is a drug payment, a separate payment for nursing, and a per diem for supplies, equipment, and services, and this payment method could be applicable, although other methods are also possible.

Lastly, what are the issues surrounding potential abuse of a home infusion therapy benefit in Medicare? As we discussed in November, the plan representatives we interviewed did not find evidence that abuse is more prevalent in home infusion than in any other service. They all use utilization management techniques like prior authorization and post-utilization review. And some

wondered how this kind of oversight could be implemented within fee-for-service.

So this concludes our presentation. We welcome your comments. And are there any issues that we have not addressed that you would like to see further explored?

MR. HACKBARTH: Okay. Thank you.

Could you put up Slide 10, Kim? I like this slide. I'm trying to get sort of a handle, a construct to think about these issues, and this creates a nice shell. But it raises the question: Is there any way that we can get more data that would help us fill this framework out more completely?

MS. NEUMAN: So there are, I think, at least three big data holes that we have, and two might be fillable, one is much more difficult. The first is that we do not know which beneficiaries in SNFs are getting IV antibiotics, what those antibiotics are, and for how long they're getting them. And, potentially, you could require more complete reporting on the part of SNFs through claims or the MDS. So that's one hole that you might be able to fill.

The second hole relates to the idea of how many of these patients would be candidates for home infusion, so

you've got people in SNFs getting IV antibiotics or people in hospital outpatient departments getting IV antibiotics. How many of them actually would be able to do it in the home? That's a much harder question. The person who is probably best positioned to know that information is actually the hospital discharge planner, who would have been in collaboration with the physician deciding where to place the patient. So, hypothetically, you could so a survey of hospital discharge planners to collect this kind of information. It would need to be nationally representative. It would probably need to be in a field for a long time. It would probably cost a lot. But, theoretically, it's possible.

The last piece is the woodwork effect, so how are prescribing behaviors going to change now that there's this broader coverage in the home? That I'm not sure there is any way to collect data on prospectively, so that's a gap I'm not sure we could fill.

MR. HACKBARTH: Let's go to Round 1 clarifying questions, Mike.

DR. CHERNEW: A lot of the challenges in this is because we're paying a bundled payment somewhere. So if you

add something else on to, say, cover something in the home, you don't actually save the money that you would say you saved because it was actually lumped in some other bundle. So my first clarifying question is: Is that basically right? So, for example, if you have inpatient care or --

MS. NEUMAN: Yes, hospital definitely. On the SNF side, we are paying a per day rate there, so --

DR. CHERNEW: But you would have to avoid the whole day.

MS. NEUMAN: You would have to avoid the whole day, or potentially the --

DR. CHERNEW: Or the walk-in.

MS. NEUMAN: -- argument that folks make is you could avoid the whole admission.

DR. CHERNEW: Yes. If you avoid the whole admission, that part I understand. But the question I had is: Is there some mechanism if this was cheaper? Refresh my memory as to how the actual rates for areas where this would be important, the DRG rate or whatever, would be lowered, because now there's a more efficient way of doing it. So if you were really running this system and someone said, look, it's a lot cheaper to do this at home, we could

discharge you from the hospital a day earlier, or whatever it is, is there a mechanism for the whole DRG rate on a average to be lowered to reflect the efficiency? Would you have to wait for that to work through the cost system for that to happen?

MS. NEUMAN: I think you would have to wait for it to work through the cost system, and then the other piece of it is that -- and the hospital people should check me on this. When they recalibrate the DRGs, they do it in a budget-neutral way. So if the costs of the DRG for people who have an infectious disease goes down, the payments for the other DRGs go up. So that, on net, the way the system currently works, you wouldn't save.

DR. CHERNEW: So now I have to ask another question. This is a clarifying question, though. Are you telling me that if the hospitals become more efficient in any given DRG, there's no way to save money by lowering the price for that DRG because the system automatically gives that efficiency back to every other Deregulation?

DR. MARK MILLER: In the short run, that's true. You might see that, for example -- if you just let things run -- and I'll give you two ways to think about it. So

let's say they get more efficient, and then maybe the need for an update over time becomes less than it would. Of course, in this world that's probably not going to be something that's going to be very big. But it may be a thing.

The other way, if you did something like this, is to mechanically -- and, you know, the hospital industry needs to take a deep breath here -- say, okay, we're doing this, and so we are going to assume that these savings are coming out of here, and at the time of the legislation make some adjustment in the overall payment rate. Then you would capture the savings at the time that the change was made. There would be much controversy around, given this, how would you estimate it and know, and there would be a hard argument to make.

DR. CHERNEW: But at least you could be consistent between the savings you were assuming in one way and the way you were capturing it.

DR. MARK MILLER: Well, there's just one other thing I want to say on this. So, for example -- you've definitely seized on the right example to have this conversation about, about the hospitalization. But the

other issue -- and you need to check me on this, Kim -- is let's say you set this up and in theory if you move a person from SNF to home, you would save, right? If they're in there for that sole reason -- which we don't know and all the rest of it, but let's pretend. But, of course, the nursing home has to be willing to let that happen, or at least at the discharge planning stage this has to be captured and moved to the right place. And the nursing home may not have a motivation to do that. So that's the other -- that's another problem of capture --

[Inaudible comment off microphone.]

DR. MARK MILLER: And that's why we have that.

Can I just say one quick thing before we move off of Mike? That exchange that you and Glenn had, can we just capture that in a paragraph or two and put that in the report, just to make sure we don't lose that thought?

MR. BUTLER: I'm just a little unclear about fraud and abuse and woodwork effect and some of these things that you brought up.

First, it wasn't a ringing endorsement. It said in interviews there's no reason to think this is any different from any of the other services. It didn't say --

you know, so it was a little bit -- it wasn't -- you know.

And then are we worried about particularly the home health for-profit kind of -- not woodwork, but Dade County effect? Is that the issue? I'm just trying to understand the concern about excessive utilization, where it may occur, and who are the likely suspects that we would want to make sure are monitored.

DR. SOKOLOVSKY: On your last point, I would say yes. With nobody really monitoring it -- because what the plan said was they monitor so carefully in terms of both prior authorization and then post-utilization review and they know things that are flags, and if those flags come up, then they can do something quickly about it. And they wondered how fee-for-service could have that same kind of structure to be able to monitor.

MR. HACKBARTH: It seems to me there's sort of a fundamental tension here. As things move from institutional settings out to the home, you know, there are real benefits: convenience for the patient, perhaps in some instances better adherence with needed care, and on a unit cost basis potentially a lower unit cost of production. Whether Medicare realizes that or not obviously is a function of

what the payment rate is. So in that sense it's all very attractive.

But it presents challenges. When you move out of institutional settings, there's less oversight, fewer people around to say is this the right thing to be done, and it becomes more difficult to bundle and create incentives for appropriate utilization. And so there's a real fundamental tension, and in that bundling is the Medicare's principal tool for dealing with utilization issues, and it becomes harder as it moves to home settings.

Now, I don't think the home health benefit, where we tried to do it through an episode payment, is, frankly a resounding success in showing bundling in the home setting really works well to control costs. And so we're torn between these two things.

Private payers, if I read the report correctly, address that tension through intensive oversight, you know, prior authorization, close monitoring retrospectively of claims patterns and the like. But those are tools that have been difficult, if not impossible, for Medicare to use. And so we're trying to fit this development into a framework, an insurance framework, where really it's pretty awkward. It's

really challenging.

DR. NAYLOR: I just wanted to, getting back to Glenn's question, as I understand it, are you saying that we don't know in skilled nursing facilities who's receiving infusion therapies and what their costs are?

MS. NEUMAN: So we know if somebody's getting an infusion. We don't know what's being infused. And they do report charges on their claims, but it's not going to be specific to this person's getting vancomycin or this person -- so we don't know to the level of detail that we would need to know to be able to say there's this many people in the SNF getting this antibiotic. We can't say that.

DR. MARK MILLER: And I also think a key thing we don't know is whether that person is there for that reason alone. So you kind of know somebody is getting infusion, and that would be the person who could move to the home.

DR. NAYLOR: Right.

DR. MARK MILLER: Whereas, if there were other -- are you with me on that?

DR. NAYLOR: Yes.

DR. DEAN: I guess I would just ask, your recent comment, Glenn, we've talked about using pre-authorization.

Why would it not work in this setting? Because it seems to me this is a procedure where pre-authorization is quite appropriate. But does Medicare not have a structure to do that?

MR. KUHN: A couple things, Tom, on that.

One is a lot of entities that do pre-authorization have their own algorithms and their own processes they use. Those are proprietary items, and if they were to use that in the Medicare program, they would have to open those black boxes, and many have been unwilling to do that.

The second thing is if a beneficiary is denied, then you have to set up an elaborate appeal process that ultimately could go all the way to an ALJ for review of it, and the appeal process could be lengthy, or they could do stuff on a short period of time, but it could be expensive and costly. So to a large extent, except in real cases of fraud and abuse, particularly in the DME area, Medicare has pretty much passed in terms of a pre-auth in the fee-for-service program. But Bob might have more to add.

DR. BERENSON: And there's one other problem which I faced when I was trying to get the agency to do some very targeted prior authorization, which is that the cost of the

prior authorization is on the administrative side and the administrative budget; the savings is in the mandatory side, so you can't spend $1 to save $5 because you don't -- I mean, somebody's got to be reviewing those cases. And so it goes to the problem of having separate walls between the two sources of funding, and so that's a very practical problem. But, again, in the long run, in our advanced imaging we made a specific recommendation, and I think in coverage policy, I think there's some very good opportunities to do pre-authorization. So it's not something we should drop. But we would have to recognize the current limitations.

DR. DEAN: Thank you.

DR. HALL: I think this is a very special circumstance here that we might start barking up wrong trees here. But let me just say at this stage, I think I heard you say that we have no ability to get at clinical indications for the use of parenteral nutrition or antibiotics, just taking two of the classes, that that information is not available to us?

MS. NEUMAN: Can you say a little bit more?

DR. HALL: Okay. So we are worried a lot about woodworking effect, which I think I would challenge that

there is much woodworking effect in this particular situation. But -- well, I'll just put it this way: I think the most telling table was actually in the reading material, Table 1, where you had the prices and the number of recipients by the major classes that are being used here.

Just as an example, there are two drugs there, trepostinil and alpha 1-protease inhibitor, that account for a little under 50 percent of all the spending, and it applies to 1,500 bodies, human beings. The other 50 percent is in antibiotics and in parenteral nutrition. That's about the same percentage, a little bit higher, and it covers 56,000 Medicare --

MR. HACKBARTH: Can you give us the page number?

DR. HALL: It's page 14. So you've got apples and oranges here. The biggest burden of cost in this whole system is that biologics are not regulated in terms of cost or competitive bidding. They're priced outrageously, and they, as always, benefit greatly very few numbers of people.

So in terms of analysis -- maybe I'll have more to say on this in part two, but in terms of analysis, I think we really need to know what's the breakdown of indications or diagnoses for parenteral nutrition, because there, there

might be some opportunities. And with antibiotics, I think we want to worry about woodworking effect. Generally speaking, the antibiotics that are used there are because people can't take the oral form of the drug, would probably be the main reason, but I can't imagine that there are too many situations where people are consciously deciding to use an IV drug at home rather than an oral drug. It just kind of boggles my imagination.

So we could also find out what the breakdown of antibiotics are. Generally, these are going to be used for people who have very serious infections that require long-term treatment, like infections of a heart valve, certain infections of the brain, or who have a very resistant organism. And, by the way, that's one of the reasons why you don't want to keep these people in a hospital, because they're nuclear weapons about to go off.

But I think that the analysis part of this would be just to find out, taking these two big classes -- we can't do much about the biologics, but the two big classes of antibiotics and parenteral nutrition, and see if we can get some clinical data on that.

DR. SOKOLOVSKY: Just one thing I wanted to

mention in terms of woodwork effect. The Cleveland Clinic did a study, which they brought in infectious disease doctors to look at all of the patients coming through the clinic who were prescribed IV antibiotics. And of those patients -- and it had to take a while because it's just not frequent an event -- 29 percent, the infectious disease doctors said, either they could have taken an oral drug or the drug they were being prescribed was incorrect. So from that, they concluded that without that kind of oversight, there was this potential.

DR. HALL: Well, that shows an area for cost savings then, if that's reproducible nationally.

DR. BERENSON: I would have endorsed everything you had said in terms of the doubt about woodwork effect, so I'm interested in that finding.

I wanted to do things. One is just establish the scope of the spending in this. In the paper, not in the presentation, I have two numbers here: 602 million for Part B drugs, equipment, and supplies and 422 for drugs covered by Part D, and not including the home health episodes that might be created in Medicare Advantage. That is the total spending, really, we think for this activity, for home

infusion?

MS. NEUMAN: It currently is.

DR. BERENSON: So that's about $1 billion. So by my back-of-the-envelope calculation, we're talking about maybe 0.2 percent or something of Medicare spending. So in terms of coming up with lots of demonstrations and things like that, I just think we want to keep that in perspective.

Having said that, I wanted to pursue what Mike's questions were around the hospital. I assume down the road, if the hospital cost structure -- if there's a shorter length of stay because some patients aren't there for 30 or 45 days getting long-term antibiotics, that somehow, maybe imperceptively, finds its way into a lower-cost structure and ultimately there is savings, without getting into that detail right now, my major concern was just what Bill said, is that we shouldn't have a system in which people are staying in hospitals for antibiotics.

Do we know -- and this goes to the issue of whether we should do a demo of antibiotics as a specific benefit. Do we know whether hospitals actually have problems finding alternatives for home infusion, given all the alternatives, outpatient, SNF, home health? Do we know

if there are a lot of patients who actually stay in the hospital simply to get drug treatment?

DR. SOKOLOVSKY: From our interviews, which is, you know, not perfect by any means -- we can't tell it from the data, but we didn't hear much in the way of many people staying in the hospital.

DR. BERENSON: Okay.

DR. SOKOLOVSKY: What we did hear were people going to SNFs to get anti --

DR. BERENSON: Okay, so the hospitals are finding some way to discharge these patients given the current incentives in the DRG system. I mean, that's what I was hoping you would say. Obviously, it's qualitative based on interviews. That would affect my views of how much effort we would want to spend on that particular demo.

MR. HACKBARTH: Bill's comment about the woodworking effect is a really important one, and that's why it's good to have physicians around.

For me that raises another question. If I understand the report correctly, private insurers are using prior authorization, which suggests to me that they think there is a woodwork problem here and some inappropriate use.

Those programs cost money to run, and, in fact, there are instances where they have dropped prior authorization because they find that they're, you know, approving all the claims. And so if we could find out more concretely about their experience and are they denying a lot of claims with -- or denying a lot of requests for services under their prior authorization programs?

DR. SOKOLOVSKY: I think that we didn't hear much initial denials so much as looking when it wanted to go longer than they thought was appropriate, kind of stopping it.

MR. KUHN: Joan, when you were talking about the notion of the demonstration, you mentioned the notion of maybe competitive bidding as maybe an option. Obviously, there's a lot of design difficulties here, but I think there's a lot of design difficulties with any demo that CMS tries to put together.

But we also know that it takes a long time to do a demonstration from the development of it, to running it, then doing the evaluation.

If it was done through competitive bidding, would that truncate the process? Or does it really matter, length

of time, whether it's a regular demo or whether it's one that's done through competitive bidding? Or are they still probably the same length of time to run them the whole time?

DR. SOKOLOVSKY: I think we think it's the same. It would help to get -- given our lack of data on what the payment rate should be, it would help in that area. But I don't necessarily think it would help in terms of figuring out is this a cost or a saver for Medicare.

MR. KUHN: Thank you.

DR. BAICKER: Even though this punchline was uncertain, I thought it was really helpful to see the different categories of where we might get information, where it's really hard to get information, to think about the cost side.

You mentioned in passing in the chapter about best practices for certain conditions. I wondered if we had a sense of on the benefit side patient outcomes in the different settings or patient satisfaction with the care in the different settings. Should we be balancing these unknown costs against any way to quantify the benefits?

MS. NEUMAN: So in terms of outcomes data across settings, there's no a lot of literature that has done head-

to-head tests. But what we heard in our interviews is that, you know, with antibiotics and IVIG, which are ones that, you know, you hear a lot about in this area, that patients generally want to go home if they can. There are some who don't feel comfortable doing it at home, but big portions of them would prefer to go home. That's what we heard anecdotally.

MS. BEHROOZI: Just back to the topic of fraud, I don't know, it could be a leading indicator, because sometimes once somebody figures out how to do it, then suddenly there's an explosion as opposed to, you know, a gradual build-up. So it struck me when you cited a separate analysis of Part B claims data found roughly 50 percent more beneficiaries receiving infusion pumps than infusion drugs. Is that as big a deal as it looks? And not that they've figured it out, they can do it. So that's one question. And then the second question is: What can Medicare do about that? What should we be thinking of doing about that?

MS. NEUMAN: Okay, so a couple of things.

First, that's on the Part B side, so we're not talking about lots of beneficiaries. It's on a smaller base.

The second piece is that, you know, we've been looking at that to try to figure out if there's some other explanation besides inappropriate billing and, you know, done some talking with CMS about that, and at this point it's still unclear. So we're kind of leaving it open-ended that we see this pattern, it's a potential area for more looking. It could be inappropriate billing, but a lot of work would have to be done to figure that out. So we kind of -- I know that's not satisfactory, but that's kind of where it's at.

MR. GEORGE MILLER: Yes, Herb hit on the point I wanted to raise, and let me see if I can put a different twist on that. From the competitive bid demonstration model, could we -- or have you considered designing a system where we would let someone like Kaiser -- or you mentioned in your information the Cleveland Clinic -- design a competitive bidding process where you have the endgame in mind and see if that would -- with a control group, and design a system where they would take both the risk and then a benefit for seeing if we could move patients to a home setting and have cost savings to that group? Would that be a way to come at the problem from the standpoint of having a

design, without going through the entire system, but with a demonstration, a competitive bid demonstration find the desired effect?

DR. SOKOLOVSKY: I think that in our ideal world it would be a place like Cleveland Clinic that would participate in this demonstration. Exactly how they would do the payment rate could be many models, but I think that would be our ideal. But as far as Medicare Advantage, a Kaiser plan, about 219 MA plans are already doing this.

MR. GEORGE MILLER: So are there conclusions to drawn from that and see if it's applicable across a wider space?

DR. SOKOLOVSKY: Again, the issue there is that they can monitor it, they can control it, and so to what extent can we transfer this to fee-for-service.

DR. MARK MILLER: George, I took your question this way -- is this what you were asking? That if you -- I think Herb was asking about getting at the price through a competitive bid. But were you saying would you design the demonstration to say for an entity -- I'm making this up -- you have some control of a geographic area, and you're sort of at risk for how this benefit goes and at risk for whether

the net spend which might be associated with these patients -- which is the $64,000 question, but let's pretend -- goes up or down? And then you would set up something where the fee that's paid to the entity somehow reflects how well they control the expenditure, that's what you're asking, is could we design a demo that way?

MR. GEORGE MILLER: Yeah. You said it much better than I did, but yes.

DR. MARK MILLER: And I think you could design this demonstration a few different ways. One could contemplate a thing like that where you say, okay, this is a geographic area, some entity, either proprietary or making their black box known, would say, okay, I'll take responsibility for this. But there are still gigantic issues about how you define the control and know what would have happened in the absence of that, given what these guys went through. But you could contemplate models like that.

DR. STUART: I would like follow up on a point that Bob made about the difficulty of discharging individuals from hospitals that require infused medications. I recall after the SNF prospective payment system went into place that there was a lot of talk about difficulty among

hospital discharge planners in getting patients into SNFs because the nursing homes found these to be really high-cost patients and they were losing money on them so they didn't want to admit them.

Has that changed? In other words, have the drugs moved from the A to the D side and, therefore, made it more profitable for nursing homes to admit patients directly from hospitals that require infusion?

MS. NEUMAN: On the SNF side, the drugs continue to be covered under the Part A SNF benefit and are bundled, except for chemo drugs. So the same incentives exist today as existed previously as far as SNFs having to consider how much total money they're going to get from the RUC payment and whether that's going to cover the cost of the drugs or not.

In general, we heard in our interviews that in a number of areas they were able to place patients in SNFs. We did hear for some very high cost drugs there might be some unwillingness to take these patients in SNFs.

DR. STUART: Were you able to then correlate that back to the hospital in terms of extra days that are spent in the hospital because of that?

MS. NEUMAN: No, we don't have the data at that level to be able to look at that.

MR. HACKBARTH: So let me just pick up on that. When we've talked about SNF payment and improving the accuracy of SNF payment, one of the issues has been how the payment system currently deals with the non-therapy ancillaries, which includes the drugs, as I recall. And I think we've been saying that they're underpaying for the non-therapy ancillaries in the current construct, and we've made specific recommendations that would shift the dollars around so that there would be better payment for those things. And that may influence the profitability of handling patients with significant drug expenses and the desirability.

DR. STUART: I think that's a really good observation because it says that if there is a problem -- and I think what you're saying is we don't know if there is a problem of people staying in the hospital because -- some people, who knows how many? -- because they can't be discharged, that this would be a more reasonable policy alternative than going down the line and trying to, you know, create this new benefit that would be provided in the

home.

DR. MARK MILLER: And the only thing I would remind -- everything that you said is correct. The only thing I would remind you of is the Commission's thinking on SNF at the moment, and this is going to be a highly scientific chart here. We're saying, yes, non-therapy/therapy in terms of the relative payments, and so we've made recommendations to make that more equal, and that's the conversation you just had. But we've also said there's overpayment occurring, and so some of those incentives may have changed in the sense that if they found the PPS more profitable over time, in general there may have been some effect there.

DR. STUART: I think we all recognize that there are moving parts here and we have to think of them together. I just think -- I guess what I'd like to see is in this analysis that we recognize that this policy is implicitly tied to other policies regarding SNF payment.

MR. HACKBARTH: As Mike or somebody alluded to earlier, this also links directly to our discussion about bundling around post-acute services. In fact, a question that I had was can we say how many of these people would

fall within a 30-day post-admission window? Is that a number that's available?

MS. NEUMAN: We don't have it. It's something we could see if we could calculate.

MR. HACKBARTH: Okay. Ron, clarifying questions.

DR. CASTELLANOS: Thank you. First of all, I live in this world with antibiotics and it's very confusion. It's a tremendous amount of silos. And the real -- excuse me, I always bring this in the real world -- it's the discharge planner in the hospital that really makes these differences to where that person goes, depending whether he or she has insurance, type of insurance. I mean, it can go all the way from the SNFs to having medication given in my office. But this is a real serious problem with silos.

Two other points. One is the woodwork effect. Bill, I agree with you, and Bob, I agree with you. You know, I think we -- I know you mentioned the Cleveland Clinic Group study. I think we should look at it a little differently. Instead of a crook behind each tree, I think we ought to look at it maybe at appropriateness and clinical guidelines and education of the medical community for appropriateness. I'm not saying there isn't some fraud or

abuse, but generally, I think, as Bill said and as Bob said, I don't think it's pervasive in this field, but it could be.

And the third point I wanted to make is I know there's a bill in front of Congress now, the Medical Home Infusion Therapy bill. You didn't mention anything about that. Do you have any information on that? It's a bill that apparently gets around a lot of these silos, but I'm not sure where it stands or what it really means.

MS. NEUMAN: So there's been a bill in Congress for the last few years to expand Medicare coverage for home infusion to cover the services and supplies and nursing and to leave the drugs in Part D. And so it's in Congress right now pending, and that's the most I can tell you about it. As far as -- I mean, it's hard to know prospects and all that.

DR. CASTELLANOS: Would that get around some of the other silos?

MS. NEUMAN: It would. It would in the sense that it's expanding coverage, creating this new coverage. So it would get around silos, but it would create its own silo in a way, you know what I'm saying?

DR. CASTELLANOS: Thank you.

DR. MARK MILLER: I mean, when they went through and set up the gaps that occur under fee-for-service at the beginning of the talk, what that bill does is said, okay, those gaps are now filled. So it's just -- it's saying the fee-for-service benefit now pays for the nurse, pays for the equipment in each of the settings. And the $64,000 question is does it save or cost money, and that's what we're discussing. And I think Congress's desire is to fill the gap, but they also can't quite figure out whether it will cost and whether it will lead to the outcomes that they want to achieve.

MS. NEUMAN: And one point I should add is that there isn't a score on the current bill that's in the Congress, but previously, our understanding is it's been scored as a cost.

MR. GRADISON: I want to inquire a little bit further about the MA program's experiences in two ways. First, because of the preauthorization and so forth, I just wonder if you can give us any sense directionally of when these plans tend to approve home infusion and tend to say no.

And the second question is whether it's possible

to obtain from the plans any even rough idea of the costs that they experience in these instances. Thank you.

DR. SOKOLOVSKY: Well, Kim thinks -- to give you a real answer. I will give you a fake answer.

[Laughter.]

DR. SOKOLOVSKY: But let me say, we did talk to many plans. Nobody really was willing to share data on that level. It's not surprising because it is proprietary. But what they did ask, on their prior authorization, they would want to know the diagnosis. They would want to know the beneficiary's age. They would want to know the drug. And they would want to know the expected duration. And a medical director on that basis would make the decision about whether it should be covered or not. And if it went beyond that duration, there would be another authorization necessary. Oh, and I forgot to mention, and how much nursing would be expected.

MR. HACKBARTH: Joan, if I understood you correctly earlier, you said that most of the action is not on denial of the initial request, but it's around the duration, extension of the duration? Did I understand that correctly?

DR. SOKOLOVSKY: They would tell us things like, if this goes beyond X weeks, that's a red flag. That was the expression we would often hear. This is a red flag.

MR. GRADISON: Well, that's very helpful because a red flag to them might be -- thank you.

DR. BORMAN: In your conversations, did you encounter anything to suggest or to predict that given some new drug that's on the way or some disease pattern that's emerging, that we should anticipate a significant change in the number of people that would appropriately require or come to use these kinds of services?

DR. SOKOLOVSKY: I don't think we heard that specifically, but we did hear of one new oral antibiotic that's quite expensive and that can, in fact, replace IV antibiotics, and under a Part D plan, a stand-alone Part D plan, it was often not on the formulary and rejected because that plan wouldn't recoup any kind of savings if there were savings from not having to have the IV.

DR. BORMAN: So that at least on a pure basis, the -- looking to the future, it is consistent, at least with my personal experience, that we are ever moving toward oral substitutes for many things that have been given

perineurially [phonetic], whether IM or IV, so that it would seem that at least in the care, quality, risk sort of evaluation that the needs for these services may, in fact, if anything, be diminishing over time rather than increasing.

Just as sort of a guess about, again, as Bob tries to say what percentage of the pie are we looking at here and how much time and energy is appropriate, I'm trying to get at is this -- seem to be something that's getting ready to explode as a need or potentially stay the same or diminish, and I would say that it's more likely to stay the same or diminish in the Medicare population.

DR. SOKOLOVSKY: The one thing that goes in the opposite direction that I could say that's not really from this study but the work we did previously on biologics, there are so many biologics in the pipeline now and it's much easier -- because they're big molecules, it's much easier to produce them as injections or infusions --

DR. BORMAN: Right.

DR. SOKOLOVSKY: -- than as orals, even though oral would be the desire.

DR. BORMAN: But the majority of those require

almost continuous monitored setting to give because of the potential side-effects, yes? I mean, it's pretty rare, I would think, to give very -- I mean, most of the biologics, at least in terms of when we heard drug administration codes and went through a whole big revamp of that through the CPT process not that many years ago related to the fact that they had to be in these fairly carefully monitored settings and that it would be the rare family that would be prepared to detect that. Mary may have some sense about that from the nursing side. But I believe that most biologics are viewed as almost like giving chemotherapy, really. They are sort of a subset of chemotherapy, depending on how you want to think about the definition. So I agree with you that if the biologics become safer, that would be the growth market here, and certainly that's something to think about.

I think that one of the big problems in this is that -- my guess would be that relatively seldom is this the sole reason that the patient was admitted to the hospital. This is going to be somebody that came in with some manifestation of unknown fevers, with a new heart murmur, with change in mental status, with trauma and ended up having a diagnosis of endocarditis or osteomyelitis or

things that need prolonged antibiotics, so that the notion that there's somebody who comes in specifically to receive IV antibiotics is really a dwindling population

And certainly the EDs that I've been associated with in the last ten years are certainly very aggressive about even sorting patients in the emergency department if they have some sort of complex laceration or something that they think needs some home antibiotics. They don't even touch down in the hospital. I mean, they have ways to link them up with that service the next morning.

And so Scott may have some experience with that in terms of administering for his group, but I think that the number of patients where it's solely that is vanishingly small. So I think -- and coming at that number, I agree with you, is going to be -- there's just no way to pick that, I don't think. I don't think anything on claims data is going to begin to get you close to that number, so I think we've got to kind of quit thinking about that we're going to understand that.

I think that, as somebody pointed out, some of these drug infusions are for prolonged periods of time -- six weeks of antibiotics for X, Y, or Z -- and certainly you

would think there are some savings there. The question will be, does that same person who has osteomyelitis or a bad bone infection need to be in a very intensive physical therapy setting at the same time. So it's not necessarily so much the antibiotic that keeps them there. It's that they have this conjoint need.

Another thing about accessing these, or where they go to get these managed is how they're getting the drug. If it's a peripheral IV line and not a port, those are more easily teachable to families. There's a lower skill set in terms of facility that's needed. Getting a patient transferred more often seemed to hinge on if they have an implanted venous access device. That's a little bit different skill set and that might be the barrier that where you would otherwise normally send them will not deal with accessing that port.

So I think there are so many nuances to this and it is such a relatively small thing, I'd be really careful about getting caught up and trying to nitpick this to that.

MR. ARMSTRONG: Yes. My question and a comment, and my question is actually in part a reflection of the questions we've been asking. And I just have to say, I'm

honestly not sure what the problem is that we're trying to solve. Is it that costs are inflating at a trend that's worrisome to us? Is it a concern about quality of care provided in home for these patients? Is it, as a couple people just recently said, that we anticipate some explosion and we want to try to kind of get a handle on what's happening before services go crazy? And what was it that inspired the mandate that we put this report together, because I feel like we're kind of fishing for, well, what are the problems that we want to analyze?

DR. MARK MILLER: All right. And you guys should offer your opinion, as well. This is my sense of it, that what motivated the Congress, and it was that there are clearly gaps in the fee-for-service benefit and I think a genuine desire of, well, if a person needs this, are they are or are they not getting the support that they need, and perhaps some instinct, and I think a lot of the starting questions kind of point to this, is, well, clearly, say for antibiotics, if you move the person out of the hospital, that has got to save money, right?

MR. ARMSTRONG: Right.

DR. MARK MILLER: And so I think when they've

offered these ideas and run into scores from CBO that says, no, not so straightforward, they've kind of come to us and said, what gives? That's kind of my take. But I think the instinct is there's a population -- and some of these populations, just to be really clear, I mean, some of them have very sympathetic and strong arguments on their situations and I think you have an emotional element that kind of runs through some of this, as well.

I'm not sure some of the questions about biologics coming on or going off, that kind of thing, at least in some of the instances, those kinds of things are really driving it. It's more the immediate, I think.

Do you guys have a reaction here? And just for the record, we only give fake answers in the most extreme circumstances, right? It doesn't happen a lot.

[Laughter.]

DR. SOKOLOVSKY: I can't believe this is up to me.

DR. MARK MILLER: Very extreme, then we'll go to the fake answer.

[Laughter.]

MR. ARMSTRONG: I mean, I asked it, in part, we have limited resources. We've got a huge agenda. And I

know this is a required report, but we have some decisions to make about how we want to invest in demonstrations and studies and stuff like that --

DR. MARK MILLER: I want to say to you guys, at least in terms of our efforts here, I mean, what I see happening here on this report is kind of laying out the product of this discussion, saying that the Congress can move in a few directions, which we've laid out for them, but there is a huge deficit in information. We've tried our best to inform you and at least give you the cells and the way to think about it. But we've done what we can.

MR. ARMSTRONG: Yes.

DR. MARK MILLER: I mean, we can't create and manufacture data, notwithstanding our fake answer approach to things. But, I mean, we can't do that, and so we're going to have to say to them, this is what we know. And I think Kim has said to you, I know this is unsatisfactory. When we communicate this with the staff and ultimately the Congress, I think they're going to be frustrated, too. You didn't give us the answer. And it's going to be, there has got to be a lot more information collected to give them the answer.

MR. ARMSTRONG: Okay.

MR. HACKBARTH: Okay. It is 9:07, so we're already, after round one, seven minutes over our budget for this topic. Could I see the hands of people who have an additional comment or question that they want to make? So I have Mary, Tom, Bill, Bob --

DR. MARK MILLER: Peter.

MR. HACKBARTH: -- and Peter. Anybody else on this side? Okay. So why don't we go through those people. Peter.

MR. BUTLER: Yes. So I'm a little bit with Scott on this, that it's not just a woodwork effect. This is like a can of worms effect or something like that. And I would caution about the degree to which we can really be specific in our recommendations.

I do think that, for me, going to Bill's example of a valve infection or something, I mean, it should be about the beneficiary and not about the cost so much, and if a course of treatment at home, I would think, would make -- we want to make sure that the patient can get the right treatment in the right place at the right time, and if there are abuse or all these other things, I mean, we ought to

find ways to be able to address that.

My last -- this is a little out-of-the-box thinking. It's too bad you can't link this to, like, an ACO or some -- if they were more tightly configured and you felt there was somebody overseeing it, you could say, okay, a pioneer ACO, you can have the benefit if you're sitting in there. Of course, you don't always know who your members are. That's the problem. But if there were some oversight structure that would naturally align with this, then you'd say, okay. For those people, we'll provide the benefit. So maybe there's something like that we could do.

DR. NAYLOR: So I think that one possible way to frame this is under option three to think about -- because you have answered the question really well about whether or not we have current data that helps to know the costs and benefits of home infusion therapy, and the answer is we don't have robust data to really get that. So I think one way to frame it is if we were to pursue -- if a study -- and I wouldn't use the word "demo" -- is to pursue this question, then maybe some of the ways in which we could benefit more than from home infusion understanding is how do you stratify groups and at what point of time can you

stratify them to say whether or not they would benefit most from hospitalization, skilled nursing facility, or home infusion.

What are the characteristics of those patients? What are the characteristics of the families? And it's a real question about whether or not people in hospitals can really assess the capacity and willingness of families to be able to do this. So I'm not sure that I would rely on the existing systems to do that.

And then whether or not this also represents the opportunity to test out a payment bundle in the way we were describing that model yesterday as a payment mechanism, that if we put all in, that we could really come to it.

And finally, I think this issue around the quality metrics that need to be examined as part of that study, if that's the direction people want to pursue. I would stay away from demo and talk about CMMI as a potential area to pursue under their innovation option or something like that. But I think that builds a little bit on George's notion, you know, where you have a chance to do some comparison with an organization that wants to do this and test against a community or comparison group that doesn't have that

availability and is using the traditional mechanisms.

DR. DEAN: Just one -- just to sort of make it more confusion, you know, one thing we have not talked about is ta some point, the home situation has to be evaluated because everything else can be appropriate and if you don't have the proper people and settings at home -- I mean, I was a recipient of home infusion therapy for about six weeks after I got an infection after my hip fracture and, you know, it went fine and it was a great benefit. But there were, even though I know a little bit about this and my wife is a nurse, there was a lot of stuff we had to learn. And so there are a lot of home situations where it just may not work even though everything else is appropriate.

DR. HALL: Well, first of all, Joan and Kim, I think this was such an excellent report. I don't think there's anything like this anywhere in the health care literature that really looks in depth at this whole process and my hat is off to you for that.

And I'm informed by the discussion. Just to give you sort of a clinical example, sometimes -- physicians will relate to this -- you do an extensive work-up for someone who thinks they have very serious disease and you end up and

you say, I've got some really good news for you. You don't have cancer. And you see this tremendous look of disappointment on their face that you didn't come up with a diagnosis.

And I would say, to really stretch an analogy, we've looked at this carefully and we probably found that in the scope of major problems we have to deal with, that this doesn't rank way up there in terms of some of the things we look at.

And if I were to make any suggestion at all, it would be that it sounds like the quality control and regulatory apparatus here is a little bit loose, and maybe that's where the biggest bang for the buck might come.

DR. BERENSON: Yes. I'm pretty much where Bill would be and where some of the other Commissioners have indicated. I wanted to just say one thing. If we wanted to propose a demo in this area, I'd be giving more emphasis to an ability to test how CMS could administer prior authorization, because that is something we've talked about. I'm actually a proponent of very targeted prior authorization, where you've got essentially a concise clinical issue that's informed by objective data, a non-

emergency situation where there is some evidence of misuse or overuse and it suggests -- the Cleveland Clinic study suggests that that might be going on here.

I would also have a criterion of very high unit cost so that your investment in that activity has a payoff, and I guess that's the one place I have some concern. It looks like the average drug cost, anyway, was $1,200 or something like that, and so I'm not -- I don't see a compelling reason, frankly, to do a demo in this area, but if I did, it would be to really sort of learn operationally how to get some experience with prior authorization.

MR. HACKBARTH: Okay. Thank you, Kim and Joan. Good job.

We'll now move on to Risk Adjustment in Medicare Advantage. We're 15 minutes behind schedule, which we must make up, and so what I propose we do is we'll end this session right at 10:30, so as opposed to an hour-and-a-half, we'll do an hour and 15 minutes on risk adjustment so that we've got the allotted time for the dual eligible discussion at the end.

DR. ZABINSKI: Okay. Last fall, the Commission made recommendations to improve risk adjustment for PACE

plans, and today we'll broaden the scope of that work and discuss improving risk adjustment for the Medicare Advantage program in general.

In Medicare Advantage, plans receive monthly capitated payments for each enrollee where each payment is the product of a local base rate and the risk of the enrollee. CMS drives these risk scores from the CMS hierarchical condition category CMS-HCC risk adjustment model. And the risk scores represent each enrollee's expected annual Medicare spending relative to the national average.

The CMS-HCC uses data from each enrollee to determine the enrollee's risk score. The enrollee's data falls into two broad categories, demographic and conditions. The medical conditions are from diagnoses coded on claims for hospital inpatient stays, hospital outpatient visits, and physician office visits that occurred the previous year.

These diagnoses are then categorized in the broader condition categories called HCCs and there are 70 of them in the current version of this model. CMS then uses the demographic data, the medical conditions, and Medicare fee-for-service spending in a regression model that produces

coefficients for each demographic variable in each HCC, which CMS then uses to determine risk scores.

As an example of how risk scores are determined, consider a female who's aged 76 on Medicaid and has been diagnosed with COPD. For this beneficiary, the following coefficients from the CMS-HCC apply. For a female aged 75 to 79, .46; for a female on Medicaid and aged, .18; and for any beneficiary who has COPD, .40.

To determine this beneficiary's risk score, you simply add all the coefficients that apply to get a total of 1.04. So this person has a risk score that is close to the national average, which is 1.0 each year.

The general purpose of the CMS-HCC is to adjust MA payments so that they accurately reflect how much each enrollee is expected to cost. Accurate payments prevent systematic overpayments and underpayments with respect to each enrollee's characteristics. From this perspective, the CMS-HCC is much better than the demographic model that was previously used to adjust capitated payments.

However, concerns remain over the CMS-HCC. First, there may still be systematic overpayments or underpayments for enrollees with specific characteristics. Therefore,

plans can benefit financially depending on the profile of their enrollees. That is, from favorable selection. Also, research from the Dartmouth group indicates there are regional differences in level of service use in fee-for-service Medicare that leads to regional differences in coding of conditions and risk scores.

And if these regional coding differences carry over into Medicare Advantage, plans that are in regions where coding is most intensive will have higher risk scores, and payments and plans that are in areas where coding is less intensive.

Finally, CMS estimates the coefficients in the CMS-HCC using constant diagnosis data from fee-for-service beneficiaries. However, there's research by Newhouse and colleagues that indicates that the cost of treating conditions may be very different between fee-for-service Medicare and MA. Therefore, it may be beneficial for plans to attract enrollees with some conditions and avoid enrollees with other conditions.

Over the following slides, we'll discuss each of these issues in more detail. An important feature of an effective risk adjustment model is that it addresses enough

of a variation in beneficiaries' costliness to minimize possibilities for plans to financially benefit or be disadvantaged simply because of their enrollees' risk profiles.

A concern some have about the CMS-HCC is is that it accounts for about 11 percent of the variation in Medicare spending. And this may sound very low as it suggests that 89 percent of the variation is not explained. But that's not as bad as it sounds because much of the variation is strictly random and cannot be predicted by any risk adjustment model.

Research by Newhouse and colleagues estimates that a lower bound on the variation that plans can predict is 20 to 25 percent. The remaining is random and not predictable. Therefore, the CMS-HCC may be explaining about half of the predictable variation.

So is explaining half of the predictable variation enough to eliminate selection problems? Well, that's not clear, but it's possible that some problems are still present.

Another issue regarding selection is that for beneficiaries who have the same condition, the CMS-HCC

adjusts payments by the same rate no matter the level of severity. But patient severity and cost do vary within each HCC, so for a given condition, plans could benefit if they attract the lowest cost beneficiaries who have that condition. At the same time, plans that focus on the sickest beneficiaries, such as SNPs and PACE, may be at a disadvantage.

And due to data limitations, it is difficult to definitively determine whether favorable selection is widespread in the MA program, but we did an analysis that may suggest, but doesn't confirm, whether MA enrollees are on average lower risk than their fee-for-service counterparts.

In particular, we examined beneficiaries who were in fee-for-service Medicare throughout 2007 and divided them into two groups, those who stayed in fee-for-service Medicare into 2008 and those who enrolled in an MA plan in 2008, and then we compared the 2007 costliness of the two groups.

We found that on average, those enrolled in MA were 15 percent less costly than those who stayed in fee-for-service, and perhaps more importantly, in 68 of the 70

HCCs, those who enrolled in MA were less costly than those who stayed in fee-for-service. I want to again emphasize that these results give no indication of the costliness of beneficiaries while they are in the MA program. They only indicate that those who enroll in MA are less costly while in fee-for-service Medicare than those who stay in fee-for-service Medicare.

For today's presentation, we'll consider three options that might improve the predictive accuracy of the CMS-HCC and reduce problems related to selection. In one option, we added socioeconomic variables, in particular, measures of race and income to the standard CMS-HCC. In the second option, we added number of conditions that each beneficiary has to the model where number of conditions is simply the number of HCCs that each beneficiary's conditions map into.

Then in a third option, we used two years of diagnosis data to determine each beneficiary's HCCs, rather than the single year that CMS currently uses. Before we cover our results, though, from each of these options, I want to introduce measures that we used to evaluate the models' predictive power.

One measure is the R-squared, which indicates how well the CMS-HCC accounts for variations across individuals. However, attempts to attract favorable risk are typically based on groups of beneficiaries defined by specific characteristics, not on specific individuals.

Therefore, many analysts have used predictive ratios, which measure how well a model predicts cost for a group of beneficiaries with the specific characteristics such as a condition. And for a group of beneficiaries, the predictive ratio is simply the costs of the group as predicted by the CMS-HCC divided by the actual costs for that group.

And the closer a predictive ratio is to 1.0, the better the model has performed. And if the predictive ratio is less than 1.0, the model is said to have under-predicted costs, and if a predictive ratio is greater than 1.0, the model is said to have over-predicted costs.

We evaluated whether adding variables for beneficiaries' race and income improves the predictive power of the CMS-HCC. The race categories we added included black, white, Hispanic, and other races. The income variable is the mean income for the beneficiaries' county of

residence.

When we added race and income to the standard CMS-HCC, we found virtually no improvement in the models' predictive power. In particular, R-squared for both models is .11, and we evaluated predictive ratios for a number of condition groups and there's almost no change in this measure when we add race and income to the model.

On this table, we listed predictive ratios for some of the groups we evaluated. If you look at the first three lines, you can see that for specific conditions, the CMS-HCC performs quite well with or without race and income in the model. But the final four lines indicate that the CMS-HCC under-predicts for beneficiaries who have no conditions, over-predicts for those who have a few conditions, and then under-predicts again for those who have eight or more conditions. And this is true with or without race and income in the model.

So I think the main thing to take away from this slide is that for a given condition, the CMS-HCC pays accurately, on average. Before a given condition, it underpays for those who have that condition, plus several others. Therefore, plans that focus on the sickest

beneficiaries such as SNPs and PACE may be at a disadvantage.

We also evaluated whether adding number of conditions for each beneficiary would improve the performance of the CMS-HCC. We found that adding the number of conditions would do little to improve the models' R-squared as it stays at .11. Also, the first three lines of this table indicate there would be little change in the predictive ratios for specific conditions.

However, adding the number of conditions to the model would improve the predictive ratios for groups defined by number of conditions. On the one hand, the standard model under-predicts for those with no conditions, over-predicts for those who have a few conditions, and under-predicts for those who have eight or more conditions.

On the other hand, a CMS-HCC model that includes categories for number of conditions predicts accurately for each of those groups. Therefore, adding categories for number of conditions to the CMS-HCC may be helpful to SNPs and PACE, and may help reduce the extent to which plans benefit simply because of the risk profile of their enrollees.

A feature of the CMS-HCC that I mentioned earlier in passing is that CMS uses a single year of beneficiaries' diagnoses to estimate the model and determine beneficiaries' risk scores. Using just one year of diagnosis data may present some problems because we have found that beneficiaries who have a chronic condition appearing on a claim in one year often do not have that condition appearing on a claim in the following year.

We found this is true both in fee-for-service Medicare and the MA program, but it is less pronounced in MA. Problems that are generated by inconsistent coding over time of conditions are that the coefficients on conditions in the CMS-HCC may not reflect the true cost of those conditions, and also, there's greater year to year fluctuations in beneficiaries' risk scores resulting in less stable revenue streams for MA plans.

Using two years of diagnosis data to estimate the CMS-HCC and determine beneficiaries' risk scores would mitigate these problems. For example, we evaluated changes in beneficiaries' risk scores from 2008 to 2009 using risk scores based on one year of data and then risk scores based on two years of data. The correlation coefficient between

the 2008 risk scores and the 2009 risk scores is .62 when using one year of data, but it goes up to .80 when using two years of data.

We also found that using two years of data to estimate the CMS-HCC and determine risk scores would provide a small improvement in the predictive accuracy of the CMS-HCC for the sickest beneficiaries. For example, the last line of this table indicates that the predictive ratio for beneficiaries who have eight or more conditions would improve from .95 under the standard CMS-HCC to .97 under a model that uses two years of diagnosis data.

Our next point of discussion is regional differences and coding of conditions. Song and colleagues from Dartmouth show that in fee-for-service Medicare, conditions are coded more intensively in regions with high service use, resulting in higher average risk scores among fee-for-service beneficiaries in those regions.

If these regional differences in coding also occur in MA, plans that are in regions with relatively intensive coding would receive higher payments for an otherwise identical beneficiary compared to plans in regions with less intensive coding. However, all MA plans have an incentive

to code conditions as intensively as possible. And studies by CMS and GAO indicate that plans have responded to this incentive, as the number of conditions coded has increased more rapidly in MA than in fee-for-service Medicare over time.

Therefore, it is possible that regional differences in coding are smaller or non-existent among MA plans. CMS has begun collecting cost and diagnosis data from MA plans that should allow us to determine the extent of regional differences in coding among MA plans. And if there are regional differences in coding intensity among MA plans, how should this issue be addressed?

Once enough data are available, we may want to use an approach similar to Song and colleagues and determine whether any regional differences in coding in MA lead to regional differences in risk scores. We could then adjust the MA risk scores in each region based on how much coding differences affect the average risk score in the region. In the regions where coding is relatively intensive, you could adjust risk scores downward. In regions where coding is less intensive, you could adjust risk scores upward.

For example, if coding intensity raises the

average risk score in a region by 10 percent above the national average, you could reduce all risk scores in the region by 10 percent so that that region matches the national average.

Then a final issue for discussion centers on the fact that CMS uses data from fee-for-service beneficiaries to estimate the CMS-HCC, even though CMS uses the model to determine risk scores for MA beneficiaries. On several previous occasions, the Commission has held the position of financial neutrality between fee-for-service Medicare and the MA program, meaning that capitated payments for MA enrollees should equal what each enrollee would cost in fee-for-service Medicare.

From this perspective of financial neutrality, use of data from fee-for-service beneficiaries to estimate CMS-HCC is appropriate. However, there's a paper by Newhouse and colleagues that indicates that in the large MA plan, the relative cost of treating many conditions differs between fee-for-service Medicare and MA.

For some conditions, the relative cost is higher in the MA plan than in fee-for-service; for others, it is lower. If these large differences are widespread in the MA

program, plans could benefit financially by attracting beneficiaries with some conditions and finding ways to avoid beneficiaries with other conditions.

This is a particularly relevant issue because CMS has begun collecting cost and diagnosis data from MA plans with the intent of using those data to estimate the CMS-HCC.

So a summary of today's discussion is as follows. We considered alternatives for improving the predictive ratio of the CMS-HCC and we found that adding race and income to the model would not help; adding number of conditions for each beneficiary would help, especially for the sickest beneficiaries; and using two years of diagnosis data to estimate the model and determine risk scores would help, to a lesser extent, but it will also make risk scores more stable over time.

We also discussed the possible effects of regional differences in coding intensity, and that issue needs more analysis. Finally, in light of a finding in a recent paper, a question will arise over whether to use MA or fee-for-service data to estimate the CMS-HCC.

So in the future, we would like to further our analysis of the CMS-HCC in the following ways: First, we

would like to evaluate a version of the CMS-HCC that has both the number of conditions for each beneficiary and then uses two years of diagnosis data. Also, we would like to investigate a model that accounts for potential interactions between a specific condition and number of conditions each beneficiary has.

For example, we may be able to tease out the extent to which diabetics who have several other conditions are more costly than those diabetics who do not have any other conditions. Finally, we'd like to consider a model that has more conditions than the 70 HCCs in the current model. CMS has begun using such a model for PACE plans and has chosen not to yet implement the same model for all MA plans. Now I turn things over to the Commission for discussion and questions.

MR. HACKBARTH: Thanks, Dan, nice job. Kate, do you want to start with clarifying questions?

DR. BAICKER: I don't have any.

MR. HACKBARTH: Okay. Herb?

MR. KUHN: Just a quick question on the coding intensity issue and just to help me kind of understand how that plays into the overall effort of the scores. For

example, on the fee-for-service side with hospitals in the last three years, we've made recommendations on the DCI adjustment, and not only to make that adjustment, but also to take money back out of the system as a result of that.

How does coding intensity play into -- does it play into the HCC scores or is that a different part of the MA plan? I'm just trying to understand the interaction there.

DR. ZABINSKI: Well, the way we have thought about it is that yeah, it would play into the risk scores. Consider a situation where you've got, if you can like clone a person, put them in two different areas so that they're basically identical. Well, if, you know, you have more conditions coded for that same person in one area than another, they're going to have a higher risk score in the place that codes more conditions.

MR. KUHN: I get that. I guess the question is, how does the MA plan that adjusts for that coding intensity -- you know, again, CMS has made adjustments in home health and SNF and in the hospital inpatient. How do they make those adjustments in the MA side?

DR. ZABINSKI: Right now there is no adjustment

for that on the MA side.

DR. BERENSON: This was a very clear and excellent

DR. MARK MILLER: Excuse me.

DR. BERENSON: I'm sorry.

DR. MARK MILLER: I'm really sorry. Okay. What I would have said there, and maybe I didn't understand. What I would have said is, is that whatever adjustments are being taken in fee-for-service end up getting reflected in whatever the relative values in constructing the weights for the HCC. Okay? And so, in a sense, all other things being equal, they will be in the underlying structure of the HCC when they manifest themselves on the MA side.

And then the only other thing -- and I wasn't quite sure whether you meant this. There are efforts on the MA side that when they have seen coding increase faster than fee-for-service, they have pulled that up.

So I would have said yes, there are. It's not SNF and it's not hospital, which is what you were answering and you're correct on that point, but there is a broader effort that says that they've observed these trends that are much higher coding on the MA side and pulled payments back.

MR. KUHN: So there's linkage to fee-for-service

overall between the two, plus when they see --

DR. MARK MILLER: Through the weights.

MR. KUHN: Through the weights. And then when they see coding that is in excess of the CMI or coding that is more intensive than for what the patients are ill, then they've made adjustments there as well? So it's consistent with fee-for-service in terms of the kind of adjustments that are going on?

DR. MARK MILLER: I think so and I think -- sorry -- that the relatives for any sets of patients in setting the weight kind of reflect all the adjustments that occur in fee-for-service. End of thought. Second thought, if the coding practices on the MA side divert significantly than fee-for-service, then there's a payment adjustment to the payments. Are you okay with all that?

DR. ZABINSKI: Yeah. Just the thought that -- I mean, the adjustment that they make on the MA side is sort of for -- you know, it's an across-the-board adjustment irrespective of region. But if there's regional differences in coding, those aren't adjusted for.

DR. BERENSON: Yeah. As I was saying, this was terrific work and I have two questions. One is around Slide

7. I just want to understand the implications of the analysis you did in relationship to what the plans are reporting now as their risk scores. I mean, this suggests that there is more favorable selection than the plans that Scott, as I remember you presenting overall nationally, it was about 1.0 or so. They were right about the same risk score as fee-for-service.

So I guess my question would be, what could explain the difference? One would be coding, I assume, and two would be that plans have figured out a way to get more favorable patients within HCC categories? Are those sort of the plausible explanations?

DR. ZABINSKI: Yeah. Those are two, and I would say a third one is that if you have an individual who's relatively healthy, you know, decides to go into an MA plan, and after they get in the MA plan, you know, the classic term is they regress to the mean.

And that's the limitation of this analysis, is that it doesn't look at people while they are in a plan, so you don't know what's exactly going on while they're an MA enrollee. It just says that before they enroll that they're relatively healthy, but once they're there, you don't know

what's going on.

DR. BERENSON: But presumably that regression happens over a longer period of time?

DR. ZABINSKI: Presumably.

DR. BERENSON: Okay. The second one is more technical. It goes to your topic of adding the number of conditions, which is based around Slide 11, but I'm really going to refer to what you put in the written material. I was actually at CMS when we, under some pressure from the plans, agreed to create a CMS-HCC model rather than the full. And as you've said, there were 189 categories in the full model and 70 in the CMS model.

At the time, I remember that that translated into about 9,000 ICD-9 codes for the full model and about 3,000 for the reduced model or the CMS model, and I didn't know how that was reducing burden, which was the argument that the plans were making, that somehow managing 3,000 codes was somehow a lot easier than 9,000. Once you're over three, I think you've got -- I'm exaggerating a little bit.

So I guess in terms of understanding the -- and so, we then did our work to find that the predictive value wasn't seriously affected, at least at that time, and so we

were willing to make that accommodation. It also, by the way, Bruce, was the time we gave up getting encounter data, which would be another way to create full HCC scores.

Do you have any views on sort of this administrative burden issue? Is it worth taking on this possibility of having a much more robust set of conditions? Do you get the predictive value gain? Is it worth it in terms of what the plans have to do to produce all of that?

DR. ZABINSKI: I would say yeah. At one point today, I mentioned that there's sort of a more advanced model that's in use for the PACE plans and CMS considered it. But it has not implemented it for the MA program in general. And there are some things in that model that are kind of nice to have in it. One I really focus on is there's an indicator for dementia, which is in that more advanced model, but not in the current version. And as you know, you know, dementia is becoming a more prominent, you know, condition. So that would be a nice thing to have added in.

DR. BERENSON: It is possible that you could then target a couple of specific conditions to add to the 70 rather than going to the full 189 or something?

DR. ZABINSKI: Right, yeah.

DR. BERENSON: So there's some intermediary kinds of things like let's get some codes for dementia in there to increase predictive value, but not go to -- although I would need to be convinced that there is significantly more administrative burden with the full model rather than a smaller model. But thank you.

MR. HACKBARTH: Could I just piggy-back on Bob? Could you go back to Page 7, Dan?

I have a question about the third bullet, and I recognize there are limits in this approach as a way for assessing what the magnitude of risk selection might be. But just for the sake of discussion, let's say we had the perfect method, and we concluded that MA enrollees were 15 percent less costly on average. Wouldn't it matter, the pattern by which that 15 percent is arrived at? So if it's spread evenly across a broad population, you know, just a little bit here and there, the people who enroll in MA plans tend to be healthier than their fee-for-service counterparts, that leads you to one set of policy options.

If, however, you get that average by differences in a small number of patients, for example, MA plans look

very much alike for the broad enrollment, but they don't have the very expensive patients, you might look a very different place for your policy solutions.

Is there any way to get at that pattern of where the differences are? If it tends to be concentrated in a few patients, then, you know, you may be thinking about, okay, what we need is some sort of policy, mandatory reinsurance where the government shares in the cost of high-cost patients and reduces the average rate across the board so plans that don't have high-cost patients are sort of overpaying for the reinsurance?

DR. ZABINSKI: I think that's one possibility, the reinsurance. And I'm going to stick my neck out a little bit and say I think the idea of adding number of conditions that a person has to the model also might be helpful in that sense, because particularly if you have something like your conditions interacting with number of conditions, like a diabetic with plus zero other conditions, one other condition, up to however many you want, eight, nine, in the model, you might be able to get some pretty good teasing out of the differences in the costliness within -- patient severity within an HCC.

MR. HACKBARTH: Yeah, and perhaps it's not an either/or, that you do more conditions or the other. But adding conditions and trying to do that approach, it seems like inevitably it is going to underpredict at the extremes. And if your problem exists at the extremes, you may need to do other things to --

DR. ZABINSKI: Yeah, that's sort of why I said I feel like I'm sticking my neck out a little bit when I say that.

DR. MARK MILLER: But on that, as long as your neck is out --

[Laughter.]

DR. MARK MILLER: On that, don't some of your results suggest that when you do the numbers of conditions, you are kind of scooping up the missed variants at the extreme?

DR. ZABINSKI: Right, yeah.

DR. MARK MILLER: And the other thing I would say is I don't see -- to your number of conditions, to your question -- and this doesn't rule out the reinsurance policy at all. But you are going to be exploring the numbers of conditions question. That's what you were saying on the

last slide.

DR. ZABINSKI: Yes.

DR. MARK MILLER: And, remember, these things are not mutually exclusive. It may be two years of data, numbers of conditions, adding conditions to the model, and then at that point you ask the question: Do you still need a reinsurance policy if you feel like you're falling short at some point in time? I still think there's even steps here that...

DR. HALL: Dan, just on that same issue, is there any information available, maybe from MA, about the dynamics of this selection process where it seems like sicker people stay with their fee-for-service and less sick move into MA? It would seem that a lot of people with active medical problems have sort of reached equanimity with the evil they know, the doctor that takes care of them, the drug companies that they have to deal with, or the drug exchanges, and they're not so attracted by MA saying you can have eyeglasses and dance lessons as they are with the hassle factor. And so I just wonder whether this is just a psychological thing that causes these people to stay out of MA. And then the advertising in MA is certainly not geared

-- "If you are a really sick person, would you like to join our plan?" is just not inherently what happens.

DR. ZABINSKI: Yeah, you know, intuitively that makes a lot of sense, and I'm not sure if there's any literature that specifically gets into that. There probably is and I just haven't looked at it yet. But, yeah, as I said, intuitively that makes sense.

MR. HACKBARTH: Years ago, weren't there some studies of differences in selection between plans that required people to change their physicians versus big network IPAs where people can keep the same physician? I vaguely recall there are some differences. And you would expect there to be some differences there.

DR. NAYLOR: So as you explore the issues around numbers of conditions, there has also been a lot of attention these -- and you mentioned it in the case of the 76-year-old with COPD about severity. And any work done to help -- not absent numbers or other co-existing co-morbid conditions, but any work to uncover severity of primary conditions?

DR. ZABINSKI: Not within the context of risk adjustment, I don't think.

DR. CHERNEW: I want to go to what in the written materials was Table 4. I can't remember what slide it was. It's the one that talks about when you add two years of data, I think.

So one of the things that is complicated with these slides is that the number of people in the groups change. So I imagine what happens is when you shift to two years of data, the number of people with zero conditions drops dramatically. It drops. Okay. So I guess my clarifying question was the number of people with zero conditions is conditioned on how many years of data you were using, just in how you did this.

DR. ZABINSKI: Correct, yes.

DR. CHERNEW: And so my then sort of related comment is: What sort of matters is not how well you're predicting for certain types of people, but if you could somehow lump these people in synthetic plans to know how you're predicting for the plan is almost more important than knowing how you're predicting for a certain type of patient for the particular disease. So, for example, if you were way off on COPD and way off on cancer but all plans had the same mix of COPD and cancer, it wouldn't matter as long as

you were right on average. And so figuring out how these people are -- how big the distribution of these traits or any other set of traits, how big the distribution across plans varies matters. So it matters if you have one plan that is all CHF, one plan that is all COPD, one plan that is all eight or more conditions, and one plan that is all no -- you know, that's the grouping that really matters for how far you're getting off for a plan as opposed to a particular type of person.

DR. ZABINSKI: That's clever.

MR. ARMSTRONG: I read somewhere, I think, in the written report that we've recommended using two years of diagnostic data once before and that it didn't go anywhere. I was just wondering why that didn't get any traction then.

DR. ZABINSKI: I'm not sure why it didn't get traction, and you are correct. It tells you how long I've been here. I mean, I was an author on that report as well. That was from 2000.

MR. ARMSTRONG: Was it as good an idea then as it is now?

DR. ZABINSKI: Yeah, same concept applied.

[Laughter.]

MR. ARMSTRONG: Okay. Just the only other brief comment I would make is that I work with a group of 1,000 physicians. Part of their practice is MA, and they're convinced that our MA patients are far sicker than the average MA or fee-for-service patient.

[Laughter.]

DR. BORMAN: I really think I understood this, which is scary, but I think you did a really nice job of laying it out. And I'll save my comments for Round 2.

DR. STUART: Yeah, I have a number, and you can tell me when I've crossed the line from 1 to 2 here.

I'd like to go back to Slide 6 and focus on that number of 20 to 25 percent of explained variance. This was a study that was done by Newhouse and others that actually used data from the RAND health experiment. They got up to 20 percent for all services combined and about 25 percent for ambulatory services. And what they had is they had all of the information that we currently have available for the HCC, and they had clinical information. And this gets to the point that Mary was talking about, that if you want to increase the predictive power of this thing, what you need is you need clinical data. So if you're looking at somebody

that has COPD, what you would want to have is lung function. If you're looking at somebody that has CHF, you'd want to know the severity, you'd want to know whether it's diastolic or systolic or various other features.

If you're interested in the severity of diabetes, well, it turns out that the ICD-9 coding is pretty good about that. And, in fact, there are either five or seven -- the number actually escapes me now -- individual HCCs within the diagnosis of diabetes. And so if somebody has complications, if somebody has an amputation for diabetes, then they've got a higher HCC score than if they have just plain old garden variety diabetes.

And that brings up the second point, which is the HCC actually does -- is an accounting mechanism as you went through. For each additional one of these conditions, you've got extra point on your score. And so for that reason, it's not surprising that adding condition counts does not increase the overall predictive amount that -- the R-square, because it's basically the same information that's there in the first place.

So my guess is -- and the fact that you get better predictive ratios by condition counts is obvious. I mean,

it's like putting the same thing in a regression model on the right-hand side and the left-hand side, and voila, it looks really good.

So to be honest, I'm not sure where the payoff is going to come in terms of just working with the elements that we currently have in the HCC, and this gets back to the point that Bob raised about the original HCC model that was developed by -- well, the people are now in RTI -- that had 189 conditions. And for the issue in terms of difficult in terms of managing that, that's an old problem. I can't imagine that any self-respecting MA plan doesn't have the capability of just going through and counting all diagnostic codes as we do when we look at claims volume. But the point being that the 189 had an R-square of, I think, 12 as opposed to 11. And so the extra hundred-and-whatever, you know, did very, very little in terms of overall prediction of the costliness of these patients.

That model, by the way, also included a whole bunch of interactions, and some of those interaction terms were statistically significant. But when you're assessing these models on literally millions of claims and individuals, everything is statistically significant. And

so you're not getting a whole lot of bang for your buck in terms of overall predictability by manipulating these types of information. So there are two angles that I think we should head, and then I'll stop for this point.

The first is we should be looking at ICD-10, and we should -- this is around the corner. It's going to happen. We ought to see whether, in fact, these scores are going to go up, as I would expect they are because the diagnoses are more precise. So that's the first thing.

Then the second thing would be to think about how you're going to integrate EMR data when we finally get that in terms of being able to use that for risk adjustment, because then you're back to Slide 6 here, where you have information that you have the same information in essence that the plan does in terms of selection, and so you have much more flexibility in terms of being able to address the questions of overselection by the plans.

Then I'll end with just one final note. I believe that it's not overt selection by the plans that leads to favorable selection in every MA plan except Scott's but, rather, that it is de-selection by or non-selection by relatively sicker beneficiaries. And the reason for that is

that if you're in the fee-for-service sector and you're sick, it means that you've got probably a bigger network of physicians that you depend upon, and so the cost of moving to an MA plan is much higher because you have to give up those relationships.

MR. GEORGE MILLER: Thank you, and, Dan, this is good work, and I appreciate reading the information.

If you could go to Slide 5 please, and I was just wondering if the regional differences in coding for the MA plans mirror the same as the other areas that we've looked a and if there's a pattern that we can learn from. As an example here, Miami-Dade County -- I mean, Dade County, is that the same issue here? Or is it different as far as the original regional differences in coding? Or have we looked at that and tried to map that? Is there a correlation between other areas that we've looked at as far as excessive or higher coding?

DR. ZABINSKI: Well, we know there has been research done that in fee-for-service the regional differences that exist also are reflected in the coding. In MA, we don't know yet. Nobody has -- the information just isn't there yet to do it. But CMS is collecting the data

that should allow us to eventually do it.

MR. GEORGE MILLER: Okay. All right. I would be interested in seeing that, if there's a pattern here.

MS. BEHROOZI: I have two quick Round 1, and then I won't have Round 2.

Can you please turn to Slide 7, Dan? I have a question about duals. Did you exclude duals or are they fully in the group that you looked at to make this analysis?

DR. ZABINSKI: They're fully in.

MS. BEHROOZI: So of the people staying in fee-for-service Medicare, there would be a lot of duals, right? Because if they've already got coverage through Medicaid, they would -- you know, irrespective of their sickness level, they've got a lot of extra coverage, so they have less incentive to go into an MA plan. Is that the correct line of thinking or not so much?

DR. ZABINSKI: Empirically, I don't know. Intuitively, once again, that makes sense.

MS. BEHROOZI: Okay, because that might have a fairly big impact on the costliness, and it might be related to how sick duals are, or it might be related to their costliness because of their income level. And I know that -

- and this is the other question. I know that when you did race and income level, you didn't see an impact, but I wonder if you separated them out -- I mean, you know, in the next paper we see that duals comprise 18 percent of the population but account for 31 percent of the costs. And it feels like what you've done here suggests that that's just because they have more conditions, but I don't know that lumping race and income together necessarily tells you the impact of either one, particularly of income by itself.

DR. ZABINSKI: In regard to the duals, being dual is an indicator in the model, and when making this comparison -- hopefully I did it properly -- I adjusted for health status and the effects, including being dual, that would have on somebody's costliness. So I think I, you know, have adjusted appropriately so that being dual or not dual doesn't really influence the results.

DR. MARK MILLER: And the other thing I would say, I mean, you can certainly pull out populations and look at different effects, but I think part of our motivation here is that I think the plans' view of this is I am a kind of plan that is focused on certain kinds of patients, often duals and often multiple chronic conditions, and the risk

adjustment system is not backing in behind me very well. And so I think one of the motivations here was to say so how could you -- and to Bruce's point, you're right, it's not jacking the explained variation up a lot, but what it's trying to say is can I calibrate the equity of payment better across different types of patients. So leaving them in and trying to get the model to explain that variance -- because it goes right to his point, which is if I'm a plan who says I'm going after those patients, I'm a SNP, you know, we're trying to make sure that the risk adjustment backs in behind that decision and the fact that I'm focused on that tail of the distribution, which is why we wanted them in because we're trying to get that variance.

Now, that's not to dispute your point. You could pull them out and look at separate effects of variables. But in the end, for policy, you want them in and make sure that when they select that person we haven't underpaid them accidentally.

MR. HACKBARTH: So I want to go back to Bruce's comments for a second, which made a lot of sense to me. One thing that Bruce said was that he thought it's likely that the issue is not so much overt selection by the plans as

opposed to self-selection by the enrollee. That makes sense to me certainly at the enrollment end of the enrollment end of the process.

The other place where selection can happen is at the disenrollment and what the profile is of the people who disenroll. And I know there used to be studies that looked at the disenrollees from Medicare Advantage or its predecessors and their costs that they incurred upon re-entering fee-for-service. And my recollection was that the disenrollees tended to have much higher than average costs when they go back into fee-for-service.

Could you say a little bit about that?

DR. ZABINSKI: Yeah, it's actually in the paper as well. I didn't include it in the presentation, but yeah, I got the same result again. Those who disenrolled in their first year back into fee-for-service, they were about 16 percent higher than average than the people who stayed in fee-for-service the whole time.

MR. HACKBARTH: Yeah, okay. I don't know. It just seems to me that, again, what you try to do to solve the problem might vary on whether it's a self-selection problem at the enrollment and/or an effort by plans to

disenroll people when they're found to have high costs. There are different sorts of problems to deal with.

DR. BAICKER: So it makes all sorts of sense to me to bake in as many of the interactions and number of conditions as you can to try to predict better, and that seems relatively low cost and likely to improve fit. And then that brings up the question of what's going on across regions between fee-for-service and MA, and there seemed to be two separate issues to me. One is differential coding across regions where actually nothing real has changed. Some places are better at ticking the right boxes, or ticking the wrong boxes, and that's about administration and ease with that. And then there's a second question which is some areas actually then treating conditions more intensively for a given set of patients, and there something real has changed in terms of resource use.

And so there's a question of how you want to deal with differential ticking of the boxes that go into the HCCs, and then a separate question of how you want to deal with differential weights attached to those HCCs based on how people with those conditions are treated in different regions. And those seem separate issues to me, and that

gets to the ultimate question of what you want your risk scores to be targeting in terms of cost. Do you want separate ones for people enrolled in MA because treatment patterns are different? Or do you want to keep targeting the way treatment patterns are in fee-for-service when you make those adjustments? And I think part of the goal is t move people into more efficient, higher-value modes of treatment. So if MA plans are really good at treating patients with diabetes and there's a big wedge between the costs for those patients in an MA plan versus the cost for those patients in fee-for-service, I don't think we want to erase that difference in the risk adjusters when people select into MA plans because we want those people going into MA plans if MA plans are better able to manage their disease.

So I think you want to keep having a wedge between -- you want that wedge between the costs to be advantageous for enrollment in MA if that's the more efficient mode to treat those people in. What you don't want to have is a reward for a greater ability to check the box that people are actually in that diabetic risk category. So that to me suggests more of an adjustment for the differential coding

and a different strategy for adjusting for differential costs.

Now, if some regions are treating diabetics much more cost intensively in fee-for-service than others, I don't think you want MA plans in low-cost regions to benefit from the fact that fee-for-service treatment for those patients in other regions is really expensive. So you want to adjust across -- you want to take into account the fact that some regions are more expensive in the sense that you don't want to then build that into your MA reimbursements. But you want to build in the fact that MA plans are more efficient at treating some disease classes within a region than others. So maybe that's three buckets.

At this point I have even puzzled Mark.

[Laughter.]

MR. HACKBARTH: [off microphone] -- different HCC factors by region? Is that what you're saying?

DR. BAICKER: I guess what I'm saying is that you don't want to -- there's certain kinds of things we want to reward and certain kinds of things that we don't. So when the fee-for-service plan in a local area spends a lot of money on diabetic enrollees, we don't want to say,

therefore, the MA plans should also get a lot more money for those diabetic enrollees. So I think we don't want to adjust regionally that way.

When local plans are better at marking the box that this person is diabetic, I think we want to net that out. So we don't want to differentially pay for better ability to flag who's diabetic, but we do want to pay for differential ability to manage diabetic patients better and lower their resource use.

DR. MARK MILLER: [off microphone].

DR. BAICKER: I'm backing away from [off microphone].

DR. MARK MILLER: [off microphone] we can get through this. I'm not quite with you yet, I honestly will say that, but let me ask you this -- because when you went through answering his question, it sounded like the last thing that you said about the ability to check the box immediately triggers in my mind more the notion of differential coding, and that there's always the MA versus fee-for-service, but there could be two managed care plans, and I could be doing it more than him. And you're sort of raising that as a --

DR. BAICKER: I'm punting on that. I don't think we're going to do such a -- I don't think we have the ability to differentiate between MA plans in the same area and their ability to check the box.

DR. MARK MILLER: Fair enough [off microphone]. But then that would sort of lead us to, yeah, you're right, there may be differences in coding and, like we're doing now -- whether we're doing it well or not -- we should continue to try and make sure we capture that back.

But to your first and I think more important question, on the geography and relative to fee-for-service and whether you're creating incentives, because I'm not sure I follow, so I'm going to ask this question: Do you think if you built the weight using fee-for-service -- sorry, using managed care data, you would address that issue?

DR. BAICKER: I don't think you want to build the weights just based on MA use patterns because we're trying to incentivize efficiency over --

DR. MARK MILLER: That's what I thought you were saying [off microphone].

DR. BAICKER: Right, so that I like having -- now, do you want it to be just the fee-for-service weights in

perpetuity --

DR. MARK MILLER: That's what I thought you were saying, too [off microphone].

DR. BAICKER: -- that's a question. But I don't think you want to ignore the fee-for-service -- the weights that fee-for-service use would generate because, to the extent that you're improving more over what's going on in fee-for-service, that's a good thing. And ignoring what's going on in fee-for-service when you calculate your weights would eliminate the incentive to drive people differentially towards MA when MA is doing differentially better by them.

DR. MARK MILLER: Right, and so that's kind of what I -- that's why I was confused, because I thought that's what you were saying. I've been thinking of this problem -- and we're going to have to face this problem. You know, someday Bruce is finally going to be right, and we're going to have the encounter data.

[Laughter.]

DR. MARK MILLER: And I swear to God, if he's not here, I'm driving to his house, we're going to break open a bottle, you know, throw it down.

But, you know, when we finally get the day, the

way I've been conceiving this problem and having this conversation with Dan is are we building weights with fee-for-service, are we building weights with MA? And what I think Kate is saying is, remember, if there's some distance there, that's a signal to the MA plan that they ought to do that and reap the reward of it. And now she's confused the hell out of me because I used to have just two things to focus on, and she's saying you might want to think of some combination of those things, maybe. Weights based on fee-for-service and MA, kind of? Is that where you're going?

DR. BAICKER: Well, for a slightly different reason from what I think you just said, we can have fake questions, too, in addition to fake answers. No.

So the reason to focus -- to include the fee-for-service-generated weights is that if fee-for-service is expensive and I'm an MA plan and I can do it better, I should be wanting to attract those people. So that argument says you should stick with the weights generated by just fee-for-service.

The caveat to that is that we want the plan, Medicare, to reap some of the benefits, too, and you don't want to say in perpetuity the MA plans, when fee-for-service

is inefficient, all of the benefits of the improved efficiency should forever accrue to the MA plan. So the argument for a blend would be that you want to share the gains. Do you want the MA plan to have some of the gains so that they do more of it when they're providing better disease management, but we want to get some of that for the program also? So that would be my reason for moving toward the --

MR. HACKBARTH: You do that at the rate level.

DR. BAICKER: Yeah.

MR. HACKBARTH: How you set the overall rate as opposed to doing it by condition.

DR. BAICKER: Yeah, I think so.

DR. BERENSON: Yeah, this has been a very interesting discussion. I think I strong want to support Bruce's notion of trying to get a hold of ICD-10 and rather than just replicating work that has already been done, although it has been a while, and ICD-9 codes using multiple conditions in the full, robust model, and I think Kate has added a very important idea here about not wanting to control out the efficiencies of Medicare Advantage. I think that's an important thing.

I guess I would get a little narrower on just a couple of things. In terms of additional work, I generally support what you said in terms of next steps, which you had sort of three bullets. I think the one that seems easiest that doesn't involve burden that was proposed 10 years ago or longer was the two-year model, and I certainly think that we should -- I think that's the ripest one for advancing the current HCC model. And I'd want to understand the reluctance to go in that direction.

I'm not sure we would get very far by adding number of conditions or going through the full model of all -- the full HCC model or some other modification. And I'm concerned in that we then have to -- well, I want to understand more about administrative burden. I think I'm with Bruce and others that it really isn't significant administrative burden, but if it doesn't add much to predictability and it does bring in the specter of different coding practices in diverting attention at the plan level and to more attention to coding every diagnosis and less on managing patients, I'm not sure what the gain would be if we go there.

So I'm more than happy to have you model it, but

that's one full step away from us wanting to recommend that. So I'd like a little more about the administrative burdens in that area

And the other thing, Bruce, you were mentioning the EMR as what is down the road, but pharmacy data I assume is readily available now, and the question is around models that include prescription drugs ordering, I thought was more robust. Would you say something about that?

DR. STUART: I'd be happy to. I'd like to put that in the context of when we moved into using these prospective models from cost reimbursement, and cost reimbursement obviously uses as the metric what was actually provided, and then you had these accounting mechanisms for putting dollars on it.

The problem with using actual utilization for risk adjustment is that it provides an incentive under certain circumstances to provide that service so that you get paid for it. So in a way it's kind of moving back to cost reimbursement, at least theoretically.

Having said that, I think it's certainly a way to kind of diagnose whether there are issues associated with severity. One of the things I was going to suggest to Dan,

for example, is to use COPD, as Mary pointed out. If you are really interested in whether somebody under the current system was less likely -- a more severe COPD patient was less likely to go into an MA plan, you're right, I would look at, among other things, the Part D drug files. I'd want to know whether they were taking -- you know, had consistent use of reliever medications, whether they were hospitalized for acute exacerbation of COPD, whether they were taking oxygen. All of these are proxy variables for severity.

Having said that, I wouldn't use any one of those in a risk adjustment model because of the potential for gaming. And I don't want to push that too far, but I'm just kind of theoretically opposed to using utilization measures in risk adjustment if I can get away from it.

If you were to just take those three measures that I just indicated in the fee-for-service, you could tell -- on Chart 7, you could tell whether people who had COPD, whether they were using these surrogate measures for severity, whether they were more likely to stay in fee-for-service as opposed to going into managed care. And you could use drugs for a lot of other conditions, but I would

be, again, hesitant to use those in an actual active risk adjustment model.

DR. BERENSON: Although the actual cost of the drug presumably would be more than the marginal increase you get, or maybe -- I mean, it probably doesn't make sense for a plan to do that, but we can have a side conversation about that.

I wanted to make one final point. I wanted to just -- didn't MedPAC do work that partly answers George's question about the Miami-Dade situation and comparison episode groupers between Minnesota and South Florida, that, as I remember the findings, Miami has lower-cost episodes but many more episodes per beneficiary, to suggest -- I think that's sort of comparable to the song at all findings -- and that was one was specific to Miami. Is that basically right? So that's --

DR. MARK MILLER: We took his question to mean and the way it was answered was: Do you see this same pattern in the coding of the MA data?

DR. BERENSON: I see [off microphone].

DR. MARK MILLER: Because all your statements are true, his statements are true, everybody is correct here,

but we're all talking about fee-for-service, and we thought he meant do you see that when you see the -- right.

MR. HACKBARTH: Comments [off microphone]?

DR. NAYLOR: Just briefly, I see the problem in -- first of all, excellent report. It was just outstanding. The opportunity here is to take a look at the recommendations as it relates to the HCC system itself, and I do think taking a look at those 70 original conditions in light of science about which factors, conditions contribute to poor outcomes is really going to be important. Cognitive impairment is really important in looking at -- we know now how it accelerates poor outcomes among chronically ill people.

On the numbers of chronic conditions, I think also placing attention on what we're learning about clusters of chronic conditions and this notion of active versus numbers of chronic conditions, so active meaning those for which there is treatment, seeing maybe -- so just kind of the refinements in at least the science related to it.

And then this building on -- gosh, I hope I got what Kate was saying, but this notion of risk being as you look at it comparing fee-for-service and MA or looking at

what MA is doing, this importance of looking a longitudinally, you know, a good plan can reduce risk over time, and so you don't want to penalize plans for doing that.

And the last thing has to do with, although it's not a part of your recommendations, the work on regional variation and the critical need to look within regions and variations within regions as well.

DR. CHERNEW: So the first thing that I want to say is I don't think that the extra coding is just, oh, we're better at coding. There's things that happen in regions, like if you have people come back to the doctor's more often, you practice more intensively, they naturally get more codes, and those codes may actually be the right codes. When you code someone in the high coding places, it's not to imply that, oh, they don't really have those things. They actually may, and by doing more prevention or other things or having people screening, you may actually be legitimately picking stuff up. It's not just, oh, we're doing a better job at checking a box in those areas.

So it's always a challenge, and I think another part of that challenge is, related to the presentation, that

coding isn't really a regional thing per se. It's not that everyone in Cleveland codes one way. It has to do with the different delivery systems, and it may vary between the MA plans and the non-MA plans and what you're using. And that makes all of this in some broad conceptual way extraordinarily hard to get right. And so I think -- and I really don't mean to be so unambitious, but our goal, I think, has to be to just do sort of well enough and avoid the worst kind of problems and to make sure we have a monitoring system where we can pick up the most egregious examples of what we think is going on, and we're going to have to constantly sort of play that. And the amount of resources we could spent through ICD-9/10 -- which, if I had to do it, I think is probably more effort than it's worth, but that's not my call. In any case, the idea of trying to get every micro thing right and putting a ton of effort into it is probably not where I would go.

The other thing that I want to say is I want to reiterate strongly what Kate said, and I want to say it slightly differently, about how we want to use -- whether we're going to use MA claims or fee-for-service claims, and here's the way that I would have said that.

The first thing is, if our goal is to make sure that MA plans are not profitable -- so that's our basic goal -- then we want to think about really what the MA costs are and adjust sort of within the MA system.

I don't think that is our goal, and so another way to think about our goal is we want to pay the MA plans what we would have paid for that person if they were in fee-for-service. Then you want to use the fee-for-service weights because that's telling you what would have been spent there. And we could, again, fiddle with complicated blending things. My personal view is we have a tendency in our efforts to get it right to completely underestimate the phenomenal administrative burden associated with getting it right.

And so I think sort of a simple view, if I were picking, I would stick with the fee-for-service claims to do this. That I think has the better incentive properties. If the MA plans were able to attract the sicker people, cure them better, do a good thing and we're paying basically the same amount as we would in fee-for-service, I would basically say, "Halleluia." And because of the bidding system in MA, a lot of that gets returned back in terms of

better benefits and other things anyway.

So to a first-order approximation, that's what I would do there, and I would then think much more about monitoring how much heterogeneity there was across plans. If you saw plans entering for just one type of person, that really might be a red flag for profitability, and I would think about monitoring that way.

MR. HACKBARTH: And just to pick up on that, for years MedPAC's position has been neutrality. It has not been to try to take the profit out of the Medicare Advantage business but, rather, have a neutral system.

MR. ARMSTRONG: Just briefly, I would say I understand risk adjustment methodology far better now than I did yesterday, and I want to thank you for that. I think I want to thank you for that.

[Laughter.]

MR. ARMSTRONG: Remember the comments about how much we really appreciate our actuaries from yesterday? That's really relevant now.

The only other point I would make is to endorse that the work we're doing to try to improve the accuracy of this coding I think is headed in the right direction. I

appreciate the report. Thanks.

DR. BORMAN: I would only want to second what Mike said about underestimating the administrative burden at multiple levels in the system. And in the pursuit of precision, we have to balance that with some sniff test of reality.

DR. STUART: just a very quick point. In 2008, CMS added additional diagnostic boxes to the physician claims form, and it increased the number of diagnoses from four to eight. And we've done some work on that, and it turns out that if you look at data for 2008, you tend to find more people that have conditions like hypertension and hyperlipidemia, conditions that tend not to be coded on most physician forms in the top positions because they generally aren't the reasons why the individual goes into the office for care.

The reason that that is important is that in the old system, when the RTI was developing this back in the last decade, most of the diagnostic codes that were actually used to develop these HCCs came from hospital claims, because hospital claims you got up to ten diagnoses. Hospitals have a very strong financial incentive to code

everything they possibly can so that the grouper puts them into a higher DRG category.

And so it might be worthwhile just seeing what happens when you use 2008 data here in terms of some of those conditions that might be treated in different ways in MA plans than you would in fee-for-service.

MR. HACKBARTH: Thank you, Dan. Very well done.

And our last item is dual eligibles.

[Pause.]

MS. AGUIAR: Thank you. Today, Carlos and I will discuss integrated care programs for dual eligible beneficiaries. These individuals receive Medicare and Medicaid. They are high-cost and require a mix of medical, long-term care, and behavioral health services. There are approximately 9.9 million dual eligibles.

This slide gives an overview of today's discussion. As you remember, in the fall, we discussed our analysis of PACE providers. During today's presentation, we will focus on dual eligible Special Needs Plans, or D-SNPs. We will also focus on a subset of D-SNPs called Fully Integrated D-SNPs, or FIDE-SNPs. We have been looking at these programs to assess whether they improve quality of

care and reduce spending. We have also been analyzing whether these programs can be expanded to enroll more beneficiaries.

During today's session, we will also update you on the CMS demonstrations on integrated care programs that are currently underway, and we will, at the end of the presentation -- we will end the presentation with a discussion of issues that the Commission can explore moving forward.

Before we begin, we would like to thank Scott Harrison and Carol Carter for their assistance on this project.

First, I'll briefly go over some backgrounds. D-SNPs are Medicare Advantage plans that only enroll dual eligibles. They are not integrated with Medicaid. However, they can be if a D-SNP also has a State contract to cover Medicaid benefits. D-SNPs are required to have a State contract by 2013, but the contracts do not have to cover Medicaid benefits and can be limited to provisions such as data sharing. As a result, the majority of D-SNPs are either not integrated or are partially integrated with Medicaid benefits. There are a little over 300 of these

plans and they enroll about 1.16 million dual eligibles.

FIDE-SNPs are a subset of D-SNPs and they have State contracts to cover all Medicaid long-term care services. There are fewer than 20 FIDE-SNPs and together they enroll about two percent of all dual eligibles in D-SNPs.

Turning now to quality, the key question is whether D-SNPs and FIDE-SNPs offer better quality of care than beneficiaries can receive in fee-for-service. However, our ability to make this assessment is limited because we cannot compare SNPs' performance to fee-for-service for the majority of available measures. Also, we should note that the available measures are process and intermediate outcome measures and not direct measures of care coordination.

Working with the available measures, we find that D-SNPs' quality of care is generally mixed. We used a proxy method to identify D-SNPs so that we could evaluate them on the full set of HEDIS measures. We identify D-SNPs as plans with 75 percent or more of their enrollment in D-SNPs. We found that D-SNPs performed better than the non-SNPs on five HEDIS measures, but performed worse on the majority of measures. Although as a group D-SNPs' quality performance

is mixed, there are some D-SNPs that do perform better than non-SNPs on the HEDIS measures and that have high star ratings.

In addition to the analysis of HEDIS measures, we used CAHPs data to compare dual eligibles enrolled in D-SNPs and non-SNP MA plans to those in fee-for-service on the rate of influenza vaccination. We found that there was no difference between dual eligibles in fee-for-service, those in non-SNP MA plans, and those in D-SNPs on this measure.

To analyze the FIDE-SNPs' quality, we used a small subset of SNP-specific HEDIS measures. The results were more positive. We found that FIDE-SNPs performed better than other SNPs on the care for older adult measures. We also found that many FIDE-SNPs have very high scores on tracking the control of blood pressure among enrollees with hypertension.

Overall, however, we are not able to determine whether D-SNPs or FIDE-SNP improve quality of care relative to fee-for-service because of the limited measures available to us to make this assessment.

Now, I will turn to our analysis of Medicare payments. As you know, payments to MA plans in general are

higher than fee-for-service spending and, in some markets, MA spending always exceeds fee-for-service. Consistent with these general MA trends, we estimate that, on average, payments to D-SNPs and FIDE-SNPs will be between ten and 12 percent higher than fee-for-service.

We also analyzed the bids for Part A and Part B services to see if D-SNPs and FIDE-SNPs expect to provide these services for less than the cost of fee-for-service. We found that the risk adjusted A-B bids for D-SNPs and FIDE-SNPs were between four and eight percent higher than fee-for-service. Based on these bids, it is not clear whether these plans can provide A-B services for less than the cost of fee-for-service.

As you remember, during the discussion of PACE program last fall, we discussed whether to extend PACE providers' flexibility to use Medicare funds to cover non-clinical services to FIDE-SNPs. PACE staff reported that this flexibility helps them provide enrollees with services that will maintain their health and allow them to live in the community.

One issue to address is if this flexibility should be extended, and if so, how. FIDE-SNPs could be given

flexibility to use their Medicare payments to cover non-clinical services. This is the flexibility that PACE providers have. Alternatively, FIDE-SNPs could be given flexibility to use the difference between the bids and the benchmark to cover non-clinical services. This approach was proposed by CMS but has not yet been finalized.

Another issue is which plan should receive this flexibility. CMS proposes to give this flexibility only to high-quality FIDE-SNPs. Another option is to also extend this flexibility to D-SNPs that are partially integrated with long-term care.

With respect to wider expansion of these programs, we find that it will be challenging for D-SNPs and FIDE-SNPs to expand to serve more dual eligibles under their current formats. Because we are not able to determine whether D-SNPs or FIDE-SNPs produce better quality of care than fee-for-service, we cannot conclude that these plans should be expanded based on quality of care alone. In addition, the higher Medicare spending on these plans raises questions about whether they should be expanded under their current payment system. It would also be challenging to increase the number of FIDE-SNPs because States have to contract with

these plans to cover all of their long-term care services and it is unlikely that a large number of States will establish these contracts in the near future.

However, there are elements of these plans that could be incorporated into larger-scale programs. For example, the key care management characteristics of integrated care programs that we reported in last year's June report were identified from D-SNPs and PACE providers. These characteristics are listed on this slide.

Another moving part is the CMS demonstrations. Last year, CMS established the financial alignment initiative to offer States the opportunity to test two models. Under the capitated model, CMS will sign a three-way contract with a State and a health plan. CMS will work with each State to develop the rates. Within a State, CMS will have a standard contract and rate setting methodology that it will apply to all health plans participating in that State's demonstration. CMS intends to develop the Medicare rates based on historical fee-for-service and MA spending within a State and to set the rates at a level where they provide for up-front savings to both CMS and the State. Proposals from the States interested in this model are

expected to be submitted over this spring and CMS expects to sign some of the contracts in September.

Under the managed fee-for-service model, States will finance care coordination programs for dual eligibles within fee-for-service. States will receive a retrospective performance payment if their programs meet certain quality thresholds and result in Medicare savings.

Over the next few slides, I will walk you through some possible directions to take this work. On this slide is a framework for you to keep in mind.

One direction is to improve the programs that we currently have. Another direction is to think about issues related to wider expansion of integrated care programs. A third direction is to assess the issue that dual eligibles' care is provided through a bifurcated payment system.

One option is for the Commission to explore outstanding issues with D-SNPs and FIDE-SNPs. It is important to note that this work would inform how to improve these programs and future integrated care programs. These issues that could be addressed include defining the criteria for a plan to be considered fully integrated, assessing which plans should be given flexibility to cover non-

clinical services, analyzing the appropriate payment system for integrated care programs, and identifying quality measures that the programs should report.

In analyzing the appropriate payment system, the Commission could consider refinements to the MA payment system and can also consider paying these plans through another payment system.

For the capitated model, the Commission could discuss how Medicare savings could be generated. One question is whether the rates should be adjusted to achieve savings. This would occur if the Medicare rates for the demonstration plans were set below current spending. However, it may be difficult to pay plans below current spending in markets where MA spending is higher than fee-for-service.

Another question is whether States should share in the Medicare savings. The argument for States sharing in savings is that the State makes an up-front investment to develop programs and Medicaid savings from reductions in nursing home use are realized over the long run while Medicare realizes more immediate savings from reductions in emergency department visits and hospitalizations. However,

programs like PACE that enroll the community-based long-term care population can produce immediate Medicaid savings by treating these beneficiaries in the community rather than in the nursing home. The policy for States to share in Medicare savings could also consider the more immediate Medicaid savings that States will realize.

Another question is whether beneficiaries should share in the Medicare savings or whether the beneficiaries should benefit in some way when savings are realized.

The Commission could also give guidance on which risk adjustment methodology should be used for the capitated model. It is not clear which methodology CMS intends to use.

Finally, CMS will have to consistent collect a sufficient amount of quality and cost data in order to evaluate and compare the demonstration programs. The Commission could explore which type of data should be collected.

Another option is for the Commission to explore additional issues related to the expansion of integrated care programs. One issue is the care management needs of disabled beneficiaries. We have not yet focused on this and

should understand these beneficiaries' needs before considering expansion of programs to this population.

The Commission could also explore a conceptual variation of the PACE model that does not rely as heavily on the day care center and could expand the PACE model to more beneficiaries.

Finally, as reported in your mailing materials, the Commission held an internal panel meeting on opt-out enrollment where participants identified standards for integrated care programs to be considered candidates for opt-out. The Commission could build on this work and develop a strategy for an opt-out enrollment policy.

The Commission could also explore the outstanding question of whether care coordination of all services for all dual eligibles can occur under the current Medicare and Medicaid payment systems or whether financial responsibility for all services should be assumed by either Medicare or Medicaid. There would be many issues to address if one program provided all dual eligibles' benefits, and the Commission could comment on these issues.

We would like for you to discuss during today's discussion the findings of our analysis. We would also like

for you to discuss which directions for moving forward you are interested in and to prioritize the order of the work.

This concludes the presentation and we're happy to answer your questions.

MR. HACKBARTH: Thank you, Christine.

Bob, do you want to go first on this one, clarifying?

DR. BERENSON: Yes. I'm trying to find -- can you go to the -- well, you don't have to go to the slide. I'm just going to ask this general question around the demonstrations. Typically, in Medicare -- this may be oversimplification, but I'll do it anyway -- in Medicare, demos are actually demos in the sense that the population is carefully defined, there's a control group ideally, it's got a time period, an evaluation, and a judgment about success. There's more of a tradition in Medicaid of sort of demonstration waivers in which authority is given to a State to basically put in across the whole system a fundamental change in how care is delivered and it's not subject to the same kind of evaluation. It's essentially a program change in the name of a demonstration.

Can we tell at this point, either from the RFP

that CMMI issued or some preliminary notions of what the States are proposing, whether it's more along the former lines, which is sort of a demonstration and a carefully controlled, or is it more like a waiver to allow the States to just change their care for the duals?

MS. AGUIAR: So the financial alignment initiative demonstrations that will be run through CMS, that's a joint effort between the -- what I keep referring to as the Office of the Duals, although they have a formal title, and the Innovation Center. So because it's being run through the Innovation Center, it has to follow some of the more traditional Medicare requirements. There will be about a three-year demonstration. There will be a robust evaluation to be done, as are all of the demonstrations that are being conducted through the Innovation Center.

Now, some of the States, and Oregon is a good example of this, they haven't submitted their final proposal to CMS yet. The way this works is that the States will have to post their proposals on their State websites for a 30-day comment period, incorporate those comments into the proposals, then send it to CMS, and then it will be up for another 30 days. But Oregon -- so from what we know what

Oregon is thinking through now, that's an example of where they are thinking of one of the financial alignment demonstrations that is related to the dual eligibles, but also aligning that with broader changes to the Medicaid system, the Innovation Center, that this demonstration through the Innovation Center wouldn't have authority over that. So they will also have to apply, I believe, for an 1115 waiver at the same time.

DR. BERENSON: I see. One more, if I could. I've seen reference in a paper that some colleagues of mine at the Urban Institute wrote expressing concern about Medicaid taking the lead with care for the duals which references, actually, a MedPAC contractor report by Jim Verdier and colleagues and making the point that Medicaid managed care has typically focused on low-income children and moms and kids and really not the duals. Can you tell me any more about what we've learned from that contract in that area?

I guess, again, I'm going -- my concern about the demos is prematurely going away from what we're doing in Medicare with SNPs, et cetera, to sort of a broad expansion of Medicaid managed care within the States and I'm concerned about the capabilities of managing that kind of thing.

MS. AGUIAR: Right. And so that is an issue that has been raised in the past, and I believe that we put this in the June 2010 report, that one of just sort of the limitations to development of these integrated care programs is that some States tend to have much more experience with the mom and kids population and lesser with Medicaid managed care for all long-term care and behavioral health. So I would say that.

The report for us that Jim Verdier did for us, which I think you said that they had quoted, I haven't seen that paper so I'm not quite sure of the context that they pulled out of that. That report that we did with him was a site visit report to look at some integrated care programs and really to sort of go through how they were able to set up what are some of the -- you know, what made them work, how they were able to get things running, and then what are some of the limitations, again, to those types of programs expanding further.

DR. MARK MILLER: [Off microphone.] That's what I wanted to emphasize. The report was about looking at dual eligible programs --

MS. AGUIAR: Right.

DR. MARK MILLER: -- in the States, so that sentence might have just been something in the introduction.

MS. AGUIAR: Yes.

DR. MARK MILLER: You know, the States tend to do more of this. This report is about looking at these things. But the report was specifically about going out and looking at dual programs, which we did.

The other thing --

DR. BERENSON: So those were sort of prototype good programs that they went out and looked at. In other words, we weren't looking at sort of average programs. We were looking at sort of state-of-the-art programs that were in the States?

MS. AGUIAR: Right, exactly. And we didn't select those programs based on quality measures. I think as you could see from this presentation, there is a limitation. We have a limitation to be able to look at some quality data. The ones that we selected is because they were fully integrated and they were really somewhat State-run.

We went to New Mexico, for example, where they had decided to put their long-term care population into Medicaid managed care and then the plans that were running that had

the option to offer a companion SNP or MA plan. And so a beneficiary that was going to be possibly enrolled into the Medicaid managed care plan had the option to enroll with the same company into their Medicare Advantage plan.

So we selected -- we basically looked at the programs in the -- I'm sorry, June 2010, the report that we did the year before that, we had gone through a list of, no, here are the integrated programs as we understand it, the ones that States are working through with working with either MA or SNPs. And so we went to those. We also went to Massachusetts and then also to North Carolina, which is a fee-for-service overlay, which is much more like the managed fee-for-service model that is being -- one of the options under the CMS financial alignment demonstrations.

Again, so that report was really to look at these programs to figure out how they were able to get set up and what were the challenges and that sort of thing.

DR. BERENSON: And real quick, the last one would be in the three-way contracts that have to be established in the capitated demos, will Medicare require oversight at least as rigorous as what Medicare provides to SNPs at this point? Do you know?

MS. AGUIAR: I have to go back, actually, before I give you a definitive answer, and check their RFP that came out in a State Medicaid Director's level, because I know that they talk about oversight. It is my understanding that in some of the more oversight in some network requirements that they are looking at the MA program as an example. But, again, I have to go back and completely affirm that.

MR. HACKBARTH: In those projects where CMS has invited proposals, they do envision passive enrollment of duals?

MS. AGUIAR: Yes, they do. And that, again -- so passive enrollment with an opt-out. And again, so not very many of the proposals have actually come out yet. The one that is up on CMS's website for comment, that is from Massachusetts and they do propose -- they have identified who their target population is. That one will operate Statewide. Their intention is to notify those beneficiaries that they can enroll in one of these programs. They call them integrated care options, ICOs. They could be managed care-based or provider-based. So they will notify the beneficiaries, now you have a choice to have one of these programs. If the beneficiary does not choose a program,

then they will be assigned to one. So the beneficiary can opt out of the program.

MR. HACKBARTH: And how early can they opt out?

MS. AGUIAR: My understanding of it is that I think that they -- I think that they will be notified that they have to make a choice, and if they don't at that point decide, no, I don't want to participate in the program, they will be assigned to one. I'm not sure after that if there's a further sort of opt out.

MR. HACKBARTH: Sort of month to month or -

MS. AGUIAR: Right. Now, there's another proposal -- and I don't want to get them too confused in my mind -- I think it's actually Michigan. There is another one that says that they will be -- again, they have a choice. They will be auto-assigned into a program, and I think they have maybe a 30- to 60-day window to then opt out once they've been auto-assigned into the program.

MR. HACKBARTH: Okay. Bill, clarifying questions.

DR. HALL: I'm just trying to get kind of the big picture of this population. You mentioned PACE several times in there and PACE Without Walls as a potential. Strictly speaking, are these SNFs or SNPs?

MS. AGUIAR: You mean the PACE Without Walls?

DR. HALL: Well, any of the PACE programs.

MS. AGUIAR: No. So they're very-

DR. HALL: They're really kind of SNP-oid -

MS. AGUIAR: Exactly. They're different.

DR. HALL: Right.

MS. AGUIAR: They have their own authority, their own --

DR. HALL: Yes. Some people just have Medicare and some just have Medicaid. Okay. So my real question, then, is what's the age distribution of the SNP population nationwide? I'd be particularly interested in how many are on the very low end, you know, below age 65, and then how many are in the sort of frail elder age, 75 and above.

MS. AGUIAR: We could get -- we'll get that for you.

DR. HALL: Do you have just a gestalt on that? I would guess it's a younger population.

MR. ZARABOZO: Well, typically in MA, you do have a younger population, but we don't know if that's true also of the SNPs and duals, and among duals, what is the distribution there.

DR. HALL: Okay.

MR. ZARABOZO: So we can do that, but we don't have it yet.

DR. HALL: Okay. Thank you.

DR. DEAN: Just on the quality of care issue. If I understood what you said, we can pretty well document that these programs are more expensive. We can't really document that the care is really better. How difficult is it -- would it be -- to really kind of get the kind of data to know the quality or outcome issues? Is that something that's doable or is that out of our reach?

MR. ZARABOZO: Well, as we mentioned with the CAHPs data, we had the person-level data so that we could classify people by different categories. The HEDIS data, there is person-level data reported, so you could do a similar classification. CMS has the data. But for important measures like intermediate outcome measures, those are done by a sampling of medical records. So you would have to go through the whole process and say, well, you have given me a sample from your large group. Some of those people may be in SNPs. Some are maybe not. So what we want is a sample that is -- just do a sample of your SNP members

so that we can compare it to other MA plans on a similar sampling basis.

And then the other issue is how do you compare this to fee-for-service? We're not quite able to do the comparisons to fee-for-service. So --

DR. DEAN: So it would be difficult --

MR. ZARABOZO: -- something can be done, but not what you would really fully want to have done.

DR. NAYLOR: So Slide 14, first bullet, I just wanted to make sure that I understood. I thought I understood one thing from the paper, but this notion of exploring whether Medicare or Medicaid should assume full responsibility for duals, and that is full sets of services, long-term and health, medical -- I mean, is that -- it seems to me a movement and a different principle. Even on PACE, it's funding stream. So I just wanted to make sure --

MS. AGUIAR: Yes, exactly. We were -- and again, I think there was, you're right, a little bit more detail in the mailing materials about this. Here, we're sort of talking about merging the funding of the financial responsibility of the benefits to either the Medicare program or to the Medicaid program. So not working through

a third entity like you do in PACE.

DR. NAYLOR: Big change. Big implications.

MR. HACKBARTH: I was just going to say that -- and some people think that, politically, that's probably not likely to happen. But conceptually, if one of the problems is that we've got separate streams of funding, one way to solve that is to join these streams of funding in a PACE program or in a fully integrated SNP, bring the two sets of dollars together and allow that private organization to manage the money. A fundamentally different approach is to say, well, let's merge the funding streams at the governmental level and say either Medicaid or Medicare has full financial responsibility for this population.

DR. NAYLOR: I really like that we're open to exploring that.

MR. HACKBARTH: Yes.

DR. NAYLOR: I mean, so the other -- one other, beneficiary savings as a potential outcome. Are there other examples in the Medicare program where beneficiaries' savings, shared savings has been a part of our thinking and --

[Pause.]

DR. MARK MILLER: In our conversations, a couple of -- just a couple things to your comments. One is that in trying to set the direction for the Commission to go, we're trying to obviously exhaust all the possibilities to make sure that you understand there's a lot of different directions. Number one.

Number two, to your point, a few times in these conversations, in talking about the shared savings between the states and all this, there have been these one-off comments about where's the beneficiary in this. If everybody is getting something out of this, why aren't we entertaining the beneficiary? Which is where that thought came from.

To your specific question, other examples, and I'm happy to take some help here, but you could kind of say, in MA, when there is reduction off of baseline -- I'm not going to save savings because we don't think it's actually a savings -- supposedly that goes back into benefits to the beneficiary. There's something there, but it's flawed by the fact that it's not real savings and it doesn't go into the beneficiary's pocket, per se.

MR. KUHN: The ACE demo?

DR. MARK MILLER: The what? Oh, the ACE demo. But actually in the ACE demo, I'm under the impression that they're abandoning it because -- I don't know who I'm looking at. I'm looking at Kelly. They're abandoning it and apparently this was kind of interesting, so the beneficiary got some money back, and Kelly, if you need to get to a microphone you should do that before I do any damage here.

But the beneficiary was getting confused by the fact that they were getting money back.

MS. MILLER: By the time the beneficiary got the money back, they had sort of forgotten what it was for, that they were part of the demonstration. So it didn't seem like it was really driving their choices about where they were getting the care.

MR. HACKBARTH: And it might be a little bit more readily understood if it's an enrollment level sort of decision that, Okay, I'm enrolling in this organization and I get some benefit from that, as opposed to just a set of services, which is a little tougher for people to grasp. And I'm the person who usually makes the one-off comment about --

DR. MARK MILLER: I was waiting for you to say that.

MR. HACKBARTH: -- about how we're talking about how the Federal Government shares in the savings and the state government shares in the savings and the provider shares in the savings and the person, you know, almost never here mentioned is the patient, which is also, as people well know, one of my concerns about the whole ACO thing. Again, it's we're going to divide up all these savings and forget the patient in the process. So that's why I'm raising that flag from time to time.

MR. ZARABOZO: Also within MA, there is -- one of the uses of the difference between the benchmark and the bid is return -- a reduction of the Part B premium. So there is a cash option, also, within MA, not frequently used, though.

MR. BUTLER: So my --

MR. HACKBARTH: How frequently is that used? Just say a little bit more.

MR. ZARABOZO: It's not frequently used, except in Puerto Rico, because of the special circumstances in Puerto Rico. So some plans offered it, but typically what it is, it's they're offering reduction in the Part B premium, but

at the same time you have higher cost-sharing or not as many extra benefits. So it's a trade-off.

MR. BUTLER: I have two questions. One relates to how important is this to a state, and the second is, how ready are they to be a participant? With respect to how important it is, you say there are 10 million dual eligibles, 18 percent of Medicare enrollees and 31 percent of the spending.

Now flip it to the state side. How much of the Medicaid spending in the state is in dual eligibles?

MS. AGUIAR: I don't have that off the top of my head. I believe, and I'm looking at Carol Carter because she was here, but I know that she took the lead on doing a data analysis where we had combined Medicare and Medicaid spending. And so, I'll have to go back and check to see if we have that statistic.

MR. ZARABOZO: But it is significant because, of course, the large expense is the long-term care.

MS. AGUIAR: Yeah.

MR. ZARABOZO: Custodial care and home and community-based services. So there's a significant expense associated for the states with this population.

MR. BUTLER: Okay. So you're likely to be high -- it's likely to be high on their list as an opportunity?

MS. AGUIAR: Yes.

MR. BUTLER: Looking at states that are in bad fiscal shape tend to also have a fairly unprogressive Medicaid system in place and are getting ready for an expanded number of enrollees and they're hardly equipped to even do that.

MS. AGUIAR: Yeah.

MR. BUTLER: And so I'm trying to get a sense, how great a partner -- it's a little related to Bob's question -- how are they going to do all this stuff on top of just kind of running the basic business? So if you give -- is there any way you can give some subjective answer to the range of readiness at states? Because I could see maybe a very uneven roll-out of this kind of thing depending on how progressive the state is, who's in the leadership position. It would impact a little bit about how I would feel about which way to go.

MS. AGUIAR: Right. So again, our previous research, when we were looking at the integrated care programs that really had been up and run by the state, we

got more of a sense of some of the barriers on the state side, and they were very frank and honest with us, and some of it was that they just don't have the resources. It requires just a lot of up-front work to develop these programs.

However, there is an advantage to them to do so because if you could have a program -- and, you know, we have seen this evidenced with the PACE program that they do this -- that they can sort of successfully manage the community-based long-term care of the nursing home certifiable population and keep them in the community as opposed to the nursing home, there is the potential for Medicaid savings. So that is the incentive for them to do so.

I mean, that said, we have heard just sort of very anecdotally that some of the states that expressed initial interest in some of these demonstrations may have to delay implementation of it, you know, just because there's a lot of things to figure out and they have a lot of other things going on, a lot of other pressures.

So even though in some states I do feel it does appear to be that this is a priority to go through these

demonstrations, some of them just may not be able to -- at the official time line, which CMS has set up the time line to sign the contracts, the three-way contracts by September. And so for some states, it seems like they won't be able to do that.

So I think originally there was about like 38 states, I think, that had submitted letters of intent to do other, the capitated model or the managed fee-for-service model, and it seems like what we're hearing is that there will be less than that that are able to do it.

MR. HACKBARTH: Christine, so one reason why a financially strapped state is interested is that they see an opportunity, perhaps, to reap some Medicaid savings by moving people out of institutions into lower cost settings. But also, aren't they motivated by an interest in sharing in Medicare savings?

MS. AGUIAR: Right. So the managed -- under the managed fee-for-service model, they will be able to save in some of the Medicare savings, to the extent that there are Medicare savings generated from that program, and they meet certain performance measures.

What is less clear, and I don't feel like I've

seen this explicitly stated in some of what's come out about the capitated model, is when CMS talks about forming these three-way contracts between the state and the health plan and CMS, and they say that the capitated rates will provide for up-front savings to both programs, but then some of the states in their applications say that they don't think that the Medicare money will only go to cover -- only go towards the Medicare services, that they will be able to cover some Medicaid services.

It's not clear whether or not in that negotiation of the capped rate and what Medicare spending could be used on, if there will be an opportunity for the states to capture some of that Medicare savings, which is why we wanted to raise the issue of while we understand the rationale, the rationale for why some of the states felt they should be sharing in the Medicare savings, we did want to address the issue of, you know, to the extent that these states are realizing more immediate long-term care savings, you know, if they will be going into these negotiations with CMS expecting to receive some of the Medicare savings, you know, one of the things that could be considered by the Commission is whether or not the potential for the states to

share in their own Medicare savings should be taken into account and, you know, whether they should share in the Medicare savings at all.

MR. BUTLER: So I won't comment on Round 2, but I think that in this case, I mean, our client is Congress. I think we can provide some important guidance and thoughts to states as a client on this and saying, Hey, this is how you might engage and solve some of your own problems. So I would think about them as a reader of this report as well.

DR. CHERNEW: So I have two quick questions. The first one is, who determines the state's share of the capitated payment portion? Is that just done through negotiation or is there a -

MS. AGUIAR: Yes, that's done through the negotiation. And again, the way that it reads so far -- our understanding to date, is what I want to caveat it with that -- is that in this negotiation there will be an opportunity for both Medicare and Medicaid to save, and it's not clear yet whether or not the states will share in some of that Medicare savings, but it will be done on a state-by-state basis.

DR. CHERNEW: And on a negotiated basis.

MS. AGUIAR: Right.

DR. CHERNEW: My second question is --

DR. MARK MILLER: And you mean in the demonstration.

MS. AGUIAR: In the demonstrations.

DR. MARK MILLER: Right.

DR. CHERNEW: It will, but I assume a he demonstration is going to set the groundwork for how you might go forward, particularly if you're doing it on a state-by-state basis.

The second question I have is, I find the idea of moving to this sort of capitated, single stream payment very appealing as a general rule. Have there been attempts to then simplify other regulations? Or do, in fact, regulations, when you do that, become more complicated because now you have to account for more things?

So I want to know what other barriers there are besides just the financial separation that prevents integration and whether or not those barriers rise or fall when you integrate the finances. Do you find everyone requiring a more detailed accounting of every penny, or are they more willing to accept the capitated rates and have

less detailed accounting of every penny?

MS. AGUIAR: I'll just say, we don't know that offhand, but we'll look into that for you.

MR. ZARABOZO: One of the purposes of the Duals Office in CMS was to address the other issues of why is it so hard to integrate, to have Medicare and Medicaid together, including, for example, appeals processes, enrollments and so on.

DR. CHERNEW: And I can see they have different utilization procedures and then you get into a big fight about whose takes prominence.

MR. ZARABOZO: Yeah. So I assume that would be part of the negotiation, is what rules apply, essentially. I'll put it that way.

MR. HACKBARTH: So there are differences within the fee-for-service programs at Medicare and Medicaid, but I think Carlos has pointed out that even at the plan level, there are very different rules that need to be reconciled and perhaps streamlined.

DR. CHERNEW: Understood your answer. The answers to whatever that is could differ by state. So it could be different in New Mexico and Ohio.

MR. ZARABOZO: That appears to be the case, yeah.

MS. AGUIAR: And I do think, though, there is some -- when CMS put out the -- it was in a state Medicaid director's level letter. I keep referring to it as an RFP, but it wasn't. But when they put that out, they sort of had laid out what some of the opportunities that they wanted to be able to align, do some of the financial alignment opportunities within that. So I think they are sort of, because it happened.

As Carlos said, they have been doing this back work to see what some of the barriers in the current system are. So I think they are trying to fix some of those under these demonstrations.

MR. GEORGE MILLER: Just a quick one. I'm intrigued by the PACE Without Walls and wondering if you have more information to share about how that may look, or is that something that we would allow the organization or the state to define for us. Have we looked at that?

And then possibly a second part of the question, what potential savings could there be if they're not limited by fiscal being and providing better benefits for their beneficiaries?

MS. AGUIAR: I can address the first one a little bit more. The savings piece, that would really have to -- I think the first step is sort of to define what it is, and the second thing to be, how would we pay for it. And so, we have thought about this. Just in our interviews, just with PACE providers and just all around, this keeps coming up as a possibility.

Interestingly, Oregon is sort of -- has asked permission to try to test a little bit of this. And so, what it really means is, the PACE model, which again there is evidence that shows that it does reduce hospitalizations and nursing home use, it's very focused on this day care center. And you have an IDT and multi-disciplinary -- you know, IDT team that really is closely monitoring.

And so, the idea of the PACE Without Walls is that, do you need that day care center? Can you have this multi-disciplinary team that somehow is maybe using telephonic management, maybe it's mobile, that could maybe perhaps -- and maybe it's perhaps for a less frail population that that could work. So it could expand to serve more beneficiaries. That's sort of the idea.

When we reported on our PACE site visits that we

had done in the fall, our hypothesis really going into that, the reason why we wanted to go see the rural PACE sites was because we thought that they might have had to have relaxed their model a little bit, and then maybe they would sort of see the challenges of operating in that environment.

You know, they would be, perhaps, a little bit more supportive of this. And so we didn't actually find that to be the case just amongst the people that we had interviewed, but we know that there is still interest in it.

And so, you know, the reason we put this as a future step is, could you think a little bit about it more? What would it look like? And then, you know, if it is so much altered from PACE, at what point does it become a care model that perhaps a managed care plan could offer? You know, is it sort of a stand-alone thing? Is it a piece of a larger program? And then that gets into how you pay for it, how would you pay for it.

MS. BEHROOZI: So just on the spending, so we don't see savings on the Medicare side with the sort of intensive programs, and I guess we don't have access to all the data on Medicaid spending, but is there anywhere, I mean, anyone, CMS, MACPAC, anybody looking at total Federal

spending on these programs, you know, the Federal share of Medicaid added to Medicare spending and seeing whether that's impacted?

MS. AGUIAR: You mean --

MR. HACKBARTH: Any SNPs in particular.

MS. BEHROOZI: Yeah, the PACE, PACE and these intensive SNPs, the dual SNPs.

MS. AGUIAR: To my knowledge, no, but we would have to go back and ask them, because I don't remember specifically asking them if they were considering -- if like MACPAC, for example, is considering to look at that now.

You know, one of the things that we did propose that we could look into further really are, when analyzing the payment system for the five SNPs, you know, one of the things we proposed -- this was more in the mailing materials, not in the presentation -- was to really look at their cost structure.

And if we were, you know, both through data that we have and then through interviews, and if we could do that, we're hopeful to try to get a sense of what's going on on the Medicaid side from them. But we could check with MACPAC to see if they have plans about that.

MR. HACKBARTH: So, let's see, in mid-February, Mark and I met with MACPAC on the issue of duals, and just wanted to raise a couple things that came up there. The first point is sort of a contextual one and it relates to Bob's initial question and that's, how fast is this particular train moving.

And it relates to this question, are we going to be seeing statewide programs under this CMS initiative where all of the duals in a given state are moved into new models, or are we just seeing what we would consider traditional Medicare demonstration projects?

And I don't know the answer to that question. One of the MACPAC Commissioners was saying he thinks it's definitely in at least some of the big states. They're talking about moving statewide, Massachusetts, California, I think are among them. So we're talking about potentially a lot of people and a fast-moving train here, which has implications both for MedPAC and MACPAC participating in this discussion.

Then much of the rest of the conversation focused on this issue of passive enrollment. Frankly, to my surprise, there were a number of MACPAC Commissioners, some

of which I wouldn't have expected, who were strong vocal supporters of passive enrollment, believing that the care that the patients are receiving in the current arrangement is so un-coordinated, in some cases poor, that the opportunities, just from a patient perspective and a quality of care perspective, were quite large, and the only way to move quickly in that direction was through a passive enrollment process.

I must say that I continue to have some reservations about passive enrollment based on the fact that the dual population is so heterogeneous, the needs are so diverse. You know, there's a segment of the dual population that's dually eligible, principally because they have low income and low assets.

On the other hand, we've got people with significant cognitive impairments and physical impairments and very different sorts of challenging clinical needs to deal with. You know, the typical managed care plan may be just fine for dealing with people who are just low-income, but it may not be well matched to the needs of a patient with significant cognitive impairments or significant physical disabilities.

And those organizations that can care well for those sub-populations have very particular clinical set-ups that allow them to be effective. And those clinical organizations are not, you know, just everywhere, statewide in Massachusetts or California.

And so, you know, quickly moving duals on a statewide basis, the whole population, given these diverse needs and the scarcity of the clinical organizations, I worry about, frankly.

The other part of the conversation, very related, is if you have passive enrollment, what does the patient need to do to opt out and how quickly can they opt out? Say it's a patient with significant physical disabilities and they find themselves enrolled in a private plan that really doesn't have the care delivery system that can meet their needs, how quickly can they get out?

My concern about passive enrollment would be, the least, if they could get out immediately and had month-to-month dis-enrollment. But again, somewhat to my surprise, there were a number of people at the MACPAC session saying that month-to-month dis-enrollment doesn't work, and that, in fact, the providers who might lose money because of the

effective management of the care, say a nursing home, they get the patients to quick dis-enroll because they see it as potential lost revenue as a result of better management.

And so, they want not only passive enrollment, but lock-insurance for fairly significant periods of time. And that combination of passive enrollment with lock-in, given the diversity of the population, causes me a significant amount of anxiety and if, in fact, this is a fast-moving train where we're going to see large states go statewide with this, I'm a little uneasy.

DR. BERENSON: Well, first let me associate myself with all those remarks and go -- up you a little more, if I could. I looked at the discussion about performance measures and I don't think we have good performance quality measures in this area.

I mean, I think the HEDIS measures are mostly irrelevant, even for an elderly medical population. They don't address those with physical disabilities. They don't address those with serious mental disability. So I don't think we can rely for good -- I mean, I just don't think the HEDIS measures are going to help us very much.

And outcome measures in this area are sort of

challenging as well. So I think we, at least for the foreseeable future, are going to have to rely more on oversight and requirements, structural requirements, and it makes me nervous that we don't necessarily have those in place, although obviously we'll see what the states propose, but I would be very concerned.

On the passive enrollment side, I have no problems with the concept of passive enrollment into a high quality accountable organization. I have great problems with passive enrollment into an organization that has no experience in this area and is being selected partly because of budget predictability.

So in terms of your questions about what we should be focusing on, so far the discussion hasn't been very much about SNPs, per se. I do think because there's a reauthorization -- when is the reauthorization for the SNP program?

MR. ZARABOZO: The duals have to have -- the contract requirement is beginning 1/1/2013, so in other words, if you don't have one now, essentially, you know, in the next few months.

DR. BERENSON: I thought the program had to be

reauthorized.

MR. ZARABOZO: The program also, in general, for 2013.

DR. BERENSON: That's what I wanted to know. I think to be relevant to our sort of customers, who are the Congress, I think we probably do want to look at the SNP program specifically over coming months and see if we want to make any recommendations about that reauthorization.

But short term, it seems to me the opportunity to develop -- and this would be challenging, but I'll throw it out -- develop some basic principles or criteria under which we think these demos should go forward related to protecting beneficiaries as well as protecting Medicare trust fund dollars, I think would be a useful early activity.

What you've done is listed a whole bunch of activities which I all think should be done. We've actually started in this area last year -- well, two years in 2010. I mean, I think we are proceeding in a very logical step-wise fashion, and I would hope we could ultimately get to the big Kahuna here which is who should take financial responsibility.

But I think we can't do it all at once and so, if

I were giving a priority for the immediate future, it would be being able to comment on those demos, so developing a basis for commenting on those demos and getting into more detail in the SNP program so we can provide some guidance on the reauthorization.

MR. HACKBARTH: Can I just say one other thing? I just want to make sure that I don't leave any inaccurate perceptions about my conversations of MACPAC. I did mention that because I wanted to make it clear to the Commissioners that we have engaged with MACPAC on an issue of mutual importance, and, you know, I took care to say with some MACPAC Commissioners, I have no idea what the overall point of view is within the Commission. You know, we didn't take a straw vote, and as in any conversation, there are some people who are more vocal and participating more accurately. And so I focused on just some things that I heard from some of the MACPAC Commissioners that caught my ear and raised some issues in my mind that may or may not be an overall reflection of the point of view in MACPAC. I just want to emphasize that.

DR. HALL: I think this is really, really important. You know, there's something about the use of the

term "duals" that it tends to sanitize what this population is really like, socially and medically. I occasionally think about Hubert Humphrey's quote that's carved into the marble at HHS that says, "You judge the character of a country by how it cares for its youth, disadvantaged people, and old."

These are people who are the most vulnerable group of individuals in our society, and by the by, they're consuming 33 percent of Medicare resources right now. They're vulnerable -- I think this is a time where they are particularly vulnerable because of differences of political opinion on the role of Medicaid, the role of Federal supports, and they're a group that can't really advocate for themselves. You don't see them lined up on the steps of any Capitol protesting very much.

Also, I think 20 years from now duals will include a very, very large proportion of older adults, I mean, a huge -- not a huge number, but a very large number who will be, by definition, dually eligible for Medicare and Medicaid. And there's a hint that there might be better programs available for them if we could figure out some of the intricacies of managing both of these payment streams.

So I think we need to emphasize kind of the human aspects of this as we go through this, that this is a very important population that is probably a growing population. So I agree entirely with what both Glenn and Bob have said. Also, I think we then need to take a look at some other quality measures. While influenza vaccination is a good metric and I applaud any group that gets good compliance with that, it really doesn't measure the things that are important to this group of people, who really, as you mentioned, can't make decisions very well for themselves often, who have very complex problems that transcend just what we pay for medical services.

So I don't think we should drop this. I think that we should try and find if there are better ways of expressing the merit of the program other than what we've looked at. I don't know what those are off the top of my head.

DR. DEAN: I would just echo what Bill said.

DR. MARK MILLER: I would just say this: Peter, you asked the question earlier. About 18 percent of the people, 30-some-odd percent of dollars on Medicare, 15/40-ish on Medicaid. So I think that's what you were asking,

what were the comparable portions.

MR. BUTLER: So, what, 15 percent of the Medicaid members and 40 percent of the Medicaid expenditures of the state.

DR. MARK MILLER: Right, so it is serious business for the state, and then to these comments, you know, that were being made up here as to why there's so much interest.

MR. BUTLER: That's bigger than I would have thought.

DR. CHERNEW: So I think based on past stuff that I've seen here, it's pretty clear to say that we have -- it's a very important population, and we have a lot of problems in the seams and a lot of things happen like churning between sites and gamings across programs and regulatory things that don't work. So I think there are probably a lot of aspects of inefficiency here, and a lot of room for improvement. And I think the challenge, in the spirit of the other comments, is that in the best cases you could see where this works wonderfully and where you can do a lot better. And in the worst cases, you could see where things could really go bad.

And so the challenge is we don't want to let the

sort of bad be the enemy of the good, so I think we have to figure out a way of going forward with this, and I'm very supportive of many of the models that were discussed. But I guess we have to make sure that we can do so in a way that the inevitable protections we put into place don't make the entire exercise worthless.

And I have to believe that there are ways to go forward, and in terms of focusing our energy, I think illuminating what those are, the places where we can get important improvements, I think that's where I would focus. And for me, what I'd like to understand is how prevalent are what I would call basically high-performing places in these states that really could do a good job and we could limit it to those places and we could have a program with some sort of entry -- in order to be eligible, you have to meet the following criteria. Is that a lot of groups? And so we really could think going forward -- are there really only a few organizations that are kind of the exception rather than the rule? I'd like to think that the former is true, that there's a lot of organizations. I've spoken to many that would say their lives would be much simpler if they could take dual stream funding with appropriate regulatory

simplification, and that they would do a great job for this population. And I actually believe that that's true. And I always feel somewhat sheepish when they note all the incredible barriers to doing that. And I think finding a way to remove those barriers without letting in a whole bunch of bad stuff should be the top priority.

MR. ARMSTRONG: I just would affirm I really support the way you're talking about going forward with this, and I really appreciate and agree with many of the comments that you all have made.

The one thing I would add would simply be I'm not sure we've really identified and we should think about how we could advise Congress or whoever on how is it that this is an issue that everyone agrees is so significantly important, and admittedly complex, but there are a lot of other complex issues, but why is it so hard for us to move this forward? Are we really asking that question and answering it in a way that allows us to be a little bit smarter about trying to get some acceleration moving forward with some of this work? I just don't know.

MR. GRADISON: This is a learning experience for me, and I certainly congratulate you for the work that

you've done.

My sense of it is that the states, somewhat in desperation, probably in desperation, are rushing to change their model of care not -- for all their Medicaid beneficiaries by moving whole blocs of people, sometimes trying to move the whole state into managed care in a very short period of time. What I'm going to say is not particularly logical, but just so you know what I'm thinking about, I think it's going to be important to try to monitor what's happening state by state with this migration of total population, not just the ones we have an interest in because they're duals, but what's happening at the state level in terms of quality of care and in terms of cost and in terms of the administrative capability of the managed care plans so quickly to take up such large numbers of people with such diverse needs.

Again, this may seem to be broadening it in a way that gets beyond what we're directly involved in, but somehow I have a feeling, at least for myself, that watching more carefully than I have in the past what's happening at the state level for their whole populations may help to inform us better what might be appropriate for this very

large segment, but not the whole Medicaid population.

DR. CASTELLANOS: It's just my experience in dealing in this group of patients, both the dual eligibles and the Medicaid patients, that there are -- like Bill said, these people are really critically in need of care. My observation, however, is that there isn't always good access to their care, and under the law they're supposed to have equal access. I would really like us to kind of look at that because I really don't think that's happening today.

MS. BEHROOZI: Just to share some of my colleagues' concern, among this population there are a lot of sicker, older people, but there are also people who have recently aged into Medicare, and they're, you know, just below the line. I mean, we have people, unfortunately, who work for a living who qualify for Medicaid, and then when they become 65 years old, they are eligible for Medicare, and, you know, they're sort of -- they're, you know, on the margin, but they're not necessarily old and sick. And, of course, they need care coordination just like all the rest of us do. We all benefit from that when we need health care services.

But to see them as a part of a monolith that can

be moved around by fiat I fear their commodification. And I love the way we started this conversation about looking at -- - I don't mean today's conversation. I mean in general the work that you have been doing, looking at the programs that can really deliver high value for those in high need. But then to sort of move the conversation along, which I think we need to do, but I do think it's a little bit different, to what to do about duals and we encounter the challenges that states are facing and the sort of dramatic actions they're taking in response to their budgetary crises with this whole bloc of people and moving them around. And in my own state, which shall remain nameless -- you know what it is -- we're right in the middle of this transition of long-term care into first Medicaid managed care -- this is just for, you know, the disabled people who are not yet eligible for Medicare -- and soon-to-be Medicare eligibles who will at least have to receive their long-term care through managed long-term care companies, not necessarily SNPs.

The wrenching transition, the lack of preparation of the carriers -- and I'm experiencing it just from a little window where we pay for the health care of the people who provide these services, and I try to talk to the people

running these Medicaid managed care companies about, okay, so, you know, you're supposed to be helping us track the hours that people work to see if they're eligible for health care coverage based on the services that they're providing that you're paying for, and they're like, "What are you talking about? Really? I don't know anything about long-term care. We'll deal with it when we get to it."

And that's not even the care of the people they are now responsible for a benefit that they've never been responsible for. So that's not to criticize them. They will get there. They're smart people. They're caring and concerned and whatever. But, anyway, I'm just adding you voice to the cautions about taking this bloc of people and doing stuff with them that may or may not make sense, especially to do it abruptly.

DR. BAICKER: I think all of the cautions that have been raised are really well taken, and it highlights in some ways that this group amplifies all the things that we've been talking about throughout the last day and a half, that risk adjustment is particularly important in this group because of the heterogeneity of the group and the complexity that they disproportionately represent. And care

coordination is particularly important with this group because of them moving not only across providers but across insurance silos.

So all of that makes things hard, but on the other hand, it makes the returns to getting it right that much greater, that there are a lot of dollars at stake and there's a lot of health to be produced in this group so that it's worth investing in getting those coordination items right, especially in this group. And the fact that the state plays such a prominent role in some ways offers more opportunities to experiment with different delivery mechanisms.

So I think states moving whole-scale their populations is not necessarily the best model for that, although sometimes it might be if they're trying to do big coordinated entities. But we should be working with them to promote that kind of experimentation because the returns might be really great in this group and then would let us draw some of those lessons to the broader population.

MR. HACKBARTH: Any other comments? Mark, anything you want to add to this or ask in order to get direction for the next phase?

DR. MARK MILLER: I was going to have that conversation with the two of you and sort through what we think we heard here. So that's how I was going to deal with it.

MR. HACKBARTH: Okay. Thank you very much. Well done, Christine and Carlos.

We'll now have our public comment period.

Up here is the slide with our ground rules for the public comment period, so please do begin with your name and your organization. And when this red light comes back on, that will signify the end of your time.

MS. CARLSON: My name is Eileen Carlson with the American Nurses Association. I just wanted to comment with respect to care coordination for dual eligibles. I think one of the major barriers to achieving this with respect to the disabled population -- who I'm not sure what percentage they account for as beneficiaries, but I imagine that their expenditures are way out of line with the percentage of the population they account for -- is that what has happened over the past few decades, people with especially congenital disabilities are surviving to a much greater age than they used to. And, unfortunately, the health care system hasn't

really kept up with that.

For example, for particular disabilities there are multidisciplinary clinics in children's hospitals, and yet as that population ages, those clinics are often closed to them, and they go out to the community, and their care is much more fragmented.

So that's just something I wanted to raise to your attention, and I would be interested to see what you all have to say about that.

MS. WILBUR: I'm Valerie Wilbur. I'm with the SNP Alliance. We represent about half of the SNP enrollees in the country. We have about 31 organizations that provide services to about 250 plans, so we have a pretty good cross-section of that population. I wanted to make several comments.

First of all, I wanted to say in moving forward, instead of looking at just D-SNPs and FIDE-SNPs, I suggest that you also take into account institutional SNPs and institutional equivalent SNPs because, at least on the facility-based side, over 90 percent of their beneficiaries are dual eligible, so they have real relevance. And those SNPs have done phenomenally well in terms of producing good

outcomes like reducing hospitalization and emergency room rates.

I wanted to second Dr. Berenson's suggestion that we think about the kind of measures that are being used to look at SNPs. I wouldn't say that HEDIS, HOS, and CAHPS measures are all bad for the populations. I think you need to look at which measures you're considering in relation to which special needs populations are being targeted by different SNPs. But I would say that they might not be the most meaningful in looking at whether SNPs are really doing anything different than what they should be doing to achieve effective outcomes for high-risk populations.

I can't remember whether Christine mentioned this, but you probably know that NQF and NCQA are doing a lot of work on appropriate measurement for the dual populations right now, and they're very bullish on more population-based approaches.

Also, SNPs have to report on structure and process and model of care -- excuse me. They have to report on structure and process, and they have a series of model of care-related elements that they have to do, and neither of those two pieces are currently included in plan ratings.

That's something that we'd like to see, although they did just add a new HEDIS measure for care of older adults, which we're really happy about.

The SNP Alliance has said really since the beginning that we really think we need to focus on outcomes, things like inpatient hospitalization, readmissions, emergency room, and long-term placement in nursing homes. And the SNP Alliance has just gotten results back from our fourth annual survey of just our members -- not all SNPs but just our members. And one of the questions raised was, you know, whether the FIDE-SNPs, for example, and some of the other SNPs are doing better than others. And what we find is that for the FIDE-SNPs, their inpatient utilization per thousand beneficiaries is significantly lower than fee-for-service duals. So 2,509 days per hundred -- or excuse me, per thousand versus 3,327 days for the fee-for-service duals. And each year in the last three years, they've reduced that number by 10 percent.

They also have 72 percent of the FIDE-SNPs didn't have any hospitalizations in the 2010 data, and the percentage of people -- the percentage of duals in fee-for-service had five times as many hospitalizations in one year

relative to the FIDE-SNPs. So they're doing quite well there. They also have much lower ER rates. And the statistics for the I-SNPs are even more impressive. They had 1,820 days per thousand compared to 7,497 days per thousand in fee-for-service, and their emergency rates were 351 per thousand versus 714 visits compared to fee-for-service. So that's one of the reasons why I really encourage you to look at what are I-SNPs doing to help keep those rates down.

I haven't seen -- is the red light on?

MR. HACKBARTH: Yes.

MS. WILBUR: Okay. I'm sorry. I wanted to echo what the other person said about the disabled. We have three members in Minnesota that were part of the Minnesota Disability Health Options Program that had to close because of the rates, problems with the rates when the frailty adjuster was taken away.

Thank you very much.

MR. HACKBARTH: Thank you.

MS. SHEEHAN: Hello. Kathleen Sheehan with the Visiting Nurse Association representing nonprofit home health and hospice. I just wanted to echo what the

Commissioners were talking about today in terms of the differences between the benefits and how that works for duals.

For example, in the Medicare home health benefit, you have to be homebound, a skilled service. For Medicaid that's different. We find that Medicaid directors sometimes get mixed up on whether or not they can require homebound status. We've been working with CMS to be sure that Medicaid directors understand the differences as they do all these different kinds of things. We have recommended that HHS consider sending a "Dear Medicaid Director" letter. We think that would be very helpful.

One of the difficulties for patients, of course, when you come into this if you're a dual, you come out of the hospital and you're on Medicare. You get the home health benefit. Then you get off the benefit. You get put on Medicaid. Then you have some sort of a crisis. You go back into the hospital. Then you're on Medicaid. So how is the patient notified? How does that happen for the patient? I think there's a lot of concern about what sort of notices the patients get and how that works in terms of the patient experience?

Last, but not least, the billing process has been a nightmare in Region 1 and 2. CMS did hold a very interesting listening session. They basically had a Medicaid director get on, state associations get on, and they had all of the people within CMS who were involved in the appeal process largely saying that CMS is spending an incredible amount of time dealing with appeals, and that has been I think because we have some Medicaid directors that have said to providers, "You must submit the bill to Medicare first, whether or not they meet Medicare standards, and bring us back a rejected bill before we'll deal with this."

Actually one of our members told us the other day that they were actually told to send a note to the physician saying, "You need to declare this patient to be homebound so we can submit it to" -- this was a Medicaid office telling this to a provider. "You need to submit it so they can be homebound."

So the billing situation is a nightmare, and I think that HHS is spending a lot of time trying to deal with this. So we appreciate any thought and attention that you all give to how do you blend these two diverse benefits, how

does it affect patients, and then how do we straighten out the billing process so that it doesn't take up a lot of provider time and a lot of CMS' resources.

Thank you.

MR. HACKBARTH: Okay. Thank you. We're adjourned.

[Whereupon, at 11:46 p.m., the Commission meeting was adjourned.]