

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 3, 2011
9:03 a.m.

COMMISSIONERS PRESENT:

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SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
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MICHAEL CHERNEW, PhD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [9:03 a.m.]

2 MR. HACKBARTH: Okay. It's time for us to get
3 started. Welcome to our guests. At this month's meeting,
4 we will be voting only on one set of recommendations, those
5 having to do with the PACE Program, and that will occur this
6 afternoon right after lunch.

7 We begin this morning with a discussion of
8 reforming Medicare's benefit design, a topic that we've been
9 discussing now for quite some time, and I think coming to
10 the point where we're nearing some conclusions. So Julie,
11 are you leading off?

12 DR. LEE: Good morning. In today's presentation,
13 we continue our discussion of potential changes in
14 Medicare's benefit design that we began last month. The
15 Commission has been considering ways to reform the
16 traditional benefit package to give beneficiaries better
17 protection against the high out-of-pocket spending and to
18 create the incentives for beneficiaries to make informed
19 decisions about their use of care.

20 The Commission has been also particularly
21 concerned about the potential impact of such changes on low-
22 income beneficiaries and those in poor health. There's a

1 basic tension between these goals. We want to protect and
2 insure beneficiaries from financial risk, but if we provide
3 too much insurance, then there's little reason for them to
4 think carefully about what and how many services to use.
5 And since people respond differently to risks and
6 incentives, that adds another layer of complexity.

7 In last month's presentation, we discussed the
8 current fee-for-service benefit design. The key components
9 were that current benefit leaves a small group of people
10 owing most of the cost-sharing, and most people get
11 supplemental insurance to cover their liability, but it's
12 often expensive and not always available.

13 Taking these issues into account, we presented
14 three alternative benefit packages for you to consider. In
15 today's presentation, we shift the focus to the role of the
16 supplemental coverage, specifically we used the MA-neutral
17 package, which is highlighted on the slide, to illustrate
18 alternative policies related to supplemental coverage.

19 If benefit design is about what the Medicare
20 program pays for, then supplemental coverage is about
21 beneficiaries pay for what the program does not.
22 Beneficiaries currently have different ways of covering

1 their share of Medicare spending and their choices have
2 consequences for the Medicare program. Because the most
3 common supplementary insurance that fills in all of
4 Medicare's cost-sharing, it hides the prices and leads to
5 higher use of the services, both the necessary and not
6 necessary.

7 Today's presentation is in three parts. First, we
8 review the role of supplemental coverage. Second, we
9 overview our basic analytical framework. And third, we
10 present preliminary results illustrating the effects of the
11 three alternative options related to supplemental coverage.

12 We begin with a very quick review of why
13 supplemental coverage matters. The classic results on the
14 effects of cost-sharing come from the RAND health insurance
15 experiment. Among its most important conclusions are, cost-
16 sharing decreases the use of both the effective and
17 ineffective services, but increased cost-sharing had no
18 adverse affect on most participants, although there were
19 exceptions among the poorest and sickest.

20 Once people decided to get care, however, cost-
21 sharing had only a small effect on the intensity of cost of
22 an episode of care. A recent review of the literature since

1 RAND found that the key results are still valid. Focusing
2 specifically on the Medicare population, most research has
3 found that those with the supplemental coverage tend to have
4 a higher service use and spending.

5 As we go through our analysis, it might be helpful
6 to organize things into three buckets. They are intimately
7 intertwined so we will just start from the top with the
8 benefit design elements. There are various design
9 parameters including, but not limited to, out-of-pocket cap,
10 deductible, co-payments, et cetera. They are the levers you
11 have to change the shape of the benefit package, and we can
12 include the policies related to supplemental coverage in
13 this bucket, also.

14 Following the arrow to the value of the benefit,
15 the combination of design elements will determine the
16 overall value of the benefit package, and there are
17 different ways to measure or benchmark its value. For
18 example, it can be done with respect to how much the
19 Medicare program spends or, in contrast, to how much the
20 beneficiary is responsible for.

21 And moving to the left of the slide, what the
22 Medicare program spends on the benefit package will also

1 determine the budgetary impact. To illustrate how these
2 three things are related to each other, suppose we start
3 with a budget constraint that whatever benefit package that
4 you create must be budget neutral. In other words, zero
5 budgetary impact. If we set the out-of-pocket cap at \$5,000
6 with a deductible at \$1,200, along with the various co-
7 payments included in the alternative packages from last
8 month and keeping beneficiaries' supplemental coverage
9 unchanged, then the program spending under this package will
10 be approximately equal to current law.

11 Now, suppose that you want to try a different
12 combination of design elements and limit supplemental
13 coverage to fill in only half of the co-payments while
14 holding other elements the same. Then the program spending
15 would be lower and there will be a substantial budgetary
16 impact. This was an example to show the mechanics of the
17 feedback loop, as shown on the slide. For the modeling
18 analysis presented today, we used one of the benefit
19 packages from last month as an illustrative example.

20 Before we turn to the results, there are a few
21 basic assumptions in the model that you should keep in mind
22 as we look at the numbers. First, we used two sets of

1 estimates on how beneficiaries respond to changes in cost
2 sharing. They are discussed in more detail in your mailing
3 materials. For convenience, we used the results based on
4 the elasticity assumptions throughout the presentation.

5 Second, we made some simplifying assumptions
6 related to supplemental coverage. We assumed the average
7 annual premiums of \$2,100 for Medigap and \$1,000 for
8 employer-sponsored retiree plans. These are, of course, a
9 highly stylized at best since premiums do vary widely. We
10 also assumed that beneficiaries keep the supplemental
11 coverage that they have and do not switch in response to any
12 benefit or premium changes.

13 As we previewed at the beginning of the
14 presentation, our general strategy for today's analysis is
15 to take one specific benefit package as an illustrative
16 example and then show three alternative options on
17 supplemental coverage. The benefit package used in the
18 analysis is the MA-neutral package from last month. If
19 you'll recall, it was labeled MA-neutral because it had the
20 co-payment structure more common under Medicare Advantage,
21 and it had approximately the same average cost-sharing
22 liability as the current fee-for-service.

1 The package has a \$5,000 out-of-pocket cap and a
2 combined deductible of \$750. It also has a \$600 per-stay on
3 hospital, a \$25 co-payment on physician, and \$100 on
4 outpatient visits, and a \$100 co-payment on per-day on
5 skilled nursing facilities. It also has a 20 percent co-
6 insurance on DME and 5 percent co-insurance on Home Health.
7 The overall cost-sharing liability under this package was
8 roughly equal to current law.

9 In today's presentation, we considered three
10 alternative options related to supplemental coverage. They
11 vary in the degree to which Medicare's cost-sharing can be
12 filled in by supplemental insurance. Under the first
13 option, supplemental coverage remains unchanged and it
14 continues to fill in Medicare's cost-sharing as it does now.

15 Under the second option, it is not allowed to fill
16 in any of the cost-sharing at all. And finally, under the
17 third option, it can't fill in any of the deductible, but it
18 can fill in half of the co-payments.

19 This slide presents the preliminary results of
20 simulating changes in out-of-pocket spending and premiums
21 for 2009 if the alternative benefit package had been in
22 effect and was combined with the three options on

1 supplemental coverage. The three bars correspond to the
2 three options, so let's look at some results.

3 Under the option that leaves supplemental coverage
4 unchanged, that's the first bar, 11 percent, that's 7
5 percent and 4 percent at the bottom of the stacked bars, 11
6 percent of beneficiaries would see their out-of-pocket
7 spending go down by \$250 or more, and about one-quarter of
8 beneficiaries would see their out-of-pocket spending go up
9 by at least \$250.

10 Now, let's look at the third bar. Under this
11 option, when supplemental coverage is allowed to fill in
12 half of co-payments but none of the deductible, 36 percent
13 of beneficiaries would see their total out-of-pocket
14 spending go down by \$250 or more, and 29 percent would see
15 it go up by \$250 or more. This is because while their
16 supplemental premiums go down, they now have to pay the \$750
17 deductible out-of-pocket first.

18 The impact will vary, of course, based on
19 individual circumstances. Overall, that change in total
20 out-of-pocket spending will vary by the beneficiary's level
21 in mix of service use and his supplemental coverage. For
22 example, people who might see their total out-of-pocket

1 spending go down tend to be those with very high spending
2 above the catastrophic cap or with the hospitalization if
3 they don't have supplemental coverage.

4 Or if they have supplemental coverage, then those
5 with a pretty small cost-sharing liability compared to their
6 premiums would also see their total out-of-pocket spending
7 go down. In contrast, people who might see their total out-
8 of-pocket spending go up tend to be those with the high Part
9 B spending, but no hospitalization if they have Medicare
10 only, and those with the high spending but below the
11 catastrophic cap if they have supplemental insurance.

12 We also calculated the relative change in annual
13 Medicare program spending under the three supplemental
14 coverage options. For example, using the first set of
15 behavior assumptions, program spending would increase by
16 about 2 percent under the alternative benefit package if
17 there's no change in supplemental coverage.

18 In comparison, under the third option in which
19 supplemental coverage fills in half of co-payments, program
20 spending would decrease by about 1 percent. Although these
21 are not budget scores, per se, they do indicate the relative
22 budgetary effect of the alternative benefit package under

1 different options related to supplemental coverage.

2 We want to reiterate several caveats and
3 limitations of our modeling results. First, as the previous
4 slide points out, our results are sensitive to the
5 assumptions underlying the model, especially the behavioral
6 assumptions. In addition, the model contains some important
7 simplifying assumptions. For example, regarding
8 supplemental coverage, we assumed the average premiums and
9 we also did not model any switching in the choice of
10 supplemental coverage.

11 The scope of our modeling excludes dual eligible
12 beneficiaries because we assumed that Medicaid would fill in
13 any changes under the alternative benefit package and would
14 keep the cost-sharing the same for those beneficiaries. We
15 also applied the consistent supplemental coverage policy to
16 both Medigap and employer-sponsored plans.

17 And finally, we want to point out that through our
18 analysis, none of our numbers captures the value of the
19 insurance that risk-averse people get when they insure
20 against undesirable outcomes. This value of the insurance
21 is real and important for many beneficiaries.

22 All three alternatives we presented today have

1 focused on restructuring what supplemental insurance can and
2 cannot do. In contrast to this regulatory approach, there's
3 an alternative of imposing an excise tax on supplemental
4 insurance plans. That tax can be applied to all sources of
5 supplemental coverage, both in Medigap and employer-
6 sponsored plans, and it can be based on the generosity of
7 that coverage.

8 To wrap up, here are some questions that the
9 Commission may wish to discuss. What should be the basic
10 structure of the benefit package? Are some design elements
11 more important than the others? And what trade-offs would
12 you consider among them? In addition, how is supplemental
13 coverage going to interact with the benefit package? Would
14 it be allowed to wrap around the benefit or would it be
15 restricted in what it can do? Would it be through a
16 regulatory approach or through an excise tax?

17 As we discussed in the beginning of the
18 presentation, your choices on the shape of the benefit and
19 the role of supplemental coverage would affect the overall
20 value of the benefit package and, consequently, the
21 budgetary impact. There are many moving parts here that are
22 interconnected and they would require much balancing as you

1 consider and weigh various aspects of the benefit design.

2 We look forward to your discussion.

3 MR. HACKBARTH: Okay, thank you, Julie. So let's
4 have Round 1 clarifying questions. We'll begin with Karen.
5 Any clarifying questions? Bill. And then Bruce.

6 MR. GRADISON: Thank you for your excellent
7 presentation. In it you said, as a key overriding concern,
8 that we would be mindful of the effects of low-income
9 beneficiaries and those in poor health. I'm unclear as to
10 what the impact of these alternatives would be in those two
11 categories, and more specifically, to those whose incomes
12 are just above the dual eligible thresholds.

13 And to be more specific, when you talk about here
14 the percentage that have higher or lower than the 200 --
15 anyway, those who would experience higher or lower payments,
16 do we know anything about how -- the relationship of the 23
17 percent, or whatever, to the income level of the people in
18 those categories?

19 DR. HARRISON: We have some limited ability from
20 the data we have. We were able to find people who had the
21 low-income subsidy for Part D and were not duals, so they
22 were, you know, in that, I guess you could say, near poor

1 category, and we found that they tended to have slightly
2 higher losses than what was projected for the average
3 person.

4 MR. GRADISON: Let me just make sure I understand
5 you. Slightly higher losses than the current loss
6 situation?

7 DR. HARRISON: Now, we haven't --

8 MR. GRADISON: Than the current benefit structure?

9 DR. HARRISON: Yes.

10 MR. GRADISON: Thank you.

11 DR. MARK MILLER: And this conversation has also
12 been going on inside among the staff. You know, we're
13 trying to see where the Commission kind of wants to center
14 itself and get it, and then we'll have some limited ability
15 to tell you about what the distributional impacts are, and
16 it will be indirect indicators like dual eligibility, LIS,
17 that type of thing. The dataset does not organize itself by
18 income, unfortunately.

19 DR. STUART: I have a question, but just an
20 observation based upon what Bill was talking about, and it
21 strikes me that some analysis within MCBS where you do have
22 income data would be useful here to address that specific

1 question, and obviously you don't have the same detail in
2 terms of the large numbers that you have with the A and B
3 claims.

4 My question relates to the application of these
5 design elements to both people who have Medigap policy and
6 who have ESI employer-sponsored plans, and it strikes me
7 that it's pretty straight-forward when you're doing Medigap
8 because we have these stylized options that are available,
9 but the employer retiree market is really heterogeneous.
10 I'm wondering if you could just give us a little idea about
11 how you approach that heterogeneity when you come up with
12 these estimates.

13 DR. HARRISON: We really don't have any way to
14 address the heterogeneity of the employer packages. And we
15 don't know -- there's a lot of things we don't know. We
16 don't know what part of the premium the current retirees are
17 paying. We don't know what would happen if the rules
18 changed, whether the employer would pick up more or less.
19 So for these people, it's very difficult to project.

20 DR. STUART: Very quick follow on. Would that
21 argue then for having kind of two panels, if you will, one
22 set of analyses for the Medigap market and the other set of

1 analyses for ESI, and just make it clear that you don't have
2 that information and so there's more uncertainty, I think,
3 in that area than in the other area.

4 DR. HARRISON: Yeah, we hope to do that for the
5 future.

6 MR. HACKBARTH: Just picking up on Bruce's
7 question for a second, we talk about the supplemental
8 options, excise tax, et cetera. Does this envision that the
9 excise tax would apply only to Medigap or would apply to
10 employer-sponsored coverage as well?

11 DR. LEE: I think that that is one of the policy
12 decisions. In terms of our modeling for today, we have
13 applied a consistent policy to any supplemental coverage,
14 but the implementation with respect to Medigap and ESI,
15 employer-sponsored to retiree plans, would actually require
16 different changes so that operationalizing that would
17 require different approaches.

18 MR. HACKBARTH: Okay. George.

19 MR. GEORGE MILLER: Yes. I also want to echo the
20 track Bill was taking, particularly on Slide Number 5. The
21 question dealing with the sickest and poorest, is that
22 mutually inclusive or exclusive? Do you have a group that's

1 sickest and poorest, or are you saying both sick and poor
2 together? Sick people that may choose this that have high
3 income. So I'm just curious just from a technical
4 standpoint, is that mutually inclusive or exclusive, the
5 term in the second bullet point?

6 DR. LEE: If I recall, those would tend to be
7 correlative with each other.

8 MR. GEORGE MILLER: Correlated.

9 DR. LEE: So I don't think they separate it
10 independently, the income and health status, but they kind
11 of -- those two aspects were correlated.

12 DR. CHERNEW: I think I would read that as
13 inclusive, like you had to be "and."

14 MR. GEORGE MILLER: And?

15 DR. CHERNEW: Yeah.

16 DR. BAICKER: It was low-income people --

17 DR. CHERNEW: With illness.

18 MR. GEORGE MILLER: With illness. Yeah, okay,
19 good. That certainly helps me. And then I'll go back to my
20 previous concern, and it may be a Round 2 question. I'll
21 come back. That may be a Round 2 question. And on Slide 6,
22 next slide, could you tell me or do you know that the

1 increase in deductibility and co-pays, is there a
2 correlation between that and increase or potential increase
3 to providers, both physicians and hospitals? Or did you do
4 that type of analysis to see if you increase both the co-pay
5 and the deductibles, is there a corresponding increase in
6 bad debts?

7 DR. LEE: We have not looked at that.

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

9 DR. MARK MILLER: For this model, the way you
10 think about it is you're kind of modeling an individual
11 beneficiary's liability and spend. It is reasonable to
12 assume that if you have more of this, the provider is at
13 greater risk for, you know, having to change.

14 MR. GEORGE MILLER: But we have to measure that
15 impact to see.

16 DR. MARK MILLER: Not in this. In here we're
17 trying to measure the budget impact and the impact on the
18 beneficiaries. Those are the two actors.

19 MR. GEORGE MILLER: Right.

20 DR. MARK MILLER: That policy question, in a
21 sense, gets enjoined when we are talking about provider
22 issues. But it's reasonable to assume that --

1 MR. GEORGE MILLER: I got you. Thank you.

2 DR. CASTELLANOS: Thank you for your presentation.

3 We appreciate it. Slide 1 just makes a statement that I
4 really -- I think we all agree to -- that we want to
5 encourage people to use high valued care and discourage them
6 -- I guess it's Slide 2 -- I'm sorry -- requires some cost-
7 sharing to discourage the use of low valued services. I
8 think that's really a good statement.

9 But in the material that you sent, you also said
10 you're going to use it to increase usage of high valued
11 services. But on Page 9 of the material that you sent, you
12 said, Cost-sharing could be structured in ways to encourage
13 beneficiaries to choose high valued services. For example,
14 you could differential co-payments between primary and
15 specialty care, and you're saying you're going to encourage
16 them to use primary care because it has higher value.

17 I don't understand that statement and maybe you
18 could clarify it. That's what you say here. I'm just
19 asking you to clarify it. It's the top paragraph of Page 9
20 in the material that you sent.

21 MR. HACKBARTH: The paper.

22 DR. CASTELLANOS: The material that was sent to

1 the Commissioners. I'm sorry. It's not on this other
2 slide. It's the last sentence.

3 MR. HACKBARTH: So that's a common feature now in
4 private insurance plans, that they have differential payment
5 for primary care services.

6 DR. CASTELLANOS: Well, I agree with that, but not
7 based on value of service. That's what she's saying here.

8 MR. HACKBARTH: Well, you can argue the point,
9 whether they're right or wrong, but, in fact, they justify
10 it based on -- they want to encourage primary care as a high
11 value service.

12 DR. CASTELLANOS: Okay. I want to understand,
13 would you clarify what you mean by high valued service?
14 That's the question I'm asking. I think what you're -- from
15 a physician's viewpoint, I find that somewhat troubling
16 because it, again, divides us instead of puts us all
17 together.

18 DR. MARK MILLER: Okay. We'll revisit the
19 language in the paper. I think the motivation in laying out
20 the structure and raising that as a possible issue is
21 whether the Commission wants to think about differentials,
22 either emergency room/non-emergency room, primary care/

1 specialists. I understand, as a physician and a surgeon,
2 you have issues about the value statement and we'll re-look
3 at that.

4 DR. NAYLOR: Just to make sure that I understand,
5 on Slide 10 it looks, just looking at these two graphs, that
6 the proposed changes around not allowed to fill in cost
7 sharing and, three, not allowed to fill in deductible have
8 essentially the same kind of overall impact. There's not
9 much difference in the two. So I'm just wondering: Is that
10 right? Am I reading that correctly overall?

11 MR. HACKBARTH: So you are saying comparing the
12 last two columns.

13 DR. NAYLOR: Comparing the last two, that those
14 two options don't seem to have -- I mean, 30 to 36, 34 to 36
15 -- major differences between the two options. Is that...

16 DR. LEE: So comparing the second and third --

17 DR. NAYLOR: Second and third options. In other
18 words, we're modeling three different -- keeping something
19 the same and looking at differences in deductibles and cost
20 sharing, and those two latter don't seem to be major -- but
21 I just wanted to make sure that I was interpreting that
22 correctly.

1 DR. MARK MILLER: What I would say, if I'm
2 following your question -- so let me start, and if it's not
3 the question, redirect. I do see something of a difference
4 here. If you sum up the bottom two blocks, that's the group
5 of people who have out-of-pocket lower by \$250 -- or \$250 or
6 more, and that's about 64 percent in the middle and 36
7 percent in the last one. And then you could also just make
8 the same point at the top of the distribution, but just to
9 focus you at the bottom, I do see a difference between those
10 two. Was that your question or were you asking something
11 else?

12 DR. NAYLOR: That was my question. I just wanted
13 to make sure. When I looked at it, the two recommended
14 changes did not, based on this graph, seem to make much
15 difference overall, and I just --

16 DR. MARK MILLER: Let me just check my fact. What
17 I just said is correct, right?

18 DR. LEE: That is correct. So the underlying
19 benefit package with the deductibles, the co-payments, and
20 all that, that is staying the same across all three bars.
21 And it's just to what extent that supplemental coverage can
22 fill in the cost sharing under that package. And the middle

1 bar, the second bar, is where there's supplemental coverage
2 that cannot fill in any of it. So the beneficiary is
3 responsible for the entire liability under that example, the
4 benefit package.

5 So if I guess the -- I kind of see the 34 plus 30
6 in the second bar, 64, versus 31 plus 5, that's 36, as a
7 noticeable difference. But I might not be understanding
8 your question.

9 DR. MARK MILLER: I am going to say now that we
10 have established the numbers, one thing that was helpful for
11 me as we thought through this, and it might help some of you
12 or hopefully it won't at least confuse you, is part of the
13 reason that you see an effect where you get these large --
14 or at the bottom of the decision lower out-of-pocket,
15 everyone though you are talking about options that say,
16 well, you cannot have any supplemental, this is because,
17 remember, what comes in here is the premium that the person
18 has to pay for the supplement begins to go down, and that's
19 where you get -- when you count that as out-of-pocket,
20 that's where you get people getting lower out-of-pocket. So
21 the supplemental policy in the middle would no longer be
22 purchasing, and so that premium comes back to the

1 beneficiary, and that explains the bottom of that bar.

2 Is that helpful or did that confuse you?

3 DR. NAYLOR: Very helpful.

4 MS. BEHROOZI: So the value at the lower -- the
5 spending being lower by more than \$1,000, that's because the
6 premium will be more than \$1,000 less or because you're
7 measuring the spending without respect to the beneficiaries'
8 actual out-of-pocket? Is it the actual cost of the premium
9 that's reflected in that more than \$1,000 savings?

10 DR. LEE: It's both. For the second bar, where,
11 you know, basically supplemental coverage is not doing
12 anything, in that particular example we subtracted the
13 average premium to get the sum of basically the change in
14 out-of-pocket spending and then subtracted the premiums. So
15 it's the premiums in the middle case that actually is quite
16 big.

17 MS. BEHROOZI: Again, for the light blue, it says
18 the person will be spending, the beneficiary will be
19 spending more than \$1,000 less across all of them, right?
20 That's what the light blue refers to. So what is that more
21 than \$1,000 comprised of? Is it the premium in all cases?

22 MR. HACKBARTH: A big hunk of it is coming from

1 lower premiums. These people are folks who are low users of
2 services who are -- forgive me for saying it this way --
3 overpaying for their Medigap policy. They're paying a lot
4 for premiums that they're not getting value in return.

5 DR. LEE: Suppose that I have a Medigap --

6 MR. HACKBARTH: Forgive me.

7 DR. MARK MILLER: Exactly. We have to have a
8 quick commercial here.

9 [Laughter.]

10 DR. MARK MILLER: Kate regularly points out that
11 when you use the term "value," you have to understand it
12 both in a dollar term and a value to the beneficiary. A
13 beneficiary may pay that premium and find high value in it
14 because it provides peace of mind, and so these terms are --

15 [Laughter.]

16 DR. MARK MILLER: Did I not do a good -- all
17 right. So we'd like to apologize to Kate on behalf of...

18 MS. BEHROOZI: I understand the point about
19 premiums would be lower if the insurance company didn't have
20 to pay but Medicare was paying at the high end. I get that.
21 It's just that sometimes when we look at spending, we call
22 it the beneficiaries' exposure, whether or not they have the

1 coverage, you know, to see what the spending above the cap
2 would be. And if Medicare is covering it, nobody's going to
3 be paying it. But you are talking about the savings in
4 premiums. That's what --

5 DR. MARK MILLER: That's right. An important
6 concept to carry around in your head -- and, again, I'm
7 hoping to clarify. You can talk about a beneficiary's
8 liability. I'm liable to pay, you know, \$1,000. And then
9 you can talk about the beneficiary's out-of-pocket, and the
10 out-of-pocket may be different than your liability depending
11 on how you have supplemental insurance. But it's important
12 to bear in mind to get that insurance you have to pay a
13 premium, and so we're putting in utilization effects what
14 they have to potentially pay and the premium that they're
15 paying to get that coverage, or the lack of a premium,
16 particularly in the middle, and a lower premium in the third
17 bar.

18 Is that all roughly right?

19 MR. HACKBARTH: Okay, so I want to get back on
20 track here.

21 DR. HALL: Julie, back on Slide 5 about the
22 sickest and poorest, I had two questions about that. One,

1 the original RAND data is a little old now, right? It's
2 about 12 years old, something like that, 10 or 12 years old?
3 Even before that? All right. So a lot may have changed in
4 that period of time, and I think if we're going to go into
5 this, we ought to have the most recent data that we possibly
6 can have about these sickest and poorest, particularly if
7 there's an age differential within the Medicare range of 65
8 to whenever. So that was one point that I had on that.

9 The other is going up to the first dot point then,
10 it really would be quite important, I think, to have a
11 little better handle on whether the adverse effect has to do
12 because for some reason or other really the effective
13 services are being underutilized. Is there any reason to
14 think that there would be any differential there? I think
15 that first point is one of the really attractive points,
16 that, wow, cost sharing reduces both effective and
17 ineffective services. Obviously, the corollary to that is
18 let's get rid of all the choices on ineffective services.

19 So I think we need a little more fleshing out on
20 the sickest and the poorest.

21 MR. HACKBARTH: I just wanted to mention that, as
22 you know, the paper does talk about more recent studies on

1 the effect of cost sharing.

2 DR. HALL: Right

3 MR. HACKBARTH: A reason that we keep going back
4 to the RAND experiment is that it is the only study that had
5 a randomized design and, thus, is able to deal with some of
6 the methodological problems that more recent studies
7 struggle with in terms of different characteristics of
8 patients and the like. And so for that reason, even though
9 the data are 30 years old, I think it bears a role in the
10 discussion.

11 DR. HALL: Of course. Right.

12 MR. HACKBARTH: But as I say, we do discuss more
13 recent studies as well.

14 DR. BERENSON: I want to ask about the behavioral
15 assumption. In looking at the literature you've cited,
16 you've got a body of literature that seems to find the
17 insurance effect is somewhere in the vicinity of 25 percent;
18 some other studies that say but when you do control for
19 severity and selection, selection bias, that pretty much
20 disappears. But then we do a special study by Hogan for the
21 Commission which seems to try to adjust for health status
22 and all the other socioeconomic factors and finds a 33-

1 percent difference in what seems to be insurance effect. In
2 the end, on Slide 12 it looks like we're in the low single
3 digits of a difference between having unchanged Medigap and
4 not allowing Medigap. It sounds like you've used
5 conservative assumptions, or what did I get wrong here in
6 sort of thinking that Hogan may be an outlier and that
7 you're using much more conservative assumptions about
8 behavior effect? Is that what -- is my inference correct?

9 DR. LEE: There are two sets of assumptions that
10 we've used. They are kind of on the conservative side.
11 They both come from the data from the RAND health insurance
12 experiment.

13 Now, we have not actually converted Hogan's
14 results into kind of an apple-to-apple comparison of
15 elasticities. So that's on our list, but we have not
16 actually made that kind of a comparison.

17 His study was set up so that the estimate is if
18 you have Medigap insurance, then what would be the
19 difference, but we will have to calculate the implied
20 estimate as a response to changes in out-of-pocket spending,
21 what would be the response. But we have not done that.

22 DR. BERENSON: But at least the initial view would

1 be you'd come up with a much greater savings, right?

2 DR. LEE: It will be a larger response, but I
3 don't know in terms of elasticities how much larger.

4 DR. BERENSON: So that is on your agenda to do
5 that.

6 DR. LEE: Yes.

7 DR. BERENSON: Because this is obviously, as you
8 said, very sensitive to these assumptions, and I think we
9 need a little more work in that area.

10 MR. HACKBARTH: At the end of the day, the
11 assumptions that matter are CBO's assumptions in that they
12 will be the arbiter of how this is scored. So explain this
13 table in the context of CBO's established methodology.

14 DR. LEE: So the assumptions that are titled
15 "Elasticity Assumptions," those are the actual behavioral
16 assumptions that CBO uses. So for their model -- I'm not
17 saying that our model is the same as CBO's. It's just that
18 we use the same behavioral assumptions in the two models.

19 MR. HACKBARTH: Yes.

20 DR. MARK MILLER: Just to put that slightly
21 differently, what we're trying -- this is not a CBO
22 estimate, just for the Commissioners to be really clear.

1 This is not what CBO would necessarily estimate. To the
2 best of our ability and what we understand about their
3 models, we're trying to track to them in that column. And
4 then the other column is some other assumptions that are
5 commonly used by other types of modelers.

6 MR. HACKBARTH: In fact, while we're talking about
7 this slide, Julie, it may be worthwhile for the audience to
8 explain the difference between the elasticity assumptions
9 and the induction assumptions.

10 DR. LEE: So they both measure how people's use of
11 services change as their out-of-pocket spending changes.
12 The elasticity assumptions, that response is measured as a
13 percent change in spending in response to a percentage
14 change in out-of-pocket spending. In contrast, induction
15 factors measure in terms of dollar change in spending in
16 response to a dollar change in out-of-pocket spending. So
17 they both are measures of how people respond, but they are
18 just measured in different units.

19 DR. MARK MILLER: Is there any difference in the
20 effect along a curve, or are they both constant?

21 DR. LEE: The measures they used, they are
22 constant numbers, but because one is elasticity is a measure

1 in terms of percent change, that when it's proportional to
2 the level of spending. So if you have a higher level of
3 spending, even though it's the same elasticity response, you
4 are going to get in terms of a dollar response, it will end
5 up being higher.

6 DR. MARK MILLER: And I think this is what's more
7 significant in driving the difference, because you could
8 obviously convert numbers to percentages, but it's really
9 the response effect as you move up and down a curve of
10 spending. That's what really drives the differences here.

11 DR. LEE: That's correct.

12 MR. HACKBARTH: I will nod my head like I
13 understand that and ask Mike --

14 [Laughter.]

15 DR. CHERNEW: I just want to confirm a few things
16 and ask a question.

17 The first thing I want to confirm is this is only
18 A, B; there's no D in here. So all the out-of-pocket stuff
19 is -- right? And the duals aren't affected by this because
20 the duals still get whatever filling in of the duals. And
21 the part that I was less sure on was this -- how does the
22 employer-provided supplemental coverage play in slides like

1 Slide 8 where the premiums go down? Is that just the
2 Medigap and it doesn't have the employer in it? Or is it --
3 this only applies to Medigap. It doesn't apply to the
4 employers? Maybe not Slide 8. The one with the -- 10, the
5 one with the -- yeah. So when the premiums go down, the
6 reason why this goes back to the person is because this is
7 only Medigap where the person is assumed to be paying the
8 entire Medigap premium as opposed to anything going on
9 for...

10 DR. HARRISON: For the middle bar, the beneficiary
11 is going to get \$1,000 back because they're not paying an
12 employer premium. But --

13 DR. CHERNEW: But what if the employer was paying
14 your premium for you?

15 DR. HARRISON: Like I said, we can't distinguish
16 between that. Now, the other thing is what do we think the
17 baseline is. The baseline is we think that the employer
18 plans cover half of your current out-of-pocket.

19 DR. CHERNEW: I guess what you're saying is the
20 employers are in here, and you have made assumptions about
21 how much of the -- when the premium goes down because
22 there's no cost sharing, you've made assumptions about how

1 much of that is going to the person and how much of that is
2 going to the employer.

3 DR. HARRISON: Right, but in the third bar, it
4 doesn't -- it tends to wash out mostly for the employers,
5 just the way the things go up and down. We didn't make a
6 big change in premium, and the policy ends up about the same
7 what the employers are doing now. So the people covered by
8 employer policies probably don't figure in much on the
9 right-hand bar.

10 DR. MARK MILLER: But his point is correct.
11 You're just saying the arithmetic runs out that way.

12 DR. HARRISON: Right.

13 DR. CHERNEW: Right.

14 DR. MARK MILLER: But his point about what's
15 happening in the bars is correct.

16 DR. CHERNEW: So the people that get these
17 reductions of 30 and 34, that assumes that they were paying
18 the premium through their employer as opposed to having the
19 employer covering that premium, for example.

20 DR. HARRISON: Right, and the assumption was
21 probably that they're paying about half of the premium.

22 DR. CHERNEW: Okay. So that was the assumption in

1 here, so that's how they decided. Okay.

2 And then my last question, which was actually on
3 8, where you said people don't switch in response to benefit
4 changes -- I think that was the bottom point there.
5 Beneficiaries don't switch in response to changes in
6 benefits. Is that changes in benefits or changes in
7 premiums or both? In other words, they don't respond to
8 changes --

9 DR. LEE: We did not model any switch in behavior
10 in their plans.

11 DR. CHERNEW: So they stayed --

12 DR. LEE: They are assigned their supplemental
13 coverage, and they stay under that.

14 DR. CHERNEW: Right, but you did take into account
15 when you were looking at their out-of-pocket on Slide 10
16 that their utilization was changing.

17 DR. LEE: That's correct.

18 DR. CHERNEW: And so their out-of-pocket is a
19 combination of paying more, or less, or whatever it is, and
20 using a different volume of service.

21 DR. LEE: Mm-hmm.

22 MS. BEHROOZI: And so on 10, for I guess both 1

1 and 3, you started with the average Medigap premium of
2 \$2,100 and assumed the employer \$1,000, and so then how did
3 you calculate -- how did you come up with the changes in
4 those premiums for bars 1 and 3?

5 DR. HARRISON: Those are the easy ones. The first
6 one we just left it the way it was.

7 MS. BEHROOZI: Doesn't that assume the change in
8 the design, the --

9 DR. HARRISON: Yeah, but we didn't change the
10 premium for that, because the design is about neutral, and
11 so it should be close to leaving the benefit the way it was.
12 So there's no change in the first bar. In the third bar,
13 there's no filling in, and so you don't pay any of the
14 premium.

15 DR. LEE: The second bar.

16 DR. HARRISON: I'm sorry. The second bar. The
17 third bar is more complicated where we rebated about half of
18 the premium for the Medigap and a small rebate for the
19 employer.

20 MS. BEHROOZI: You did, but would the insurance
21 companies do that? Is there any regulation of Medigap rate
22 setting or anything?

1 DR. HARRISON: Yeah, there's medical loss ratios
2 stuff, and, in fact -- I mean, frankly, it might make it
3 harder for the Medigap plans to offer a skinnier benefit.

4 MS. BEHROOZI: One other question on Slide 12.
5 This is the models. I'm not asking, you know, what you
6 assumed, but in the models, the only differences among
7 beneficiaries that it reflects -- and I guess that's in the
8 elasticity assumptions, or the other one? Whichever one is
9 the rate of spending, right? I mean, it doesn't assume
10 health status -- I mean, it doesn't incorporate in any way
11 health status except to the extent that that's reflected in
12 spending or income levels, right?

13 DR. LEE: That's correct.

14 DR. HARRISON: Except that the duals are not in
15 here.

16 MR. BUTLER: So, Glenn, you said you nodded that
17 you understood, so I'll take one for the team and look dumb
18 and see if I understand it.

19 [Laughter.]

20 MR. BUTLER: On Slide 12, if you do not allow cost
21 sharing, which is what this option is, either the deductible
22 or the co-pays, is the 2.5 percent aggregate Medicare Part A

1 and Part B spending? That's the estimate of the impact on
2 bending the cost curve, so to speak, in terms of the
3 spending impact, downstream spending impact of having no co-
4 pays or deductibles permitted --

5 MR. HACKBARTH: This is program spending. This is
6 not total spending program beneficiary. This is --

7 MR. BUTLER: It's what the government is paying
8 for Part A and Part B.

9 MR. HACKBARTH: Correct.

10 MR. BUTLER: That's a big number, and it's not
11 CBO. I know that. It's just MedPAC.

12 DR. MARK MILLER: [off microphone] not a dumb
13 statement. You got it right.

14 MR. BUTLER: Okay. I'm just trying to dumb it
15 down.

16 DR. MARK MILLER: I just want everybody to know
17 you got it right. And just to be clear, it's not an
18 estimate, but these are directionally in magnitude, the
19 impact on spend here. And A, B, you know, given Mike's
20 question, not D. A, B.

21 DR. BAICKER: So I very much appreciate the shout-
22 out and the presentation and the Q&A to the insurance value

1 of insurance, and I'll have a little more in my tiresome way
2 to say on that in the next round. But I did have a
3 clarifying question that will help inform that.

4 We talked a little bit last time -- and I'm not
5 sure what the current state of the data is -- about evidence
6 on the persistence of spending. So do we know for these
7 people, you know, not only what their spending is, but what
8 their odds of falling into different spending bins are? And
9 in a big-picture way, that's very hard to know, of course,
10 but there are proxies for it, like the correlation of year
11 1, 2, 3 spending, something like that.

12 DR. LEE: Actually it is on our list. We do not
13 have the numbers, but we should be able to get some
14 longitudinal patterns of their spending, or at least the
15 main uses like hospitalization.

16 DR. MARK MILLER: But I also don't want to raise
17 expectations too much. The development of this data set was
18 fairly complicated in getting spend and supplemental
19 coverage characteristics into the same data set, and we can
20 add additional years, but, I mean, I don't know what time
21 frame you were thinking about probabilities, but if she's
22 thinking very long time frames, are we going to be able to

1 do that, like the probability over somebody's life and that
2 type of thing?

3 DR. LEE: Actually, I understood your comment as
4 more of a descriptive, you know, kind of historical pattern
5 rather than actually modeling that and incorporating that
6 into the model, which we are not.

7 DR. BAICKER: And my understanding of the
8 complexity of assembling this data set is that it's the
9 different pieces about who has what kind of coverage and all
10 of that. The question about persistence of spending could
11 be gleaned from a more stripped down data set where you just
12 say, okay, 30 percent of next year's spending is explainable
13 by this year's spending or 80 percent is explainable.

14 MS. UCCELLO: Can we go to Slide 7? And I just
15 want to clarify here that this is just an example. The
16 deductible here is listed as \$1,200, and this is budget
17 neutral. And that \$1,200 is much different than the \$750
18 we're using, so I just want to clarify that that's just a
19 number that's put in there.

20 DR. LEE: That was, if you recall, when we modeled
21 in the June 2011 report some budget-neutral trade-offs, just
22 with out-of-pocket gap and deductible. That would be budget

1 neutral. And so that's kind of the general levels that we
2 got, and this is just an example to kind of illustrate the
3 dynamics.

4 MR. HACKBARTH: So, Julie, put up 12 for a second.
5 This table is based on the newer benefit package with the
6 \$750 deductible and all of the features that are on Slide --
7 whatever the number is -- 9, right?

8 DR. LEE: That's correct.

9 MR. HACKBARTH: And as I interpret the table on
10 12, this benefit package with the \$750 deductible would
11 increase Medicare spending by 2 percent, assuming
12 supplemental coverage is left unchanged.

13 DR. LEE: That's correct. So all the --

14 MR. HACKBARTH: So my next question is: If we
15 wanted the number in that cell of the table to be zero, how
16 high would the deductible need to be? Would it be the
17 \$1,200 number, roughly?

18 DR. LEE: Yes, roughly.

19 MR. HACKBARTH: So that's how these dots connect,
20 Cori.

21 MS. UCCELLO: Thank you. In Slide 10, one of the
22 issues we're facing is if we do change the plan design, what

1 do we do with the supplemental? Do we do an excise tax or
2 do we mandate some changes? And I'm wondering here if the
3 third column can be thought of -- and I'm just thinking out
4 loud here. If that can be used to think about an excise tax
5 on, say, the C and F plans and this could be the impact of
6 people moving to a less generous Medigap plan because of the
7 excise tax. I'm not sure the baseline of that is right, but
8 I'm wondering if...

9 DR. MARK MILLER: Well, I had to answer that
10 question, and I'm happy for someone else to do it. I would
11 caution you and not commit to saying, yeah, maybe that's a
12 proxy for it. I think if the Commission sort of shifts and
13 says -- or not shifts, but sort of settles and say, you
14 know, I'd rather think of tax policy instead of regulating
15 the Medigap, I think we have got to take a couple steps
16 back, look hard at this model and figure out how we can
17 trace things through. So I wouldn't necessarily -- I get
18 it. In a sense you're saying, But it's like a dollar, and a
19 dollar is like -- you know, and that's like a premium
20 change. And maybe in the end we come back to you and say,
21 Yeah, you could roughly approximate it. But I'd want at
22 least ten minutes to think about it.

1 MS. UCCELLO: And I don't disagree. So now I'm
2 turning into round two here, but I think in order for me to
3 address this question of which way is best to go, tax or
4 regulatory, I need to flesh out a little more the impact of
5 the tax side.

6 MR. ARMSTRONG: My list of dumb questions has
7 already been asked. Special thanks to Peter, I want to
8 shout out.

9 [Laughter.]

10 MR. HACKBARTH: Speaking of round two, round two
11 questions or comments?

12 DR. BORMAN: I'm reminded, I think it was Mark
13 Twain that said that you could keep your mouth shut and have
14 everybody think you're stupid and open your mouth and prove
15 it, so I just sort of offer that I was silent in round one.
16 However, unfortunately, there is round two.

17 [Laughter.]

18 DR. BORMAN: Just a general comment. I think
19 appropriately we shed a lot of concerned light on issues
20 that would concern the lower-income and perhaps what we know
21 now as economically vulnerable populations in addition to
22 their medical burden. I think we do need to be open to the

1 consideration that we have this very challenging economic
2 environment to which there appears to be not a lot of end in
3 sight. And so we have a lot of people whose concepts about
4 their retirement and their health care in retirement and how
5 they are going to pay for it are certainly shifting sands at
6 best. And I would like to see at some point a notion about
7 modeling to the beneficiary who pays the highest tiered
8 premium, if that makes sense, because we do a lot of focus
9 and I think we assume the average premium paid or the lowest
10 premium paid, but we don't ever consider this from the point
11 of someone whose income at least currently mandates they pay
12 the highest Medicare premium, because one could certainly
13 envision that income threshold changing as part of the
14 issues to deal with it, and --

15 MR. HACKBARTH: So you are talking now about the
16 Part B premium or Part D premium with the new income --

17 DR. BORMAN: Right, right. And does that, as we
18 think about that and the directions that may go, does that
19 sort of change how you look at things for what will likely
20 be an increasing share of the population that becomes
21 subject to that and yet whose resources and ability to use
22 them may have changed and who may be a group that is more

1 likely to want to purchase a variety of Medigap plans not to
2 necessarily totally fill in, but because they are subject to
3 higher risk because of the -- or higher expenses because
4 they're paying that higher Part B premium to start with, if
5 that kind of makes sense. It's a little fuzzy.

6 If you go to Slide 15, I will try to kind of at
7 least give you my thoughts as you go kind of down here.

8 With regard to the basic structure of the benefit
9 package, I think one thing that we can all conclude probably
10 is that the value -- and kudos to Kate for reminding us
11 regularly -- for the beneficiary's dynamic is maybe the best
12 way for me to think about this across these things. At
13 different points in my life, each of these things may shift
14 in their relative value to me. When I'm a young elderly,
15 maybe my biggest concern is, you know, what I pay today
16 because I'm not envisioning all these services that I'm
17 going to use, and so the cumulative co-payments maybe don't
18 bother me, or I think I'm unlikely to have a catastrophe so
19 I don't worry so much about a catastrophic cap. But as I
20 age and I see what happens to me, my values shift.

21 So I think when we're trying to look at the
22 population as a whole, we'll never get it perfect for

1 everybody, so in my view at least, the trade-off should be
2 to some reasonable middle ground that tries to help all
3 those considerations a bit but cannot fix them all for
4 everybody, would be my personal take on that. And that to
5 me makes the secondary argument that there probably will
6 continue to be a place for some supplemental coverage
7 because of that dynamic for people across time.

8 Now, should it be totally fill in supplemental is
9 a second question, but in terms of the eliminate
10 supplemental option, I think that would be wrong because it
11 takes away part of the ability for people to customize a
12 little bit as their dynamic and value changes.

13 In terms of budget neutrality, if I understand
14 kind of what we're talking about a little bit, in my view,
15 given all the fiscal considerations, I would be hard pressed
16 to think myself being prudent as a Commissioner if we did
17 not look at budget neutrality. I think that has to be our
18 baseline and that we go away from that only with the gravest
19 and deepest considerations and compelling evidence that it's
20 the right thing to do. I just think in light of how we
21 consider all our other actions, to do anything to her than
22 that would be irresponsible.

1 I would ask do we know about for people that do
2 purchase Medigap -- not get their Medigap through Medicaid,
3 but for people who purchase it, what is the churning in that
4 market or what is the turnover? Is it pretty much that you
5 buy a supplement and you kind of stick with Plan N or P or
6 Q, or whatever it is, over your lifetime? Or is it that
7 people use that as a way to address their shifting needs as
8 they age? I think just sort of some general sense about if
9 that's just I buy it once and I forget about it, then that's
10 very different than if it's a way for me to tailor my
11 spending as I go forward.

12 And then on the supplemental coverage part,
13 obviously I think we should allow it. We may need -- maybe
14 we want to restrict it from being a total fill-in, but I do
15 think we need to continue to allow it in terms of Medigap
16 and employer-sponsored, particularly, you know, to Bruce's
17 point that the employer-sponsored are all over the map and
18 it's hard for us to consolidate them into something we can
19 work with. I also think they're clearly becoming a dinosaur
20 and a vanishing thing, and I'm not sure that the amount of
21 time it would take us to model all that is worth the effort
22 for what I think just economics are going to drive away.

1 Then, finally, in terms of restructuring the
2 supplemental and applying an excise, again, in order to
3 offer people options, I think the excise tax probably more
4 directly supports that behavior and would opt probably to go
5 that direction a bit more than regulatory. I think if we do
6 regulatory, maybe it's just to try and limit that complete
7 fill-in, and other than that, kind of stay out of trying to
8 micromanage that. So trying to address this question.

9 MR. HACKBARTH: Thank you, Karen, for responding
10 to the questions on this last slide. To the extent
11 possible, I'd ask other Commissioners to try to do the same
12 because it's really important in terms of trying to advance
13 the work to the next step.

14 MR. GRADISON: I want to build on Karen's comments
15 and some in the first round of Mike's with regard to
16 switching. My recollection is the original choice of
17 Medigap policies, once they were structured under law, was A
18 through J and additional ones were added. I think it would
19 be really interesting -- and maybe somebody has already done
20 this -- to take a look at what kind of switching took place
21 when these additional options were offered as well as what I
22 understand your point to be, what kind of switches take

1 place in a fixed environment where the number of options has
2 not changed. I'm not sure what light it would shed on this,
3 but it might, and that's the only reason I mention it.

4 Thank you.

5 MR. HACKBARTH: Is there a database that allows us
6 to look at switching behavior among plans? Or do we just
7 have access to raw aggregate figures on how many people are
8 in each of the options?

9 DR. HARRISON: Aggregate at the state level.

10 DR. CHERNEW: You might be able to get data from
11 United, which has the AARP data, to enable you to do that.
12 But they're pretty big.

13 DR. STUART: Well, I don't know about the rest of
14 you, but I personally hope that Karen is wrong about the
15 demise of retiree coverage.

16 The point I'd like to make, I'm going to put
17 another oar in the water on this issue of elasticity
18 estimates, and if we could put up Slide 2, it really focuses
19 on that middle bullet point. When we talk about lower- and
20 higher-value services in the context of the Commission's
21 debate, we have tended to take a technocratic approach to
22 that in the sense that, you know, reasonable analysts would

1 say these services are worth more than those services. But
2 when it comes down to the question of behavior, it's really
3 how the beneficiary values those services that matters.

4 One other thing that makes it very difficult to
5 estimate what would happen if you reduced the value of
6 insurance to people that currently have it is that we tend
7 to focus on the objective factors that generate the demand
8 for services. So Hogan controls for health status, and we
9 have all these other things that we're controlling for, but
10 the one thing that's almost impossible to control for is how
11 the individuals value those services. And you could make
12 the argument that individuals who purchase insurance
13 actually place a higher value on the services they use.
14 Whether they're objectively worth more or not, we don't
15 know. If that's the case, then it would suggest that if you
16 were to remove the insurance from these people, they would
17 still -- I mean, they value those services so that they
18 would still be relatively price insensitive to that change.

19 And so it may well be that the kick that we would
20 get if we were to implement one of these services that adds
21 cost sharing may be much less than we really think that it
22 is if we do not consider those individual valuations.

1 MR. GEORGE MILLER: Just to follow up on what
2 Bruce said, because my second-round question had to deal
3 with Slide 5, but along the same lines, and that is the
4 question about what is the effective or ineffective services
5 and the value put on it and who determines that value,
6 because bullet point two here -- I want to follow up on my
7 first-round question, particularly with the sickest and the
8 poorest individuals. And my question and my concern -- more
9 a question than a concern -- is this still the population
10 that has the largest segment of disparities in that
11 population? And how can we from a policy standpoint impact
12 that group of individuals in a positive way? And is there a
13 way to carve out this group if it is, in fact, that way to
14 incentivize them through policy to use more effective
15 services versus ineffective services? But, again, it goes
16 back to what Bruce just said and Kate has mentioned about
17 the value of that service.

18 I'm not sure what's the most effective policy way
19 to do that, but if there is an agreement on effective
20 services from a policy standpoint, can we incentivize those
21 folks to use that and using cost as a lever to do that?

22 MR. HACKBARTH: Ron, could I just jump in here for

1 a second? Put up Slide 2 for a second. The second bullet
2 here I want to just focus on for a second.

3 Early on in our conversations about the Medicare
4 benefit package, we talked some about value-based insurance
5 design, where you would ideally structure the benefit so
6 that there would be more coverage for high-value things and
7 less coverage for low-value things in a very, to use Bruce's
8 term, technocratic sort of way, its value as seen through
9 the eyes of an analyst who looks at the costs and benefits
10 of different services.

11 There really isn't much -- there isn't any of that
12 in this package. You know, we have paid lip service to that
13 as an ideal, but in the options that we're looking at, we
14 really haven't incorporated that into the design because
15 it's hard to do.

16 To me, the second bullet is not talking about a
17 technocratic assessment of value but, rather, saying now if
18 the patient sees more of the cost, they will do their own
19 judgment about the value of the service and whether they
20 want to have it given that they see a little bit more of the
21 costs. So this is a patient-centric statement here, not the
22 technocratic statement.

1 Now, there are, you know, open issues about
2 disproportionate effect on people who are ill or people from
3 different ethnic or racial groups, and I don't mean to
4 minimize any of that. But the point here is let's reveal a
5 little bit more of the cost to the patient at the point of
6 service, allow them to make judgments. Broadly speaking,
7 the evidence suggests that if they see a little bit more of
8 the cost, people will use fewer services that they value
9 less.

10 DR. CASTELLANOS: Glenn, I really like your
11 comments because that's the real-world experience. This is
12 what I see in my practice. If the patient has some exposure
13 to his or her costs, they usually make pretty good
14 decisions. The real problem that I see is what's happening
15 is it's a moving target. As Karen said, most of us are very
16 healthy right at this time, but as we get older and more
17 mature, we're going to see bumps in the road. And it's
18 very, very, very difficult in my opinion to be able to
19 automatically from a health policy viewpoint dictate what's
20 going to happen ten years from now.

21 I think we have a moral obligation -- let's go
22 back to some of the questions you said. I think we as

1 society have a moral obligation to provide some kind of a
2 basic structure, and I think we really need to do that. I
3 think supplemental coverage should be allowed, but with
4 today's economy people can't afford it today. It's a
5 significant issue in what people -- how they're going to
6 spend their money. And, unfortunately, value of services --
7 and you gave a good example. Most people who don't have
8 insurance, they have coverage because they go to the
9 emergency room.

10 I mean, I'm telling you right now. It is a mixed
11 bag in the real world, and we need to be extremely careful
12 on some of the recommendations we make.

13 DR. NAYLOR: So I support the objectives for
14 Medicare benefit redesign, and I think I was way ahead of
15 Peter in acknowledging what I know and don't know. But it
16 seems to me that the opportunities to both achieve changes
17 in redesign and to achieve savings for the program are
18 pretty substantial, and it looks as if the second model that
19 was talked about, the opportunity to not allow to fill in
20 cost sharing, creates an avenue that also seems to affect --
21 seems to have less of a negative effect on a larger group of
22 people than currently, if I'm interpreting that correctly.

1 So I think we should really pursue this. I mean,
2 I think that this is -- I absolutely agree with earlier
3 comments around this is a continuum, and we operate on a
4 trajectory, and people, to the extent that there can be
5 changes in the kind of regulation -- and certainly we should
6 model excise taxing and see what that does and what might be
7 trade-offs in both of those options. But I do think that we
8 know through behavioral economics that the way that we
9 structure these programs can have a major impact on the way
10 people make decisions. And I think that this is a really
11 important part of a formula to get there.

12 That said, I do think also the issue of sickest
13 and poorest are not an "and," meaning I don't see them as
14 inclusive. We know for years about a population that use
15 more resources than others, and some of them are poor and
16 some of them are really sick. And even Hogan's work showed
17 that people who had a severe illness or were poor were less
18 sensitive to cost sharing.

19 So I think that we have to really figure that out,
20 but that said, I think this is an extraordinarily important
21 part of a toolkit getting to benefit redesign that creates
22 the right set of incentives and at the same time promotes

1 access to higher-value and less use of lower-value services.

2 MR. HACKBARTH: Let me just build on Mary's
3 comment for a second and use it to ask a very specific
4 question that I'd like to invite reaction to.

5 If you put up Slide 12, the questions for --
6 actually, put up 15 first, the questions for discussion, the
7 second bullet here, the overall value of the benefit package
8 and budget neutrality. This is one of the important policy
9 variables here that I want people to react to.

10 Now put up 12, please, Julie. As we pointed out
11 earlier, the benefit design that we're talking about
12 actually by itself would increase Medicare expenditures by
13 about 2 percent, and it turns into a net saver for the
14 Medicare program only if coupled with a supplemental
15 insurance policy. This analysis was done using a regulatory
16 approach, but it could be done either through a regulatory
17 mechanism or through a tax. Let's set that choice aside for
18 a second. I'd really like people to react to the go up by 2
19 percent and then I offset that and a little bit more through
20 the supplemental insurance policy, however we choose to
21 effectuate that change, because you could well say, well, we
22 shouldn't have a plus 2 at all, we should have a Medicare

1 budget-neutral redesign of the benefit package, in which
2 case if you coupled it with a supplemental policy, the
3 savings would be larger than the minus 2.5 or minus 1. And,
4 obviously, our thought is we work through what that would
5 entail the very high deductible, the \$1,200 that we talked
6 about seemed daunting to us, and thus, we went for a
7 combination that had a lower deductible and achieved net
8 savings through the combination of Medicare redesign and
9 supplemental policy. But there are different ways to
10 address that, and I'd really like people to reflect on that
11 specific choice.

12 DR. HALL: I guess the only point I would make at
13 this point is that when we talk about choice and using cost
14 sharing as a way to incentivize people to make wise choices,
15 I think it's well to keep in mind that in terms of health
16 insurance, particularly for Medicare, this is not like
17 ordering Chinese in that there is some present value from
18 fried rice one night and maybe dim sum the next night.
19 Generally, value is perceived at the point when there's
20 immediate need for it -- a sudden change in health status, a
21 death of someone in the family, whatever it is. And if that
22 is going to give people incentive to make right choices, we

1 have to make sure that there are not some unintended
2 consequences. For example, are there some underwriting
3 considerations as one starts to skip around from these
4 plans? I don't know whether ACA will take care of that or
5 not, but I could see some nightmare situations where
6 decisions have to be made very rapidly.

7 Now, that's a little bit off the central point
8 here, but let's make sure that what we put together is going
9 to have some health care value as well as a financial value.

10 MR. HACKBARTH: So, Bill, is your question about
11 the ability of Medicare beneficiaries to switch and buy
12 supplemental insurance policies?

13 DR. HALL: Right, without any implication -- I'm
14 not even worried about the cost implications, but just
15 whether they're going to run into underwriting --

16 MR. HACKBARTH: Yeah, what are the rules, Scott,
17 on switching?

18 DR. HARRISON: My sense is what happens is you get
19 a policy and you generally stick with it.

20 DR. HALL: Right.

21 DR. HARRISON: But your insurer might often let
22 you step down to a lower-value policy, but they're unlikely

1 to let you get a richer benefit unless they underwrite you.

2 MR. HACKBARTH: And there's no restriction in
3 terms of guaranteed issue, no regulatory rules --

4 DR. HARRISON: There are some states that have
5 guarantee issue, and they let you change year to year.

6 MR. HACKBARTH: But it's a matter of state law.

7 DR. HARRISON: New York is one of them, actually.

8 MR. HACKBARTH: Yes. It's a matter of state law.
9 There are no federal protections.

10 DR. HARRISON: Correct.

11 MR. HACKBARTH: Even after ACA there are no
12 federal protections.

13 DR. HARRISON: Correct.

14 MR. KUHN: As I looked at this paper and listened
15 to the presentation this morning, I kind of reflected a
16 little bit kind of more of an environmental assessment
17 before I kind of get into more details here, and that is, at
18 the September meeting we looked at kind of the initial
19 chapter for the March report, and it kind of sets the
20 environmental framework for where Medicare's going. And I
21 don't remember the number specifically, and I might be off
22 here a little bit, but I think what that report told us is

1 that over the next decade, we're going to see the Medicare
2 population be decidedly younger. Basically one-third of
3 them are going to be between age 65 and 69 because of those
4 that are aging into the program.

5 What we're also probably going to see is those
6 aging into the program are going to have less resources,
7 one, because their retirement plans have taken a hit as a
8 result of what has gone on in the market, some have taken in
9 relatives to live with them because of the state of the
10 economy. But this group that is coming in will be younger
11 but probably will have less resources.

12 But also I think the third thing that paper
13 reflected on for us was the fact that over the next decade,
14 this population is probably going to be more used to seeing
15 designs that we're talking about here in terms of their
16 private coverage, and so the seamless nature of them moving
17 from what they have now into the Medicare program with these
18 kind of changes probably won't be as dramatic perhaps --
19 that could be argued -- as we might think others.

20 So as I think about that, as the environmental
21 notion in my head and trying to think about, as Glenn
22 mentioned earlier, the value-based insurance design, if you

1 looked at that second bullet point or dot point that you
2 talked about in terms of the overall value of the benefit
3 package and the budget neutrality, you know, if you think --
4 and then one other kind of fact on this environmental
5 assessment. If you even go back to the letter that we did
6 on the SGR where we talked about the growth in the Medicare
7 program -- and well over 50 percent will be from aging into
8 the program -- I'm just kind of struck by the need to really
9 think pretty hard about the benefit package in at least a
10 budget-neutral or some kind of manner there, just with these
11 growth factors in some of these environmental assessments
12 that are out there.

13 So those would be my initial thoughts coming into
14 this right now.

15 MR. HACKBARTH: You're saying not go 2 percent up
16 but start with a budget-neutral redesign?

17 MR. KUHN: [off microphone] Correct.

18 DR. BERENSON: First I'll start with a round one
19 question, actually, which I didn't ask, but as I'm
20 formulating my answer in round two. Do you make any
21 assumptions about behavioral effects of purchasing
22 supplemental if Medicare has a catastrophic benefit that

1 there will be lower purchase of Medigap insurance? Okay.

2 DR. MARK MILLER: The only thing implied in the
3 model is that the premium would go down. You make no
4 assumptions about people saying I am, therefore, not going
5 to purchase the plan. We assume they stick with the plan,
6 but the premium comes down.

7 DR. BERENSON: But conceivably there would be some
8 behavioral effect there, and that would help us in a sense,
9 meaning we have -- well, where I'm going to come is I'm not
10 sure we -- I wouldn't go the regulatory route. First let me
11 just say I would do this only budget neutral. I would not
12 have an increased cost to the program. And so we need to
13 address, given what I've seen about what might happen to the
14 deductible there, I think we want to address supplemental.
15 I'm less attracted -- I'm unattracted to a regulatory route,
16 and in a way it's the obverse of all the controversy about
17 the individual mandate saying people have to buy insurance
18 when we come along and say you can't buy insurance, we're
19 going to prevent you from doing that.

20 I think the market is starting to work. Plan N,
21 as I understand it, which from pure dollars and cents is a
22 much better deal. Lower premium, higher cost sharing is

1 starting to sell, as I understand it. It's being marketed.
2 It's starting to sell. So, in general, I think there is a
3 market that works reasonably, but I wouldn't want to tell
4 people they can't buy peace of mind for having first-dollar
5 coverage if they want to use their money to do that.

6 I think we have an alternative, and that is the
7 excise tax approach, which I think is ripe because of the
8 induced spending in Medicare. I think it's probably
9 reasonable to have such a policy. So I would want you to do
10 the staff work on that model of affecting supplemental.

11 I guess my final point is to go back to what I was
12 talking about in the first round, if we think the Hogan work
13 was pretty good work, I would like to see us follow through
14 on developing elasticities and modeling where that would
15 take us. I understand CBO ultimately is the scorekeeper
16 here, but I assume they would be interested in new
17 information. And it seems to me, not knowing anything about
18 this, that those elasticities would be very different from
19 what the current assumptions are from the RAND study, and I
20 think would generate probably much greater savings, but I'd
21 be -- I mean, if the work can be done relatively
22 straightforwardly, I would encourage us to do that and see

1 if that affects the analysis.

2 [Pause.]

3 DR. CHERNEW: So first let me say I agree
4 completely with Bob for the reasons that Bob said about the
5 excise tax versus the regulatory approach, and I think that
6 that is the right way to go. I have a mild problem with the
7 term excise tax, in part because I think it's important to
8 remember what we're doing, is we're not taxing a product
9 really. What we're doing is making sure that people pay the
10 full cost of the product, because right now they're getting
11 a subsidy. So really removing a subsidy.

12 I understand it has this tax, it's going to look
13 like it's a tax, but what we're really doing is saying if
14 you want to buy the full dollar coverage, you have to pay
15 the full cost of that to the entire program, not just for
16 the little subsidized part. And that will come off like a
17 tax, but I think that that is right pricing, or something
18 like that. Anyway, so that's my first point.

19 My second point is that I see two things the
20 benefit design packages that were discussed. The first one
21 is, this desire to integrate A/B, because there's these
22 separate deductibles and crazy things, and I think that's

1 really important just to maintain this beneficiary centric
2 as opposed to site of care centric design, so I'm very
3 supportive of everything that goes into integrating A and B.
4 And I basically like these designs.

5 I think what one has to be careful of when one
6 does this is that what I imagine would happen is, for the
7 750 deductible, people -- even if we aren't saying it in
8 this document, people will start giving you value-based
9 insurances on kind of arguments. But we don't want to
10 discourage colonoscopy and we don't want to discourage all
11 these other various things, and I would be supportive of
12 that statement in a value-based insurance design way.

13 And likewise, I worry about the out-of-pocket max,
14 not because I dispute at all the insurance value of having
15 out-of-pocket max. I think that's very important. I worry
16 that there could be a lot of waste above the out-of-pocket
17 cap for certain types of patients and certain types of
18 treatments, and we're basically precluding using any cost-
19 sharing component no matter how crazy the service is that
20 people want to buy.

21 So if you happen to have a serious illness, as
22 tragic as that is, for example, there's some services which

1 we're saying, You just -- you won't have to pay for a whole
2 bunch of things, and I can envision the system just running
3 there to provide those types of services. So I'm much less
4 worried about that in an MA or even an ACO kind of world.
5 But in the world that we seem to be talking about here, I'm
6 worried that there could be a lot of wasteful services
7 marketed to sick people in various ways.

8 And I also, frankly, worry that there are some
9 high value services and pharmaceuticals that are over that
10 that we don't even touch in various ways, and there's some
11 low value pharmaceuticals over there that I think we should
12 touch.

13 So the point is, I think that this is a fine and
14 focused design. I think in practice, we'd have to worry
15 about exactly what the incentives are, and I'm not so sure
16 I'm as supportive -- I would be supportive of a deductible,
17 assuming that policy had some value-based waivers, and we
18 don't have to talk about that, and I'm supportive of the
19 out-of-pocket cap, but I'd like to see some mechanism
20 through coverage or some other way to try and at least
21 provide some financial incentives to discourage things that
22 might be wasteful going forward.

1 MR. HACKBARTH: Let me just pursue that for a
2 second. So I think your points make sense, and so the
3 question is how do we pursue them. One approach would be to
4 say, Well, this is the basic benefit design. We think a
5 feature of it should be to grant discretion to the Secretary
6 to modify the cost-sharing for some particular services,
7 either a high or low value, and for it to be able to apply
8 across the full range, including people who have exceeded
9 the catastrophic cap.

10 DR. CHERNEW: Right.

11 MR. HACKBARTH: Or we could -- another approach
12 would be to say, Well, let's take this in steps and this is
13 step one, and MedPAC will come back and try to delve more
14 specifically into these value-based design elements that may
15 be added on at a later point, so a sequential process.

16 DR. CHERNEW: I'd prefer [off microphone].

17 MR. HACKBARTH: Well, the third one was going to
18 be, we don't move forward with this until we can work out
19 all of the value-based insurance.

20 DR. CHERNEW: That's my least preferred --

21 MR. HACKBARTH: Yes. Me, too.

22 DR. CHERNEW: -- of them. I like the first one,

1 but I think the first and the second one aren't mutually
2 exclusive.

3 MR. HACKBARTH: Right.

4 DR. CHERNEW: I think our recommendation should
5 recognize it. If there's a service, the Secretary should
6 have authority to charge you even if you've exceeded the
7 out-of-pocket cap for those services and not have it just be
8 a blanket whatever it is. I don't know if they have to work
9 through the MedPAC or coverage kind of thing and they may
10 never do it, but then I think we can simultaneously think
11 about that.

12 MR. HACKBARTH: Am I right there's some precedent
13 for this in current law? Isn't the Secretary granted
14 authority about adding coverage for preventive services?

15 DR. CHERNEW: Oh, yeah.

16 MR. HACKBARTH: So it would be not a totally novel
17 thing to say the Secretary ought to be granted some
18 discretion.

19 DR. CHERNEW: On the deductible side. The
20 deductible side, it's already there actually. I don't think
21 you'd be able to change it in that way. I think it's the
22 out-of-pocket max side that you worry about, the financial

1 consequences, not what people are spending now, but in the
2 future, imagine you were going to develop something and it
3 was like, oh, and any patient who has had a serious illness,
4 heart attack or cancer, all the services, because they would
5 hit -- they're the people that would hit the out-of-pocket
6 max. All the services that they buy at the margin are free
7 to them.

8 MR. HACKBARTH: Okay. Mitra.

9 DR. MARK MILLER: Can I just -- real conscious of
10 time because we're over time. I mean, the other way to
11 think about your second point, the catastrophic cap, is not
12 to have total, you know -- you could continue some small set
13 of cost-sharing even after you pass the catastrophic cap.
14 That's the way D is designed.

15 The reason I'm stepping through this carefully is
16 I'm afraid these two are going to explode. Are we able to
17 look at anything like that? And we can also just discuss
18 this offline, and maybe we'll just leave it at that. I see
19 what you're saying about that. I'm going to put some
20 thought into that with these guys.

21 MS. BEHROOZI: So, I think to go down some of your
22 questions, so the redesign, I think, is really two parts.

1 Right? It's the out-of-pocket cap and it's loading some
2 more costs onto the front end, and then separately, there's
3 the whole issue of limits on supplemental coverage.

4 So the out-of-pocket cap issue, as I understand
5 it, is really only about 10 percent of the Medicare
6 population, right? Because everybody else, other than that
7 10 percent -- 90 percent of people have supplemental
8 coverage through Medigap, employers, or they're dual
9 eligibles, right?

10 So I'm not feeling real great about dealing with a
11 10 percent problem by loading costs up front. I think
12 that's really the wrong direction to go. If you want to
13 achieve coverage for that 10 percent, maybe it is about, as
14 Bob said, new kinds of Medigap coverage that will be more
15 attractive and affordable ways of funding an out-of-pocket
16 cap that doesn't just take the burden off the insurance
17 companies or off the employers or off the state Medicaid
18 programs, and then load it onto Medicare beneficiaries
19 across the board at the front end.

20 And in particular, I really don't understand the
21 value-based concept of deductibles which, you know, you
22 aren't distinguishing between types of service, you're not

1 distinguishing between high and low, and it goes somewhat to
2 the issue of the value of insurance coverage, as Kate would
3 say, that it's for somebody to pay 190 bucks a month or
4 whatever for their Medigap insurance policy is something
5 predictable and knowable, but having to pay \$300 or \$450 or
6 whatever for a procedure might be a hurdle that they can't
7 surmount at that point, not just because they are poor, as
8 in dual eligible, but something came up. They had to pay
9 for something else unexpected or expected or whatever.

10 I think that that kind of thing, as Bruce said,
11 value is in the eye of the beholder. It's not -- it's a
12 whole bunch of different circumstances that go into someone
13 making a judgment about the value of a service for them.
14 And, you know, Glenn, you referred to VBID as being
15 technocratically driven, but I think of it as being
16 clinically driven actually. Right?

17 Whereas a person who makes their choice, the
18 patient centric, as you say, or the beneficiary centric, is
19 not always the best person to be making the clinical
20 judgment. Economically rational choices for individuals
21 given all their circumstances may be health care irrational
22 choices.

1 And I think that we see some evidence about that.
2 We see, in Part D, people have been taking their medications
3 when they are covered, and then they get to the donut hole
4 and they stop taking them. Now, how much more evidence do
5 they need for themselves that they should be taking that
6 drug? But somehow, they can't come up with the \$58 for that
7 month's worth of medications, or the \$120.

8 If they can't do that, why do we think they're
9 going to avail themselves of all the health care they need
10 if they have to pay \$750 out-of-pocket before they get to
11 any level of coverage.

12 I was disappointed, I think, the way the paper
13 laid out the findings in the 2010 Chandra paper about the
14 California Medicare Advantage program findings where there
15 was a hospital offset associated with higher co-pays for
16 outpatient and drug benefits, where it said hospital
17 spending increased significantly for chronically ill
18 patients as patient visits and drug use decreased.

19 Overall, however, the size of this offset was not
20 large enough to overcome the effects of co-payment changes
21 on physician visits and prescription drugs. So it sounds to
22 me like we're just looking at the dollars. Right? The

1 dollars saved on people not going to the doctor and not
2 taking drugs was about equal to what those people ended up
3 spending in the hospital.

4 But if you're this person who was here, who was
5 taking drugs, who was going to the doctor, and that's like
6 on Slide 11 at the bottom, the people who would see an
7 increase in their out-of-pocket spending, they're the people
8 who are spending money on going to the doctor. Right?

9 The people who are going to so-called save money
10 are the ones who are now going to the hospital, but you're
11 going to see people shift out of that bottom category and
12 into the top category. They're going to not, you know, as
13 Chandra found, those people, those individuals, those humans
14 are going to reduce their drug and doctor spending and end
15 up in the hospital, and that I don't think is consistent
16 with the kind of value that we want to drive here.

17 I think that also in the paper, there was a
18 hundred dollar threshold to see. On this slide, it was
19 changes less than 100 was the middle band and changes above
20 -- you know, spending more than \$100 more or spending less
21 than \$100 -- less -- whatever. You know what I'm trying to
22 say here. I think that showed more people would be spending

1 more and the impact of that spending more, they might not be
2 spending it. That's really the problem.

3 Bruce suggested that people would continue
4 spending it if it was of value to them. My bigger concern
5 is the people who wouldn't spend it because of that greater
6 change. So I think -- and, you know, I just feel like it's
7 not the future. It's not the enlightened way to go with
8 benefit design, is to load more up-front costs. We're
9 looking at eliminating co-payments for generics among LIS
10 patients, I mean, LIS beneficiaries.

11 I understand that that's a very targeted thing,
12 but the point is we recognize that you don't always have to
13 apply a co-payment. I think it's in the footnotes to the
14 paper. Only 5 percent of Medicare Advantage plans impose a
15 co-payment for home care. Scott has told us about the high
16 value of home care in a sort of integrated delivery design.

17 So this notion of across-the-board first dollar
18 cuts being the way we should be designing the Medicare
19 program of the future I just think is absolutely not the way
20 to go.

21 Now, okay, I also recognize that there are higher
22 program costs associated with everything being filled in

1 indiscriminately. But that doesn't mean the reaction to it
2 is to impose -- or the right response, rather, is to impose
3 costs indiscriminately. So, Glenn, you and I have had this
4 conversation, that in the absence of other management tools,
5 all you've got is the dollars.

6 And Medigap plans tend not to manage. That
7 doesn't mean they can't. They're insurance companies. They
8 can require a prior authorization or they can, you know,
9 impose various kinds of management tools, whether it's
10 through limited cost-sharing or whether it's through other
11 rules.

12 So it does seem to me that it's about the nature
13 of the plan and the costs, you know, how well those plans
14 control costs, and if they don't, then -- I like the way
15 Mike put it -- then they should -- then people should pay
16 the true cost of that plan, whether you call it an excise
17 tax or whatever. But that's spreading it.

18 That's in a way that people are more able to bear
19 it, are more able to make a broader judgment about the value
20 of what they're buying, rather than at the moment they need
21 care or should be getting care to prevent them from having
22 to be hospitalized later, that that would be, I think, the

1 more progressive way to go and one that's more consistent
2 with the things we've been doing.

3 MR. HACKBARTH: So, Mitra, you've made a bunch of
4 really good and important points. The choice we have right
5 now, though, is not between a comprehensive first-dollar
6 plan and one that has more front end cost-sharing. We have
7 an existing Medicare program that has a lot of front end
8 cost-sharing and no catastrophic cap.

9 So we wouldn't be moving from what you and I might
10 consider to be a better place to one that's embracing cost-
11 sharing philosophy. There's a lot of cost-sharing in the
12 existing plan.

13 MS. BEHROOZI: But not when people have Medigap
14 coverage. That's that second part, and so I'm addressing --

15 MR. HACKBARTH: Well, that's, in fact, where I was
16 going to go. So what happens now is that people cope with
17 that high degree of cost-sharing, both at the front end and
18 the back end, by saying, Well, I want to buy supplemental
19 coverage. And that's a reasonable response to what is a
20 relatively limited benefit package.

21 But the problem, though, is that that does
22 increase Medicare expenditures, and so to use Mike's term,

1 it's not right pricing what people see for that supplemental
2 coverage. It's an understatement of the true cost of what
3 they're buying.

4 So, you know, the option that I see is, for better
5 or for worse, we have a Medicare benefit package that has
6 lots of patient cost-sharing. Can we rationalize that cost-
7 sharing a bit and then couple that with a supplemental
8 policy that says, Well, people can buy insurance, additional
9 insurance if they wish, but they really ought to see the
10 full price of that and it not be borne by the taxpayers.

11 And because I share some of your concerns about
12 loading up too much front end cost-sharing, that's why we
13 did the 2 percent thing with the 750 deductible as opposed
14 to the \$1,200 deductible. But, you know, there are
15 constraints here.

16 And sort of the big policy choice here that we've
17 not focused on but is increasingly part of the debate is,
18 more and more you hear provider associations say, You can't
19 use cutting payment rates per unit of service as your only
20 mechanism to control Medicare costs. We need to figure out
21 how sensibly to share this burden across taxpayers,
22 providers, and beneficiaries.

1 And this is an effort to say, Here's a
2 contribution that we can make in terms of the benefit
3 structure. It's not coming out of provider payment rates.
4 It yields a net savings to Medicare, if you combine the
5 coverage with the supplemental policy, and it rationalizes
6 the Medicare benefit package somewhat. Is it perfect? Is
7 it what you or I would design as the ideal insurance plan?
8 Probably not.

9 MS. BEHROOZI: But really my point was that I get
10 that we shouldn't continue increasing the cost of the
11 program by what some call overly-generous coverage, but I
12 would agree to do that only in a fashion that spread it, a
13 fashion that didn't burden the choice of whether or not to
14 seek appropriate care at the point of care.

15 I would support something like an excise tax or,
16 as Mike says, right pricing. I'm not saying don't address
17 anything, leave it all the way it is, but I don't agree with
18 the path of prohibiting Medigap coverage from covering up-
19 front costs.

20 DR. CHERNEW: She's agreeing.

21 MR. HACKBARTH: I agree with that as well. I
22 prefer the excise tax approach for all the reasons that Bob

1 --

2 DR. MARK MILLER: But there is one wrinkle, I
3 think, in what she's saying, and since you're right here,
4 let's see if this is right. What I also heard you saying is
5 that in this -- you know, you could have -- let's just use
6 the \$750 deductible as the example. You'd have a \$750
7 deductible. That would be one way, but you have a problem
8 with the point of service, you know, barrier from a
9 beneficiary getting a service.

10 And what I heard Mitra saying is I would rather
11 have a plan that allows the deductible to be filled in and
12 to bear a larger tax on such a plan. That's what I heard
13 her saying. Is that correct?

14 MS. BEHROOZI: Exactly, so that it's spread.

15 DR. MARK MILLER: You guys were all saying, I'd
16 prefer the tax approach. She's saying, I prefer the tax
17 approach and I want to be clear that I would let people fill
18 all the way in on the deductible or some number less than
19 800.

20 MS. BEHROOZI: Right, right. And not that
21 everybody would have to and that everybody would have to
22 bear that tax, but that you could have that option available

1 at the right price.

2 MR. HACKBARTH: So I'm not sure what the
3 significance of that is. So you're saying there's a
4 graduated tax with a higher tax on the one that has zero
5 cost-sharing at the point of service and a lower tax on the
6 one, the supplemental?

7 MS. BEHROOZI: Exactly. And I think that's what
8 Mike said, right? The right price for each thing, not the
9 right price for Medigap in general, and it's somewhat
10 consistent with what ended up happening in PPACA about the
11 Cadillac tax. There's a threshold, you know. So I think
12 that's more the direction that things are going.

13 MR. HACKBARTH: Yeah. And I don't want to --
14 haven't thought about the feasibility of that exactly, how
15 you would do it, but in principal, that makes sense to me as
16 well. Peter.

17 MR. BUTLER: Phew. I'll try to be smarter rather
18 than dumber. Okay, just a couple of quick points. One is,
19 I would want to reinforce Herb's point about the incoming
20 consumers being younger and maybe poorer, and also a
21 different generation of purchasers. I'm reminded of the
22 movie network, you know, I'm mad as hell and I'm not going

1 to take it anymore.

2 They are, I think, more price sensitive people, at
3 least at the premium -- at the time they're picking their
4 premium. I'm not talking about the fragile elderly, and I
5 wouldn't under-estimate the, you know, the opportunity to
6 use that purchaser's sophistication.

7 Second, I'm still troubled a little bit about
8 looking at this Part A and B in isolation, and Part D as
9 well as all of the other discretionary spending on health
10 care that elders are facing, because they are linked. And
11 so, we're kind of carving out just the A/B piece and making
12 judgments on that.

13 Having said that, I agree with not only going to
14 budget neutrality, but I would think beyond that. I think
15 this is an issue we probably should have addressed earlier
16 on rather than later, and you've made the point, Glenn, on
17 we tried to work so hard on the provider side, or the health
18 plan side to -- and with almost no engagement on the
19 insurance side when it really comes down to it. It's such a
20 huge part of the equation. So I'd go as low as 2-1/2
21 percent.

22 And then finally on the -- I would also agree with

1 an excise tax for the reasons noted, and also agree with the
2 most recent comment. If you really want first dollar
3 coverage, and I think a lot of people would pay even an
4 actuarial value -- above the actuarial value for the peace
5 of mind, but, you know, they should pay a big price for
6 that.

7 Now, the dumber part of my last comment is, is
8 there any carrots to actually even reduce maybe even Part B
9 premiums or something in a way that is even -- I know that
10 cuts into another part of the budget neutrality issue, but
11 is there -- it's not a penalty, but a full value on that
12 side of the equation, on the excise tax, or is there
13 something that is still overpaid for somebody that says, I'm
14 just going to take pure old Medicare?

15 MR. HACKBARTH: To go back a couple or three
16 sentences, you know, as I said at the last meeting, I'd
17 thought about what might be a carrot in this, and if you
18 look at this through the lens of total beneficiary financial
19 responsibility, out-of-pocket payments at the point of
20 service plus premiums, including any excise tax added onto
21 the premium, what are other ways that we can make this more
22 attractive to beneficiaries and minimize the financial

1 burden.

2 The one that I came up with is have the Government
3 offer a supplemental policy with lower administrative costs
4 than the individually-marketed supplements. And that's a
5 way to reduce the total out-of-pocket costs to beneficiaries
6 without increasing Federal spending. It basically comes out
7 of the pocket of the supplemental insurance industry.

8 And then the question is, well, is that a good
9 policy or a bad policy, and as I said at the last meeting,
10 my view is that Medicare Advantage plans that assume full
11 responsibility, clinical and financial, have the potential
12 to do things that traditional Medicare cannot do. I don't
13 see value added in paying deductibles and co-insurance.

14 That is not private industry doing things that
15 traditional Medicare cannot do for itself. It's a simple
16 administrative function that the Government can do for less.
17 And so, let's try to keep the total increase in beneficiary
18 cost to a minimum. That would be one thing that I would
19 consider, you know, as part of the package. Kate.

20 MS. BEHROOZI: Guess what I want to talk about? I
21 think the whole motivation for this discussion is great in
22 recognizing that the basic Medicare benefit is not a very

1 good insurance package, that it doesn't offer people the
2 protection against catastrophic costs that we think is a
3 fundamental function of insurance, and that's why we're in
4 this box where everybody has -- where most people have
5 supplemental coverage, because we're not providing this
6 basic insurance function.

7 So moving to a world in which we do and then fewer
8 people end up taking out supplemental coverage, I think of
9 that whole thing -- I'd want to price that whole thing as
10 budget neutral as one of the options to think about. We're
11 taking over a function that the supplemental plans are
12 providing now as part of the basic benefit, and then allow
13 people to top that out using right pricing or an excise tax
14 that incorporates the effects on the program overall, so the
15 pricing would have to depend on how much of an extra now I
16 think we thought the plans imposed on the basic Medicare
17 program and price that in.

18 All of that makes a lot of sense to me as a
19 direction to go, but I don't feel like it's completely
20 interwoven into our discussion and in the chapter in a way
21 that I think highlights the main purpose of what we're
22 trying to do, which is improve insurance value.

1 Even talking about the number of people whose
2 costs would go up and the number of people whose costs would
3 go down suggests that there are readily identifiable winners
4 and losers and that we're redistributing money from some
5 people to other people. If the average costs stay exactly
6 the same and the variance went down, we would have improved
7 the value of the program. We would have made things better
8 without changing the amount of money spent by reducing the
9 exposure to risk.

10 And so, I would love to weave that into our whole
11 discussion, that it's not about whether your costs will go
12 up. It's about the risk you face of very high costs going
13 down.

14 MR. HACKBARTH: And that's the reason for your
15 earlier inquiry about whether we can look at costs over time
16 for a given beneficiary.

17 MS. BEHROOZI: So the simplest way to do that
18 would be to assume -- to just look at the distribution of
19 costs and figure you could be anywhere in there next year,
20 and instead of saying the number of people whose spending
21 goes up, you would say the odds of people -- of the odds of
22 you facing higher spending. Doing that translation sort of

1 depends on a certain amount of independence of spending that
2 probably isn't there.

3 I am not advocating doing a sophisticated micro-
4 simulation of people spending over time. But I think
5 drawing on evidence from the existing literature or some
6 basic aggregate correlations we could say some things about,
7 you know, say half of spending is predictable and half of
8 spending is uncertain, or whatever number the literature
9 supports, to then say, even for people whose spending
10 doesn't change, there are odds of having this really bad
11 thing happen has now gone down, and that could be done
12 without a lot of detailed micro-simulation.

13 You would also then, I think, want to think about
14 if possible, including some order of magnitude on the value
15 of insurance delivered, again without doing a micro-
16 simulation, but drawing on some of the literature on the
17 insurance, value of insurance. What I worry about is that
18 the only numbers that we talk about are things like, you
19 know, if spending -- if your spending was exactly the same
20 under this other program, 23 people would have this level of
21 spending and 73 people would have that level of spending.
22 Oh, and there's insurance value.

1 We could put an order of magnitude on that by
2 using estimates from the literature, risk-aversion, and
3 saying, you know, this creates X billion dollars of value
4 for people, you know, with all appropriate caveats, and not
5 a detailed model, but at least some sense of scope that the
6 protection against high out-of-pocket costs is a real value
7 to people.

8 And we know it's a real value by looking at how
9 many people buy Medigap insurance, that clearly people want
10 to avoid those bad states of the world, so the program would
11 be delivering this value, that if at least tried to quantify
12 a little bit would give people a sense that it's important.

13 MR. HACKBARTH: Kate, going back to one of your
14 first statements, what I heard you say, and I want to check
15 this, is that your preferred approach would be to go with a
16 design that is budget neutral relative to the current
17 benefit package?

18 MS. BEHROOZI: Well, I guess --

19 MR. HACKBARTH: A higher deductible, for example?

20 MS. BEHROOZI: I guess I was being a little more
21 flexible than that in saying that I don't think that the
22 basic Medicare package has to -- that we use as a benchmark

1 has to be budget neutral. Comparing the basic package we
2 have now to the modification of the package is a little bit
3 apples and oranges in calling that budget neutral in that
4 under our model, the new benefit would be taking on some of
5 the function of the previous Medigap policy.

6 So if I were going to have a budget neutral
7 benchmark, I would have it be the basic package plus Medigap
8 coverage. So total spending -- so that's not budget
9 neutral. That's spending neutral.

10 MR. HACKBARTH: Well, if we put up Slide 12, so if
11 you look at this slide, what we're saying is we're looking
12 for a benefit package that is slightly better than budget
13 neutral when you take the two policies combined, the
14 restructuring.

15 MS. BEHROOZI: Yes. I think we're saying the same
16 thing.

17 MR. HACKBARTH: Cori.

18 MS. UCCELLO: In terms of budget neutrality, I
19 think -- is your question then, should it be budget neutral
20 from like the get-go with just the design without the other
21 changes? And, I mean, just overall, we need to be, I think,
22 better than budget neutral incorporating the other items.

1 And I think a \$1,200 deductible is too high to have that do
2 it alone.

3 And I have jumbled comments here, but in terms of
4 thinking about the excise tax versus the regulatory
5 approach, I think Bob and Mike made some compelling
6 arguments that I'm leaning toward, but I still want to see
7 some more modeling to see how some of this shapes out.

8 And in terms of the elasticities, I wonder if we
9 need to think more about this and taking into account what
10 Bob was saying, too, that maybe we can help influence how
11 CBO was thinking about this, is if we think that it's really
12 the first encounters that are the most sensitive to cost-
13 sharing and high spenders may be less sensitive, to
14 incorporate those kinds of things into those assumptions.

15 And I also like the idea of including some kind of
16 cost-sharing, nominal co-pays or something, above the cost-
17 sharing cap makes sense. And I wonder, Glenn, you talked
18 about thinking about having Medicare itself offer some kind
19 of supplemental coverage. This would be further down the
20 road, but I think it might also be useful to think of this
21 in combination with some potential premium support types of
22 approaches that kind of ties that stuff in together.

1 And in terms of the issues, too, I think we can't
2 simply keep the same plan design, add a cost-sharing cap,
3 and then expect the excise tax or whatever to carry the load
4 for making it budget neutral, because I think doing so --
5 the concern there that Mitra has is that you're increasing
6 the cost at point of service too much for some people.

7 But my concern would be then the people who might
8 still want that first dollar coverage, with the extra excise
9 tax to make that all budget neutral, those plans now are
10 going to be priced so high that they're going to be even
11 less affordable. So I'm not sure how that addresses the
12 concerns about people facing cost-sharing at the point of
13 service.

14 MR. HACKBARTH: [Off microphone].

15 MR. ARMSTRONG: Most of the points I want to make
16 have been made so I'll march through this pretty quickly.
17 First, I support the objectives that we're trying to
18 achieve. I thought Kate did a nice job of making the point
19 I wanted to make, and that is that, you know, this
20 proliferation of these Medigap plans is, to me, symptomatic
21 of a flawed basic benefit for the Medicare beneficiaries
22 themselves.

1 I also think this is important. Someone made this
2 point, but I would amplify it again, that at MedPAC, this is
3 an enormous opportunity for us to complement all the work we
4 do on provider payment with work on the benefit design, and
5 to be thinking about how these are two different, but also,
6 frankly, complementary and powerful levers for us to be
7 using. And I think it's time for us to be pushing this
8 lever a whole lot more than we have been in the past, and so
9 I think this is really an important agenda for us.

10 I also really appreciate the point about how this
11 gives us a chance to modernize the Medicare benefit as a
12 whole new wave of beneficiaries start relying on these
13 benefits, beneficiaries who have different experiences and
14 expectations. I support the cap. I think it's overdue.
15 And I think that all of this actually -- and I really
16 appreciate the points made about a concern about a small
17 percentage of beneficiaries who will go through that cap
18 quickly.

19 We really do need to think about how in the design
20 of the benefits, there is still -- maybe it's like Part D,
21 but there's still some kind of financial incentive to the
22 individuals for certain kind of benefits, and I don't really

1 know what that design looks like, but I think it's really
2 worth further consideration.

3 In terms of cost neutrality or budget neutrality,
4 again I would take this point of view that you're looking at
5 the total out-of-pocket cost for the beneficiaries. I think
6 there's a cost to this \$5,000 cap, but I think it should be
7 more than neutralized. I think it can be, frankly,
8 overwhelmed through the projected reductions in medical
9 expense trends that come from some of the other benefit
10 designs that we're talking about.

11 I would also just add that there is tremendous
12 value, and I don't know what micro -- whatever the term is
13 that you use -- modeling means, but what I do know is that
14 the vast majority of health insurance in our country relies
15 on evidence-driven adjustments to incentivize valuable
16 services, that improve health, and at lower expense trends,
17 and they ask patients to pay more out-of-pocket for those
18 things that don't.

19 And it's about time that we started applying the
20 same standard. And, frankly, I think we're going way too
21 slow in terms of trying to over-analyze and figure this all
22 out, and that there's plenty of evidence in Medicare

1 Advantage plans and in other insurance plans that we should
2 also be looking to. And I think that's all I have to say.

3 MR. HACKBARTH: Okay. Thank you, Julie and Scott.

4 Our next item is Part D, and we'll have two
5 component there, our annual status report on Part D and then
6 a more focused discussion on beneficiaries with high drug
7 spending.

8 Shinobu, you can start whenever you are ready.

9 [Pause.]

10 MS. SUZUKI: Good morning.

11 Today I'm going to give you a quick update on how
12 the Part D program is working for Medicare beneficiaries,
13 and continue our discussion from the September presentation
14 on beneficiaries with high drug spending and discuss ways to
15 reduce spending growth.

16 In general, Medicare beneficiaries seem to have
17 good access to prescription drugs. All individuals have
18 access to dozens of Part D plan options, and many continue
19 to receive drug coverage through former employers.

20 Prescription drug coverage for Medicare
21 beneficiaries haven't changed very much since the program
22 started. In 2011, about 60 percent of beneficiaries are

1 enrolled in Part D plans, an additional 13 percent get their
2 coverage through employer plans that receive Medicare's
3 retiree drug subsidy. Some beneficiaries receive their drug
4 coverage through other sources of creditable coverage, such
5 as VA, TRICARE, and FEHBP.

6 Although 2011 data are not available, last year,
7 about 10 percent had no drug coverage or had coverage less
8 generous than Part D's benefit.

9 Surveys indicate that beneficiaries enrolled in
10 Part D are generally satisfied with the Part D program and
11 with their plans.

12 There hasn't been a dramatic shift in enrollment
13 patterns from year to year. In 2011, about two-thirds of
14 the beneficiaries are in stand-alone prescription drug plans
15 and the remaining one-third are in Medicare Advantage
16 prescription drug plans. Most LIS enrollees are in PDPs. A
17 larger share of MA-PD enrollees have enhanced benefits that
18 provides, for example, coverage in the gap. In 2012, about
19 the same number of plans will be available.

20 The national average bid for 2012 came in a lower
21 than for 2011. That means the plans are expecting the
22 average benefit costs for basic benefits to go down by about

1 4 percent between 2011 and 2012.

2 The chart shows the year to year changes in the
3 average bids from plan sponsors. As you can see, the bids
4 have fluctuated over the years.

5 The drop in expected costs for 2012 is likely due,
6 at least in part, to the expiration of patents for some of
7 the top selling brand-name drugs. For example, Lipitor, a
8 popular drug used to treat high cholesterol, is expected to
9 face competition from a generic market entry later this
10 month.

11 The base beneficiary premium will be \$31 in 2012,
12 which is a decrease from \$32 this year. That's not going to
13 be the average of the premiums beneficiaries will pay in
14 2012. The actual average premium will depend on how the
15 enrollment changes after the annual open enrollment period
16 ends on December 7th.

17 Higher income beneficiaries pay a surcharge
18 calculated based on their income, similar to income-related
19 premiums under Part B of Medicare.

20 The average plan bid we just saw reflects plans'
21 expectations about what it would cost to provide basic
22 coverage for a beneficiary with average health. You saw

1 this chart in September. There are two things I want to
2 call your attention to: the low-income subsidy, which is
3 the white bar, and individual reinsurance, which is the red
4 bar. These are two of the fastest growing components of
5 Part D spending.

6 Payments for low-income subsidy continues to be
7 the largest component of Part D spending. The subsidy has
8 grown by 34 percent cumulatively over this period. Payments
9 for individual reinsurance has grown the fastest between
10 2007 and 2011, with a cumulative growth of 60 percent. This
11 is the subsidy that covers most of the catastrophic costs
12 for beneficiaries who have very high spending.

13 We are focused on these two components because the
14 growth of these magnitudes will soon make the program
15 unaffordable, particularly in the current budget
16 environment. In the second half of the presentation, we'll
17 talk about a policy that may help slow the growth in
18 payments for low-income subsidy and individual reinsurance.

19 In September, we discussed the characteristics of
20 beneficiaries who have spending high enough to reach the
21 catastrophic phase of the benefit. Before we go into the
22 policy discussion, I'd like to recap some of the key

1 findings from our analysis of the high-cost beneficiaries.

2 Using 2009 Part D data, we found that over 80
3 percent of high-cost beneficiaries received Part D's low-
4 income subsidy. They had high drug spending because they
5 filled many prescriptions, and the average cost of
6 prescriptions filled were more than twice as high as those
7 filled by other Part D enrollees. Although high-cost
8 beneficiaries are using many drugs in classes with generic
9 alternatives, they tended to use more brand-name medications
10 compared to other Part D enrollees.

11 What this analysis showed is that most of the
12 payments for individual reinsurance are made on behalf of
13 low-income subsidy enrollees. And it also suggests that
14 encouraging the use of generic drugs could potentially
15 reduce program spending by slowing the growth in payments
16 for both low-income subsidy and individual reinsurance
17 without affecting access to needed medications.

18 Here is a quick background on how the low-income
19 cost-sharing subsidy works. The cost-sharing amounts for
20 low-income subsidy beneficiaries are set by law. This is
21 different from how things work for other Part D enrollees,
22 where cost-sharing amounts are set by their plans.

1 For about 80 percent of LIS beneficiaries the law
2 sets nominal copays. For example, an LIS enrollee who is a
3 dual eligible with an income under 100 percent of poverty
4 would pay a little over \$1 for generic drugs and \$3.30 for
5 brand-name drugs.

6 So, I have here an example of a hypothetical plan
7 with four tiers. The plan charges \$7 for generics. That's
8 the top row. An individual who does not receive the low-
9 income subsidy would pay \$7 at the pharmacy for generic
10 drugs. An individual who received the low-income subsidy
11 would pay \$1.10, while the LIS program picks up the
12 difference, which in this case is \$5.90.

13 If an individual receiving the LIS, instead,
14 filled a brand-name medication, the subsidy amounts would be
15 much higher. In this example, about \$37 for preferred
16 brand-name drugs on tier 2, and about \$77 for brand-name
17 drugs on tier 3. If we could encourage this individual to
18 take a generic version of the drug, the subsidy payments
19 would be \$30 less for each drug switched from tier 2, and
20 \$70 less for each drug switched from tier 3.

21 Here are some aggregate spending and utilization
22 information that compares LIS enrollees to non-LIS

1 enrollees. The key things to note here are that LIS
2 enrollees fill more prescriptions and the cost of each
3 prescription is higher, on average, compared to non-LIS
4 enrollees.

5 In 2009 they filled, on average, five
6 prescriptions per month compared with 3.6 for non-LIS
7 enrollees. The average cost per prescription was about 50
8 percent more expensive as non-LIS enrollees, costing \$68, on
9 average, compared with \$45 for non-LIS enrollees.

10 Although some of the difference likely reflects
11 the difference in the health status and medication needs
12 between the two groups, as you'll see in the next slide,
13 part of the reason the cost per prescription is much higher
14 for LIS enrollees is because they tend to take more brand-
15 name drugs compared to non-LIS enrollees.

16 Plan sponsors have generally been more successful
17 at encouraging generic substitution among non-LIS enrollees
18 than among LIS enrollees. In 2009, non-LIS enrollees had an
19 overall average generic dispensing rate, or GDR, of 72
20 percent compared to 68 percent for LIS enrollees. The
21 difference in GDRs between LIS and non-LIS enrollees varies
22 by class, but in general, LIS enrollees tend to have a lower

1 GDR compared to non-LIS enrollees. For example, for
2 antihyperlipidemics used to lower high cholesterol, GDR for
3 LIS enrollees was 7 percentage points lower compared to non-
4 LIS enrollees.

5 Given that generic drugs cost significantly less
6 in most cases -- and typically require much lower cost
7 sharing -- a policy that encourages beneficiaries to use
8 generics when available has the potential to lower program
9 spending without affecting access to medications.

10 One way to encourage more generic use is to use
11 financial incentives. A cost differential that makes
12 generic prescriptions relatively more attractive can have a
13 strong impact on the use of generics. But a policy based on
14 financial incentives must be carefully constructed,
15 particularly for this population, to ensure access to
16 medications they need. It also needs to take into account
17 variations in plan formulary structures so that it can be
18 applied uniformly across all LIS enrollees.

19 We would not expect the cost sharing policy to
20 apply to dual-eligible beneficiaries residing in
21 institutions.

22 To provide stronger incentives to plans, in the

1 future, CMS may want to rate plan performance based, in
2 part, on generic dispensing rates for selected drug classes.

3 Here is an example of a policy that would make
4 generic drugs relatively more attractive. Under the
5 alternative cost-sharing structure, the copays would depend
6 on whether the drug class has generic substitutes or not.
7 The table shows how this example would work for drugs in a
8 class with generic substitutes.

9 The top portion of the table shows the current
10 cost-sharing amounts for dual eligibles under 100 percent of
11 poverty. The bottom half shows what happens to the copay
12 amounts under a policy that eliminates cost sharing for
13 generic drugs and increases copays for brand-name drugs when
14 generic substitutes are available. In this example, we have
15 set the copay amount for brand-name drugs at \$6.

16 For brand-name drugs in classes with no generic
17 substitutes, cost-sharing amounts would stay the same so
18 that beneficiary would have the same access to those drugs
19 as under current law.

20 Although the extent to which generic substitutions
21 are possible varies by therapeutic class, higher generic
22 use, when possible, can mean significant savings. For

1 example, in 2009, spending for antihyperlipidemics by LIS
2 enrollees who were subject to copays totaled \$2.2 billion.
3 That's about 90 percent of the total that was spent for this
4 class of drugs by all LIS enrollees.

5 Of that \$2.2 billion, \$1.8 billion was for brand-
6 name drugs. If the generic use rate among these
7 beneficiaries were increased to 63 percent, which is the
8 average generic use rate across all non-LIS enrollees, the
9 low-income cost-sharing subsidy payments would be reduced by
10 more than 10 percent, or by more than \$100 million. Plan
11 costs would also go down by about the same amount.

12 For the seven classes that we looked at a few
13 slides ago, which accounts for about 40 percent of spending
14 for drugs taken by this population, spending on these drugs
15 could have been reduced by over \$1.3 billion if the generic
16 use rates were similar to those of non-LIS enrollees.

17 Lower Part D spending for this population would
18 have effects beyond just reducing spending for low-income
19 cost-sharing subsidy. Lower plan bids would reduce direct
20 subsidy payments Part D makes to plans, and it would also
21 lower premiums that non-LIS enrollees pay. And if fewer
22 beneficiaries reach the catastrophic phase of the benefit,

1 it would also reduce Part D's payments for individual
2 reinsurance.

3 Here are some issues you may want to discuss:

4 What cost-sharing amounts are appropriate for this
5 population with limited incomes? In our example, we changed
6 the cost-sharing from \$1.10 for generics and \$3.30 for
7 brands to \$0 and \$6. For LIS enrollees with income above
8 100 percent of poverty, the current cost-sharing amounts are
9 at \$2.50 for generics and \$6.30 for brand-name drugs. What
10 are the appropriate amount for this group of beneficiaries?
11 Are there other, non-financial, ways to encourage the use of
12 generic drugs?

13 In the next draft, we will have additional
14 information on plan formularies, drug prices, and quality
15 ratings of Part D plans.

16 Finally, I will put this slide up for the
17 discussion session. This re-states the example of the
18 policy option that we just talked about. The two key
19 features of the policy are first, the policy would modify
20 Part D copay amounts specified in law for Medicare
21 beneficiaries with incomes at or below 135 percent of
22 poverty to further encourage the use of generic drugs when

1 available in a given class.

2 Second, there should be Secretarial review of the
3 therapeutic classes periodically to determine an appropriate
4 classification for implementing the policy.

5 That concludes my presentation.

6 MR. HACKBARTH: Okay, thank you, Shinobu.

7 Could I ask a clarifying question on slide 11?

8 A common structure among Part D plans is to
9 distinguish between preferred brands and non-preferred
10 brands, and you didn't address that in the way this
11 particular table is set up. So if we're talking about a
12 plan that distinguishes between preferred and non-preferred,
13 is there an opportunity to have different copays for LIS
14 beneficiaries for preferred versus non-preferred brands?

15 MS. SUZUKI: I think that could be done. I guess
16 it might be something the Secretary may have to approve on a
17 case-by-case basis, given the variation in plan formulary
18 structures across different plans. Not all plans have
19 preferred/non-preferred.

20 MR. HACKBARTH: Right.

21 MS. SUZUKI: If we do implement this type of
22 policy, you may have to consider how this type of policy

1 interacts with the differentiation between preferred and
2 non-preferred brand-name drugs.

3 DR. MARK MILLER: And just to follow up on the
4 plan-by-plan approval, CMS reviews plans each year. The
5 Secretary establishes therapeutic categories and then the
6 plans submit their tiering structures and then CMS sort of
7 reviews that.

8 So in some sense, that review occurs now.

9 MS. SUZUKI: Right. So there is a guideline for
10 classification. Plans can have their own classification
11 that the Secretary reviews. But the review is conducted
12 every year to make sure the formulary doesn't discriminate,
13 for example, against some type of disease.

14 DR. MARK MILLER: The reason that I'm saying that,
15 just to conclude this thought -- I'm sorry, I didn't
16 necessarily anticipate that we would have this conversation
17 right here, but here we are. Sorry, that probably just made
18 it worse.

19 So if that review had occurred and the policy was
20 in law or regulation, whichever way this is executed, you
21 are allowed to charge up to this price on the non-preferred
22 therapeutics, the review process would have occurred and

1 then the law could say in that circumstance the plan could
2 raise the cost-sharing accordingly.

3 MS. SUZUKI: I think -

4 DR. MARK MILLER: Your lawyer seems to indicate
5 that it's okay for you to say yes here.

6 MR. HACKBARTH: Which lawyer is she going to
7 choose?

8 [Laughter.]

9 DR. MARK MILLER: I'm just trying to say that if
10 we made this policy, there is kind of an underlying review
11 process that might enable it to go forward, if we were to
12 choose something like that.

13 MS. SUZUKI: Yes.

14 DR. MARK MILLER: I'm not asserting that we
15 should. And there may be other issues that I'm not focusing
16 on right at the moment.

17 MR. HACKBARTH: Scott, clarifying question?

18 MR. ARMSTRONG: Actually, that slide and I think
19 the comments you were making were speaking to this. It's
20 not a big deal, but I just want to confirm that we're really
21 distinguishing between these different categories purely on
22 the basis of whether there's a generic alternative or not.

1 And that -- now, we spend a lot of time arguing that there
2 are actually some non-preferred generics where there's more
3 than one generic alternative.

4 And so I assume we really didn't try modeling, to
5 a more sophisticated degree, those different categories than
6 just generic versus non-generic.

7 MS. SUZUKI: Right, I mean, I think class-by-class
8 -- I mean, this is going to vary by class. And that's sort
9 of beyond our knowledge. And it's something that maybe the
10 Secretary -- this is why we're sort of saying the Secretary
11 should conduct a review of the classification to make sure
12 that the policy can be implemented.

13 MR. ARMSTRONG: But in every drug class, all
14 generics are created equal and all brand names are created
15 equal, according to our analysis? That was a question.

16 DR. SOKOLOVSKY: That's the way it was modeled.

17 MS. SUZUKI: That's the way we're modeling; right.

18 MR. ARMSTRONG: Okay.

19 MS. UCCELLO: Two related questions. First is why
20 are there so few LIS beneficiaries in MA-PD, as opposed to
21 stand-alone plans?

22 And two, do MA-PD plans do a better job of

1 controlling costs among the LIS population?

2 MS. SUZUKI: So a lot of the duals, at the
3 beginning of the program, got assigned to PDP and so they're
4 already in PDPs, the majority of them. A lot of them also
5 sort of get facilitated enrollment to PDPs if they don't
6 choose a plan on their own and those are two specific PDPs.

7 I think that's probably the reason that they're
8 almost all in PDPs. But 20 percent of them are in MA-PDs.

9 MS. UCCELLO: Do the MA-PD plans do a better job?
10 Do they have fewer high cost?

11 MS. SUZUKI: We haven't done a close look at how
12 they compare. We have looked at risk scores in the past and
13 compared low-income subsidy enrollees in PDPs versus MA-PDs,
14 and it seems like MA-PD enrollees had a lower risk score.
15 And so there may be health-status related issues, as well.

16 MR. BUTLER: So what do we know, if anything,
17 about the 10 percent of the beneficiaries that either choose
18 not to have Part D or drug benefits that are less than what
19 Part D offer?

20 MS. SUZUKI: I don't -

21 DR. SOKOLOVSKY: The early analysis -- and I don't
22 think there's been very much going forward -- they were

1 people who tended not to take many drugs and didn't think
2 that the penalty was worth it for them at this point.

3 MS. BEHROOZI: So in the paper -- this isn't
4 directly relevant to what the presentation is on, but just
5 on the issue of people's behavior and response to costs.

6 In the paper, you say that 30 percent of enrollees
7 make it to the coverage gap, make it to the donut hole;
8 right? And then 8 percent make it through the donut hole to
9 the catastrophic coverage phase.

10 So I wonder -- you might have done this before and
11 told us before -- or can you do this? Can you look at the
12 rate of spending of people who are approaching -- you know,
13 that the 30 percent, to see whether they should have come
14 out the other end or whether they just stopped spending? I
15 don't know if you've done that.

16 MS. SUZUKI: I have not looked at that. There are
17 papers where I think they've looked at a subset of people
18 who saw some reduction in use when they entered the coverage
19 gap. It's something that we can certainly look into.

20 DR. CHERNEW: When you did some of the estimates,
21 there are some drugs that are going to go off patent soon,
22 some big ones certainly, anti-cholesterol drugs and stuff --

1 did you take into account what would happen in the future or
2 just what would have happened in the past?

3 MS. SUZUKI: This is just a snapshot from 2009 PDE
4 data.

5 DR. CHERNEW: So it's before some of the ones that
6 were big went off.

7 DR. MARK MILLER: The only thing I would add to
8 that is I think there's two phenomenon. One, more generics
9 and do they have a signal to move to them?

10 DR. CHERNEW: Right, the reason I said that is it
11 is -- I agree very much, again, with what Scott said.
12 Having a generic in class doesn't imply some sort of perfect
13 substitution in a whole number of ways, particularly since
14 this population is a little bit different. So knowing when
15 they're switching molecules versus they're just using the
16 branded drug and the generic exists for that exact thing --
17 they're just very different.

18 And in many of these classes, you're going to get
19 a lot more, the current brand of drugs are going to become
20 generic going forward. And getting them to make sure they
21 switch to the generic version of that is really important to
22 avoid some of the problems.

1 DR. BERENSON: On slide 11, you may have said this
2 but I missed it. Is the alternative cost-sharing package
3 budget neutral to the initial one?

4 MS. SUZUKI: It is not budget neutral the way it's
5 constructed because we've made generic drugs free in this
6 example. But I don't think we've figured out how many of
7 the brand name drugs would be switched.

8 DR. BERENSON: Assuming no change in patterns,
9 about two-thirds currently are generic, so you've brought
10 that down by \$1.10 and you've raised the others by \$2.70.
11 It almost looks like it's budget neutral with current
12 utilization patterns, but you didn't intend to do that.

13 DR. SOKOLOVSKY: But you did estimate savings,
14 taking into account -

15 MS. SUZUKI: Right. The savings that I discussed
16 were taking into account -

17 DR. BERENSON: Okay, I did miss something then.

18 MR. HACKBARTH: Can you say that again, Shinobu,
19 just the last sentence?

20 MS. SUZUKI: So the savings that I estimated did
21 account for the fact that the generics are free. In which
22 case, long-term subsidy is picking up more of the cost

1 sharing for generic drugs.

2 MR. HACKBARTH: Yes. So in the offset package
3 that we discussed last time as part of the SGR discussion,
4 there was an option related to LIS cost-sharing and -- I
5 can't remember off the top of my head -- the estimated 10-
6 year savings from that. They were how much?

7 MS. SUZUKI: I believe it was \$16 or \$17 billion
8 over -

9 MR. HACKBARTH: Over 10 years. Yes, that sounds
10 right. And that was based on this cost-sharing structure or
11 a similar cost-sharing structure?

12 DR. MARK MILLER: Her lawyer is not going to allow
13 her to answer that question.

14 [Laughter.]

15 DR. MARK MILLER: What we did there is we put
16 together that estimate using some aggregate numbers working
17 out of a CBO 2010 report and looking at some of our own
18 data. And what I think -- the way we would characterize
19 this is we had some general policy parameters in mind, but
20 we didn't model specific policy parameters. Now what we're
21 trying to do is fill in behind that, and we put a
22 conservative placeholder in there and shaved off how much

1 savings in the hope that we could design something that
2 would fill in that savings estimate.

3 Is that fair enough?

4 DR. BERENSON: This is going to -- I'm not sure
5 you'll have an answer to this, and I'm not sure I can ask
6 the question right. But I'm interested in -- do we know
7 whether the LIS patients -- we have a 4 percent difference
8 in aggregate in the generic prescribing. Do they see the
9 same clinicians writing prescriptions and the clinicians are
10 somehow writing different prescriptions for this population?
11 Or are they seeing a different class of prescribing
12 clinicians? In which case, cost-sharing policy may be less
13 helpful.

14 Do we have any idea? Or is it a mixture? Which
15 is what I would assume, both things are probably going on.

16 MS. SUZUKI: I don't have the answer for that, but
17 we do have prescriber information on the PDE. So it's
18 something that we could look at.

19 DR. BERENSON: I mean, I guess the point I'm
20 making here is if they're seeing just the different profile
21 clinicians, it may be that cost-sharing policy isn't going
22 to directly change that prescribing behavior. And it might

1 be helpful, if this doesn't take a lot of work, to sort of
2 get some sense of that.

3 MS. SUZUKI: One of the things we were trying to
4 add to the policy discussion is to say that maybe we should
5 add more incentives to the plans to increase the generic use
6 among this population, for example, using ratings based on
7 these generic use rates.

8 MR. KUHN: Just a quick question on this notion
9 that Mark mentioned a moment ago, the signal to move, but
10 kind of take it up from the generic substitution from the
11 brand name up to kind of the health plan level. Every year
12 there is a certain number of switchers within the LIS
13 population. Some are moved by CMS because of changes in the
14 plan bids. Some will move because they might just want to
15 select another plan.

16 What is kind of that number of switchers we're
17 seeing every year? And how many of them are being moved by
18 CMS and how many move on their own accord? Do we know?

19 MS. SUZUKI: I don't have the numbers, but I
20 believe last year it was less than the million who was
21 reassigned by CMS. I'm not sure that we -- we don't track
22 the, what we call choosers, on a regular basis, but there

1 are some people who did choose their own plans. CMS won't
2 reassign those people. But it's not something that we've
3 tracked in close detail.

4 DR. HALL: On Slide No. 9, I've been puzzling why
5 -- what are some of the reasons why generic use would be
6 lower for LIS, and at least some things that come forward
7 would be that they are sicker and older. You alluded to
8 that a little bit, and that would make sense. The other is
9 that there is something going on in the PDP programs that
10 allows this to happen. Or, third, there's some great
11 conspiracy here that we haven't unearthed yet. Can you help
12 with that a little bit?

13 MS. SUZUKI: I think we've also thought that there
14 are multiple reasons, one of them being that maybe they
15 don't have as much incentive to choose the incentives when
16 the financial incentives they face is very different from
17 the financial incentives non-LIS beneficiaries face. That
18 could be one of the reasons. But I agree that health status
19 probably has something to do with it. The fact that they're
20 also almost all in PDPs may also affect their prescribers'
21 behavior.

22 DR. HALL: Right. Just as a follow-up point, this

1 is generally not a decision point where consumers are very
2 informed on this. Their physician or their health provider
3 gives them a prescription for something. I mean, I can't
4 remember a situation where somebody would just quiz
5 themselves and go to the literature to see whether a generic
6 would be equivalent. So some governments, like New York
7 State, for example, really won't allow us to write non-
8 generic prescriptions. I mean, basically, you have to make
9 a conscious decision -- well, it used to be on paper, but
10 now it's electronic -- that you are going to be willing to
11 accept the generic if a generic exists. So I'm very puzzled
12 by that, why this difference occurs. But, obviously, it
13 needs to be looked at.

14 DR. SOKOLOVSKY: One of the things that I want to
15 say is we've been doing focus groups with beneficiaries on
16 the drug benefits since before the drug benefit began --

17 DR. HALL: Mm-hmm.

18 DR. SOKOLOVSKY: -- and in the first year, 2005,
19 all the beneficiaries we spoke to were very suspicious of
20 generic drugs -- a majority of them were. In years going
21 forward, we've heard consistently from the non-LIS
22 population, particularly those that were hitting the

1 coverage gap, that they were going to their physicians and
2 saying, is there anything you can do to lower my costs? Are
3 there any generics available? And you hear them talking
4 about it like we would be doing it here. It's quite
5 amazing, the difference.

6 DR. HALL: Hmm.

7 DR. SOKOLOVSKY: And you don't hear quite that
8 level of change in the LIS.

9 MR. HACKBARTH: So there are multiple potential
10 hypotheses --

11 DR. HALL: Right.

12 MR. HACKBARTH: -- why this differential exists.
13 Our policy option focuses on one, that there's economic
14 incentive at work. Is there any way to explore through data
15 the other hypotheses, so not being research? I'm not much
16 help here, but is there any movement of people from the LIS
17 population to non-LIS status where you could actually track
18 people and see if their behavior changes as they move? My
19 hunch is that there probably aren't a lot of people who
20 graduate from LIS status, given that we're talking about the
21 population we're talking about. But is there any way that
22 we can try to shed light on these other hypotheses?

1 MS. UCCELLO: Can we look the other way?

2 DR. NAYLOR: [Off microphone.] Non-LIS --

3 MR. HACKBARTH: Or when they move in, yes. Yes,
4 that's probably the more plausible possibility.

5 MS. SUZUKI: That's definitely a possibility,
6 something we can look into.

7 MR. HACKBARTH: Yes.

8 DR. MARK MILLER: And this doesn't mean we don't
9 look into it, but would you expect the bias there to be if
10 I'm on a generic because I was non-LIS and more sensitive to
11 it and then I moved to LIS, you would be less likely to
12 immediately go to a name brand than the average person who
13 started out on LIS --

14 MR. HACKBARTH: Right. That would be your
15 hypothesis to test --

16 DR. MARK MILLER: So you would have a little bit
17 of a bias in what direction you expect to -- but it doesn't
18 mean we can't.

19 MR. HACKBARTH: Okay. Mary.

20 DR. NAYLOR: Very briefly. I think I know the
21 answer, but the PPACA changes that will be going into effect
22 in 2012 that you mention in this terrific report, you can't

1 model what effect -- I mean, so you won't know the added
2 value of this recommendation in terms of cost sharing on top
3 of the ones that will be implemented going forward?

4 MS. SUZUKI: You're talking about phasing in and
5 the gap, or -- I'm sorry, what --

6 DR. NAYLOR: [Off microphone.] I understood that
7 you were already -- so I may be wrong in the assumption that
8 there are already efforts to reduce cost sharing in 2012,
9 2013, and I'm still wondering about the added value of this
10 recommendation on already expected implementation efforts.

11 MS. SUZUKI: So right now, we're talking about LIS
12 enrollees. They don't face the coverage gap. The phasing
13 in of the coverage gap affects the non-LIS population.

14 DR. NAYLOR: [Off microphone.] I'm wrong. There
15 are other cost sharing reductions that have been recommended
16 as part of -- thank you.

17 DR. CASTELLANOS: As a physician, I was reading
18 the material that was sent to us and I really was intrigued
19 by a statement that beneficiaries who do not enroll in Part
20 D have a lower drug spending, as you would expect, but they
21 have better health and lower risk scores. Now, I know you
22 referred to an article in Health Affairs. I didn't have

1 time to look at that, but that's intriguing, because the
2 best way to save money is to get them out of Part D so they
3 don't have to be there. We have very little emphasis on
4 well care that I've noticed, at least mentioned on the
5 Commission, and I'm just curious if you had any comments why
6 these people -- what's the difference between those people -
7 - something what Peter asked, a similar question.

8 DR. SOKOLOVSKY: I think the arrow points the
9 other way. At least, the literature that is available
10 suggests that the people who didn't enroll in Part D were
11 the people who already were pretty healthy and not taking
12 many drugs.

13 DR. CASTELLANOS: But why were they healthier and
14 why do they have better risk? Do we ever look at that
15 population and try to say, hey, what are they doing that we
16 should be doing?

17 MS. SUZUKI: And part of the problem trying to
18 look at their utilization is we have no utilization
19 information for them on the prescription drug side.

20 DR. CASTELLANOS: Just an interesting comment.
21 Thank you.

22 MR. HACKBARTH: George.

1 MR. GEORGE MILLER: Yes. I'm kind of intrigued by
2 the information Joan said for the focus group meetings, why
3 there is suspicion about generic drugs. Did you dwell any
4 deeper and try to understand why?

5 DR. SOKOLOVSKY: We have in the past. This isn't
6 something we've explored recently, but in the past when it
7 was more widespread, we would hear things like generics are
8 fine for other people but I'm more sensitive. We also heard
9 other people talking more like it's like a store brand is
10 never as good as a name brand.

11 MR. GEORGE MILLER: Okay. All right. Well, with
12 that said, from a policy standpoint in that those are the
13 reasons, and with all due respect to people's perceptions
14 about that, from a policy standpoint, why don't we -- I
15 think it was just mentioned in New York -- is make a policy
16 that generics would be the drugs unless the provider
17 specifically had an indication that it should not be a
18 generic drug, just from a policy standpoint to flip this,
19 because if there's not a logical reason, I don't understand
20 Slide No. 9.

21 MR. HACKBARTH: This is actually something that
22 Cori and I talked about.

1 MR. GEORGE MILLER: Yes.

2 MR. HACKBARTH: There was a piece in one of -- I
3 think it was Tab A from the last meeting that talked about
4 this issue of resistance to generics. As I understand it,
5 this is currently a matter of State law and varies from
6 State to State on whether a physician can, must substitute
7 generics in certain circumstances. So for the Federal
8 Government to legislate in that area would be potentially
9 problematic. It would be intervening in a matter that's
10 well established as a State law issue.

11 MR. GEORGE MILLER: Okay. Thank you.

12 MR. HACKBARTH: Bruce.

13 DR. STUART: If we could go back to Slide 11. The
14 copays that you see there are for essentially the duals, and
15 there are LIS beneficiaries who have higher incomes and they
16 have slightly higher copays. I guess my question is, in a
17 way, that's kind of a natural experiment, and I wonder if
18 we're trying to understand what would happen to LIS
19 beneficiaries if you change the copay structure, if you
20 compare these two groups. They're not strictly comparable,
21 but they're both poor. Have you looked into that?

22 MS. SUZUKI: I have looked at them and compared

1 them for a couple of therapeutic classes. In most cases,
2 there is no difference in the generic use rate. We are
3 talking 250 versus 630, roughly, this year, compared to 110
4 versus 330. We didn't see any difference.

5 DR. STUART: Well, just a suggestion, and then
6 another thing here that's important in terms of
7 understanding the copay structure for LIS, and I think I'm
8 right here, is that these copays are per prescription
9 regardless of the days' supply, is that correct?

10 MS. SUZUKI: Mm-hmm.

11 DR. STUART: So if you think about it, if an LIS
12 beneficiary fills either a generic or a brand, it's the same
13 whether it's 30 days or 60 days or 90 days, and so that
14 would be interesting to look at when you're comparing the
15 LIS to non-LIS in terms of whether some of this difference
16 is due to differences in days' supply.

17 MS. SUZUKI: I guess, in the aggregate, I think
18 non-LIS enrollees are more likely to take drugs that have
19 more days of supply, on average, than LIS enrollees.

20 DR. STUART: Actually, I would expect that to be
21 true, because the duals came from Medicaid and most State
22 Medicaid rules basically mandate a 30-day supply. But if

1 that's the case, we're looking at moving from dual to non-
2 dual, that difference of days' supply is also something I
3 think we would want to consider.

4 MR. GRADISON: This seems important to me, that
5 there be an opportunity for physician override. I had been
6 assuming as a layman that a generic was either
7 therapeutically equivalent or chemically equivalent and
8 that's just the end of it. I don't think it is in every
9 instance. I've been struck in the literature, for example,
10 with regard to thyroid supplements, that there is some
11 evidence that the generic isn't equivalent in terms of the
12 stated strength of the bottle. I don't know any better way
13 to say it as a layman. So I just think we have to be
14 careful about this. I'm not in any way objecting to the way
15 in which we approach it, but circumstances differ.

16 DR. BORMAN: Could you just refresh me, because
17 maybe I have missed it and I am just not into it, why we
18 wouldn't apply something to encourage the use of generics
19 more in the institutional LIS group? We say we exclude
20 that, and it's 13 percent of the group.

21 DR. SOKOLOVSKY: I think the reason is because
22 there is no cost sharing at all of institutional and we

1 don't think there could be because, first of all, they're
2 not making a decision, generally speaking. They're getting
3 what they're being given. And also, to the extent that
4 these are duals, they don't have much -- once they're
5 institutionalized, they really don't have the cash.

6 DR. BORMAN: I mean, I understand that they aren't
7 making decisions, but someone is making a choice for them.
8 So the entity that gets the payment for them, are we
9 motivating their behaviors in other ways to use the drug
10 money wisely, or is there -- it just doesn't apply?

11 MS. SUZUKI: I think some of the things we could
12 consider are, you know, are there things plans could do to
13 work with the long-term care facilities to increase generic
14 use. But as far as cost sharing policy goes, there's not
15 much we can do there for this population.

16 DR. BORMAN: I would just hope that -- 13 percent
17 is a non-trivial chunk when, if my gut feeling is correct,
18 they would be likely to have pretty high drug use by virtue
19 of the conditions that cause them to be where they are, and
20 so I just wouldn't want that group to get lost in the
21 shuffle, whether or not it belongs under this initiative or
22 this investigation.

1 MR. HACKBARTH: So let me play with this for just
2 a second, because I really don't understand how it works.
3 So most of the Medicare beneficiaries who are
4 institutionalized are going to be duals and also covered,
5 therefore, by Medicaid. So Medicaid is actually providing
6 their drug -- well, with the switchover in Part D, so
7 Medicare is paying. So how do the dollars flow? If the
8 nursing home is buying and distributing the drugs, how do
9 they get paid now for those drugs?

10 MS. SUZUKI: Once they're -- you know, for the
11 people who are outside of the SNF-covered days, it's just
12 like what Medicaid used to do. They pick up the cost of the
13 drugs. But now Part D plans pay for those drugs --

14 MR. HACKBARTH: Yes --

15 MS. SUZUKI: -- on whatever pre-negotiated payment
16 terms with the pharmacy --

17 MR. HACKBARTH: So they pay directly to the
18 nursing home. Yes. Okay.

19 Round two. Scott.

20 MR. ARMSTRONG: So to the issues for discussion, I
21 don't know exactly what the dollar amounts are for different
22 levels, but I believe and strongly support a direction that

1 you've laid out to model zero out-of-pocket costs for
2 generics. I just want to acknowledge, too, the point I made
3 earlier. I think it's kind of a blunt tool and it's, I
4 think, a good step, particularly given we have a fairly
5 narrow goal here, and that is to increase the generic use
6 rate for this population of beneficiaries because we know
7 their expenses are higher because they don't use generics at
8 the same rate. So I really support that.

9 We talk about next steps, getting more involved in
10 formularies and some other things, and I think there, there
11 is additional opportunity for us to have an impact on the
12 drug expense trends for our beneficiaries by being a little
13 bit more focused in on not all generics are the same. And,
14 frankly, there's great value in some brand name drugs that
15 maybe should also have zero copays, but that's beyond what
16 we're trying to do here. I realize that.

17 And the way that the policy statements or policy
18 options are laid out, I think that language is good and look
19 forward to continuing to work on this.

20 MS. UCCELLO: Yes. I, too, agree with the policy
21 options, and in terms of the cost sharing amounts, I
22 definitely agree with the zero for the generic, and I'm

1 guessing that the zero is a bigger driver for shifting to
2 generics than the difference between the generic and the
3 brand. So I'm comfortable enough with six. You know, maybe
4 it could stay at three or whatever, but that range seems
5 appropriate to me.

6 I would go further with respect to plans and
7 include a measure of GDR in the quality measures. I think
8 it is important to get some way to get the providers in on
9 this, and since we can't do, because it is more of a State
10 policy of the generic-only dispensing, that kind of thing,
11 that the lever that we do have is including something like
12 this as a quality measure.

13 MR. HACKBARTH: Plans are highly motivated to do
14 generic substitution. It's not like their incentives are in
15 a different direction and so they need some additional push.
16 Presumably, they are pursuing every angle they can think of.

17 Kate.

18 MS. BLONJARZ: I agree, as well, that I think this
19 is a great down payment towards a more value-based design
20 and that in the future we could think about more
21 differentiation based on values to individual patients and
22 also think about non-price levers that promote. You know,

1 we know that having to renew more often leads to less
2 adherence than getting more at once or automatic refills
3 promoted here. There are other levers that could be
4 promoted, and the plans have some incentive to do that and
5 we could encourage that, but this seems like a nice first
6 step.

7 MR. BUTLER: So I don't have a clue what the price
8 elasticity -- I do remember a little of my economics --
9 would be on these, but I understand the concept and support
10 it. I am reminded of when the State of Illinois said, let's
11 do a \$100 copay for the first day of admission for Medicaid,
12 as if that was going to be anything but just a flat-out
13 budget cut. It had nothing to do with affecting demand.

14 So having said that, the only thing -- and maybe
15 it's just too hard to do -- there are not only differences
16 between generic and brand, but there's a difference in the
17 value of the drugs and how much you need them to stay alive
18 versus they're somewhat discretionary. If you could
19 differentiate, too, and say, okay, it's zero for the ones
20 you've absolutely got to have, but if there's some
21 discretionary, is there a second tier that would say, for
22 those that there is some copay - I realize which would be

1 grouped into that which would not is a very difficult
2 decision, but I wish you could do that.

3 MS. BEHROOZI: Yes. This is the kind of first
4 dollar coverage policy I like, because it's not just about
5 the zero on the generic drug, but it's about raising the
6 cost on the brand name drug where there's a generic
7 available. So I really want to make that clear, going back
8 to the earlier discussion. It's not that I think there
9 should never be up-front costs, but it should be -- there
10 should not be barriers to people being able to access care,
11 and this way everybody can get the drugs that they need.

12 Just on what motivates people, yes, in New York
13 State, there was no limitation with respect to generics
14 versus brands as long as the pharmaceutical companies were
15 successful in keeping up the pressure, convincing people
16 that it would be second-class health care to require people
17 to take generic drugs, and frankly, our fund covers people
18 who there but for the grace. I mean, a lot of them are very
19 low income and sometimes are on Medicaid and we have been
20 doing what we call mandatory generics, but it's free
21 generics, high-priced brands is really a better way to
22 characterize it, for a number of years, and our generic

1 substitution rate is close to 99 percent, I think it is. So
2 that means wherever a generic is available, people are
3 taking it almost all the time because it's free, despite
4 that there has been for all this time all this pressure.
5 And I can get for you what the change was, if we can truly
6 find it, before to the after.

7 But certainly in our focus groups, and I think
8 we've talked about this, I might have even mentioned it
9 here, that we found, particularly among more recent
10 immigrants and certain ethnic groups, more resistance and
11 more distrust and we have to do a little more education with
12 them. But again, the fact that it's free helps a lot.

13 And whether it's different providers, Bob, I think
14 there are providers who, yes, fall into patterns because
15 they've got lots of patients for whom there's no cost. I
16 mean, we find that with our own plan, right. And so then,
17 yes, you do have to pay attention to the providers and what
18 their patterns are. But when they see what's free for their
19 patients, that's one of the things that's also going to
20 drive their behavior, because they're going to want their
21 patients to be happy. They don't want their patients to
22 say, hey, how come last month I was paying, whatever, \$1.10

1 and now I'm paying \$6 or whatever.

2 So I think those are all the points, but I think
3 the direction is really great and I love this work.

4 DR. CHERNEW: My comments were said.

5 DR. BERENSON: Briefly, I support the policy. I
6 would be interested in pursuing some of the discussion we
7 had around hypotheses here, not as much -- I don't think the
8 four percent is a huge differential. I think our policy
9 will partly address that. It's learning more about the 28
10 percent who don't -- where there is no generic writing, and
11 it might include some of Bill's ideas, that at least when I
12 was practicing, there were some particular drugs I was told,
13 you can't use generic for those, and I didn't know at the
14 time how much of that was just urban legend and how much of
15 it was based on science. So that might be there.

16 I mean, Mitra has got a very plausible theory as
17 to that providers who have a large population of people with
18 little cost sharing can get into one pattern. I would be
19 interested in knowing whether there's also a pattern of some
20 clinicians just ignoring the cost sharing and that's their
21 pattern.

22 So, in any case, I think this is worth pursuing if

1 it helps us in the bigger sort of picture of understanding
2 Part D. I think in terms of the LIS specific problem, I
3 think we've got a policy here that I can endorse.

4 MR. KUHN: I'm very supportive of continuing this
5 work and I think it's going to help us. As Kate, I think,
6 indicated earlier, in terms of a downpayment on value-based
7 design, I think is good work. Thanks.

8 DR. HALL: I agree this is very important work and
9 I guess we ought to be worried at least about one thing, and
10 that is sort of the law of unintended consequences. I would
11 hate to see us trash Part D. It's made an enormous sea
12 change in the availability of pharmaceuticals to a large
13 percentage of our older population.

14 But I think from a 30,000-foot level, I think the
15 goal here ultimately should be to link prescribing patterns
16 with clinical outcomes. Call me crazy, but I think that's
17 kind of why we use drugs. When physicians are dealing with
18 PDP plans, they may be dispensing medication to maybe ten or
19 12 plans in the same community, all of which change their
20 formularies on a year-to-year basis. It's just -- if you
21 were an alien coming down to earth and looking at
22 dysfunctional systems, you would say, well, of course, it is

1 not going to work. Now, that's somewhere in the future, but
2 I think the more we can link this -- and that may be -- may
3 be -- why the MA plans seem to be a little more rational,
4 because they may be incentivized to keep track of the health
5 of their populations. Maybe or maybe not.

6 MR. HACKBARTH: Could I ask you to go back to your
7 initial comment about unintended consequences and trashing
8 Part D. Could you be more specific about the risk that you
9 see.

10 DR. HALL: Well, I mean, sound bites, I guess.
11 MedPAC looked at prescribing in Part D and found that it's a
12 mess, that somehow, despite the equivalency of generics,
13 they're not being used. Well, that's true, but five years
14 ago, it was a very different scene, and not a pretty one in
15 terms of availability of drugs based on people's financial
16 needs.

17 DR. MARK MILLER: Yes. I agree that the tone, I
18 think, here should be, whether it's coming across or not, is
19 that D had a lot of impacts in terms of access, but also
20 general movement to generics, and in a sense, all we're
21 trying to do --

22 DR. HALL: Right.

1 DR. MARK MILLER: -- is bring that LIS along
2 behind that. That's really the tone that I think is in our
3 heads, anyway.

4 DR. NAYLOR: I also support the general direction
5 and your work, and with all the caveats about making sure we
6 know the health status and how they might be different, the
7 LIS population, and also about efforts that are continuing
8 to really make sure we understand when generics and brands -
9 - when brands should be used, et cetera.

10 I think the notion of other ways to encourage use
11 of generic drugs that you also outlined are really
12 important, that they should be simultaneous, so the work
13 around beneficiary education, particularly in the context of
14 growing public understanding about the shortages of generic
15 medications that are frequently and increasingly occurring,
16 I think that this is going to be a really important issue.

17 I also think provider -- I mean, your earlier work
18 showed that some providers just don't believe that brands
19 are better than generics, so the kind of provider education
20 and rating both plans and providers in terms of use of
21 generics when appropriate for the right population, et
22 cetera.

1 I also think this annual exam that we now have --
2 I don't know if it now includes a kind of annual review of
3 medications, because it's one thing to look at these
4 individually, but many of these older adults, frail older
5 adults, are on way too many that negatively interact with
6 each other. So an incentive that would help somebody to
7 take a look at the big picture would be great.

8 DR. CASTELLANOS: I had two questions. One, I
9 just don't get it. Insurance companies and plans prefer
10 generics from a cost saving viewpoint. The patient from a
11 cost sharing viewpoint, unless he or she has some peculiar
12 idiosyncratic response to the drugs, I would assume if
13 they're clinically indicated, would prefer it. The
14 pharmacy, not the drug company manufacture but the
15 pharmacists, make more money dispensing generics than
16 proprietary drugs. I'm a physician, but I've learned
17 something on this Commission. Follow the money.

18 [Laughter.]

19 DR. CASTELLANOS: What's happening here? I mean,
20 there's got to be something happening here.

21 MR. HACKBARTH: The disconnect that we're focused
22 on is at the patient level for this particular population,

1 the LIS population. So I agree with your basic analysis,
2 but the tool that the plans use to encourage people, the
3 patients, to switch to generics, one of their principal
4 tools is the cost sharing lever, and they've, as Bill says,
5 they've used that tool very effectively to greatly increase
6 the use of generics under the Part D program, but there are
7 regulatory limits, statutory limits on their ability to use
8 that tool for this population. And basically what we're
9 trying to do is propose a way that they can use that tool
10 without impeding access to needed drugs for LIS
11 beneficiaries.

12 DR. CASTELLANOS: I understand what you're doing.
13 Let me just give you a real world experience. I live in
14 Florida, where they have to sell by generic. I get maybe
15 one phone call a year from a pharmacy saying, hey, we have
16 got to change this because they can't do it. A lot of plans
17 do a lot of different things, but I don't think that's --
18 have we looked at the State level to see if there's problems
19 with, like in Florida, where you have to fill with a generic
20 by law?

21 DR. SOKOLOVSKY: We haven't looked at it. There
22 are a number of States that have that same kind of law, but

1 there are also quite a few States that don't.

2 DR. CASTELLANOS: [Off microphone.] Are there any
3 problems with --

4 MR. HACKBARTH: Ron, could you turn on the
5 microphone?

6 DR. CASTELLANOS: Are there any problems with the
7 States that have that law?

8 DR. SOKOLOVSKY: We have not looked at that.

9 MR. HACKBARTH: Are there States that go the other
10 way, that they impede substitution as opposed to encourage
11 it? In other words, by impede, I mean there are higher
12 hurdles that --

13 DR. STUART: I think you're going to find that
14 that was the way it was back in the 1960s and 1970s but not
15 so much now, and my guess is that most States, in fact, do
16 what Florida does, but it's certainly something that you'd
17 want to take a look at, because, again, it gives you some
18 kind of natural experiment here.

19 MR. GEORGE MILLER: Yes. I'm going to follow up
20 Ron. His last comment hit where I was. In fact, after you
21 had passed on to me, I thought about that, that for the
22 States that do, we should take a look at it and see if that

1 has a significant impact. I've heard two on this panel,
2 which is New York and Florida, at least, that allows the
3 physician or other provider to write for generics, and if
4 there is a significant number, that is a savings. And then
5 we can use the other non-financial levers for the rest of
6 the population where the State will not allow that. And
7 Mitra mentioned that zero worked pretty well for her
8 beneficiary group. Ninety-nine percent is pretty good.

9 DR. CASTELLANOS: Pretty close.

10 MR. GEORGE MILLER: Pretty close, yes. So we
11 could use that as the lever, too. So I support the
12 recommendations, but my caveat is to look at those States
13 that allow the providers to write generic and make that a
14 policy issue -- for those States that allow it -- and for
15 those who don't, use the other financial levers, and again,
16 I like the term zero, Mitra's example.

17 DR. STUART: I can just see the title of that:
18 The Power of Zero. We can -- it's got a real appeal.

19 I'd like to pick up on something Scott mentioned
20 in the first round, which was he was distinguishing between
21 preferred generics and non-preferred generics, and again, it
22 may be the power of zero, but if you look at most plan

1 formularies for non-LIS beneficiaries, what you see is that
2 the difference -- this would apply to therapeutic classes in
3 which there are multiple branded products -- but in those
4 circumstances, you will find frequently that the difference
5 between the generic copay and the preferred brand copay is
6 actually less than the difference between the preferred
7 brand and the non-preferred brand.

8 And so the question is, and maybe you are already
9 planning on doing this when you get into the formularies, is
10 to look at the percent of LIS beneficiaries who are using
11 what turn out to be non-preferred brands within the plan
12 that they happen to be enrolled in because the structure of
13 the cost sharing that they face makes no distinction between
14 preferred or non-preferred brand, and I have no idea what
15 the potential savings would be, but I think the policy
16 implications would be, what if you raised -- what if you
17 took account of the plan's distinction between preferred and
18 non-preferred and applied that at some lower level to the
19 LIS population.

20 MR. GRADISON: [Off microphone.] I support what
21 you are doing --

22 MS. BEHROOZI: I support the policy direction that

1 you are going and would agree with the power of zero.

2 MR. HACKBARTH: Okay. Thank you very much. Well
3 done.

4 We will now have our public comment period before
5 breaking for lunch.

6 [No response.]

7 MR. HACKBARTH: Seeing nobody rising to the
8 microphone, we will adjourn until -- oh, we are right on
9 time -- 1:15.

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

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AFTERNOON SESSION

[1:19 p.m.]

MR. HACKBARTH: Okay. It's time to begin our afternoon session, and the first topic is coordinating care for dual eligibles in the PACE program.

MS. AGUIAR: Today we will continue our discussion on the Program of All-Inclusive Care for the Elderly, also known as PACE. As you know, PACE is a provider-based integrated care program that enrolls nursing home-certifiable beneficiaries age 55 and older with the goal of keeping them in the community. During the September meeting, we discussed the findings of our research on PACE, and in October I presented draft recommendations for your consideration. Today I will review the findings from our research and the draft recommendations. Because PACE providers are paid on the Medicare Advantage payment system, Carlos is sitting with me to address your questions on MA.

Before we begin, I will address the Commissioner questions from the October meeting. Scott asked about the context of this work within our future work on dual-eligible beneficiaries. In the spring, we anticipate discussing flexibilities that are characteristic of PACE that could be extended to managed care-based integrated care programs. We

1 also anticipate discussing broader issues on dual eligibles,
2 such as strategies to increase enrollment into integrated
3 care programs and the structure of federal and state
4 financing for integrated care programs. However, today we
5 will wrap up our discussion of PACE.

6 Karen also raised a question on the rationale for
7 providing pro-rated payments and outlier protection to PACE
8 providers and not to MA plans, and I will address those
9 questions during the discussion of those draft
10 recommendations.

11 Now I will move on to reviewing the findings from
12 our research on PACE.

13 As you remember from the previous meetings, we
14 concluded from our site visits with PACE providers that the
15 PACE model does provide a fully integrated model of care.
16 We identified key characteristics of the program which are
17 listed on this slide. We also identified three areas for
18 improvement and developed draft recommendations to address
19 each area. For the remainder of the presentation, I will
20 review the draft recommendations and our findings that led
21 to these recommendations. These are the same draft
22 recommendations that I presented during the October meeting.

1 As a reminder, the goals of these recommendations are to
2 more accurately pay PACE providers for the beneficiaries
3 they enroll, to support the growth of the PACE program by
4 improving the payment system and expanding enrollment, and
5 to pay all integrated care programs for dual-eligible
6 beneficiaries through the same payment system.

7 The first draft recommendation is: The Congress
8 should direct the Secretary to improve the Medicare
9 Advantage risk adjustment system to more accurately predict
10 risk across all MA enrollees. Using the revised risk-
11 adjustment system, the Congress should direct the Secretary
12 to pay PACE providers based on the MA payment system for
13 setting benchmarks and quality bonuses. These changes
14 should occur no later than 2015.

15 The purpose of the first part of this
16 recommendation is to improve the accuracy of the MA risk
17 adjustment system. We found that the risk adjustment system
18 underpredicts costs for very complex patients, which are the
19 types of patients that PACE providers enroll, and this
20 recommendation would address this issue. When the system is
21 revised, the amount of the frailty adjuster should be
22 revised because improvements to the risk adjustment system

1 may result in the need for a reduction in the size of the
2 frailty adjuster.

3 The second part of this recommendation addresses
4 the county benchmarks and quality bonus program. We found
5 that because Medicare payments to PACE are based on the pre-
6 PPACA county benchmarks, Medicare spending increases when
7 beneficiaries move from fee-for-service into PACE in the
8 majority of counties PACE sites operate in. We estimated
9 that for 2012 Medicare will spend about 17 percent more on
10 behalf of PACE enrollees than it would spend on these
11 beneficiaries if they were to remain in fee-for-service.
12 Under this recommendation, payments to PACE providers would
13 be based on the PPACA-revised county benchmarks which are
14 the benchmarks used for MA plans. This change would reduce
15 Medicare spending on PACE and better align it with fee-for-
16 service spending levels. Finally, PACE providers were
17 exempted from the MA quality bonus program and therefore are
18 not able to receive bonus payments. This recommendation
19 would permit PACE providers to participate in the quality
20 bonus program. These changes would also make the payment
21 system for PACE more consistent with the SNP-based
22 integrated care programs.

1 We estimate that this recommendation would have no
2 effect on federal spending on PACE relative to current law
3 in the first year and would decrease spending by less than
4 \$1 billion over five years. This is the smallest bucket we
5 use for the five-year impacts; however, we expect the
6 financial impact to be much less than \$1 billion because of
7 the small size of the PACE program and because the improved
8 risk adjustment system and quality bonuses would mitigate
9 some of the payment reductions from moving to the MA
10 benchmarks. We do not expect this recommendation to have
11 adverse impacts on Medicare beneficiaries' access to care.
12 Paying PACE providers on the PPACA-revised benchmarks would
13 lower payments to PACE; however, the improvements to the
14 risk adjustment system -- I'm sorry, would mitigate, as I
15 said before, these payment reductions. In total, we do not
16 expect these changes to reduce PACE providers' willingness
17 and ability to care for Medicare beneficiaries.

18 The second draft recommendation is: After the
19 changes in draft recommendation 1 take effect, the Congress
20 should change the age eligibility criteria for PACE to allow
21 nursing home-certifiable Medicare beneficiaries under the
22 age of 55 to enroll.

1 This recommendation addresses enrollment in PACE,
2 which is our second area for improvement. We found that
3 PACE programs are generally small and enrollment is slow;
4 however, reaching enrollment targets can help sites operate
5 at or above breakeven. Our research also indicates that the
6 PACE model could serve the nursing home-certifiable
7 beneficiaries that are younger than 55. This draft
8 recommendation would allow, but not permit, PACE providers
9 to enroll beneficiaries that are not currently eligible for
10 PACE, and doing so would also help providers increase
11 enrollment to achieve economies of scale faster.

12 We do not expect a large enrollment increase into
13 PACE due to this recommendation, and, therefore, we expect
14 that the cost to the Medicare program from beneficiaries
15 under 55 enrolling into PACE would be offset by the savings
16 achieved from paying PACE providers on the PPACA-revised
17 benchmarks. Therefore, we do not expect this recommendation
18 to increase federal spending on PACE relative to current
19 law. We do expect this recommendation to increase access to
20 PACE services for nursing home-certifiable Medicare
21 beneficiaries under the age of 55. This recommendation may
22 also help PACE providers to increase their program

1 enrollment.

2 The third draft recommendation for your
3 consideration is: After the changes in draft recommendation
4 take effect, the Secretary should provide pro-rated
5 Medicare capitation payments to PACE providers for partial-
6 month enrollees.

7 This draft recommendation also addresses
8 enrollment. One barrier to enrollment is that PACE
9 providers do not receive retrospective payments for
10 beneficiaries enrolled after the first of the month, and
11 because of this sites have not been able to enroll some
12 beneficiaries that are in immediate need of services. This
13 recommendation would also address this issue by enabling
14 PACE providers to receive Medicare payments for partial-
15 month new enrollees.

16 With respect to Karen's question of why this
17 recommendation would apply to PACE and not MA plans, MA
18 plans can enroll beneficiaries after the first of the month,
19 and the beneficiaries can receive their Medicare services
20 through fee-for-service until the MA plan receives the full
21 capitated payment. However, PACE providers furnish services
22 that are not covered under Medicare fee-for-service. And

1 because of this, PACE providers, unlike MA plans, cannot
2 enroll beneficiaries after the first of the month. In
3 addition, some potential PACE enrollees are in immediate
4 need of services, and if they cannot enroll in PACE, they
5 may instead be admitted to nursing facilities or home- and
6 community-based services. PACE providers would then miss
7 the opportunity to enroll these individuals.

8 We do not expect a large enrollment increase from
9 this recommendation, and, therefore, we expect that the cost
10 to the Medicare program from this recommendation would be
11 offset by the savings achieved from paying PACE providers on
12 the PPACA-revised benchmarks. Therefore, we do not expect
13 this recommendation to increase federal spending on PACE
14 relative to current law. We do expect this recommendation
15 to increase access to PACE services for some nursing home-
16 certifiable Medicare beneficiaries. This recommendation may
17 also help PACE providers to increase their program
18 enrollment.

19 The fourth draft recommendation is: After the
20 changes in draft recommendation 1 take effect, the Secretary
21 should establish an outlier protection policy for new PACE
22 sites to use during the first three years of their programs

1 to help defray the exceptionally high acute-care costs for
2 Medicare beneficiaries.

3 The Secretary should establish the outlier payment
4 caps so that the costs of all draft recommendations do not
5 exceed the savings achieved by the changes in draft
6 recommendation 1.

7 This recommendation addresses outlier protection.
8 We were told by PACE staff that although most of the rural
9 sites did not use the outlier protection that was available
10 through the rural PACE grant, having it available was an
11 incentive to their sponsoring organization to open the site.
12 The outlier protection under this recommendation could help
13 PACE programs and prevent insolvency due to extremely high
14 costs incurred before a provider reaches a breakeven point.
15 A mechanism that helps to ensure financial stability during
16 start-up would provide an incentive for sponsors to open
17 PACE programs. As under the rural PACE demonstration, the
18 outlier protection would be available for the first three
19 years of the program and could only be used on high acute-
20 care expenditures for Medicare beneficiaries. CMS could
21 structure the outlier protection similar to the one
22 available to the rural PACE sites. In order to not increase

1 total Medicare spending, the Secretary should determine the
2 size and structure of the outlier pool and the per enrollee
3 and per provider outlier payment caps so that the outlier
4 protection, the expansion to enroll beneficiaries under the
5 age of 55, and pro-rating capitation payments for partial-
6 month enrollees can all be completely financed from the
7 changes in the PACE county benchmarks.

8 Karen, to address your question from the October
9 meeting, the reason the outlier protection would only apply
10 to PACE is that, unlike MA plans, even a few enrollees who
11 incur exceptionally high costs during the first few years of
12 operation can jeopardize a PACE program's fiscal solvency
13 because of the very small scale of the programs, and this
14 financial risk may be significant enough to dissuade
15 sponsors from opening a PACE program.

16 With respect to implications, this recommendation
17 would not increase federal spending on PACE relative to
18 current law because the outlier protection would be funded
19 by the reduction in Medicare spending from basing PACE
20 payments on the PPACA-revised benchmarks. In addition, we
21 do not expect this recommendation to have adverse impacts on
22 Medicare beneficiaries' access to care. This recommendation

1 may be an incentive for sponsors to open new PACE sites.

2 The final draft recommendation for your
3 consideration is: The Congress should direct the Secretary
4 to publish select quality measures on PACE providers and
5 develop appropriate quality measures to enable PACE
6 providers to participate in the MA quality bonus program by
7 2015.

8 This recommendation addresses our final area for
9 improvement which is quality data. As you recall, CMS
10 requires PACE sites to report outcome measures; however,
11 those measures are not yet publicly reported. Publishing
12 quality measures would permit the policy community to
13 evaluate PACE and would help beneficiaries and their
14 families make more informed decisions about joining PACE.
15 In addition, CMS needs to identify which measures will be
16 used to evaluate PACE providers so that they can participate
17 in the quality bonus program.

18 We estimate that this recommendation would not
19 impact federal spending on PACE relative to current law, and
20 this recommendation should not have adverse impacts on PACE
21 providers. We do not expect this recommendation to
22 adversely impact Medicare beneficiaries' access to PACE

1 services, and it could enhance beneficiaries' ability to
2 choose a program that meets their needs.

3 This concludes the presentation, and this slide
4 summarizes the five draft recommendations to facilitate your
5 discussion. Thank you.

6 MR. HACKBARTH: Thank you, Christine.

7 So this is at least our third session on PACE and
8 maybe even the fourth. So what I propose we do is limit
9 ourselves to just one round of comments on the
10 recommendations. Everybody saw these recommendations in
11 draft form at the last meeting, had an opportunity to
12 provide input at that point and, in addition, between the
13 last meeting and this one. So I think we can get right to
14 round two, and, Karen, I think it is your turn to lead off.

15 DR. BORMAN: Just one quick question, because I
16 support the substance of the recommendations. We are tying
17 the implementation of 2, 3, and 4 to number 1, correct, but
18 not number 5?

19 MS. AGUIAR: Yes, that's correct.

20 DR. BORMAN: I just wanted to make sure I was
21 clear.

22 MR. GRADISON: I just wanted to indicate my

1 support of all the recommendations and my appreciation for
2 the fine job that has been done by the staff. Thank you.

3 DR. STUART: I also support the recommendations.
4 I just have one question regarding nursing home certifiable,
5 what that means, and in a sense how PACE providers recruit
6 enrollees or, in fact, do they recruit? Who searches whom
7 here? I'm assuming that we don't have people that have
8 signs on their back that say, "I'm nursing home
9 certifiable," so I'm wondering how this process actually
10 works in practice.

11 MS. AGUIAR: So we've heard from, again, the PACE
12 sites that we visited, who their referral sources are, and
13 they really do differ. In some of the sites it really is
14 word of mouth. Once they are able -- you know, they went
15 into the business of opening a PACE site because they felt
16 there was a need in the community, and then they get
17 referrals from word of mouth of other PACE enrollees. In
18 other instances, they get referrals from hospitals, and that
19 actually was what tied into the pro-rated recommendation.
20 So it really sort of very much differs. They could get from
21 -- physicians could, you know -- they could get referrals
22 from physicians, from hospital systems, from family members,

1 from word of mouth, from other participants. It really does
2 vary.

3 DR. STUART: Is the certification done at the time
4 of enrollment into the PACE program?

5 MS. AGUIAR: Yes, it is. The way that it works is
6 they'll get a referral, and then the PACE staff have to do a
7 very comprehensive assessment of that person. But then the
8 certification is done by the state, and so, again, there is
9 a lag there, which we have heard from PACE providers that
10 there is a lag sometimes.

11 DR. STUART: I'm not going to take much more time.
12 A very quick one. Is it possible for a PACE program to
13 actually enroll somebody who is currently in a nursing home?

14 MS. AGUIAR: You know, I'm not 100 percent sure.
15 I think -- and I'll have to check on that. I don't think
16 there's anything either in statute or regulation that would
17 say that they couldn't do that. I think the issue is the
18 people that enroll in PACE have to be able to live safely in
19 the community, and so if you do have someone who has been in
20 a nursing home, perhaps they have lost their housing, and so
21 it would be -- they would have to make sure that if they
22 were to take the person out of the nursing home that they

1 could safely treat them in the community.

2 DR. STUART: This is something you might want to
3 look at because there is a program in -- I believe it's
4 Minnesota that is designed to identify nursing home
5 residents who wish to return to the community and to
6 facilitate that. And if you were to tie that into a PACE
7 program, that would be obviously one way to do that.

8 MR. GEORGE MILLER: Yes, thank you. I also want
9 to say that I support the recommendations, and I certainly
10 want to thank the staff for doing an excellent job of
11 pulling all this together and then summarizing it. I think
12 this is very good work.

13 Also, I appreciate when the staff answers
14 Commissioners' questions as you did today, I think that is
15 also very helpful and reminds us of what has taken place,
16 for those of us who have slept since the last meeting.

17 I do want to challenge the staff to do one thing,
18 and that is, although you said that the cost for PACE is
19 approximately 17 percent more than fee-for-service spending,
20 I don't know if you've had the time to look at the analysis.
21 If those patients were in the PACE program, what would have
22 been the spend on that population of patients so that we

1 could determine if it may have been greater than the fee-
2 for-service spend because there's no coordination of care
3 like the PACE program does. And I thought I had alluded to
4 that a little bit last time. I may not have been very
5 articulate -- I may not have articulated it appropriately,
6 but I think I've slept since then and got it straight.

7 MR. ZARABOZO: Well, that 17-percent figure is
8 supposed to be a comparison between what enrollees in PACE
9 are paid compared to what they would have cost in fee-for-
10 service Medicare. That's what that is.

11 MR. GEORGE MILLER: Okay. So that includes if
12 they had been hospitalized or used other --

13 MR. ZARABOZO: Right, anything that would have
14 occurred in fee-for-service for that particular kind of
15 person.

16 MR. GEORGE MILLER: Thank you.

17 DR. CASTELLANOS: I wholeheartedly support this.
18 Just one clarification. If draft recommendation 1 is
19 implemented or a delay in implementation or whatever
20 happens, we are still going to go ahead and push for the
21 quality reporting irrespective of what happens. Is that
22 right?

1 MS. AGUIAR: Yes. The fifth draft recommendation
2 is not tied into the first draft recommendation having to
3 happen first.

4 DR. CASTELLANOS: Right, but there may be a delay
5 in Congress on doing draft recommendation 1.

6 MS. AGUIAR: Right

7 DR. CASTELLANOS: But we're still going to push
8 for the quality reporting.

9 MS. AGUIAR: Right, exactly.

10 DR. CASTELLANOS: Good job. Thank you.

11 MS. AGUIAR: Thank you.

12 DR. NAYLOR: So I also support the recommendations
13 and want to really congratulate the staff on their efforts,
14 both through their site visit work and evidence review to
15 really capture the critical essence of a program that has
16 been demonstrated consistently over multiple studies to do
17 better, to improve quality of life, reduce hospitalizations,
18 improve mortality.

19 I really in recommendation 1 also appreciate the
20 attention first to getting to the risk adjustment and then
21 to the payment change, and so I really appreciate the
22 language that talks about using the revised system to move

1 toward implementation of the payment system.

2 And I also would say that, like all of our
3 recommendations, I hope we will continue to monitor the
4 impact of what happens here on a program that I think serves
5 an important need, albeit to a small community but that can
6 teach us many lessons for care of dual eligibles across this
7 country. So thank you.

8 DR. HALL: I also support this very strongly. I
9 think this takes this very important program and really
10 mainstreams it now for the emerging number of older people
11 we're going to be seeing over the next 20 years. I think
12 it's a great step forward.

13 MR. KUHN: I'd just like to add my comments to
14 Christine and the staff for a nice job on this project, and
15 I strongly support the recommendations.

16 DR. BERENSON: Could you just remind me what the
17 original purpose was of excluding people under 55?

18 MS. AGUIAR: So that is in the statute, and I
19 actually don't -- I don't know. I can only speculate that
20 when that statute to make PACE permanent, it really was
21 based off of the demos that had gone on before, you know,
22 from On Lock Program, and I don't know if the under 55 was

1 included in that, but I don't actually know why that cut-off
2 was made.

3 DR. BERENSON: We haven't heard anybody out there
4 saying there's some reason to keep that, right, all the
5 people you've talked with?

6 MS. AGUIAR: No, no. And, again, we asked the
7 PACE providers whether or not they thought that this would
8 be -- they would be able to appropriately manage and care
9 for that population. We didn't ask beyond the precedent
10 providers.

11 DR. BERENSON: Okay.

12 MS. AGUIAR: So we didn't hear any pushback from
13 the PACE providers on that.

14 DR. BERENSON: That makes sense to me. I was just
15 curious. In any case, I support these well-thought-out
16 recommendations, and I concur with everybody else about the
17 good work that has been done here. Thanks.

18 DR. CHERNEW: I also support the recommendations.

19 MS. BEHROOZI: Yeah, same here. Great work. Like
20 Mary, I appreciate the attention paid to the order of the
21 risk adjustment and the payment change. But with respect to
22 recommendation 5 on quality, I would have a similar concern,

1 that it be clear that people would be using that data not to
2 compare PACE to some MA plan with a lot less frail people
3 and, you know, younger people or whatever, but that somehow
4 the quality measures would be reflective of what that
5 particular population would otherwise be experiencing, you
6 know, some way of risk-adjusting the quality measures to
7 make it fair.

8 MR. BUTLER: Just a process question. Most of our
9 recommendations that we vote on get ultimately housed in the
10 March or June report. Last month, we had the letter on SGR.
11 Is this another one-off where we vote, or does this
12 ultimately get housed into a formal report? I know
13 obviously we vote on it publicly.

14 MR. HACKBARTH: The June report will include a
15 broader look at dual eligibles in these recommendations.

16 MR. BUTLER: So we're just way ahead of ourselves
17 for once. Okay.

18 DR. MARK MILLER: And just so you know, the other
19 thing that happens routinely is whenever there's a vote
20 taken and some action is taken, Ariel and Kahlie make sure
21 that the committee staff know that the action is taken. And
22 even though it doesn't get housed and printed until the June

1 report, you can be assured that the staff know what's going
2 on there. They've been briefed over the last few days and
3 each month before this, and so we'll just send something up
4 to them that says, "By the way, those recommendations you
5 saw? Those were voted on," or whatever the outcome is here.
6 But then it will all be formally written up and put in June.

7 DR. BAICKER: I support the recommendations.

8 MS. UCCELLO: Just a quick question first. Does
9 this have any negative impact on state Medicaid programs at
10 all?

11 MS. AGUIAR: I don't think so, no. This has come
12 up a lot and also in our conversations with some of the
13 other interested groups, the PACE interest groups, that, you
14 know, we're really trying to clean up the Medicare side of
15 the house. There are lots of areas on the Medicaid side
16 that we can't say anything about, so we are only saying on
17 the Medicare side. So none of these would require states to
18 have to also do pro-rated payments or also expand to under
19 55 or anything like that.

20 MS. UCCELLO: Okay. Thank you. I'm very
21 supportive of these recommendations and have one suggestion.
22 In draft 4 when we talk about this outlier fund, I would

1 characterize it more as removing a barrier rather than
2 providing an incentive. It's a subtle difference there, but
3 I think it's somewhat important.

4 Also, you know, we talk about -- we've spent
5 several meetings now talking about PACE, and sometimes
6 people may wonder, myself included, you know, why we spend
7 so much time talking about a program that covers such a
8 small share of the Medicare population. But I think it's
9 really important that we spend more time on this population
10 and other duals and populations like this because these are
11 some potentially very high spenders. And so they really do
12 deserve our focus, and I think it's appropriate that we've
13 done so.

14 MR. ARMSTRONG: You could say that our PACE
15 conversations have been well paced, right?

16 I do want to say I support these recommendations
17 as well. I like the evolution of this program into a more
18 standard application of the MA risk adjustment system, the
19 requirement of the quality reporting, and those changes are
20 terrific.

21 To Cori's point and points others have made, this
22 is a fairly small slice in a much bigger issue, and in

1 particular, as we frame this in the broader context, I think
2 we need to remind ourselves, if I have this correct, that
3 we're actually expecting that we are going to be investing
4 in a program that costs the Medicare program more money, 17
5 percent more than the expenses the Medicare program would
6 have incurred otherwise. And we're believing that there's a
7 good investment on this -- or a good return on this
8 investment, but we're not exactly sure. And as you start
9 expanding this to more and more patients, beneficiaries, we
10 have to really understand how investments in programs like
11 this will actually be part of a solution to a cost problem
12 for dual eligibles. And we haven't really solved that one
13 yet. We think it's good, and obviously these are arguments
14 we make with MA plans more broadly and elsewhere. But I
15 just think there's going to be an opportunity for us as we
16 go toward this June report to continue to reflect on that
17 question.

18 MS. AGUIAR: The only thing I would say about that
19 -- and I completely agree with you. That's the reason why
20 we tied the expansion to the under 55, the pro-rated, the
21 policies that would cost to the first draft recommendation
22 to reduce the county benchmarks. So it wouldn't be really

1 an investment from a Medicare financial perspective.

2 MR. HACKBARTH: So the 17-percent figure is the
3 current where they don't have the MA benchmarks applied to
4 them. They have the old benchmarks, not the new ones. And
5 so we're proposing that they be brought down in conjunction
6 with better risk adjustment.

7 MR. ARMSTRONG: So maybe I misunderstood, but my
8 sense is whether it's 17 percent or not, this is a richer
9 program, and that the beneficiaries are getting -- we're
10 spending money on this group of beneficiaries, more money
11 than we would if they were not in the PACE program.

12 MS. AGUIAR: Right, exactly. So now we spend more
13 because of the county benchmarks. That's the issue, because
14 they're not on the MA benchmarks.

15 MR. ARMSTRONG: Oh.

16 MS. AGUIAR: So this recommendation would move
17 them to the MA payment system in terms of the benchmarks and
18 the quality bonus, and so that added investment gets into
19 more of the MA versus fee-for-service, which is more Carlos'
20 realm. But that was what precipitated some of -- the first
21 recommendation.

22 MR. ARMSTRONG: Well, it's a good thing you're a

1 lot smarter about this than I am.

2 [Laughter.]

3 MR. ARMSTRONG: But I still think that there is
4 this whole idea of if we believe a solution to the big
5 issues we have around managing care for and the expense
6 trends for dual eligibles comes from investing in these more
7 holistic programs, at some point we really have to
8 understand where really is the return on that investment and
9 how do we think about that as we go forward with this. And
10 we want to believe. We like this. I really like this. But
11 I just think that's a question we're going to have to keep
12 in front of us as we go forward.

13 DR. STUART: I think you can still look at this in
14 a return-on-investment perspective if you include Medicaid
15 because, after all, these are nursing home-certifiable
16 enrollees, and to the extent that you're reducing nursing
17 home admissions among these individuals, they're not going
18 to be Medicare nursing home admissions but Medicaid nursing
19 home admissions. So, overall, there could be some savings,
20 and I know there have been some studies that have looked at
21 that. So that might be just something that you'd want to
22 add to the report.

1 MR. HACKBARTH: Okay. I think it's time to vote.
2 So, Christine, would you put up recommendation 1? All in
3 favor of recommendation 1, please raise your hand. Opposed?
4 Abstentions?

5 Okay. Recommendation 2? All in favor of number 2
6 -- do you want to put that one up, Christine, in case
7 somebody wants to read it? Okay. Opposed to recommendation
8 2? Abstentions?

9 Number 3, all in favor? Opposed? Abstentions?

10 Okay. Number 4, all in favor? Opposed?
11 Abstentions?

12 And number 5, all in favor? No one is opposed and
13 no abstentions.

14 Thank you. Well done. I appreciate your work on
15 this.

16 Let's see. So next is Medicare's payment system
17 for skilled nursing facilities.

18 [Pause.]

19 DR. CARTER: Okay. The payment system Medicare
20 uses to pay skilled nursing facilities needs to be reformed.
21 The program's payments to SNFs have been consistently high
22 relative to facility costs for 10 years, and in this past

1 year's update, the Commission stated that it would examine
2 whether Medicare's payments need to be rebased. The first
3 reform we'll talk about is about that need to rebase
4 payments. Aside from the level of payments, the Commission
5 already recommended changes to the prospective payment
6 system that would affect the distribution of payments.
7 Those changes would address the shortcomings of the PPS that
8 result in widely varying financial performance based in part
9 on the mix of patients a facility treats. Rebasing would
10 address the level of payments.

11 Another possible reform would address the lack of
12 an incentive to avoid unnecessary hospitalizations, which
13 raise program spending and expose beneficiaries to care
14 transitions that can result in poor patient outcomes. The
15 Commission discussed the need to align incentives between
16 hospitals and SNFs to discourage unnecessary
17 hospitalizations from SNFs.

18 There are three reasons to consider rebasing
19 payments. First, Medicare margins are high and have been
20 since 2000. Second, there is a large variation in cost per
21 day that is not related to wages, case mix, or beneficiary
22 characteristics. And, last, some providers manage to have

1 relatively low costs and furnish relatively high quality,
2 suggesting that payments could be lowered.

3 In this chart, we're looking at the trends in
4 costs and payments between 1999 and 2009, and you can see
5 that the cumulative increase in payments increased 68
6 percent while costs rose 40 percent. Increases in payments
7 have far exceeded the updates facilities have received
8 during this period. The GAO and the OIG found that the
9 original PPS rates were relatively generous because they
10 were based on costs incurred during a period when only
11 routine costs had limits on them. The mix of facilities was
12 also different in the base year, with a much higher share of
13 high-cost hospital-based facilities than the current mix of
14 facilities.

15 SNF margins have remained above 10 percent since
16 2000. In red is the median, with the 25th and 75th
17 percentiles also shown. Margins rose quickly after payments
18 were added by the BBRA and BIPA and then declined when some
19 of the additions expired. The revised case mix groups
20 implemented in 2006 have led to higher Medicare margins.
21 Since 2006, average profits have risen from \$49 a day to \$79
22 a day in 2009. To understand this increasing profitability,

1 we looked separately at trends in costs and payments.

2 After adjusting for wages and case mix, costs for
3 freestanding SNFs with the largest increases -- those are
4 the ones in the top 25th percentile of cost growth -- grew
5 an average of 66 percent, while standardized costs declined
6 for SNFs with the smallest growth. These differences in
7 cost growth are not explained by the amount of intensive
8 therapy or medically complex days or their patient
9 demographics -- that is, the shares of dual-eligible, very
10 old, or minority beneficiaries that they serve. In fact,
11 facilities with the lowest cost growth had a higher case mix
12 than the high-growth group.

13 Facilities managed their costs per day by
14 increasing their length of stay (which spreads their fixed
15 costs), having higher census, and providing therapy to more
16 than one beneficiary at once. Since 2002, the average
17 length of stay has increased 11 percent. Facilities with
18 the highest cost growth still had Medicare margins over 14
19 percent in 2009, indicating that the PPS exerts little
20 fiscal pressure on facilities.

21 Looking at 2009, the costs per day in freestanding
22 SNFs varied 30 percent between the 25th and 75th percentiles

1 after adjusting for wages and case mix. This variation was
2 the same for SNFs by ownership group and their shares of
3 dual-eligible beneficiaries, minority, and very old
4 beneficiaries. These findings suggest that the variation is
5 not related to location, case mix, ownership, or beneficiary
6 demographics.

7 Turning to revenues, we found that SNFs with the
8 highest growth in revenues had almost double the share of
9 intensive therapy days compared to SNFs with low revenue
10 growth, even though their patient mixes were similar in
11 terms of average case mix and shares of dual-eligible
12 beneficiaries, minority, and very old. Facilities in this
13 high-growth group had median Medicare margins of 23 percent
14 compared to 14 percent for the low-growth group. While
15 patient frailty has increased over time, those changes were
16 nowhere near the changes in the amount of therapy provided.
17 Between 2006 and 2009, at admission, patients' ability to
18 perform activities of daily living (as measured by the
19 Barthel score) declined 5 percent, and their cognitive
20 function declined 3 percent, while intensive therapy days
21 during this period increased 36 percent. Beneficiary age
22 and diagnoses are virtually unchanged. While shorter

1 hospital stays would shift some therapy provision to the SNF
2 sector, the growth in the therapy days far outpaced this
3 shift. Facilities paid more attention to furnishing just
4 enough therapy to qualify patients into the next highest
5 case mix group. And because of the way assessment periods
6 work for establishing payment rates, facilities would
7 continue to get paid for one level of therapy care even
8 after that level was no longer being provided.

9 Another piece of evidence that payment levels are
10 too high is the work we have done on the efficient provider.
11 We identify a group of facilities that have consistently
12 relatively low costs and relatively high quality for three
13 years in a row and then look at that group's performance in
14 subsequent years. Compared to the average, these relatively
15 efficient SNFs had community discharge rates that were 29
16 percent higher and rehospitalization rates that were 16
17 percent lower. On the cost side, relatively efficient SNFs
18 had costs per day (after adjusting for differences in wages
19 and case mix) that were 10 percent lower than other SNFs.

20 Before we look at some rebasing options, I wanted
21 to make a couple of points about the current Medicare
22 environment. You may be aware that CMS lowered payment

1 rates to SNFs by 11 percent this fiscal year. This
2 reduction represented a correction to overpayments that had
3 resulted when CMS implemented the new case mix groups the
4 year before. When any new classification system is
5 implemented, payments should be the same under the new
6 system as they would have been under the old one. However,
7 the changes to the case mix system generated almost \$4.5
8 billion in spending. To re-establish budget neutrality,
9 payment rates were lowered, but they were lowered from the
10 level that had been set too high. Even after the reduction,
11 payments are higher than they were two years ago -- before
12 the increase and then decrease in rates.

13 By lowering payments, rebasing will put some SNFs
14 that are now profitable in the red and those that are
15 already losing on Medicare further away from breaking even.
16 We looked at the characteristics of SNFs with negative
17 margins and found that their costs were 30 percent higher
18 than other SNFs' after adjusting for wages and case mix. To
19 the extent that their losses are due to higher costs,
20 rebasing the PPS will further erode their Medicare margins.
21 If these SNFs could not lower their costs under fiscal
22 pressure, some facilities might cede market share to more

1 efficient SNFs. However, some SNFs with negative Medicare
2 margins tended to furnish less intensive therapy than other
3 SNFs. This is consistent with our findings that the PPS
4 systematically disadvantages SNFs that do not furnish a lot
5 of therapy. To the extent that the financial performance of
6 SNFs with negative margins is rooted in their mix of
7 patients, a revised PPS that would base payments on patient
8 and stay characteristics would redistribute payments more
9 equitably across SNFs and narrow the disparities in
10 financial performance.

11 To give a sense of the impacts of rebasing, we
12 modeled margins in 2009 if payments had been lowered under
13 three options: a 5-percent reduction in payments, and
14 setting payments at the 75th and 70th percentiles of the
15 distribution of the cost per day. Looking down the rows,
16 you can see the margins that would result with each level of
17 rebasing. I should point out that these estimated margins
18 are higher than what we would see in 2013 because by then
19 there will have been two years of productivity adjustments
20 that will lower their payments, and those are applied
21 against the updates. We will also need to consider how the
22 industry responds to the productivity adjustments, which may

1 slow their cost growth. For December, we plan to model
2 margins in 2013 under various cost growth and rebasing
3 assumptions. While rebasing would lower payments, we wanted
4 to remind you that a revised PPS would redistribute payments
5 across SNFs.

6 Here you can see the estimates of the impact a
7 revised PPS would have payments. We compared payments under
8 current policy with payments under a revised PPS. These
9 results are consistent with the results we reported in 2008.
10 I should point out that, on net, aggregate payments would
11 not change; they only get redistributed. A revised PPS
12 would lower payments to SNFs with high shares of
13 rehabilitation patients. For example, we estimate that
14 payments would be 5 percent lower for SNFs that treat high
15 shares of rehabilitation cases -- those are in the top 10th
16 percentile of cases -- and raise payments to SNFs with low
17 shares by 13 percent. There are even larger differences for
18 SNFs with the highest and lowest shares of intensive therapy
19 cases -- those in the ultra high and very high case mix
20 groups. Payments would shift from SNFs that don't treat
21 many medically complex cases to SNFs that do. Here I've
22 shown SNFs that treat high and low shares of special care

1 cases, but the trends were similar for clinically complex
2 cases. The impacts illustrate how a revised PPS could
3 redistribute payments across SNFs based on the mix of
4 patients they treat. As such, we think that rebasing should
5 be accompanied by revising the PPS. We will come back to
6 you in December with estimates of rebased options in
7 combination with the revised PPS.

8 The goal of rebasing is to set the level of
9 payments that balances the desire to increase the fiscal
10 pressure on facilities while maintaining beneficiary access
11 without rewarding inefficiency. The option is to rebase SNF
12 payments that would better align payments with costs.
13 Because this would not correct the known shortcomings in the
14 PPS, the option would also revise the PPS to base therapy
15 payments on patient and stay characteristics, establish a
16 separate non-therapy ancillary component, and implement an
17 outlier policy. The Commission will continue to assess the
18 financial performance and access to care and may make future
19 recommendations if needed.

20 Now let's turn to our second possible --

21 DR. MARK MILLER: Can I just add one thing?

22 DR. CARTER: Sure.

1 DR. MARK MILLER: For those of you who have been
2 on the Commission a little bit longer, this second -- the
3 therapy, the NTA component, and the outlier -- these are the
4 recommendations we made a few years ago, so we're saying the
5 rebasing would be done in the presence of those
6 recommendations. So the Commission has already worked
7 through the second half of this.

8 DR. CARTER: Yes, you made those recommendations
9 back in 2008.

10 So the second possible reform has to do with a
11 rehospitalization policy. Last year, the Commission stated
12 that it would examine a rehospitalization policy for SNFs as
13 one way to improve care for beneficiaries and to lower
14 Medicare spending. Avoidable rehospitalizations of SNF
15 patients expose beneficiaries to hospital-acquired
16 infections and poor care transitions. Under current policy,
17 SNFs have a financial incentive to transfer high-cost
18 patients to a hospital, even those with conditions that
19 typically can be managed in a SNF. The variation in risk-
20 adjusted rates suggests that lower rates are possible. A
21 rehospitalization policy for SNFs would align hospital and
22 SNF policies to improve the transitions between the two

1 settings.

2 MedPAC reports the rate of risk-adjusted
3 potentially avoidable rehospitalizations for five
4 conditions, and those are respiratory infections, congestive
5 heart failure, kidney and urinary tract infections,
6 electrolyte imbalance/dehydration, and sepsis. Those five
7 conditions make up about three-quarters of the
8 rehospitalizations from SNFs.

9 These rates vary 60 percent between the 25th and
10 75th percentiles, and there is an almost three-fold
11 difference between the 10th and 90th percentiles. The
12 median rate for hospital-based facilities was almost half
13 that of freestandings. Hospital-based facilities have lower
14 rates in part because they have ready access to ancillary
15 services, without the need to readmit patients. Compared to
16 other SNFs, those with the highest rehospitalization rates
17 had similar shares of medically complex days. They also had
18 higher shares of dual-eligible beneficiaries. This is
19 consistent with another study's finding that all-cause
20 rehospitalization rates were more than a third higher for
21 nursing home residents compared to those who had resided in
22 the community. We also found that facilities with the

1 highest rates were disproportionately for-profit. On
2 average, for-profit facilities had rates that were 25
3 percent higher than nonprofit facilities.

4 We also found that some facilities have
5 consistently high and low risk-adjusted rates. For example,
6 we found over 900 facilities that were in the worst quartile
7 of rates three years in a row, and 200 of those were in the
8 worst 10th percentile three years in a row.

9 Many factors that influence rehospitalization
10 rates are within a SNF's control, and these are listed on
11 the slide. They include transition care, drug
12 mismanagement, the use of hospice and advance directives,
13 staffing and physician presence, the financial incentive to
14 rehospitalize, and local practice patterns. Family,
15 patient, and staff preferences also play a role in the
16 decision to rehospitalize.

17 A rehospitalization policy could prompt facilities
18 to ensure good care transitions, improve their medication
19 management, ensure adequate staffing especially at night and
20 on weekends, and ensure families and patients are aware of
21 their options regarding advance directives and hospice.

22 Consistent with the Commission's past

1 recommendations for a hospital readmission policy, a
2 rehospitalization for SNFs would include potentially
3 avoidable conditions. By being focused on select
4 conditions, the measure would give direction to providers
5 about which care processes need improvement.

6 The time period should start with a measure that
7 covers the entire length of the SNF stay. This would hold
8 the SNF accountable for care throughout the beneficiary's
9 stay and does not encourage SNFs to delay rehospitalizations
10 until after the measure's time period is over. Starting
11 with this measure would allow a policy to be implemented
12 relatively quickly because CMS and MedPAC have both have
13 risk-adjusted models for the SNF portion of the stay. In
14 the future, the measure could be expanded to include 30 days
15 after discharge from the SNF to encourage facilities to
16 ensure effective care transitions for patients going home.
17 This phased approach would allow CMS to move forward with a
18 policy and begin to lower rates while a risk-adjusted
19 measure that includes 30 days post discharge is developed.
20 CMS will need to monitor provider behavior after the
21 measurement window to ensure providers are not shifting care
22 to beyond the window.

1 In terms of the penalty, the penalty would target
2 facilities with above average rates over three years.
3 Relative performance has the key advantage of not assuming
4 every hospitalization is avoidable. Basing a penalty on a
5 pattern of performance avoids penalizing providers for one
6 bad year.

7 For consistency with the hospital policy, a
8 penalty could range up to 3 percent. And, last, these rates
9 should be publicly reported so that providers can gauge
10 their relative performance and beneficiaries may use this
11 information in selecting a post acute-care provider.

12 This policy option would reduce payments to SNFs
13 with relatively high rehospitalization rates for select
14 conditions. An initial measure would include risk-adjusted
15 rates of potentially avoidable rehospitalizations during the
16 SNF stay. The measure could be expanded to include 30 days
17 after discharge from the SNF once a risk-adjusted measure is
18 available.

19 With that, I'll end my presentation, and we've
20 posed three questions:

21 The first is: Do you have any questions about the
22 rebasing or rehospitalization policies?

1 The second: Is there additional information you
2 would need to further develop these policies?

3 And, third, what level of rebasing should we be
4 thinking about?

5 MR. HACKBARTH: Thank you, Carol [off microphone].
6 Karen, I think you were up for clarifying -- oh, no.
7 Scott's champing at the bit to ask a clarifying question.

8 MR. ARMSTRONG: Just one. The recent changes in
9 payment for -- or nonpayment to hospitals for readmissions,
10 do we have a sense for -- I mean, how does that interact
11 with the second policy proposal here? Would that
12 potentially mitigate some of the impact of what we would be
13 trying to do in payment policy change for the SNFs? Do we
14 have a sense for how that would interact?

15 DR. CARTER: Well, right now a hospital obviously
16 gets penalized for the readmission, but right now the SNF is
17 not held accountable for that. So if the patient does come
18 from the SNF, the SNF is not being held accountable for
19 that. So this is trying to align those.

20 MR. ARMSTRONG: That I get. I just was wondering
21 -- and maybe it's really beyond the scope of this analysis,
22 and I think actually part of what we're acknowledging is

1 that we are the global payer, but we deal with payment
2 policy within these different silos. And so maybe that's
3 just the reality of this. But it just seems to me that
4 there is an incentive that didn't exist a couple of years
5 ago for hospitals to manage the readmission rate, and it may
6 have some impact which could mitigate the impact of this
7 second policy here. But I just didn't know if we had tried
8 to take any of that into account, and it sounds like we
9 really haven't.

10 DR. CARTER: We haven't. I mean, we've thought a
11 little bit about how the windows overlap or don't overlap,
12 but we haven't looked at kind of the relative -- what's
13 going on with each of those sectors.

14 MR. ARMSTRONG: Okay. Thanks.

15 MR. HACKBARTH: There are a couple different ways
16 to look at this readmission policy. One is strictly in
17 terms of this silo and its impact on payments for skilled
18 nursing facility care. The way I'm more inclined to look at
19 it, though, is that when, say, Peter is trying to figure out
20 how to reduce hospital readmissions, I want to make sure
21 he's got eager partners out there in the post acute-care
22 community who are aligned with that goal, and lining up

1 these policies is important in that regard.

2 MR. ARMSTRONG: So, in fact, that's more important
3 than making sure our estimated impact of this new policy is
4 really accurate within the SNF payment.

5 MR. HACKBARTH: Yeah.

6 DR. MARK MILLER: Also, the way I take Scott's
7 comment is if the baseline on SNF readmissions before the
8 hospital policy was up here and the hospital policy pulled
9 it down a bit, then putting this policy in place may not
10 have quite the effect. And, you know, that will end up
11 getting estimated under new baselines at CBO and all that in
12 the presence of the hospital policy, and from a program
13 perspective, you get the benefit one way or the other.
14 Either the hospitalization doesn't occur or the penalty
15 applies. But it probably means the baseline been affected a
16 bit, and that's the way I took your initial comment, and I
17 think you're probably right about that. But I don't think
18 it's zero left out there.

19 MS. UCCELLO: On Slide 6, it says that SNFs can
20 manage their costs by increasing the length of stay. But
21 then when we compare the relatively efficient SNFs versus
22 others, the efficient ones have lower lengths of stay. So I

1 was just wondering how that jibed.

2 DR. CARTER: Well, one's an average for the whole
3 industry, and the efficient providers is a discrete subset.
4 It's only 9 percent of the facilities, so you're right in
5 the sense that they seem to have different patterns. But --

6 MS. UCCELLO: That's just the way it is.

7 DR. CARTER: That's just the way it is.

8 DR. BAICKER: I was interested to learn that the
9 case mix doesn't go very far in explaining a lot of
10 variation that we see, and I wondered if you had a sense of
11 how big a role patient risk adjusters play in the
12 probability of readmission and whether we're able to adjust
13 -- whether you think that having adequate risk adjusters is
14 within our grasp, and if it's not, how much of a problem do
15 you think that will pose in terms of penalizing those who
16 enroll the sickest.

17 DR. CARTER: These are risk-adjusted rates. We
18 have worked with the contractor to develop a risk-adjusted
19 rate, and we've revised them once. I think they're pretty
20 good in terms of the risk adjustment model. It has 17 co-
21 morbidities, and it includes things like presence of
22 catheters and tube-feeding and pressure sores and DNR. I

1 think it's pretty robust.

2 DR. BAICKER: Those end up being good predictors
3 of future readmission?

4 DR. CARTER: Yes, they're pretty good.

5 MR. BUTLER: Sorry for the audience, but Table 5
6 in the text is not in front of us in this presentation, but
7 it has important data, I think. You separate the SNFs with
8 negative margins from those with positive margins, and the
9 ones with negative margins are 10-percent loss on Medicare,
10 and the ones with positive margins are 20-percent profit.

11 So what's not synching up for me, in the hospital
12 world we looked at these and we say if you're financially --
13 the financially stressed organizations have found a way to
14 make money on Medicare; therefore, the efficient -- you
15 know, we could maybe do something with the rates. Here I'm
16 sitting there, and you say if you have a 10-percent negative
17 margin on Medicare, how are you even staying in business?
18 Because the payer mix isn't different between the -- you've
19 still got 60 percent Medicaid. How are these places staying
20 afloat? If they have a 10-percent loss on the Medicare side
21 alone, I think that they'd be in deep trouble overall. I
22 know it's a little bit of a round two, but it doesn't add up

1 to me.

2 DR. CARTER: I wish that we had sort of the
3 private payer rates. We don't have that, and the cost
4 report doesn't -- it only has Medicare and non-Medicare. We
5 cannot sort of tease out, because, you're right, the
6 Medicaid shares are similar. And so I'm wondering about
7 kind of what's happening with the private pay rate.

8 MR. BUTLER: But at least 69 percent here is
9 Medicare/Medicaid, and I don't know if dual eligibles is in
10 addition to that or are they part of the Medicare -- anyway,
11 you don't have a lot of private pay to draw upon, that's for
12 sure, any way you look at it. Okay. That's one question.

13 Then the other is the cost differences. My
14 impression is in skilled nursing care there's probably as a
15 percentage of costs, there's less variable costs maybe than,
16 say, in hospitals because you don't have all the supplies
17 and other things. So you've got the cost of the plant, and
18 then you've got the cost of the staff. Do we have any idea
19 in these cost differences what might be due to kind of the
20 fixed versus the variable -- and maybe that's, again, a
21 round two, something to kind of understand how some are more
22 efficient than others. And is it realistic, therefore, if

1 they strap things down and become more productive from a
2 staffing standpoint, they might be able to make it, is
3 different from, you know, having a fixed plant and other
4 costs that are kind of not too hard to adjust.

5 MR. HACKBARTH: Go ahead, Carol. I'll let you go
6 first.

7 DR. CARTER: I haven't looked at fixed and
8 variable. I did compare sort of the routine versus
9 ancillary, but that's still a different question than what
10 you're asking. I haven't looked at that. I'm looking a
11 little bit at Craig, because we could look at sort of the
12 overhead shares, which I know vary considerably across
13 facilities, but it's still different than fixed and
14 variable. I'm not sure I can get a good read on that from
15 the cost reports.

16 MR. BUTLER: You should be able to separate the
17 overhead from the --

18 DR. CARTER: Yes, I can certainly separate the
19 overhead.

20 MR. ARMSTRONG: It's different from routine versus
21 ancillary --

22 DR. CARTER: Right.

1 MR. ARMSTRONG: -- because both have overhead in
2 them.

3 DR. CARTER: Right.

4 MR. HACKBARTH: So related to both of your points,
5 Carol, do we know what percentage -- going back to Table 5 -
6 - what percentage of those SNFs in the negative margin
7 column are hospital-based SNFs?

8 DR. CARTER: This is only data for the
9 freestanding.

10 MR. HACKBARTH: Okay.

11 DR. CARTER: So hospital-based in general is about
12 six percent of the industry. This column is the 13 percent
13 of facilities that lose money for the freestanding
14 facilities.

15 MR. HACKBARTH: Okay.

16 DR. MARK MILLER: And then the only thing I can
17 think of for Peter's initial question, the other thing you
18 can have is this is a one-year snapshot, right, so perhaps
19 it's not minus-ten the next year, because if it's
20 consistently year over year, it's really hard to see how
21 they stay in business, but whether there's some variability.
22 And then the other side of it is the private pay, which we

1 have a hard time seeing.

2 MR. ARMSTRONG: So what I'm obviously trying to
3 get at, how much, with the right management, the right
4 systems, the right staffing, you know, they can stay in
5 business, the access won't be an issue, versus they're
6 structurally never going to get from here to there.

7 MS. BEHROOZI: I think my question is related and
8 I hope it hasn't already been answered. Carol, the average
9 costs for those low-margin or money losing SNFs was 30
10 percent higher, you said, right? Do you know what the
11 variation in that range of costs is? I mean, is their
12 negative margin really all about their costs or is it about
13 -- is there something about the payment system, because
14 also, the bigger -- the biggest differentiation is in the
15 intensive therapy mix of days, right?

16 DR. CARTER: Right. I mean, I think it's both a
17 cost structure and a revenue difference, but I haven't
18 looked at the variation in costs for the SNFs that lose
19 money and I can do that.

20 DR. CHERNEW: I have a very basic question about
21 risk adjustment. When you do risk adjustment, you could
22 have a lot of things on the left-hand side. You could have

1 spending, or you could have probability of readmission, or
2 you could have a whole bunch of things. It seems like we
3 have the word risk adjustment here and coming throughout,
4 but sometimes we say these are the same patients risk-wise
5 and we are talking about spending, and other times we are
6 saying these are the same patients risk-wise and we are
7 talking about readmissions.

8 So my question is, are there different risk models
9 for predicting the risk of different outcomes, or is there
10 basically one risk model and we just talk about that like
11 risk is for all, and if the latter, what's on the left-hand
12 side of that risk model?

13 DR. CARTER: Okay. So these are different risk
14 models. When I standardize for costs, I using the nursing
15 component of the case mix. The SNF payment system doesn't
16 have one neat CMI like in the hospital world. It has one
17 for the nursing and one for the therapy, and I don't use the
18 therapy because providers can control that. And so we're
19 really -- they do tend to vary with nursing, but the nursing
20 component is separate and it's based on nursing time. So
21 that's what we use to standardize for cost. On the --

22 DR. CHERNEW: So risk adjust -- by standard the

1 cost, you mean to risk adjust. When you say the spending is
2 the same risk adjusted, you mean you're using a model of
3 risk adjustment that's based on the, I think you call it
4 NTA, or the nursing --

5 DR. CARTER: Just the nursing.

6 DR. CHERNEW: Just -- okay --

7 DR. CARTER: Right. It's based on the nursing
8 components, the CMI.

9 DR. CHERNEW: All right.

10 DR. CARTER: Right. The hospital,
11 rehospitalization risk adjustment model is what I was
12 talking about before, and it has -- it's comorbidities, sort
13 of the presence of catheters and tube feeding and pressure
14 ulcers and stuff like that.

15 DR. CHERNEW: And the dependent variable is did
16 you get sent back to the hospital, so --

17 DR. CARTER: Yes.

18 DR. CHERNEW: Okay.

19 DR. MARK MILLER: We built that one ourselves with
20 a contractor, whereas the standardization of costs is using
21 the payment system.

22 DR. CARTER: Right.

1 MR. HACKBARTH: So in the same vein, when you were
2 talking with Kate, I think I heard you say patient
3 characteristics don't explain variation in cost very well,
4 but then later say that the risk adjustment does work pretty
5 well for readmission to the hospital. Did I hear that
6 correctly?

7 DR. CARTER: Yes, you did.

8 MR. HACKBARTH: And so just to put this in Mike's
9 framework, so using patient characteristics, which is to me
10 a layman risk adjustment, is not very good at predicting
11 variation in cost per day for a skilled nursing facility,
12 but we do have a risk adjustment model which is pretty good
13 at predicting the risk of readmission to the hospital. Did
14 I follow that correctly?

15 DR. CARTER: You did, and when I was talking about
16 how we can't explain cost differences, I tried to separate
17 out that the case mix index doesn't explain those costs
18 because we've standardized for that. But we also looked at
19 the cost differences between dual and sort of for facilities
20 that have lots of duals, that have lots of old, really old
21 benes and minority benes, and we still didn't see that those
22 cost differences. So when I said patient characteristics, I

1 was talking about some of those demographic characteristics
2 but also the CMI.

3 MR. HACKBARTH: Yes. Kate.

4 MS. BLONJARZ: And I was trying to distinguish --
5 not sure that I did so effectively -- between being able to
6 predict at an individual level which patients are more
7 likely to get rehospitalized versus explaining variation
8 across SNFs in the rate of rehospitalization. So what I
9 understood is that we can do a reasonably good job at
10 predicting who is going to be rehospitalized, which is
11 important because then those risk adjustors are going to
12 inoculate SNFs against being penalized for taking patients
13 that are just worse off, but then it doesn't -- there is
14 still a lot of variation in rehospitalization left, meaning
15 SNFs are then performing differently conditional on that mix
16 of patients they happen to grab.

17 DR. MARK MILLER: I think that's right, and -- oh,
18 Carol.

19 DR. CARTER: No. I think the R-squared on the
20 rehospitalization is about 0.6 or 0.7, so it's pretty good.
21 I mean, I took that as pretty good. Yes.

22 DR. MARK MILLER: And to the extent, though, that

1 there is still unexplained variation, remember, the rest of
2 the policy is, okay, we're going to look at rates over time
3 for the SNF, not case by case, and so you kind of build in
4 some cushion that way.

5 DR. BERENSON: Yes. I'm back at a basic question,
6 also. I get confused about sort of the terminology of a
7 skilled nursing facility, basically. The Table 5 in the
8 handout and the paper is the finances of an institution that
9 is a nursing home that includes patients who have SNF
10 benefits from Medicare, right? I mean, that is what we're
11 referring to as a skilled nursing facility?

12 DR. CARTER: Yes.

13 DR. BERENSON: Okay.

14 DR. CARTER: So I would say 95 percent of
15 facilities also are a SNF and a nursing home, but there's a
16 small share of facilities that are only Medicaid and a small
17 share that are only Medicaid.

18 DR. BERENSON: Okay. So I got that far. So then
19 when we have Medicare days are only about nine or 12
20 percent, or about ten percent, and Medicaid is about 50
21 percent, and duals are about a third, it's telling me that
22 the duals are mostly being covered for their residential

1 stays by Medicaid and some portion of that ten percent
2 Medicare is for duals, right? Is that basically right?

3 DR. CARTER: Yes, but we're only looking at the
4 Part A benefit side of things. So this is while they're in
5 a Part A covered stay.

6 DR. BERENSON: All right. What percentage are
7 Medicare only, not duals? Do we know that, in terms of the
8 payer mix -- beneficiary mix? Is it small, very small, or -

9 DR. CARTER: It's small.

10 DR. BERENSON: Okay.

11 DR. CARTER: Yes.

12 DR. BERENSON: And I guess where I'm ultimately
13 going with that background is do we know on the readmission
14 or -- yes, the readmissions, the rehospitalization policy,
15 where people go after a SNF stay, what percentage stay in
16 that same facility, versus going to their home, versus going
17 to a residential community?

18 DR. CARTER: I don't have that with me, but I have
19 it. I can get back to you on that, yes.

20 DR. BERENSON: I think that would be important for
21 the few -- I mean, I'm all for aligning the incentives --
22 well, this is around two things. I'll come back to that.

1 I'll explain why I'm asking this in the second round.

2 DR. CARTER: Okay.

3 MR. KUHN: We're real excited about hearing round
4 two, Bob.

5 [Laughter.]

6 MR. KUHN: Two quick questions, Carol. One, kind
7 of picking up where Scott was going a little bit, he was
8 talking about the hospital readmission activity that was
9 part of PPACA. I'm curious about ACOs and the final rule
10 that CMS put out there. Do we know or did they estimate --
11 the Office of the Actuary estimate how much they thought how
12 much ACOs would help curb rehospitalizations from SNFs?

13 DR. CARTER: The straight answer is I don't know -

14 MR. KUHN: Okay.

15 DR. CARTER: -- and so --

16 MR. KUHN: And then the second question, on Slide
17 9 where you were talking about the payment reductions that
18 were in this final SNF rule, the 11 percent, you had -- we'd
19 also had in the paper where we talked about -- where it was
20 talked about where CMS has tried to curb therapy services in
21 the past and has met with uneven success in that. So 11
22 percent is what CBO scored or where OAC scored where they

1 think they are. Do we have any estimates or is there any
2 kind of conversation of what folks think the actual real
3 savings might be as a result of that? I mean, are people
4 already thinking about work-arounds to get around these new
5 changes that are out there?

6 DR. CARTER: I haven't talked to a lot of people
7 about that. I have heard that the estimated impacts will be
8 smaller, but I haven't really looked into that.

9 DR. HALL: We've used the word "variation" quite a
10 bit as we've gone around the room, but what about regional
11 variation?

12 DR. CARTER: In rehospitalization?

13 DR. HALL: And just in rates, for example, or
14 margins, I should say. How do we know this isn't being
15 differentially skewed because of some large urban areas that
16 have --

17 DR. CARTER: Well, these are standardized for
18 wages, so at least the differences in wage rates have been
19 taken out --

20 DR. HALL: Mm-hmm.

21 DR. CARTER: -- in terms of the variation in cost.
22 We do see considerable variation in the rehospitalization

1 rates --

2 DR. HALL: Right.

3 DR. CARTER: -- with much lower rates in sort of
4 the Dakotas, Montana, Wyomings of the world, and that, in
5 part, is because they have a higher share of their SNFs are
6 hospital-based and so those facilities have much lower
7 rehospitalization rates and so it pulls down their State
8 average. I think there's about a two-fold variation in the
9 State rehospitalization rates.

10 DR. HALL: Because every time we've looked at
11 almost any sort of medical phenomenon, whether it's hospital
12 admissions, operative procedures, there's just incredible
13 regional variation that -- I guess the one thing we don't
14 want to do is compromise areas that are doing a good job and
15 have sort of a different economic model that they have to
16 face, but --

17 DR. CARTER: Well, I do think if you implement a
18 policy where you're targeting folks with above average, then
19 you won't be disadvantaging facilities that are already
20 doing a good job.

21 DR. HALL: Okay.

22 MR. HACKBARTH: Carol, do we know anything about

1 variation in use of therapy across regions?

2 DR. CARTER: I haven't looked at that.

3 MR. HACKBARTH: Okay.

4 DR. CARTER: So no.

5 MR. HACKBARTH: All right. Mary.

6 DR. NAYLOR: So the readmission rate for skilled
7 nursing facility Medicare beneficiaries hasn't -- in the
8 five conditions that you followed, as I understand it,
9 hasn't changed much in ten years. It's somewhere between 13
10 and 14 percent for those five. What's the all-cause -- in
11 30 days -- all-cause readmission rate for those
12 beneficiaries?

13 DR. CARTER: I don't know, and if I reported it to
14 you, I would be using other folks' studies.

15 DR. NAYLOR: I mean, I --

16 DR. CARTER: We don't calculate that.

17 DR. NAYLOR: Because I'm trying to put the
18 perspective of --

19 DR. CARTER: I mean, it would be higher,
20 obviously, right, because it's including any reason somebody
21 goes back to the hospital.

22 DR. NAYLOR: So it would obviously be higher than

1 13, but we know all cause for all Medicare beneficiaries is
2 somewhere between 19 and 20.

3 DR. CARTER: Mm-hmm.

4 DR. NAYLOR: So I'm trying to put where -- how big
5 a problem is this for -- in terms of readmission rates.

6 The other thing is, do you have any sense, in the
7 notion of rebasing, if -- a lot of the recommendations
8 around how we could get to better care and outcomes for this
9 group, at least evidence-based, such as EverCare, use nurse
10 practitioners or physicians assistants, et cetera. So the
11 question is would rebasing position us -- I mean, how would
12 it affect our ability to address and implement some of the
13 kinds of solutions that we know can result in avoiding
14 rehospitalization and improve care outcomes?

15 DR. CARTER: We look at sort of whether facilities
16 with low costs are also able to have relatively good quality
17 and we do find facilities that manage both of those. And so
18 I guess I think of it as does rebasing have to affect
19 quality, and I guess I don't necessarily get there, because
20 we can identify providers that manage to maintain -- to
21 manage their costs and maintain good quality.

22 DR. NAYLOR: So I will get back to that. And the

1 last thing, in terms of tracking, I think it would be great
2 if, and you may already know this, the idea of what's
3 happening at State levels to transition people from nursing
4 homes back to the community and what has that done in terms
5 of the population, and the only reason I say that is I think
6 it's about 70 percent of the people in skilled nursing
7 facilities are going to long-term care. I don't know if
8 they're going back to the same long-term care facility, but
9 a very high proportion of this population. So to know
10 what's happening in terms of the long-term care population
11 might have some bearing on policies related to skilled
12 nursing facilities.

13 DR. CARTER: States obviously vary in terms of how
14 aggressive they've tried to move their long-term care
15 residential population into the community, so there's sort
16 of the States have done differing kind of strategies and
17 really effort to rebalance their long-term care dollar in
18 terms of the in-facilities versus home and community-based
19 services. We know that nursing homes with bed hold
20 policies, I mean, States that have bed hold policies, that
21 really affects their hospitalization rates, but that's still
22 different than what we're looking at, which is when somebody

1 -- let's say it's a long-term care patient and they get
2 hospitalized. Now they may be in a Part A stay. That's
3 what we're looking at now, is the Part A stay and how likely
4 are they to be rehospitalized. And even if they're sicker,
5 we're risk adjusting for that, and so I don't know that it
6 would necessarily affect the rates of rehospitalization that
7 we're looking at, because we are trying to control for the
8 complexity of the patient.

9 MR. HACKBARTH: If a patient is a long-term
10 resident in, say, a nursing home, they have a
11 hospitalization and they receive SNF care, would the
12 probability of rehospitalization be affected by the fact
13 that rather than going home where they may have very little
14 in the way of supports, their home is a nursing home?
15 Without really knowing anything, it seems like it may even
16 reduce the risk of rehospitalization if they live in a place
17 where they've got supports beyond what most people have at
18 home. Just a thought.

19 DR. CARTER: Mm-hmm.

20 DR. NAYLOR: Another alternative is that the
21 people who are remaining in the long-term care -- so it's
22 counterintuitive to me, but the patient characteristics

1 don't matter. I mean, are, in fact, sicker, higher
2 cognitive impairment. But you are saying they --

3 MR. HACKBARTH: [Off microphone.] I didn't say
4 they don't matter, but that we adjust for differences in
5 patient characteristics.

6 DR. CARTER: Mm-hmm. Mm-hmm.

7 MR. HACKBARTH: Ron.

8 DR. CASTELLANOS: Confusing subject. Just for
9 clarification, go to Slide 6 for a second. What I'm seeing,
10 and I keep saying the real world experiences, and I think
11 Peter will agree and George will agree that patients in the
12 hospital today are getting out of the hospital into a lower-
13 cost setting, case managers, et cetera, and a lot of these
14 patients, especially the orthopedic and joint replacement
15 patients, used to go into a rehab hospital, but now because
16 of the 75 percent rule they're going into other low-cost
17 settings. What I'm seeing is that -- you mentioned the cost
18 growth. You adjusted this for patient mix and for risk
19 adjustment also?

20 DR. CARTER: No, these have been adjusted by the
21 nursing component of the -- you know, the case mix index
22 associated with the nursing component, and we looked at

1 differences in duals and minority and --

2 DR. CASTELLANOS: Okay --

3 DR. CARTER: -- but it's not risk adjusted in the
4 same way that I was talking about before.

5 DR. CASTELLANOS: Okay. It's not risk adjusted --

6 DR. CARTER: Right.

7 DR. CASTELLANOS: Okay. That explains that. I
8 think we all agree that the patients going into a SNF today
9 or into some post-acute setting are a little sicker now than
10 they have been in the past --

11 DR. CARTER: Well, we actually looked at that, and
12 when I look at the Barthel scores for incoming patients,
13 they are a little sicker, but they're not -- that doesn't
14 explain the increases in therapy and stuff that we're
15 seeing. So it's true they have -- they are a little sicker.
16 They have fewer abilities to perform ADLs and their
17 cognitive function is a little worse, but it's not
18 commensurate with what we're seeing on the payment side.

19 DR. CASTELLANOS: I think on the next slide, 7,
20 you kind of answered that by saying that it was not
21 commensurate with increased therapy, but these people are
22 requiring that. I know the orthopedic guys are because

1 they're increasing the level of therapy. I just see a
2 disconnect with what you're saying and perhaps maybe what
3 I'm saying in the real world. I'm just saying that, Carol.
4 I'm not criticizing you, but I'm just saying --

5 DR. CARTER: I don't feel criticized.

6 DR. CASTELLANOS: -- I'm saying this in the real
7 world.

8 DR. CARTER: Yes. I mean, and also, the other
9 thing when we look at the DRGs for, like, hip replacement,
10 those -- the biggest impact was on the home health as
11 opposed to SNFs. Actually, they really had much more of an
12 increase in those patients than the SNFs did.

13 DR. CASTELLANOS: That's what I said. Any of the
14 post-acute settings --

15 DR. CARTER: Yes.

16 DR. CASTELLANOS: -- I'm sure there's going to be
17 increased settings. But I just thought it would be
18 reflected here, also.

19 MR. HACKBARTH: So, Ron, just let me pick up on
20 one thing that you said. So I don't think there's any
21 question that, in fact, the patients are getting more
22 therapy. In fact, what the data seem to indicate, that they

1 are getting more therapy, in part because it's very
2 profitable.

3 MR. GEORGE MILLER: Right.

4 MR. HACKBARTH: And so the reason I think it's
5 related to profitability is that you see how quickly people
6 respond to differences in the thresholds and how you qualify
7 for higher payment levels. They are acutely sensitive in
8 terms of the amount of therapy provided to where they get
9 more money or less money.

10 DR. CASTELLANOS: I guess I'm saying that they're
11 getting more therapy appropriately, not because of --

12 MR. HACKBARTH: And what I'm saying is that you
13 wouldn't expect to see this pattern of the amount of therapy
14 changing dramatically in response to payment changes if this
15 was all clinically driven.

16 DR. CASTELLANOS: I think you -- I understand
17 that. Thank you.

18 MR. GEORGE MILLER: Yes. You just said what I
19 started to say, because this is an example, at least in my
20 opinion, of looking at silos versus looking at where service
21 is given. And since we saw the same issue, or the same type
22 of response to payment in the home care business, especially

1 around the intensity of therapy, would lead us -- at least
2 lead me in my mind to think that we need to look at more
3 than just silos. We took the SNF, we did the home care, but
4 dealing with this across silos so that we can have that
5 impact and probably be ahead of the curve on policy changes.

6 But just to respond to Ron, my question has to do
7 with Slide No. 12. Do we have -- and that's the definition
8 that was very well done in the paper of efficient provider.
9 But do we know demographically what that efficient provider
10 looks like? Do we have a model of that, and are they
11 located in rural areas or urban areas or suburban areas and
12 what their case mix would be in their patient population? I
13 should look at Carol.

14 DR. CARTER: I can get back to you on that. So
15 sort of who's in that circle?

16 MR. GEORGE MILLER: Yes, who's in that circle, and
17 is there something that we can learn from them? Are they
18 all for-profits? Are they all not-for-profits, although the
19 data --

20 DR. CARTER: I don't have that in front of me.

21 MR. GEORGE MILLER: Yes. The data wouldn't say
22 they're not-for-profit.

1 DR. CARTER: Mm-hmm.

2 MR. GEORGE MILLER: That would be interesting to
3 know. And the follow-up, is there something we could learn
4 from them? And it seems, if I remember the data correctly,
5 they did not use a high level of therapy disproportionately
6 than the numbers we saw on the previous slide, if I remember
7 correctly from the efficiency --

8 DR. CARTER: I will have to get back to you on
9 that.

10 MR. GEORGE MILLER: Yes. That would be
11 interesting to find out. I could be wrong. Thank you.

12 MR. GRADISON: Is it fair to say that the changes
13 you were recommending would at least maintain the access to
14 care that we have today and maybe even improve it, or do you
15 think it might have an impact in perhaps affecting the
16 amount of certain therapies that are made available and the
17 intensity of the care that's actually given?

18 DR. CARTER: I don't think it would affect -- for
19 those providers that are furnishing therapy that's not
20 related to patient characteristics, you could see a
21 reduction in the services that are being provided and that
22 would save the program money and I don't think access would

1 be affected.

2 MR. GRADISON: Okay.

3 DR. CARTER: And that's what we're striving for,
4 and that's why I think we've tried to pair the rebasing
5 policy with a redistribution based on the revising the
6 payment system, so you don't have the sort of systematic
7 biases that are there now.

8 MR. GRADISON: About a dozen years ago, I did some
9 work with the for-profit nursing homes. I haven't done this
10 for eight or nine years, so it's nothing recent. But I was
11 struck at the time, coming back to, I think it was -- it may
12 have been Peter's comment -- by the way in which many of
13 these companies, the few that were able to stay in the black
14 at that time, were able to have sufficiently high margins on
15 their private pay and their Medicare to overcome the very
16 low margins on Medicaid.

17 While it probably is not directly relevant to what
18 we're talking about here, I'm sure I'm not the only one in
19 the room that kind of wonders what the impact of what is
20 going on in the States in Medicaid reimbursement might mean
21 to Medicare beneficiaries, which is -- I've always thought
22 just as an outsider and now a newcomer to this organization

1 that the principal justification for knowingly providing
2 higher margins on Medicare business was to help to preserve
3 the availability of the nursing homes, which, if Medicare
4 reimbursed them along the lines of Medicaid, might lead to
5 something like we saw back in that period. At that time,
6 five of the seven largest for-profit nursing home chains
7 went through Chapter 11. This wasn't one of those
8 theoretical concerns or crying wolf. It actually happened.

9 One thing that struck me there, and this is more
10 specific, had to do with the ones that didn't get in that
11 difficulty. There were some. My sense was part of it was I
12 don't think the government had a darn thing to do with it.
13 That was my view at the time. But I think part of it was
14 that the debt level, the debt service was a real challenge
15 which couldn't be overcome by the ones that went under. But
16 also, I think it had to do with location, and that's really
17 the main point I want to make.

18 I don't know how you would get these data, and I
19 understand why you have urban and rural, but it seemed to me
20 at the time that one of the principal explanations for why
21 some of the nursing home organizations were able to sustain
22 themselves was locations in areas where they would be able

1 to -- by their location, not manage with policy, by their
2 location -- manage the proportion of Medicaid patients. In
3 other words, they would be in areas where they were more
4 likely to get a larger than normal percentage of Medicare
5 patients and private pay.

6 I appreciate the difficulty in getting private pay
7 information. To me, this is a real important element of
8 this and I wish -- I don't know how you do it, but I wish we
9 knew how more about how that interacts with what we are
10 talking about. But I accept your statement about the
11 difficulty of obtaining that data.

12 DR. CARTER: Well, we don't have Medicaid revenue,
13 but we have Medicaid days, and so I can make sure to look at
14 that when I compare sort of the profitability on the
15 Medicare side of whether facilities look different in terms
16 of their Medicaid share days.

17 MR. GRADISON: I think that would be helpful to
18 know.

19 DR. CARTER: I do know that when we last year
20 looked at who was in the top quartile and bottom quartile of
21 Medicare margins, they did differ in their Medicare share
22 with facilities that had higher shares of Medicare doing

1 better.

2 I think for sort of the cross-subsidization, I
3 think Glenn wants to talk about that.

4 MR. HACKBARTH: So, Bill, this is an issue that
5 actually we've spent a fair amount of time discussing over
6 the years, and let's start by stipulating that we all have a
7 strong interest in making sure Medicare beneficiaries have
8 access to needed nursing facility care.

9 The problem with using higher Medicare rates and
10 margins to cross-subsidize for Medicaid is this: first of
11 all, it doesn't get the money to the right institutions. So
12 if the premise is correct that Medicaid is a losing
13 proposition, Medicare is a profitable one, the ones who most
14 need the money are the ones that are going to have small
15 Medicare shares and large Medicaid shares. The ones who
16 most benefit, however, from using Medicare to cross-
17 subsidize Medicaid are the reverse, the ones with big
18 Medicare shares and lower Medicaid shares. So the money is
19 very, very poorly targeted if what we want to accomplish is
20 to make sure that Medicaid payment does not drive
21 organizations under.

22 MR. GRADISON: Sure.

1 MR. HACKBARTH: The second problem that we face if
2 we use Medicare to cross-subsidize Medicaid is if the
3 Federal Government says, oh, we will assume responsibility
4 for the bottom lines of nursing facilities, it is not just a
5 license, it's an invitation for the States to keep cutting
6 Medicaid reimbursement because the Feds will make up the
7 difference and that simply isn't a sustainable policy.

8 The third problem is that the further you drive
9 these rates apart, Medicare and Medicaid rates, it starts to
10 affect business plans and it creates a very strong incentive
11 to build your organizational plan and your investment around
12 getting the really profitable Medicare patients and spending
13 as little as possible on Medicaid.

14 So I understand the allure of saying, well, we
15 will just cross-subsidize, but it creates all sorts of bad
16 incentives and it's not an inherently stable system.

17 MR. GRADISON: Well, I agree with everything you
18 said. What I'm trying to figure out is why, in the face of
19 that powerful logic, for years we have knowingly had a
20 system which does what you advise against. That's all.

21 MR. HACKBARTH: Politics. You know more about
22 that than I do.

1 [Laughter.]

2 MR. ARMSTRONG: So, first of all, I support the
3 direction that we're heading in with both of these different
4 sets of policies around rebasing the payments. I think
5 we're overpaying, and we're not paying -- our payments are
6 not distributed the way they need to be, and so I think that
7 the kind of analysis you're doing is right on. We should
8 continue with that.

9 I also support the work around creating incentives
10 to address the high variation in rehospitalization rates.
11 Our approach here has been to create penalties where they're
12 high. I would love it if we could imagine some upside
13 opportunities for SNFs that have really great
14 rehospitalization rates or are considered to be quality
15 institutions by whatever measures we have, to give them some
16 flexibility, perhaps, around three-day prior hospitalization
17 requirements or some other benefits to create, you know,
18 parallel incentives for reducing rehospitalization rates or
19 for other goals that we might have.

20 The last point I would make is just this -- I know
21 you're expecting me to make this -- is that this whole
22 conversation just feels so constrained by the fact that

1 we're trying to deal with skilled nursing facility payment
2 rates within the context of this artificial barrier between
3 the different parts of our care delivery system. I think we
4 have to do that, and we've really tried to be as attentive
5 as we can to aligning incentives for skilled nursing
6 facility payment with hospital payments and others.

7 But the world I live in may not be the real world
8 that Ron lives in, but the world I live in is one where
9 there could be patients who have very high SNF costs but
10 whose overall costs are low and this approach doesn't give
11 us any opportunity to really think about that. And so I'm
12 going to be much more interested as we go forward with our
13 MedPAC agenda in bundling payments and other ways of trying
14 to be smarter about the fact that Medicare is a global payer
15 for all of these things and I think we could do a better
16 job.

17 MR. HACKBARTH: Cori, can I just jump in here for
18 a second? I meant to do this before Scott started. I want
19 to get folks to react to one of Carol's discussion
20 questions, so Carol, could you put up your last slide. The
21 third one. We've talked abstractly about rebasing the rates
22 and rebasing the rates doesn't have a specific meaning in

1 terms of, oh, it's this percentage or this many dollars. So
2 that would be a question that we would need to answer.

3 And let me just offer a couple thoughts for people
4 to react to, not that these are answers, but they're sort of
5 benchmarks to take into account. One is that, in the past,
6 when Medicare has established new prospective payment
7 systems, what it does is establish the initial rates based
8 on average cost that exists at that time. So that's sort of
9 one tradition, if you will, for how we establish rates. So
10 one approach here would be to bring the payment rates down
11 to the level of the existing costs.

12 Another potential benchmark is to look at the cost
13 level of efficient providers. In fact, our charge from the
14 Congress in the statute governing MedPAC is that we are to
15 make recommendations on rates that are consistent with the
16 efficient provision of the services in question. So that's
17 another potential benchmark.

18 Now, just to be clear, I'm not suggesting that we
19 choose one or the other, but I'm trying to define some
20 potential boundaries in how we think about how much rebasing
21 would be appropriate here and I invite Commissioners to
22 offer any additional thoughts on that topic.

1 Scott, is there anything you want to say on that?

2 MR. ARMSTRONG: Well, just generally, I would say
3 I think there's opportunity for a lot of rebasing here in
4 that if our standard in other sections of our payment policy
5 has been to rebase toward efficient providers, then I would
6 apply the same standard to this area, as well.

7 MS. UCCELLO: Yes, I agree with Scott. I really
8 like the direction of this entire package, but I am
9 attracted to using the efficient provider as kind of the
10 base.

11 DR. BAICKER: I think this is a great direction,
12 as well, and I thought you made a very strong case that
13 avoidable rehospitalizations were a nice marker for other --
14 to target for this, and I just wonder, going forward, it
15 would be interesting to know more about how well that maps
16 to the other components of care. If it doesn't, that's okay
17 because it's an important outcome in and of itself. But
18 sometimes we worry when you target particular outcomes that
19 you can actually worsen other outcomes if you divert
20 resources and attention, you know, teaching to the test or
21 people targeting just the things that are in the limited set
22 that goes into the payments.

1 Now, naively, this seems like a good one in that I
2 would imagine that all the things that go into avoiding
3 avoidable rehospitalizations are positively correlated with
4 lots of other things we all care about, but that would be
5 something good to think about in possibly incorporating
6 other measures in addition to avoidable rehospitalizations
7 or thinking about the repercussions of targeting just this
8 one but not other ones. Do we think that it is
9 complementary to other things we care about or substituting
10 for other things we care about?

11 MR. BUTLER: I'll answer your question first, and
12 that is like most successful transitions, it's a
13 combination. First in the rebasing, you need to have
14 probably something like three years, and then you need to
15 take into consideration some aspect of cost. In this case,
16 it may be not more than 105 percent or 108, whatever it is,
17 and then a component of either a mean or efficient provider,
18 whatever the standard is you're shooting for. So if you
19 take multiple years, the cost that you're at now as well as
20 whether it's mean or efficient provider, you can blend those
21 together and have a graceful but rigorous transition.
22 Something like that is what I'd do. And I just thought that

1 in the last two minutes, so I do know if that's helpful.

2 MR. HACKBARTH: [Off microphone.] -- pretty
3 consistent with what's been the practice in the past in
4 moving to new payment systems --

5 MR. BUTLER: I think it, generally, has worked.
6 When one system has done that, it gives you some chance to
7 make the adjustments. Okay.

8 I'm very supportive -- I remember well about two
9 years ago or maybe three years ago when I said, okay,
10 hospitals should get dinged for readmission rates, and maybe
11 they're the first ones even though they may not be most
12 responsible, they should show some leadership. If I were to
13 say, what party is the most important other party, it is the
14 skilled nursing homes, and sometimes they say, well, they
15 don't have the data, they don't have the sophistication. I
16 think most of these nursing homes do understand pretty darn
17 clearly the criteria they use to send somebody to the
18 hospital, when they call on an ambulance. It's usually one
19 nurse and the medical director in combination kind of have
20 protocols that say, we don't want any more of this, whatever
21 the reason. And so I think it is quite doable, even in
22 places that are relatively small or perceived to be

1 unsophisticated.

2 I did want to put one other kind of -- I don't
3 know what to do about it, but the worst cases are where you
4 still have, hopefully not very often, the medical director
5 of one or more nursing homes that has 20 patients in the
6 hospital with long lengths of stay which is an economic
7 incentive for that medical director -- the medical director
8 is conflicted on multiple fronts, and I've seen this in many
9 hospitals where they take them right out of the nursing
10 home, which helps the nursing home and the medical
11 director's role there, and then helps their own income as
12 they have extra long lengths of stay in the hospital, as
13 well. And that's terrible abuse when that -- and if it
14 still occurs, but the system kind of does not actually align
15 for sometimes with the medical director who is coordinating
16 care on behalf of the nursing home and the hospital, and
17 that's still -- you know, you have to be attuned to that as
18 you're trying to align two organizational financial
19 incentives, the hospital -- and it's still a physician that
20 admits and discharges patients, and how that person is
21 positioned in this equation is not irrelevant.

22 MS. BEHROOZI: This is -- it's really great to see

1 the development of the work, Carol. I'm trying to get at
2 what I think of as the revenue maximization that's going on.
3 I mean, you know, I think you said this, Glenn, there are
4 people with a business model that it's a natural thing in
5 business to maximize the revenue, and unfortunately, the
6 payment system here is somewhat easier than some to figure
7 out, to game, frankly, in some cases, and maybe achieve that
8 cross-subsidization that you have clarified why it's a bad
9 thing to do.

10 I guess I feel like the revising of the PPS really
11 gets at the revenue maximization stuff as does the
12 rehospitalization, you know, looking at policies to address
13 that. The rebasing is -- just because the revenue
14 maximization has been so effective by so many people, but
15 maybe not by everybody. So I am concerned that there are
16 some providers who are suffering negative margins -- I don't
17 know this, I don't have any facts on this -- but it's
18 because they're not, whatever, treating two people at a time
19 and only providing that one extra day of therapy to cross
20 the line and that kind of thing.

21 So I do really think it's important, similarly to
22 what we said with PACE, putting the risk adjustment first

1 and then the change to the payment, you know, basing it on
2 the current MA policy. I would just want to make sure that
3 we -- on Slide 12, it says rebase and do the revision to the
4 PPS. I know we've recommended it before, but it might be
5 very important to revise the PPS first, like I said, even
6 though we recommended it before, and then see how that will
7 shake out, whether there's anybody who will suffer
8 incorrectly from that. I think that will make it better.
9 And then you can rebase from there.

10 MR. HACKBARTH: That's a good point, and also this
11 was an issue with home health rebasing, where we also wanted
12 to synchronize improvement in the payment system with the
13 rebasing for just that reason.

14 DR. MARK MILLER: Working with that thought, or
15 maybe the way to think about it is to make it clear in the
16 language that rebasing, then using -- or, sorry, the
17 recalibration or reforming the underlying system, then using
18 that, you engage in rebasing. But in order to not let the
19 recalibration process go on forever, set a date certain for
20 both of those steps to be done, because that's the catch.
21 If you just say, don't do it until, then it may never
22 happen. So you put a backstop on it, and that's kind of the

1 construct we put in the PACE arrangement.

2 DR. CHERNEW: This isn't an area that I have a lot
3 of experience in, so I may be a bit off base, but I have a
4 few general thoughts. My first comment is I'm a little
5 skeptical of necessarily how good the case mix of the
6 quality-type measures are because some of the things that
7 are going on here, it's hard to measure well, like the right
8 quality measures, something to do with is the therapy
9 working or preventing you from getting worse, and I'm not
10 sure we have all those right outcomes. So we're kind of
11 doing, I think, a reasonable job, and I guess I'm basically
12 convinced of the arguments, but I guess the data is not so
13 overwhelming that it's clear.

14 And that wouldn't bother me quite so much except
15 my bigger concern is that imagine we wanted to do something
16 like reduce the rates to the level of an efficient provider.
17 That doesn't mean that the inefficient providers are just
18 now going to become inefficient. Bad things could happen in
19 a whole series of ways that we need to think about if we
20 were to do that. And I worry about that. And if we had
21 good quality measures or I thought it would all work out,
22 that would be one thing.

1 So I guess in the end, I am supportive of some
2 level of rebasing, or some other payment reform, and I could
3 think of a bunch of things besides rebasing. I could think
4 of some sort of mix payment, like we lower the rates but
5 give them some cost amounts, so some novel thing of doing
6 that. I could think of -- maybe the problem is just we're
7 paying too much for therapy and the right thing to do is not
8 to make a big change and just lower the amount we pay for
9 therapy. There's some discussion in the materials where
10 they're providing -- this might not be the right word --
11 group or double therapy instead of single therapy, but
12 they're still getting paid because they do each one, so it's
13 cheaper, and they found this -- now, I have no idea if
14 that's better or worse quality, for example, but maybe the
15 challenge is we could just solve this problem in a much more
16 straightforward way of lowering the therapy rates.

17 DR. CARTER: Well, CMS has made a number of
18 corrections pointing at that, but our contention is still
19 you have a payment system that has a basic incentive to do
20 therapy, and at least the amount of therapy that was being
21 provided concurrently or in groups was 25, 30 percent. So
22 mostly it was still individual therapy that was going on -

1 DR. CHERNEW: I'm not advocating any of these
2 because I said I don't know, but I am sure of one thing.
3 You could lower the payment for therapy enough so there
4 would be no incentive to do the therapy. We just may have
5 not gotten there yet. And I am not advocating that, just to
6 be clear when people start calling me. My only point was
7 it's not clear how to compare that.

8 Another thing you could do is you could pay a
9 certain amount for therapy and have some -- we've talked
10 about copays and consumer incentives. Maybe there's people
11 that want more therapy and people that want less therapy,
12 they think it's going to work well for them and not work for
13 others, and you let consumers decide one way or another in
14 doing therapy. And again, I'm not advocating that.

15 My only comment is that my general concern about
16 trying to do this all through rebasing is we end up pulling
17 down things which clearly hit some people we want it to hit
18 and likely hit some people we don't want it to hit and we
19 always have this problem in every heterogeneous service
20 category. We're going to do this all through December and
21 January. There's going to be some big margin. Our instinct
22 when we see the big margin is to cut the rate and we're

1 going to worry that the people on the one side -- we could
2 get into the situation we're driving out the good and
3 protecting the bad because you can only survive if you're
4 doing, you know, doubles therapy or whatever it happens to
5 be.

6 And so I guess the only thing I would add, because
7 I simply don't know which of these many options are right
8 for what I do believe is a problem you identified, is to
9 make sure that we're as strong as we possibly can be in
10 monitoring the very outcome -- the outcomes that are going
11 on, and I very much agree with Peter that we kind of go a
12 little slowly into this in a blended or other way so we
13 don't end up causing a disaster and then after the fact
14 having to jump back in and say, oh, this didn't work out the
15 way we thought.

16 MR. HACKBARTH: Carol, could you put up the table
17 that has the redistribution that occurs from -- yes. So
18 moving to the sort of revised payment system that we've
19 recommended in the past move substantial amounts of money
20 around. And isn't there also, or is it just in the paper, a
21 table that has it by -- well, I guess all the breakdowns are
22 here. I guess this is the one I was thinking of.

1 So if you reduce the rates, you know, by five
2 percent due to rebasing, there are some -- concurrent with a
3 redistribution of the payments, there are going to be some
4 people who are still much better off even after the rebasing
5 than they are today, and I just wanted to make sure that
6 that was clear.

7 DR. CHERNEW: [Off microphone.] Within each of
8 these categories, there's heterogeneity --

9 MR. HACKBARTH: There's heterogeneity. Fair
10 enough.

11 On the issue of how confident are we in our
12 quality measures, you say you're inexpert on this. I'm even
13 less expert than you are on that subject. To me, I think
14 that that really does go to how quickly you want to move
15 towards any new level of rates, and that would be your
16 policy variable. You might say, well, we want to ramp down
17 more slowly as we monitor what happens to access, et cetera,
18 given that uncertainty. And if you're very confident in
19 your measures of quality, then you have a short transition.
20 Do you see that similarly? Bob.

21 DR. BERENSON: Yes, most -- well, the first part
22 of what I wanted to say has just been sort of dealt with. I

1 agree with the way Peter laid out the factors related to
2 where we get to. I would be relative aggressive on where we
3 want to get to. But I think we need to think pretty
4 carefully about a transition. Peter said maybe three years
5 is typical. In this case, it might be longer. I guess
6 Medicare Advantage is five or six or something is their
7 transition to a new rate, so we're not always doing three.

8 I was around at the latter part of the last
9 century when all those bankruptcies happened. I was at CMS,
10 and it wasn't a pretty sight. I think one of the issues
11 there would be related to a transition to a rebased amount,
12 but I think we need to do pretty aggressive rebasing and
13 Peter laid out the kinds of factors we typically consider
14 and I think that's how we would do it, average costs,
15 efficient costs, et cetera.

16 The point I was going to make, will now make, one,
17 is I think it's real important to proceed with the
18 rehospitalization policy that you're laying out, the 30-day
19 rehospitalization. I know there's an attraction to bundling
20 payments and having larger units and CMS -- ACA set that up.
21 CMS has now announced four models of bundled payments that
22 they're going to test. I think it's not going to be so easy

1 to bundle the nursing homes' money in with the hospital's
2 money into a single bundled payment, and I very much like
3 the idea that we will align payments, have them having
4 consistent incentives to work together, and I do take the
5 point that if the hospital incentive system works there may
6 be less savings uniquely from what we would be doing with
7 SNFs, but we would be aligning incentives and so I think
8 that's real important.

9 And the final thing is looking to the future work.
10 The reason I asked about where people go to after discharge
11 is that I think it's -- I can conceive of it much more in
12 the control of a nursing home for their residents who were
13 in a SNF stay and are staying in the nursing home and to try
14 to provide incentives to reduce rehospitalizations, and
15 indeed to reduce hospitalizations for that population. I
16 think there's less than in the case of the hospital, less
17 control that a nursing home has over a patient who's
18 discharged to their home with multiple chronic conditions,
19 and so I'm not so sure I want to jump into that one. But I
20 think I'd start by understanding where they are being
21 discharged to with the emphasis on the patients who are
22 staying in a facility, presumably their own.

1 MR. KUHN: Thanks. Let me start with the
2 rehospitalization. I would just say, Carol, you did a very
3 good job, I think, of capturing both the key methodological
4 and the decision points and I can't think of anything else
5 to add in this area.

6 The only thing I would add is some conversation
7 here, I think in round one, about the distribution of kind
8 of what was going on in different parts of the State, and in
9 the paper that we looked at, there was twice there was
10 references to States that had low rates of rehospitalization
11 and States that had high rates of rehospitalization. So I
12 think a chart that kind of showed us kind of the array of
13 States and where they are would be very helpful on a go-
14 forward basis.

15 On the issue of rebasing, I liked the work that's
16 done so far. I'd like us to continue this work. And I
17 think anything we can do to more closely align payments with
18 costs makes sense to me.

19 What would be helpful, I think, in future
20 conversations, whether it's charting or more explanations of
21 how it goes forward, is mechanically how all of that would
22 occur, I think would just help in terms of understanding how

1 robust it is. It would deal with things that Peter is
2 talking about as well as Bob in terms of a transition. So I
3 think a mechanical way of thinking about kind of how that
4 works would be helpful.

5 The other thing I wanted to raise here, and I know
6 it's not on the discussion points, but if we could revisit
7 this policy, I would just ask if it would be for
8 consideration. In 2008, you made the policy recommendations
9 for both NTA and outlier. If we do rebasing, I guess I
10 would say, is it a policy consideration that we still need
11 both of those or would one do?

12 And so I ask that for two reasons. One, again, if
13 you do the rebasing, do you still need outlier? Do you
14 still need NTA? And the second thing is we all know that
15 CMS is stressed out. I mean, they're putting together the
16 ACA, and if we can think of anything around this table that
17 could reduce the workload on CMS and create less work for
18 them but still achieve policy objectives, is this one thing
19 where we can say, you know, in 2008, this made sense to do
20 both of those, but if we're going to do rebasing, one of
21 those would make sense on a go-forward basis. We don't have
22 to do both.

1 So, again, this was a policy in 2008, but in the
2 combination with the rebasing, is that just something we
3 would want to revisit? I just ask that question.

4 MR. HACKBARTH: Let me ask another question back.
5 So to this point, the conversation led by Mitra has been if
6 you're going to rebase, it's even more important to
7 distribute the dollars accurately, because you run the risk
8 of doing real harm if the dollars are maldistributed. So
9 each of those policies that you mentioned were focused on
10 trying to make sure that the payment system is as fair as
11 possible. So if you coupled them with -- if you do rebasing
12 the need is even greater for them, not less. So what am I
13 missing?

14 MR. KUHN: I hear what you are saying, Glenn, but
15 I am kind of looking at it in a different way, is that, you
16 know, is there a need for both of them? And I want to go
17 back and reread the 2008 recommendations. Is this a
18 layering on or are these all stand-alone that need to be out
19 there as we go forward? That just is a question I'm asking,
20 if we could, you know, maybe the next time, at least just
21 kind of look at that and see if that still makes sense.

22 And, I think, not only for workload for CMS, but

1 also for an industry, a SNF industry that's going through a
2 lot of changes, as well. You know, how many new things can
3 they absorb at the same time?

4 MR. HACKBARTH: Bill.

5 DR. HALL: Not to say what's already been said,
6 but I'm very worried that we should not go too fast in this
7 arena. We say the nursing home industry. It's really not a
8 single industry. It is so much more heterogeneous than the
9 hospital enterprise throughout the country. Some of these
10 nursing homes, freestanding, are mom-and-pop operations.
11 Some are run by religious orders. Some are run by very
12 shrewd businessmen. Some have very close relationships with
13 hospitals. It is bereft with legitimate conflict of
14 interest on the part of all parties, and the ACA in some
15 sense increases that tension, particularly around the whole
16 subject of readmissions.

17 So whatever we do in every phase, and particularly
18 if it's going to be rebasing, I think let's do this in a
19 very programmed and conditioned manner so that we don't run
20 the risk of what we already know happened once before that
21 caused tremendous disruption in the industry, which is going
22 to really, really affect the hospital industry, as well. So

1 I think that we're on the right principle, but I think we
2 have to be very careful in the implementation.

3 DR. NAYLOR: So I echo the need to be cautious. I
4 think on the issues, I would really like to be more
5 confident that we did have the quality measures. Some of
6 the ones that have been talked about in the paper are pretty
7 gross measures and don't necessarily reflect the two
8 communities that are served by skilled nursing facilities
9 which have been articulated, those that are coming post-
10 acute and going home, and those that are coming from a
11 nursing home, going in and back, and I think are measures.

12 I do think that we have opportunities here. I
13 mean, if we create the right set of incentives to prevent
14 that index hospitalization through the use of a skilled
15 nursing facility, we could have really created a better
16 quality environment, particularly for the nursing home
17 residents, to prevent those kinds of issues that
18 unnecessarily result in hospitalization and all the things
19 that are associated with that.

20 If we go readmission, and particularly ambulatory
21 care sensitive readmission, targeted ones are not
22 necessarily the right ones, so I think all-cause readmission

1 becomes really important for this population as a measure.

2 And I finally think that not all readmissions, as
3 exemplified by Moore's summary [phonetic], are in the
4 control of either the skilled nursing facility or the
5 nursing home. I mean, this issue around transitions and
6 early hospital discharge to get into, you know, that maybe
7 should have been a day later or something like that, those
8 kinds of things are not all within the control. So I think
9 we need to be really looking at the kind of incentives that
10 create the blending of hospital post-acute care. I'm sorry
11 to hear that bundled payments aren't going to help us get
12 there. I think that for Medicare, it could help us get
13 there. But I am concerned that we rely too much on one
14 setting when they don't control all the factors that
15 contribute to rehospitalization.

16 DR. CASTELLANOS: You know, you asked the question
17 about, do you have any questions on rebasing and
18 rehospitalization. I'm looking forward to the next hour's
19 discussion about the hospital capacity. But I don't know if
20 we've ever looked at the SNF capacity, and I know getting a
21 skilled nursing bed for some patients are virtually
22 impossible. The pulmonary assist patients, you can't find a

1 nursing home that will take that patient.

2 Nursing homes have the ability to say yes or no,
3 and so when we start looking, we need to really think risk
4 adjustment and we really need to look at -- and I agree with
5 what's been said. We need to do this very slowly or
6 otherwise we're going to have a lot of -- we can't find
7 nursing home beds now, and the reason you're seeing the
8 hospital-based SNFs half the readmission rate is because
9 they're in the hospital and they're being taken care of
10 appropriately. But I don't know if that's really available
11 throughout. So I would also like to maybe look at the
12 capacity of, in general, of the nursing homes.

13 MR. HACKBARTH: Yes. I think Carol can help me
14 out here, but, in fact, we have looked at the capacity of
15 nursing homes in the context of our annual update
16 recommendations and one of our findings has been consistent
17 with what you say, that getting access to SNF care for some
18 types of patients is problematic. And what we've attributed
19 that to is the payment system, where some types of patients
20 are much more profitable than others and it's the complex
21 non-therapy patients that are having difficulty finding
22 appropriate placements. And so the redistribution of the

1 payments that we've recommended is very important on that
2 access issue.

3 Carol --

4 DR. CARTER: Well, I mean, one of the things I was
5 particularly wanting to update this analysis to reflect the
6 new case mix groups because they do a better job on the
7 medically complex cases. They really expanded the case mix
8 groups for those patients, and so I wanted to see whether we
9 still were seeing whether current policy compared to a
10 revised PPS would still be moving money around, and I was a
11 little surprised, actually, to see that we have still very
12 consistent findings.

13 And so part of what Herb was asking before, about,
14 well, so maybe you don't need to kind of target this NTA
15 stuff, well, the relative weights still only vary five-fold,
16 but NTA costs vary 18-fold. And so you can't move enough
17 money through getting people in the right case mix group.
18 Now, that's just for drug and respiratory care, but that's
19 going to affect the SNF's willingness to admit a patient, or
20 that's our concern.

21 MR. GEORGE MILLER: Yes. Much has been said
22 already, so I won't repeat that, but let me see if I can

1 highlight a few things that I think is important, which is I
2 think we should go slow. This is a very vulnerable
3 population, especially the dual eligibles and what Ron just
4 mentioned about some patients not being able to be placed.
5 I think this is an important consideration and we want to be
6 careful. Deliberate, careful rebasing, but do it in such a
7 way that we not do more harm than is currently being done.
8 I think that's an important issue.

9 And then also on Slide 12, this may be part of
10 round one's question, but I would be interested in knowing
11 what the outlier policy will be. Historically, we've had
12 some outlier policies that other organizations will take
13 full advantage of and have done very well with that, so we
14 have to be very deliberate about that outlier policy since
15 that reflects dealing with an issue that is outside their
16 control and they can help mitigate that versus being in an
17 open-ended situation.

18 DR. STUART: I support the general direction here.
19 I particularly support the idea of looking at synergies
20 between reducing rehospitalization rates in the nursing home
21 and what the impact is on hospitals and vice-versa.

22 I would also like, if we could move back to 11, I

1 think one of the points that has been raised around the
2 table is you start moving around money and you're going to
3 have unintended consequences, and one of the things that we
4 might do with a table like this is just simply look at --
5 start by looking at the number of nursing facilities that
6 are going to be affected by each of these. I mean, we start
7 with an industry that in some parts of the country is
8 virtually all for-profit. In other parts of the country, it
9 is mostly not-for-profit, and so some of that would come out
10 here. But I also would like to see some of the regional
11 implications. When we talk about other forms of
12 institutional post-acute care, we know that that's
13 regionally distributed and so it would be interesting to see
14 if there are any implications on rebasing in the nursing
15 homes for areas that have long-term care hospitals and have
16 more ERFs and other kinds of alternatives for long-term
17 care, or alternatively, don't have alternatives where this
18 might be even more serious in terms of its short-term
19 impacts.

20 MR. GRADISON: If we had started at this end of
21 the table, I probably would have been the first to use the
22 word "caution" or "go slow." Others have already used it,

1 and I support that view. I definitely think we should
2 continue to explore this, but I think we've got to move
3 ahead with great care -- great care.

4 DR. BORMAN: I guess I get to be a little bit
5 contrarian. No big surprise. And part of it is we've had,
6 as you've noted, Glenn and Mark, some of these pieces of
7 conversation over a period of several years and I guess I'm
8 having a little trouble discerning out what we will
9 potentially address in our update process versus this
10 particular aspect of it that we've sort of deemed policy.
11 It's sort of like one of those Venn diagrams, if I have the
12 term right, where there's an overlapping area here.

13 While I think this is a huge area and a very
14 important one to me personally and professionally, we need
15 to do with all deliberate speed and caution. I also think
16 we've spent a fair amount of time identifying that there's a
17 problem in this area. I don't pretend to know what the
18 ideal fix is, but I also think we are in some danger of --
19 it's so difficult to wrap our arms around, despite Carol's
20 wonderful job at helping us to get there, that we perhaps
21 disable ourselves from starting to act. And I would rather
22 not see us get into inertia about this based on our concerns

1 about making a mistake. And maybe the correct answer is to
2 take our initial action in terms of the update and continue
3 to do that as we've made some recommendations in that area
4 over the past several years.

5 But I worry a little bit about wanting to be all,
6 know all, be at the sort of Holy Grail end point before
7 we're confident in saying anything, and perhaps there will
8 be some middle ground in being able to make some
9 recommendations, perhaps at -- even if we say we think we
10 could be at this percentage, maybe cut that by half to give
11 ourselves wiggle room, or just make some -- perhaps,
12 ultimately, at the end of the day, we may have to come to
13 some empiric conclusions as a means to moving forward. And
14 so I would just not want to see us put this in such a long-
15 term queue that we lose our power to move forward.

16 MR. HACKBARTH: So can I just respond to that? So
17 here would be my approach, is that based on this
18 conversation, we will put together a draft recommendation
19 for discussion at the December meeting to be considered as
20 part of the update process. And then where we go past
21 December will depend on how people react to the draft
22 recommendation. But this isn't something that I envision

1 we're going to put on the back burner. We're going to try
2 to move it ahead and get more concrete, obviously, in the
3 next conversation and see how people react to it.

4 Mark.

5 DR. MARK MILLER: And I haven't discussed this
6 with Glenn, so -- I mean, as you think about putting that
7 together, if you try and square the thoughts of, well, what
8 about the update? There does seem to be a lot of evidence,
9 but I'm concerned about how fast we move, you know, if you
10 try and thread these things, you could imagine a
11 recommendation that says, okay, we're not going from here to
12 here in one step. We'll start taking, as you move through
13 some time frame, and precede it with the recalibration and
14 reform, notwithstanding your comments, but precede it with
15 that and then start a step-down so that you get on this
16 road, and then if there is some adjust that's needed,
17 remember, we look at this every year. We come back if this
18 transition isn't working for some reason. We can make
19 recommendations at that point on it.

20 So as I was listening to it and thinking about
21 having to come back in December with a recommendation,
22 that's what I was starting to frame up in my mind without

1 having discussed it.

2 MR. HACKBARTH: That's quite consistent with what
3 I --

4 DR. BORMAN: I would just like to make sure that
5 in order to get the beneficiaries in the system to a better
6 place, that we just move in a, you know, like I said, with
7 deliberate speed, maybe -- I like that term --

8 MR. HACKBARTH: Yes.

9 DR. BORMAN: -- and, you know, too much --

10 MR. HACKBARTH: Yes. A question, Carol. Have SNF
11 rates been reduced in recent history? My recollection is
12 that there have been some times when, for various reasons,
13 the rates have been reduced.

14 DR. CARTER: Yes, and I'm trying to -- I think
15 they were reduced because of the parity adjustment when they
16 implemented the 2009 RUGs -

17 MR. HACKBARTH: Yes.

18 DR. CARTER: -- back in 2006. They took a parity
19 adjustment, I think, in 2010, if I'm remembering. So that
20 lowered payments by, I think, three percent, but then that
21 was offset with an update. But I think that --

22 MR. HACKBARTH: Okay. I forgot about the offset

1 with the update --

2 DR. CARTER: Yes. I think it's really just been
3 through kind of the parity adjustments.

4 MR. HACKBARTH: What I was trying to remember is
5 whether we have any prior experience of how SNFs respond to
6 reductions in payment --

7 DR. CARTER: Well, if the rates were lowered 3.3
8 percent with the parity adjustment and spending still went
9 up in the subsequent years, I guess that's some evidence
10 that --

11 MR. HACKBARTH: Yes, and what about margins?

12 DR. CARTER: They've been steadily increasing.

13 MR. HACKBARTH: Increasing, yes. So I can't
14 recall the numbers on SNF, but my recollection is on home
15 health, in the face of reductions, the margins have been not
16 only maintained, but actually increased, even though the
17 rates are going down, and even though every time the rates
18 are cut, there is a prediction that this is going to be the
19 end of the world as we know it. And so I think -- I'm a
20 cautious person by nature, and so I resonate with the words
21 about caution. On the other hand, there's such a thing as
22 being too cautious. Money is scarce, and if we're

1 overpaying SNFs, that means there's less to pay other
2 providers adequately and we have to be cognizant of that, as
3 well.

4 MR. BUTLER: One very quick question. What is our
5 total spend in Medicare on SNF?

6 DR. CARTER: About \$27 billion.

7 MR. BUTLER: Okay.

8 MR. HACKBARTH: Scott.

9 MR. ARMSTRONG: Yes. All I wanted to do -- this
10 is sort of the problem of being first in the second round --
11 was make the point you made. I appreciate that all of us
12 here care deeply about the vulnerability of these patients
13 and the variation from one skilled nursing facility to
14 another, but these margins are spectacular, and the
15 difference between the cost and the revenues is spectacular,
16 and that we really, I think, have to move forward with steps
17 to start dealing with a mismatch between what we're paying
18 and what we're getting from the sector. I just hope that as
19 we go forward -- today's not a decision day, but as we go
20 forward, we need to put this in the context of \$330 billion,
21 ten-year trend sort of proposals that we've got responsible
22 for making these decisions in that context.

1 MR. HACKBARTH: One last question, Carol. I think
2 Bruce -- I guess he stepped out for a second -- made a point
3 that really rang a bell with me. In talking about other
4 post-acute providers like long-term care facilities and ERFs
5 and the like, we've often noted that they are not spread
6 evenly across the map. And in the course of making that
7 observation, we've said that, well, one of the reasons that,
8 say, long-term care hospitals don't exist in some parts of
9 the country, including my State of Oregon, is that SNFs play
10 that role, or at least part of that role, in those
11 communities.

12 And I think it was Bill Scanlon who made the
13 observation, which struck me as an astute one, that these
14 categories are not fixed and the capabilities that a SNF has
15 is in part dependent on what other resources exist in the
16 community. So if there are lots of other different types of
17 post-acute providers available, you may have a SNF with a
18 narrow range of capabilities. But if there aren't any long-
19 term care hospitals or ERFs or others, they may have a
20 richer range of capabilities because they're expected to
21 play a broader role in the local health care system.

22 So it would be interesting, as Bruce suggested, to

1 look at SNF profitability, performance in different types of
2 markets. Are they performing less well in areas where they
3 have to carry a broader responsibility in that local health
4 care system? So just -- it just strikes me as an
5 interesting hypothesis. I don't know where it will lead us.

6 Okay. Thank you, Carol.

7 The last topic today is an installment on the
8 hospital update discussion which we will engage in in more
9 depth in December. As you know, one of the factors that we
10 consider in our payment adequacy analysis is what's
11 happening to the supply of given service, in this case
12 hospital services. And Zach, lead us through it.

13 MR. GAUMER: Thank you. Good afternoon. First
14 I'd like to thank Jeff Stensland and David Glass and Matlin
15 Gilman for their assistance with the material you're about
16 to hear and the material that you read in the chapter
17 earlier this week. In this presentation, I'm going to walk
18 you through a variety of measures that we look at each year
19 to collectively assess Medicare beneficiaries' access to
20 hospital services and hospitals' access to capital.

21 Specifically, you'll see measures pertaining to
22 hospital utilization, capacity, the scope of services

1 hospitals offer, and the financial stability of the industry
2 as it relates to capacity growth.

3 Each year, the Commission deliberates and makes a
4 judgment as to the adequacy of hospital payments. MedPAC's
5 standard payment adequacy framework includes four basic
6 components, which are listed on the slide above here. Today
7 we will cover the first two components of the framework, and
8 next month we'll present data on hospital quality metrics as
9 well as payment and cost information, the last two bullets
10 on the slide. That will include margin data as well.

11 At the conclusion of my presentation today, I'll
12 ask you if you have questions about the material I've
13 presented, ask for general feedback on the measures you've
14 seen, and ask for any enhancements that you'd like to see.
15 Then in December, after you have seen all the data related
16 to the four components of the framework, you'll discuss the
17 overall adequacy of hospital payments.

18 Based on our evaluation, we conclude that Medicare
19 beneficiaries' access to hospital services remains good and
20 hospitals maintain access to capacity -- excuse me -- access
21 to capital. In addition, it appears that capacity at
22 facilities is growing and as that is occurring, an industry-

1 wide shift is taking place in the site of service from the
2 inpatient setting to the outpatient setting.

3 Contributing to these conclusions are a variety of
4 facts. First, inpatient utilization and hospital occupancy
5 rates continue to trend downwards as outpatient utilization
6 continues to trend upwards. Combining the next two facts on
7 the slide above, we see that we observed the number of acute
8 care hospitals increasing and bed capacity remaining
9 relatively flat.

10 Next, the scope of services hospitals offered in
11 2009 increased from the previous year. Hospital
12 consolidation continued to increase in 2010. Next we
13 observed hospitals adding staff faster in the last year than
14 in the previous two years. And finally, the industry
15 demonstrated continued investment in capacity as borrowing
16 and construction spending moderated in 2010, but remained at
17 high levels.

18 Between 2004 and 2010, Medicare inpatient hospital
19 discharges per fee-for-service Part A beneficiaries declined
20 6 percent. At the same time, Medicare outpatient
21 utilization increased 23 percent. In conjunction with these
22 utilization trends, we observed a decrease of 1.9 percent in

1 the all-payer hospital bed occupancy rate, and that was from
2 2004 to 2009.

3 These three trends suggest that the model of
4 hospital care is changing in the United States and the site
5 of hospital services shifting from the inpatient to the
6 outpatient setting. The decline in occupancy is consistent
7 with two other pieces of data that we've looked at.

8 First, we observed a decline in the share of
9 Medicare beneficiaries using inpatient hospital services in
10 a given year, falling from 23 percent of beneficiaries in
11 2004 to 21 percent of beneficiaries in 2010. Therefore,
12 beneficiaries used the inpatient benefit less often in 2010
13 than 2004.

14 Second, we continue to see an increase in
15 outpatient observation claims, and a corresponding decline
16 in one-day inpatient stays. From 2006 to 2010, the number
17 of outpatient observation claims increased by 16 claims per
18 1,000 beneficiaries. In contrast, we observed a decrease in
19 the number of one-day inpatient stays of five stays per
20 1,000 beneficiaries. Therefore, cases that had previously
21 been a short inpatient stay are now more likely to be
22 treated on an outpatient basis.

1 The number of acute care hospitals entering the
2 Medicare program exceeded the number of hospitals exiting
3 the program in 2010. Specifically, you can see on the chart
4 above that 30 hospitals entered the program while seven
5 exited the program, and this was the ninth consecutive year
6 in which hospital openings exceeded closings. In addition,
7 while the number of openings was on par with the volume of
8 openings we've seen in recent years, the seven closures in
9 2010 were, by far, the lowest volume of closures we have
10 seen throughout the last decade.

11 Those seven closures tended to be slightly larger
12 than those that opened. Excuse me. The hospitals that make
13 up those seven closures tended to be slightly larger than
14 those that opened. They're in a mix of urban and rural
15 areas. They had lower occupancy rates than their nearest
16 competitors, and most were non-profit.

17 We also know that most of these facilities closed
18 as inpatient facilities and reopened as outpatient-only
19 facilities. In contrast, the 30 hospitals that entered the
20 program in 2010 were relatively small. They were primarily
21 located in urban areas and tended to be for-profit entities.

22 In addition, many of these 30 facilities appear to

1 specialize in one or a few clinical areas. The last thing
2 I'll say here is that the characteristics of the closed and
3 open hospitals that we observed this year more or less match
4 those characteristics that we observed in 2009.

5 As facility level capacity grew, inpatient bed
6 capacity remained relatively flat. AHA survey data reveal
7 that the raw number of hospital beds increased slightly from
8 2006 to 2009, but our own analysis of bed capacity on a per
9 capita basis display that bed capacity declined slightly
10 from 2.75 beds per 1,000 people to about 2.67 beds per 1,000
11 people.

12 Scott, at one point last year, you inquired about
13 the geographic variation in bed capacity. And as was the
14 case last year, the story this year is that we observed wide
15 variation in capacity on the state level. For example, in
16 North Dakota, South Dakota, and the District of Columbia,
17 bed capacity exceeded about five beds per 1,000 people. And
18 in Oregon, Washington, and California, bed capacity was less
19 than two beds per 1,000 people.

20 Hospitals and their affiliated providers expanded
21 the scope of services they offered in 2009. Over 94 percent
22 of the nearly 50 clinical hospital services we track each

1 year were offered by a larger share of hospitals in 2009
2 than in 2005. The most pronounced expansion of services
3 during this time period was for robotic surgery, translation
4 services, PET scanners, bariatric weight control services,
5 and indigent care clinic services.

6 For example, robotic surgical services were
7 offered by 11 percent of hospitals in 2005. In 2009, 24
8 percent of hospitals offer this service, and that was a 13
9 percentage point difference between those two years. Many
10 of the services that grew most rapidly, as you can see here,
11 were either relatively new or very specialized services.

12 By contrast, on the bottom of the chart here, you
13 can see that about 6 percent of services were offered by a
14 smaller share of hospitals in 2009 than in 2005, and all of
15 these services were facility-based, post-acute care
16 services. Assisted living, Home Health, and skilled nursing
17 services were those that saw the biggest decline.

18 In addition, the majority of services grew more
19 rapidly at urban hospitals compared to rural hospitals. We
20 view this as a consequence of the relative complexity of a
21 given service rather than declining access in the rural
22 setting.

1 Hospital industry consolidation has increased in
2 recent years. The trend in hospital mergers and
3 acquisitions suggest that owning and operating hospitals
4 remains an attractive use of capital. In 2010, the hospital
5 sector saw 72 separate merger and acquisition transactions
6 in which 125 individual hospitals were acquired.

7 The red bars on the chart above illustrate the
8 number of hospital transactions which increased above what
9 had been a relatively steady trend in transactions over the
10 last few years. The textured bars or the pink bars, as they
11 appear, suggest the number of hospitals involved in these
12 transactions also increased in 2010.

13 As was the case in 2009, in 2010 regional hospital
14 systems were more active than either national systems or
15 individual free-standing hospitals in making hospital
16 acquisitions. In addition, a disproportionate share of
17 acquires were for-profit entities.

18 A variety of sources have also recently observed
19 that physician group practices are a growing piece of the
20 trend in hospital consolidation. A report released by the
21 Center for Studying Health Systems Change in August of 2011
22 concluded that the pace of hospital employment of physicians

1 has quickened in many communities.

2 Bureau of Labor Statistics employment data reveals
3 that the number of individuals employed by hospitals
4 increased 5 percent over the last four years. That's from
5 October of 2007 to September of 2011. During this time,
6 hospitals added about 220,000 jobs, and as of September
7 2011, the hospital industry employed about 4.8 million
8 employees.

9 Just as a reminder, the reason we look at
10 employment trends each year is not as a measure of general
11 efficiency. Instead, we view employment as an indicator of
12 financial well-being.

13 The rate of employment growth has varied over the
14 last four years, and as you can see on the figure above, in
15 the first year of this period on the far left hospital
16 employment increased about 2.3 percent. In the second and
17 third years, the growth rate was more flat.

18 Following the decline in the economy, employment
19 growth during this period slowed to less than half a percent
20 per year, or slightly 1 percent over the period. However,
21 in the most recent year, hospital employment accelerated
22 again, increasing more than 1.7 percent.

1 In the context of other health care providers and
2 the rest of the economy, hospital employment has been
3 positive. As hospital employment increased 5 percent
4 overall, employment for other sectors in the health care
5 sector collectively increased 10.5 percent and employment
6 for the rest of the economy declined 6.1 percent.

7 Two somewhat related measures of hospital
8 investment and capacity display similar trends over the last
9 decade. Taken together, we believe hospital borrowing and
10 construction spending indicates that overall the hospital
11 industry maintains access to capital markets and continues
12 to build capacity.

13 However, we also believe that capacity growth is
14 occurring differently now than in prior years. In 2010,
15 hospital tax exempt municipal bond offerings amounted to \$28
16 billion. The value of hospital construction spending in the
17 same year amounted to \$27 billion.

18 In the context of the ten-year trend, we view the
19 2010 levels of borrowing and construction to have moderated
20 from the historically high levels of 2008. Both borrowing
21 and construction grew steadily from 1999 to 2004. Then
22 starting in 2005, both grew rapidly for five years. During

1 this period, hospital capacity surged. Borrowing and
2 construction crested in 2008 at approximately \$51 billion in
3 borrowing and \$34 billion in construction.

4 Since 2008, both measures have moderated to levels
5 that remain high and are similar to levels observed prior to
6 the surge that began in 2005. Several factors have
7 contributed to the moderation of capital investment and
8 capacity growth. These include the trend in the decline of
9 inpatient utilization and the economic downturn.

10 As a result, over the last two years, we have
11 observed that hospital construction projects now tend more
12 toward outpatient services, such as emergency departments,
13 imaging, and surgical services. Inpatient services are
14 currently considered a somewhat secondary focus within
15 construction projects. In addition, hospitals are now more
16 likely to choose to renovate existing capacity than to build
17 new facilities.

18 In summary, we conclude that Medicare
19 beneficiaries' access to hospital services remains good and
20 that hospitals maintain access to capital. However, it is
21 also apparent that an industry-wide shift is occurring and
22 the site of service from the inpatient setting to the

1 outpatient setting. Inpatient utilization is declining as
2 outpatient utilization is increasing.

3 Similarly, occupation rates and the share of
4 beneficiaries using inpatient services are down. The number
5 of facilities is expanding, and yet, bed capacity remains
6 flat. In addition, hospitals are expanding service
7 offerings, consolidating, adding staff, and increasing
8 capacity through borrowing and construction. But they're
9 doing these things with a deference towards outpatient
10 capacity.

11 At this point, I welcome any questions and
12 feedback you might have. I also welcome any suggestions you
13 might have for other measures that we're looking to add to
14 the payment update. However, I'll remind you that in
15 December, Jeff Stensland and others on the hospital team
16 will be presenting the second installment of hospital
17 updates, update measures to you, and those will include
18 quality and margin data.

19 Finally, we're particularly interested in hearing
20 your thoughts about the implications of the site of service
21 shift from the inpatient to the outpatient sector. Thanks
22 for your time.

1 MR. HACKBARTH: Round 1 clarifying questions.

2 MR. GRADISON: On Chart 5 where you have the
3 openings and closings, do you have any information with
4 regard to closings that might be related to action that CMS
5 has taken, basically to remove the certification, if that's
6 the right word, where the hospitals haven't met the
7 requirements to be readmitted to the program?

8 MR. GAUMER: I haven't looked specifically into
9 that. I haven't seen anything about that in the trade
10 press, but I can take a look.

11 MR. GRADISON: Thank you. And one final question
12 with regard to the inpatient/outpatient, I'm aware there's a
13 fair amount of data with regard to hospital-based -- I know
14 sarcomial infections, which I assume are from hospital
15 stays, but I don't remember seeing any data if there are
16 any, which relate to infections related to outpatient care?
17 It's not directly on point, but if you come across anything
18 along that line, I'd just be interested in learning about
19 it.

20 MR. GAUMER: Okay.

21 MR. GRADISON: Thank you very much.

22 DR. STUART: Thank you. I have two quick

1 questions, one on Slide 4. Do we have any sense of how much
2 of that increase in outpatient hospital utilization is due
3 to purchase of physician practices? In other words, is it
4 possible for hospitals to essentially take a large physician
5 practice and say, Oh, well, now you're an outpatient
6 department?

7 MR. GAUMER: I think that might be a subject that
8 comes up tomorrow in Jeff's presentation. Do you want to
9 hold off until then?

10 DR. STUART: I can wait.

11 MR. GAUMER: Okay.

12 DR. STUART: And my second question is regarding
13 Slide 7. And I've seen this each year since I've been on
14 the Commission and every time I have the same question. I
15 mean, this tells you what happens in an individual year.
16 And what I really want to know is, what does it look like
17 cumulatively?

18 So if we have all of these things happening every
19 year and these numbers are a whole lot bigger than the net
20 increase in the number of hospitals, so clearly we know
21 there's consolidation going on. But if there's some
22 cumulative way to show us what that looks like, I think it

1 would be helpful in terms of making these decisions.

2 MR. GAUMER: Okay. We can look into doing that.

3 MR. GEORGE MILLER: Yes, thank you. We just
4 finished the 2010 census and there's been significant
5 population shifts. Some states and communities
6 congressionally have lost -- my home state of Ohio has lost
7 three Congress persons in that state alone. So I'm curious,
8 back on Slide 5, at least in my mind, there should have been
9 probably -- with huge population shifts, that should have
10 been greater new hospitals, at least in theory, in some
11 places in the south. I notice in the text, Texas picked up
12 quite a few. I can't remember the other state.

13 But it would seem to me just longitudinally, we
14 should have seen more hospitals, particularly in the south.
15 I remember several years ago the big boom in Las Vegas,
16 although I don't think that's the case anymore. Do you know
17 why there wasn't more of a distribution around the country
18 because of population shifts?

19 MR. GAUMER: Well, what we do see is that among
20 the openings, nine of them were in Texas, so among the nine
21 were in Texas.

22 MR. GEORGE MILLER: Right, I saw that.

1 MR. GAUMER: Three were in Pennsylvania. And
2 there was kind of a distribution, I would say, away from the
3 upper Midwest.

4 MR. GEORGE MILLER: Right. But you had growth in
5 those other states and I don't see that reflected, because
6 if nine were in Texas, the other states in the south seemed
7 to have picked up a huge population shift.

8 MR. HACKBARTH: So you used what happened to
9 congressional seats --

10 MR. GEORGE MILLER: Right.

11 MR. HACKBARTH: -- as a result of the census. So
12 it's a ten-year census. This is a ten-year period.

13 MR. GEORGE MILLER: Oh, yeah.

14 MR. HACKBARTH: And in that ten-year period,
15 you've got --

16 MR. GEORGE MILLER: Got you.

17 MR. HACKBARTH: -- just eyeballing the yellow
18 lines, several hundred new hospitals opened.

19 MR. GEORGE MILLER: Yeah.

20 MR. HACKBARTH: In a ten-year period.

21 MR. GEORGE MILLER: Yeah.

22 MR. HACKBARTH: And we've got how many hospitals

1 nationwide, 3,000?

2 MR. GAUMER: Maybe 3,500 PPS hospitals.

3 MR. HACKBARTH: So a significant number have
4 opened. Now, as Zach pointed out in his presentation, these
5 vary a lot in size. You know, some of these could be
6 relatively small specialty hospitals. I knew you were going
7 to say that, George.

8 MR. GEORGE MILLER: Yeah, I was getting there.

9 MR. HACKBARTH: Yeah.

10 MR. GEORGE MILLER: Right. That's where I want to
11 concentrate on. All right. Now that we've got the number
12 out there, what type of hospitals are we talking about? And
13 I think I asked the last two years. Do we also do analysis
14 of the number of beds available? You know, a hospital could
15 open, but another hospital could still be open, but have
16 closed beds or not staffed beds. So the actual bed
17 capacity, and I think that was indicated by the -- indicated
18 a little bit by the decrease in inpatient utilization.

19 MR. HACKBARTH: Let me ask a related question to
20 George's. In the New York Times yesterday, there was an
21 article about three brand new hospitals opening in New
22 Jersey in the relatively new future. Now, in each of those

1 cases, it's a full replacement facility for an older
2 hospital. In this, how is that counted?

3 MR. GAUMER: Okay. Those will not be reflected in
4 here because the provider numbers are not changing, and if
5 they were double-counted in some way, you know, we're going
6 through some effort to make sure they don't get double-
7 counted.

8 MR. HACKBARTH: Yeah, so we can net it out and
9 there will no addition to the hospital count.

10 MR. GEORGE MILLER: Well, that's a question. In
11 Springfield, we had two hospitals. We're closing two and
12 we've built one replacement for the two because the two
13 merged. And before we built the new hospital, we merged the
14 two provider numbers, so that would have been counted last
15 year, I guess. Okay. I got it.

16 MR. GAUMER: I'll add one thing, though, and that
17 is, those hospitals that are new facilities on the same site
18 or under the same provider number would be reflected in the
19 construction data that we look at and they would be
20 reflected in the bed capacity analysis that we do. So if in
21 the case they added more beds, we're going to pick it up in
22 the bed capacity analysis.

1 MR. GEORGE MILLER: In my case, we went from 600
2 beds down to 254 beds, two hospitals with a capacity of 600
3 beds down to one hospital with 254 beds.

4 MR. GAUMER: Okay.

5 MR. HACKBARTH: Okay.

6 DR. HALL: As you go through these data, there are
7 lots of different metrics that are being used here and I
8 think some are more reflective of hospital capacity for a
9 Medicare patient than others. And I think at some point, we
10 probably need to kind of agree on which are the metrics that
11 are going to have the most sustainability.

12 For example, on Slide Number 4, occupancy rates, I
13 think those data are very useful; whereas, when we look upon
14 services somewhere along the line, I guess that's Number 6,
15 it doesn't resonate with me as a very good marker of
16 anything. In fact, robotic surgery has a lot more to do
17 with acquisition of technology than anything else.

18 The translation is usually something that is
19 mandated by various states or communities, depending on
20 dominant ethnic populations, and ditto with PET scanners.
21 That's just trying to catch up with the other folks in town.
22 And bariatric surgery has a little bit to do with Medicare,

1 but it's largely a non-Medicare based service.

2 And I don't really -- can't suggest what are the
3 right metrics, but I think probably access to capital,
4 occupancy rates, shifts to outpatient are probably where
5 we're going to get the most bang for the buck.

6 MR. GAUMER: Okay, thank you.

7 MR. KUHN: Maybe picking up a little bit where
8 George was probing a little bit, of these 30 or so hospitals
9 that we had open up, do we know the types of hospitals they
10 are? Are they behavioral health? Are they -- because I
11 know right now we have a moratorium for long-term care
12 hospitals, and I can't remember where we are with physician-
13 owned specialty hospitals. Is there a moratorium there?

14 MR. GAUMER: I think it's about to come upon us or
15 it might be happening right now, but the data that we have
16 now have not captured the moratorium.

17 MR. KUHN: So within that 30, do we know what kind
18 of -- are they just general acute care or are these all
19 types of hospitals?

20 MR. GAUMER: What we tried to do here is to weed
21 out the LTACs or the ERFs that sometimes land on the list of
22 PPS hospitals for a year before they convert into LTACs or

1 ERFs technically. So the list of hospitals or the chart
2 that you're looking at here reflect PPS hospitals mainly,
3 and then when we try to determine whether or not they appear
4 to be specialty hospitals or have some other specific focus,
5 you know, that's kind of a judgment call based upon -- since
6 we don't have data for them really yet, because they're
7 brand new facilities, you know, looking at their Web
8 presence and also trying to determine how they're marketing
9 themselves, and it turns out that maybe -- I think the
10 number was about 40 percent of these 30 hospitals were
11 pretty clearly single or double specialty hospitals.

12 And then there was another 30 percent that
13 appeared to be focusing on a handful of things as opposed to
14 a very large general hospital, and that handful of things
15 was often ER, imaging, surgical --

16 MR. KUHN: Cardiac, orthopedic, those?

17 MR. GAUMER: Yes, sir.

18 MR. BUTLER: And a third are in Texas with no CON
19 and a lot of entrepreneurial spirit.

20 MR. KUHN: And then on the closures and the
21 openings, do we look at like the number -- I mean, obviously
22 this is the numbers of facilities, but do we also look at

1 the number of beds and what kind of beds those are? Because
2 I know in the paper, we talked about -- and we are -- at the
3 last meeting, we talked about the loss of psych beds or
4 behavioral health beds and concerns about certain lines of
5 business. You looked at those one lines of business, but
6 also there are certain beds that take care of these really
7 critical type patients. Are we looking at that as well?

8 MR. GAUMER: We don't actually, but I can try to
9 take a look. Right now it's just very generally staffed
10 beds, but I can look at that.

11 DR. BERENSON: On Slide 10, I'm trying to relate
12 the borrowing and borrowing and construction spending to
13 sort of this major economic downturn we've had. Do you have
14 any rules of thumb for typical lags between a decision to
15 construct, when the bond is offered, and when the actual
16 spending occurs?

17 MR. GAUMER: I don't actually. I might look to my
18 colleagues on that.

19 MR. BUTLER: Say the question again. When the --

20 DR. BERENSON: A decision to have a major
21 construction project, the bond offering to get the capital,
22 and the actual construction spending. What's sort of the

1 lag?

2 MR. BUTLER: It depends on the size of the
3 hospital, but you could look at a six-year cycle kind of
4 between the time you decide you're going to build something,
5 and it would be a couple of years later that you'd be
6 breaking ground and you wouldn't be borrowing until you
7 start spending that money. So it could be as long as two or
8 three years after you've made the decision that the
9 borrowing would occur.

10 DR. BERENSON: So the construction lag would be
11 going on before you actually secure the funding, the
12 financing?

13 MR. BUTLER: You can't really get and use the
14 money until you start your construction. So you would --
15 yeah.

16 DR. BERENSON: So I guess the point I'm making
17 here is --

18 MR. GRADISON: I've wondered whether some of this,
19 particularly in those three years, was actually refinancing
20 at lower rates rather than for new construction. So I think
21 you'd have to find out what they were raising the money for.
22 It isn't necessarily for construction, I don't think.

1 MR. GAUMER: We did look into the refinancing
2 issue, and specifically, I think we showed in the paper that
3 the share that is new financing, you do see kind of a lot of
4 refinancing taking place between 2005 and 2009, but that the
5 general trend in borrowing is still there, the same flow or
6 the same wave.

7 DR. BERENSON: Yeah. The other one, do we have
8 any information about this new phenomenon of free-standing
9 emergency departments? That wouldn't be in this data, I
10 assume, and how prevalent is that?

11 MR. GAUMER: I've been looking through some of
12 that stuff. I don't think the analysis is really complete
13 yet, but we do see a bunch of that taking place. I've
14 looked recently at some shops like that opening in the
15 Houston area. There's a bunch associated with Swedish
16 Hospital up in Washington State. And so, I can look into
17 that more.

18 DR. BERENSON: And again, picking up on Bill
19 Hall's comment, I'm not sure how I would use that for making
20 a judgment about Medicare spending, but it's interesting
21 information as to what's going on. So I wouldn't spend a
22 lot of time.

1 MR. GEORGE MILLER: If I could just follow up on
2 Bob's point, because I think it's a good one, particularly
3 if some of this in the red line is refinancing versus new
4 hospital construction, especially with the interest rates
5 coming down. I know my system refinanced to get us a lower
6 rate to build, and Peter is correct. There's about a three
7 to six-year time frame as far as when the funds are
8 available and then you actually start construction. In
9 fact, we even changed architects, so it took us a little
10 longer.

11 MR. HACKBARTH: So there are two distinct issues.
12 One is the refinancing question and the other is whether
13 there are lags in the data, the implication, I think, being
14 that this decline may continue out into the future. The
15 effect of the 2008 crisis may still be resonating through
16 the system.

17 DR. BERENSON: Yeah, no, I mean that's the
18 implication. I do see that the employment has turned back
19 up again, which would seem to suggest maybe it's bottomed
20 already, but it could well be that there's a continuing
21 decline here that we would be seeing.

22 MR. HACKBARTH: Mike.

1 DR. CHERNEW: I have a question about Slide 3,
2 which is, I think, the main indicators you used. So on the
3 bed capacity one, you do it per capita, and I think you mean
4 per beneficiary.

5 MR. GAUMER: Actually, no, it's per capita.

6 DR. CHERNEW: Because it's for everybody?

7 MR. GAUMER: Yeah. We look at everybody and --
8 yeah.

9 DR. CHERNEW: I understand. But you could think
10 of all the other ones, also, being per capita. In other
11 words, if there was an expansion of the number of hospitals,
12 you would want a general expansion. So if you do the number
13 of beds not per capita, you might find a slight increase.
14 You do it per capita and then it looks flat, and the same is
15 true for a lot of these ones.

16 So I guess there's a general question of what the
17 right scale is. Certainly, employees, again, is going to go
18 with the general flow of things. So I think my -- I realize
19 there's this complexity because for the capacity ones
20 they're serving the entire population, and then for some of
21 the utilization ones, you care a lot about Medicare per se.

22 But in any case, I guess I would -- I understand

1 now what you're doing and my recommendation would be to just
2 think about which ones really make sense to think about per
3 capita and which ones don't. Certainly I agree that that's
4 true for bed capacity. I'm not so sure some of the other
5 ones you might also want to make a similar adjustment.

6 MR. GAUMER: Okay, thanks.

7 MS. BEHROOZI: This might just be one that I
8 missed. On Slide 6, the specialized services, you know, so
9 where do you get this data from, I wonder?

10 MR. GAUMER: This is AHA survey data, and the way
11 it works is that the hospitals centrally -- I'll probably
12 offend our friends at AHA in simplifying this -- but the way
13 I understand it is in these surveys, the hospital is
14 checking essentially whether or not they provide translation
15 services or not and they check it at that hospital or within
16 their network or within their system.

17 MS. BEHROOZI: Self-reported. But also, like
18 translation isn't something that enhances a code or
19 anything? It's not really -- it's not billable. It doesn't
20 generate revenue, right?

21 MR. GAUMER: Right.

22 MS. BEHROOZI: But like adding PET scanners means

1 that you would be able to generate revenue in an indigent
2 care clinic I don't think is a big money maker. I'm just
3 wondering in terms of the analytical construct why we have
4 those all on the same chart. I don't mean to be challenging
5 it. I feel like I'm missing it. I keep seeing those as
6 very different.

7 MR. GAUMER: Sure. Yeah, this wasn't intended to
8 be a DRG-like comparison to see, you know, which volume of
9 which service is going up or down. This was just what types
10 of departments or what types of services in general are
11 hospitals adding or subtracting. And, you know, if we saw
12 five services that 100 or maybe 1,000 hospitals were
13 dropping in the Midwest, that would raise a red flag and
14 we'd want to talk about it, I think.

15 MR. HACKBARTH: So one way to think about looking
16 at these data is, are there services that we're particularly
17 concerned about? And I think this is where Bill was going.
18 Because of the financial situation of hospitals, are burn
19 units closing or psych units closing or indigent care
20 clinics?

21 There's certain services that we may want to
22 really have advance warning, as much advance warning as

1 possible if a negative trend is developing, as opposed to
2 just sort of giving us the long list or giving us the top
3 five increasers and the top three decreasers, maybe it would
4 make sense to try to identify some sort of sentinel services
5 that we really want to track. Is that --

6 MS. BEHROOZI: Also, just distinguishing the
7 revenue-generators from the cost, you know, the cost drivers
8 or whatever the things that might drag them down. If
9 there's more of a need for indigent care services -- I mean,
10 there's other things measuring that, obviously, or more of a
11 need for translation services that they're not going to get
12 reimbursed for, is that a harbinger of further stress, you
13 know, to come later rather than the things, you know,
14 imaging and whatever where they can arguably make a buck or
15 something.

16 MR. BUTLER: Just to slide that shows the split
17 between the outpatient and the inpatient decline, just a
18 clarification there. So is this just hospital inpatient and
19 outpatient spending? So it wouldn't say Part B, fee-for-
20 service Part B beneficiary outpatient services? It's just
21 the hospital part of Part B?

22 MR. GAUMER: It's volume and not spending and it's

1 -- yeah, it's just the hospital part of Part B, that's
2 correct.

3 MR. BUTLER: But you say the volume --

4 DR. MARK MILLER: Charges in service. Yeah,
5 claims goes to dollars. So it's like how many discharges
6 and then how many --

7 MR. BUTLER: Well, services, and how do you count
8 the number of services on the outpatient side?

9 MR. GAUMER: How do we count the number of --

10 MR. BUTLER: Sort of like you said before, if you
11 have an employee position that wasn't -- every visit would
12 be a part of that. So you've got a lot of different things
13 in there anyway.

14 DR. MARK MILLER: On the outpatient bills, there
15 is an indication of how many units of whatever the bill is,
16 along with the dollars. So we can count the units that are
17 provided.

18 MR. HACKBARTH: So is there any --

19 DR. MARK MILLER: I'm sorry. So if I did two X-
20 rays, we count two X-rays as services, as opposed to how
21 much spending on X-rays. That's what the outpatient per-
22 service is.

1 MR. GAUMER: That's correct.

2 DR. MARK MILLER: Right?

3 MR. BUTLER: It's hard for me because they're not
4 weighted and everything. You've got observation stage,
5 you've got all kinds of stuff in those numbers, and no
6 question they're going up faster than the inpatient is going
7 down, but it's hard to draw too many conclusions from an
8 aggregate number like that.

9 MR. HACKBARTH: They are not intensity-weighted in
10 any way.

11 MR. GAUMER: They're not, no. It's raw volume of
12 services.

13 DR. MARK MILLER: And I think, rightly or wrongly,
14 what drove it in this instance is that we were looking at
15 discharges per bene going down, which is a unit, an item, a
16 widget -- sorry -- and then we wanted to try and say, Okay,
17 on the outpatient side, then I don't want to count dollars
18 and compare it to discharges. We were trying to put it on a
19 comparable basis, which may not have worked for you, but
20 that was the thinking.

21 DR. BAICKER: Just a very quick thing following up
22 on that. If I had in mind a model where every discharge

1 translated to four services, you know, that things are
2 getting broken up and so the same stuff is being done, but
3 it's being counted differently, that would also be
4 consistent with a quicker growth rate and also they're off
5 of different bases and whatnot, but I would be interested to
6 know if there were just a way to calculate a summary
7 statistic of the typical stuff that's done in a discharge
8 would show up as X services.

9 Obviously there are going to be a lot -- there's a
10 lot of variation there, but should I have in mind that it's
11 kind of one for three or one for one or trying to think
12 about rough apples and apples.

13 MR. GEORGE MILLER: Excuse me. Kate raised an
14 interesting question on that very issue and that is, would
15 the discharge bill that's dropped, that would include X-rays
16 and lab and all outpatient procedures, but you're counting
17 it once versus all those things were done, and then
18 comparing that to an outpatient procedure where there would
19 be multiple ones.

20 MR. GAUMER: That's correct.

21 MR. GEORGE MILLER: Okay. Thank you.

22 MR. ARMSTRONG: I think this is a Round 1

1 question. I don't really have a specific question about
2 your analysis, which actually I think is really excellent,
3 but more it's around what we're trying of the accomplish
4 with this analysis, and generally speaking, I want to make
5 sure I'm thinking about this right.

6 We're trying to evaluate payment adequacy as a
7 function of whether capacity is meeting demand in hospital-
8 based services, right? Are there enough hospitals out there
9 to take care of our beneficiaries, generally speaking?

10 MR. GAUMER: Yeah, I think that's fair.

11 MR. ARMSTRONG: And so, on Slide 2, we have a
12 series of indicators that we look at for that. And I guess
13 what I'm saying is that this is all good, but I'm not sure
14 it's doing a great job of helping us to answer that
15 question, because I think capacity matched to demand, the
16 things I worry about more would be, first, I'm far more
17 worried that we have too much capacity and that actually it
18 creates demand, and that there's nowhere in here that we
19 consider that or talk about that.

20 Second, I worry about huge variation in
21 utilization because demand is actually a function of the
22 number of beneficiaries times day per thousand, or something

1 like that? And so, we're worried that there's going to be a
2 big growth in beneficiaries covered by the program, and the
3 way we think about it is the only way to match that growth
4 is to build more hospitals, but we never really talk about,
5 well, what about days per thousand? Shouldn't we be
6 actually more consistently monitoring some kind of
7 utilization statistic like that?

8 And so, you tell me if that's kind of beyond what
9 we're really trying to deal with here, but it just seems
10 that, at least when I think about this, those are the things
11 I worry a lot more about than, you know, some of the
12 indicators that we're measuring right here. To me, that was
13 a Round 2 comment.

14 Are we limited to looking at these indicators in
15 this chapter, maybe is the really the more specific question
16 that I have.

17 MR. HACKBARTH: The answer to that is no. Not
18 limited in any way. And I agree with looking at some other
19 indicators like, say, days per thousand and trends in that.
20 Any of these indicators is not going to be hard-wired to a
21 particular update number. Although this is part of the
22 payment adequacy analysis, it doesn't lead through some

1 formula to a conclusion that the update numbers should be
2 higher or lower, at least I've never thought of it that way.

3 I think of it more as sort of scanning the
4 environment in a consistent way to see if there are things
5 that leap out at us as potential significant signs that
6 there's a change afoot in the care delivery system that we
7 should be aware of. But having said that, again I think we
8 could well add some other indicators to this. It may be
9 subtract some that we currently have to better do that job.

10 MR. ARMSTRONG: So I just made my Round 2 comments
11 then. I mean, I think --

12 MR. HACKBARTH: It was a good job.

13 MR. ARMSTRONG: That's the kind of information, as
14 we go forward, I'd really like to know much more about, you
15 know, how are we -- what kind of patterns are we seeing,
16 what is our theory about how days per thousand or other
17 statistics like that are influenced by whether it's our
18 payment policy or it's other things going on in the
19 marketplace.

20 MR. HACKBARTH: Yes. So when we get to the
21 December discussion, we will be looking at some other
22 indicators still like access to capital. Bill mentioned

1 that as something that he thinks would be meaningful to look
2 at and that's part of what we'll talk about in December. So
3 I'll shut up. Let's go to Round 2. Karen.

4 DR. BORMAN: In terms of looking at some of the
5 questions that Zach brought to us, one thing in getting to
6 maybe in the same ballpark as Bob Berenson's question about
7 free-standing emergency centers, I know in the past
8 sometimes we've looked at provision of trauma services, and
9 I think that that may, in fact, be something of a proxy for
10 the ability to deliver acute care services, because in order
11 to sustain some sort of trauma system, you probably need to
12 have a number of services that you can provide acutely.

13 And so, I know in the past we've looked at that,
14 and it sounds in the chapter like you may have looked up
15 some things that you didn't put either in the draft chapter
16 or on the slides, and if you do have that number, if we do
17 consider it, maybe as an index or a proxy for emergency
18 care, that might be helpful to add back to the list.

19 The one thing I would say about the bariatric
20 service is that it may be something that exemplifies the
21 service line approach to hospital services because it does
22 take a fairly broad multi-disciplinary team to do properly,

1 and most -- because I see it from the surgical side and I've
2 listened to a number of presentations by the bariatric
3 general surgeons who do the bulk of this.

4 It sounds as though that is the organization. So
5 if we were trying to maybe get a little bit of a handle on
6 service lines, that's one. But I guess one in my mind that
7 maybe matches up a little better to Medicare beneficiary
8 needs might be oncology, specialized oncology services,
9 because I think that is a disease that we do see, you know,
10 prostate cancer, breast cancer, lung cancer certainly we
11 see more in the Medicare population, and if we wanted a
12 service line proxy, that might be a better one. I don't
13 know that that's why you picked bariatric, but I just throw
14 that out there as a conversation piece.

15 In terms of the implications of the site of
16 service shift from the inpatient to outpatient setting, this
17 so interdigitates with the payments cross-settings, the
18 conversation that we're going to have tomorrow, and I think
19 the two, at least for me the draft chapters really
20 reinforced each other a lot in the sense of, as Ron
21 Castellanos said earlier, following the money in terms of,
22 as we've looked at the growth in various Betos categories,

1 as we've looked at just different kinds of service growth,
2 looking at observations services, imaging services, dah,
3 dah, dah, these are where the building is going.

4 Now, it seems to be maybe on a little bit of a
5 time lag and that's explained by the capital funding. But I
6 don't know that I exactly understand where the shift in the
7 site of service will necessarily impact how much money it
8 takes to deliver.

9 I mean, what's changing here is the mix of
10 services that is being delivered under the hospital
11 umbrella. And so, the question still remains, I would
12 think, and maybe I'm not understanding this correctly, for
13 the update, is the update adequate to support the mix of
14 services that are being delivered using, as a filter, are
15 these the right ones for Medicare beneficiaries. So if I
16 have that wrong, I need correction.

17 But it seems to me it's more important -- the part
18 about the shift is more important as we think about the
19 payments across the settings than maybe it is specifically
20 about the hospital update. I freely admit I might be
21 missing something there, but that strikes me.

22 MR. HACKBARTH: Bill.

1 MR. GRADISON: This is an annual exercise. The
2 rural study, in-depth rural study is not, but it seems to me
3 that there is some very good information already developed
4 there that could permit us to have a much more expanded
5 report on access to rural hospitals than the other factors
6 that you're looking into without doing any additional work
7 and hopefully without committing us to make such a deep dive
8 into rural issues every year.

9 DR. STUART: I'd like to pick up on a point I made
10 in Round 1 on Slide 7. Zach, what I'd really like to know
11 is, how many years is it going to take before we have a
12 single national hospital chain?

13 DR. MARK MILLER: We'll --

14 DR. STUART: And I ask that in the context of this
15 tradition of having long-term Medicare projections.

16 MR. GEORGE MILLER: Well, following Bruce, let me
17 be provocative in a different way and that is, along with
18 Scott's concern or things he's worried about, about bed per
19 thousands, it just occurred to me that maybe, especially
20 with the critical access program, maybe every hospital isn't
21 a hospital and the fact that we have specialty hospitals,
22 maybe we need to think about -- to look at a different

1 payment mechanism for a different class of hospital.

2 Again, I'll be very kind. Nothing against
3 specialty hospitals at this point and for-profit hospitals.
4 But if that's what they are, then maybe we ought to put them
5 in a different category, different payment, because they're
6 not providing the full service, and create a different
7 payment mechanism so that the thrust of the payment --
8 excuse me -- beds per thousand isn't impacted by that group
9 because they do a specialty and not a full service hospital.

10 I don't know if that has traction at this point in
11 time or if it makes sense when we're doing a payment update,
12 but that may be something to consider down the road, create
13 a whole new category for that type of hospital that doesn't
14 offer the full services and doesn't have all the
15 complexities that is required by regulation and law for
16 full-service hospitals, create a whole new category, and
17 then we would decrease that bed per thousand to your point.
18 Something to think about and just throw it out for
19 discussion or not.

20 DR. CASTELLANOS: Could you turn to Slide 3,
21 please? Mike brought up a point about the bed capacity and
22 that's per capita. I can understand why they do that. And

1 per capita, it looks like we're okay. Nancy Kane, last
2 year, I remember, and myself had some issues. I think the
3 national study shows that, but there's certainly regional
4 changes.

5 In my community, we have two times the normal
6 national average of people over 65. We have a 30 percent
7 fluctuation. With the aging of the Medicare population and
8 the fastest generation growth is between 80 and 90, that
9 capacity may be interesting to see bed capacity per Medicare
10 population. It may be an important thing to look at. We
11 are a Medicare payment advisory commission, so maybe that
12 would be an interesting statistic.

13 Can you go to, I guess it's Slide 6? Bill kind of
14 pointed out some issues there and I'd like to kind of point
15 out some issues, and I think Scott said it, also. The
16 services that you're listing here, I'm not quite sure what
17 the value to the Medicare system really is.

18 I understand if I comment on robotic surgery, my
19 other urology colleagues are going to probably lynch me on
20 it, but the real value isn't known yet. It's much more
21 costly and really the statistics are really unknown whether
22 it is of value. I really think we have such an increase of

1 robotic surgery, we do robotic surgery in our community, and
2 the only reason we're doing it is because it's a marketing
3 tool. I'm sorry, but is that a value to the Medicare system
4 or is it a value to the surgeons doing it and perhaps the
5 hospitals?

6 And, Bill, you mentioned the PET scanning, the
7 reason we have an increase there is you want to keep up with
8 what's happening in the community. So I think we really
9 need to look at what the value to the Medicare system is.

10 MR. HACKBARTH: So two points. One is, as I said
11 earlier, it seems to me that we may want to go down the path
12 of identifying some select services that we think have some
13 particular importance. I'm not sure exactly where that path
14 leads, but that makes sense to me and that's a comment that
15 both Bill and Ron have made.

16 The second thing I would say, though, is for
17 people in the back of the room who can't read the fine print
18 at the bottom, this is not a normative statement at all.
19 Zach did not choose these particular services. There's a
20 list of 50 services on the AHA survey. He is simply
21 reporting the five at the top and the three at the bottom.

22 And so, he didn't select bariatric surgery as

1 something particularly important to highlight. It's just
2 that it was one of the five on the top of the list. So I
3 just wanted to make that clear to people who can't read the
4 small print.

5 DR. MARK MILLER: And actually, just because there
6 have been so many comments on this table, let me give you
7 some different ways to think about this, not -- you know, we
8 can narrow it down and say there are certain things we want
9 to track, sentinel services, if you will. But just to give
10 you some sense of where this comes from.

11 One way to think about all of these measures is --
12 and I think Glenn was saying this a few minutes ago. It's
13 like if you saw large numbers of hospitals closing and
14 occupancy rates going up extremely rapidly and lines of
15 services being dropped, you know, huge movements in the
16 data, you might say something is up and we need to be paying
17 attention to it.

18 In the past, some of what drove this table is
19 people would say, Well, you're counting hospitals and you're
20 counting beds, but you could have a hospital and you could
21 have beds, but lines of services could be discontinued and
22 we'd like to know about that. So that drove some of this.

1 And the reverse, which is, you might say robotic
2 surgery, it's just a loss leader or, you know, a CT scanner
3 that was put in, you know, to keep up with the Joneses or
4 for revenue, whatever the case may be, that's also
5 indirectly telling you what the circumstances of hospitals
6 are, where they're putting their efforts and whether they
7 have the revenue to do those types of things.

8 And so, I get the sentinel important service idea
9 and we can certainly organize this data much differently,
10 but in the past, people have asked those questions -- these
11 questions about this data for those reasons as well. You
12 would see lots of additions of imaging services, and then
13 people would say, What are we doing? Why is this happening
14 and should we start focusing on that? So it kind of cuts a
15 lot of different directions in what this data can be used
16 for. Sorry. I didn't mean to go on.

17 DR. CASTELLANOS: One more point. I know we're
18 seeing that construction is down or slightly down. I just
19 would like to know the capital spending that hospitals do.
20 Is it down because construction is down or is it down
21 because EMR costs are so high now and hospitals are putting
22 so much money into EMR, et cetera, maybe that's where the

1 money is going in the capital spending rather than
2 construction.

3 MR. GRADISON: Maybe they all have their atriums.

4 DR. NAYLOR: So this was an excellent report and
5 under the quality, I think one factor to highlight that
6 really stood out for me was not just the growth in
7 employment, but the growth in recruitment of people with
8 advanced training and skills relative to less training and
9 skills.

10 So there's investment in physician assistants,
11 pharmacists, more nurses, fewer licensed practical nurses.
12 I think that that's a really important statement to
13 highlight in terms of, you know, Medicare's capacity within
14 the hospital system.

15 DR. HALL: I'll pass.

16 DR. CHERNEW: I really do like looking at this
17 work. My one concern would be, in the spirit of what Ron
18 was saying earlier, this is going to be local, and so it's
19 useful to look at these numbers, but I'd also like to know,
20 how much variation is there? Are there areas that have what
21 seems to be a shortage and other areas that seem to have a
22 big surplus in capacity?

1 Because I think we could get these numbers and
2 they could look perfectly fine for whatever reason and we
3 could be completely missing out about access in some areas
4 than others.

5 MS. BEHROOZI: Mary, I actually had a different
6 reaction when I saw what you were looking at. I mean, I
7 think the fact that it's not all at the doctor and all --
8 that the hospitals are relying on physician assistants and
9 RNs and higher skilled people within certain classifications
10 is good, except that we also know that lower skilled people
11 cost less.

12 And so, I think in other contexts we've talked
13 about moving toward having people work at the top of their
14 licensed or non-licensed position, or whatever, in order to
15 make for a more efficient, whether it's a hospital or a
16 nursing home or whatever institution that's separate from
17 the numbers of them and the relative numbers of them. And
18 I'll have more to say offline to you guys about the way you
19 characterize hospital employment. That's offline.

20 DR. MARK MILLER: Oh, it's on.

21 MR. BUTLER: Okay. So speaking of on the
22 transcript, George, you know, after you say specialty, you

1 have that little laugh. How can you capture that on the
2 transcript? That kind of says it all.

3 [Laughter.]

4 MR. BUTLER: Then we know what you're really
5 thinking. So next time you do that, okay.

6 MR. GEORGE MILLER: We could [off microphone].

7 MR. BUTLER: Okay. Here's the positive thing and
8 then I'll have some constructive suggestions. It is trying
9 to capture, give us guidance in any of the pricing update,
10 and it basically says, Do we have reasonable access to not
11 just hospitals, but to hospital services. Is there anything
12 in the baseline that would suggest, that would help give us
13 guidance on the update?

14 And I think overall, you've captured it. It's a
15 relatively stable set of services. You can argue it up a
16 little, down a little, but it's about the same number and
17 about the same places with about the same range of services
18 and there's nothing that pops up that says that the supply
19 has gone one direction or another dramatically in a way that
20 you ought to take that into account in pricing. So that's -
21 - and so, if you didn't change a word in the chapter as it
22 is, I think you've kind of captured that.

1 So now most of mine could be, I think, how do you
2 make it better maybe next year even rather than this year?
3 So on the services, I won't pile on, on the AHA survey, but
4 I would suggest it would be interesting to have such things
5 as how many are meaningful users? How about, do they have
6 Medical Homes? How about tracking the number of employed
7 primary care physicians? How about, are they in an ACO or
8 not?

9 I mean, some of those would be interesting because
10 they're what we're trying to encourage. And then when you
11 look at the financial health, you could also kind of say,
12 And by the way, are those things merited? Are the same
13 people that are financially healthier, are they having the
14 kinds of services that we're looking to have occurred? And
15 then you'd have a little richer analysis in terms of kind of
16 the services we're trying to create that are new as well as
17 the correlation with the financial health.

18 On the financial health side, I don't like
19 employment, so I'm in your camp on that. I don't think it's
20 a very -- if you were to look at the financial health and if
21 Wall Street were to look at it, they would never look at the
22 number of FTEs in an organization.

1 I think it's pretty simple. I think you look at
2 operating income, you look at day's cash on hand, because
3 that tells you how much cash they've got in the bank, and
4 those two things by themselves capture a tremendous amount
5 of information about the financial health of an
6 organization. You may have a lot more employees because
7 you've merged with two lousy places that are weak, together
8 you have more employees, but it doesn't -- you know, so
9 those are the two big indicators that rating agencies look
10 at, operating income and day's cash on hand.

11 I think it would be very helpful to know if day's
12 cash on hand are trending dramatically down, and so you have
13 a bunch of places that are just on the brink, and if they're
14 also not making operating income, they're in trouble.

15 And then the third one, on the capital spending, I
16 think we're also kind of beating around the bush and looking
17 at ability to borrow and things like that. I would look at
18 the total capital spending as a percentage of depreciation,
19 and that you do put in here and you do say it's gone from
20 1.6 in 2006, or Citigroup or whoever -- Moody's -- said it's
21 gone from 1.6 to 1.1. It's kind of systematically ratcheted
22 down.

1 So right now, the total capital investment is just
2 barely over depreciation, and if you -- that means, if you
3 could replace everything at the price you bought it for,
4 you'd be about even. But we know things cost more than they
5 do. So over time, if that thing is at that level, you're
6 going to see that, you know, you're not keeping up with
7 things.

8 And as Ron pointed out, even if you looked at the
9 mix of spending now, you would say -- and by the way, that's
10 a median number so that means half the places now are not
11 replacing what they've already got. And if you looked at
12 the mix, you'd see IT has gone probably from, say, 5 percent
13 to 25 percent of that capital spending in the last four -- I
14 don't know, but whatever it is, it's gone up 14 percent a
15 year while others have not.

16 So I would look at those three things, operating
17 income, day's cash on hand, and capital spending as a
18 percentage of depreciation. Finally, I think the private
19 equity presence, that is something -- I'm glad you put that
20 in there. It's something to kind of follow because it's
21 having an impact in markets, whether it's in Boston or even
22 places like Duke that is pairing with an organization or the

1 big Catholic chain.

2 It's a different kind of newer source that may
3 have good or bad consequences, I don't know, but it is. And
4 so, I think it's good that you put it in there because I
5 think people are thinking about, okay, I've tried every
6 other route. Maybe I'll do that. And so, I'm glad it's
7 highlighted.

8 DR. BAICKER: I share the feeling that we might
9 tweak the measures or come up with slightly different
10 metrics, but that the picture seems fairly consistent that
11 we don't see evidence of an access problem. I also, as you
12 know, I'm not a huge fan of the employment metric, although
13 it's an indicator of industry.

14 I don't know if it's for the same reason as
15 metrics or not, but I want to avoid thinking that we want to
16 evaluate our policies based on their affects on employment
17 so the causality can sometimes get muddy.

18 With that said, I think the overall picture seems
19 fairly clear and I think Mike's suggestion of getting a
20 little more nuance on variation within the average would be
21 helpful. With that said, these metrics seem very
22 informative.

1 MR. HACKBARTH: Okay. All right. Thank you,
2 Zach. We are finished for today. We'll now have our public
3 comment period.

4 [No response.]

5 MR. HACKBARTH: Okay. It looks like we are done
6 for today and we will reconvene at 8:30 tomorrow morning.
7 Thank you.

8 [Whereupon, at 4:43 p.m., the meeting was
9 recessed, to reconvene at 8:30 a.m. on Friday, November 4,
10 2011.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 4, 2011
8:32 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
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

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Payment rate differences across ambulatory sectors - Ariel Winter, Dan Zabinski, Jeff Stensland	3
Mandated report: Medicare coverage of and payment for home infusion - Joan Sokolovsky, Kim Neuman, Kelly Miller	86
Public Comment	117

1 P R O C E E D I N G S [8:32 a.m.]

2 MR. HACKBARTH: Okay. Good morning. We have two
3 sessions today, the first on payment rate differences across
4 ambulatory sectors. And who among this distinguished group
5 is going to first? Jeff.

6 DR. STENSLAND: All right. Good morning. Before
7 we start, I want thank Matlin, Carlos Zarabozo, and Kevin
8 Hayes for their help in examining differences in payment
9 rates across sectors.

10 The reason we're discussing payment differences
11 across settings is that we're seeing a shift of Medicare
12 patients to settings where Medicare pays higher rates.
13 Hospitals have been acquiring practices for a long time, but
14 the pace of practice acquisitions is accelerating, so the
15 effect of discrepancies in payment rates across settings is
16 increasing in importance.

17 Many factors have been cited as contributing to
18 this trend such as the desire of new physicians to have
19 stable, predictable working hours, increased difficulty and
20 cost of running a private practice, preparing for
21 accountable care organizations, and the potential for
22 increased reimbursements from both Medicare and private

1 insurers.

2 Regardless of the cause of this trend, it will
3 shift billing of services from free-standing practices to
4 outpatient departments. The result of such a shift would be
5 to increase program spending, increase beneficiary cost
6 sharing, and potentially create an increase in providers'
7 coding and billing expenses, even if the care received by
8 the patient does not change at all.

9 Let's see. I'm missing something.

10 Today we're going to talk about -- there's two
11 different types of practice acquisitions, and the purpose of
12 this slide is to show that we are not concerned about all
13 different types of practice acquisitions. There's only a
14 specific type of acquisition that causes concern.

15 Specifically, we are concerned about the first
16 type of acquisition on this slide. In this case, a hospital
17 acquires a practice and starts billing for the services as
18 if the practice is an outpatient department. As I said
19 before, it's possible that care does not change at all, but
20 Medicare prices could increase substantially.

21 A second concern is that inefficiencies could
22 develop. When the physician office becomes an outpatient

1 department, there are some overhead cost increases that may
2 not have anything to do with patient care. For example, the
3 hospital would now generate two bills, one coded for the
4 physician service and a second bill coded for the hospital's
5 facility fee. The patients are often confused when they
6 start getting two bills for a service that they used to
7 receive one bill for. Hospitals may pursue this less
8 efficient method of delivering outpatient visits purely
9 because Medicare and private payers set up financial
10 incentives to declare a physician's office part of the
11 outpatient department.

12 As I said, we're not saying all practice
13 acquisitions create concerns. The second type of
14 acquisition shown in this slide is where a hospital acquires
15 a physician practice and continues to bill for services as a
16 freestanding physician's office. Hospital ownership of the
17 practice and integration of care is not dependent on the
18 hospital calling the physician office an outpatient
19 department. Under this second type of acquisition, the
20 change in ownership by itself does not result in a change in
21 Medicare payments. Changes in Medicare payments will depend
22 on changes in the services provided and the quality of those

1 services. And today's discussion would not affect this
2 second type of acquisition in any way.

3 And now Dan will talk about some of the trends in
4 physician hospital.

5 DR. ZABINSKI: Okay. To determine the extent to
6 which hospital acquisition of physician practices has caused
7 a shift from free-standing physician practices to OPDs, we
8 examined Medicare claims. From this analysis, we found that
9 among all office visits provided to Medicare beneficiaries,
10 the percentage that were provided in OPDs increased from 5.9
11 percent in 2008 to 7.3 percent in 2010. And although this
12 chart also indicates that the OPD share of office visits
13 increased from 2004 to 2008, the rate of increase has been
14 higher in more recent years. Other ambulatory services have
15 also shown a steady increase in the percentage being
16 performed in OPDs.

17 For example, we examined the ambulatory services
18 provided by cardiologists from 2008 to 2010. We found that
19 among ambulatory echocardiography services, the percentage
20 that are provided in OPDs increased from 22 percent in 2008
21 to 29 percent in 2010. Also, among nuclear medicine
22 services provided in ambulatory settings, the percentage

1 provided in OPDs increased from 11 percent in 2008 to 16
2 percent in 2010.

3 This trend may be, at least in part, due to large
4 differences in Medicare payment rates between sectors. For
5 example, when Medicare payment for a commonly provided
6 echocardiography service is provided in an OPD, it is 102
7 percent higher than when it is provided in a free-standing
8 physician practice. And for a commonly provided nuclear
9 medicine service, the Medicare payment rate is 75 percent
10 higher if it is provided in an OPD.

11 As an example of how a shift of services from
12 free-standing practices to OPDs would affect spending and
13 beneficiary cost sharing, consider the case of a mid-level
14 office visit indicated by CPT code 99213. I'd like to focus
15 your attention on the last row of numbers on the table.

16 If this service is provided in a free-standing
17 physician practice, total payment for the service would be
18 the nonfacility rate in the physician fee schedule of
19 \$68.97, with the physician receiving the entire payment.

20 But if it is provided in an OPD, there would be a
21 reimbursement for the physician's service at the facility
22 rate in the physician fee schedule of \$49.27. This is

1 obviously a lower rate than the \$68.97 that is paid in the
2 free-standing practice. However, I want to emphasize that
3 this difference is due to lower reimbursement for
4 physicians' practice expense when provide in an OPD, but
5 reimbursement for physician work effort is the same in both
6 settings.

7 Then in addition to the \$49.27 paid to the
8 physician when this service is provided in an OPD, the
9 hospital would be reimbursed \$75.13 under the outpatient
10 PPS. Adding these reimbursements together results in a
11 total payment of \$124.40 if the service is provided in an
12 OPD, which is 80 percent higher than when the service is
13 provided in a free-standing practice.

14 What we see on this table is typical of most
15 ambulatory services: that payments are much higher when
16 provided in an OPD compared to a free-standing practice.

17 The data that we've presented so far, although
18 they present a shift from free-standing practices to OPDs,
19 the shift has not been large. But a large shift is still a
20 concern because when you have a large shift from free-
21 standing practices to OPDs, you have a potential to
22 substantially increase aggregate program spending and

1 beneficiary cost sharing.

2 For example, in 2010, there were 220 million
3 office visits provided in free-standing practices. But if
4 50 percent of them had been billed as provided in an OPD,
5 program spending would have been higher by \$5.4 billion and
6 beneficiary cost sharing would have been higher by \$ 1.3
7 billion.

8 Now I'll turn things over to Ariel who will
9 present policy options for addressing these issues we
10 discuss today.

11 MR. WINTER: I'm going to start off by proposing
12 some principles for aligning payment rates across settings.

13 First, Medicare should strive to ensure that
14 patients have access to settings that provide an appropriate
15 level of care. If same service can be provided safely in
16 different settings, it may be undesirable for the prudent
17 purchaser to pay more for that service in one setting than
18 another.

19 Further, payment variations across settings may
20 encourage higher-paid settings to expand and attract more
21 patients, thereby leading to higher Medicare spending.

22 Therefore, Medicare could base payment its rates on the

1 resources needed to treat patients in the lowest-cost,
2 clinically appropriate setting.

3 There are some important factors that we may want
4 to consider in aligning payment rates across settings.
5 First, there may be differences in patient severity across
6 settings that could affect the cost of providing the
7 service. Second, hospitals incur additional costs related
8 to their unique mission and regulatory requirements. Many
9 hospitals maintain standby capacity to handle emergencies,
10 and they are also subject to regulations like EMTALA and
11 Conditions of Participation which do not apply to
12 physicians' offices.

13 Finally, there are differences in the level of
14 packaging of services in the outpatient PPS and physician
15 fee schedule. For example, the cost of ancillary services
16 and supplies are more likely to be packaged with a primary
17 service in the outpatient PPS than the fee schedule, and
18 this can affect our ability to compare payment rates across
19 settings.

20 We're going to talk about an option to equalize
21 total Medicare payment rates across settings for E&M office
22 and outpatient visits that are not provided in emergency

1 departments. And the rationale for selecting these services
2 is as follows:

3 We noted on the prior slide that we need to be
4 mindful of patient severity differences by setting. One way
5 to look at patient severity is to compare average HCC risk
6 scores for patients who are treated in different settings.
7 And as you know, risk scores are used to adjust Medicare
8 Advantage payments. They indicate the expected costliness
9 of beneficiaries based on their age, gender, and diagnoses
10 in the prior year.

11 We found that Medicare patients who receive E&M
12 visits in outpatient departments have higher risk scores on
13 average than patients who are treated in physician's
14 offices. However, the coding structure for E&M visits
15 accounts for variations in resources related to patient
16 complexity.

17 For example, CPT code 99213, a mid-level visit, is
18 used for visits that typically include 15 minutes of face-
19 to-face time between the physician and patient, whereas CPT
20 code 99214 is for visits that typically include 25 minutes
21 of face-to-face time and also involve a more detailed
22 history and examination. So if a sicker patient requires

1 more time and resources, this should be reflected in the
2 code assigned for the E&M visit.

3 We also noted that hospitals incur additional
4 costs related to their standby capacity and regulatory
5 requirements. However, we should ask whether it makes sense
6 for Medicare to cover these additional costs if the program
7 can obtain E&M visits from a lower-cost setting.

8 Finally, very few ancillary services are packaged
9 with the cost of these E&M visits in the outpatient PPS,
10 which means that the unit of payment is similar across
11 settings.

12 This table illustrates how this policy option
13 would work using a mid-level visit as an example. The first
14 column of numbers indicates payment if the service is
15 provided in a free-standing physician's office. In 2011,
16 Medicare pays the physician \$68.97, which includes the work
17 RVU, the professional liability insurance, and the
18 nonfacility practice expense. There is no outpatient
19 payment so the total payment is \$68.97.

20 The second column of numbers indicates total
21 payment if the service is provided in an outpatient
22 department. The physician receives a payment of \$49.27,

1 which is less than the payment for a visit provided in a
2 physician's office because the practice expense amount is
3 lower when the visit is provided in a facility. However,
4 the physician work stays the same.

5 The hospital receives a payment of \$75.13, and the
6 total payment is \$124.40, which is 80 percent higher than
7 the payment in the first column.

8 Finally, the third column of numbers indicates the
9 total payment amount if the service is provided in an
10 outpatient department, but the outpatient rate is lower so
11 that the total payment is equal to total payment when the
12 service is provided in a physician's office.

13 To accomplish this, the outpatient rate is set
14 equal to the difference between the physician fee schedule's
15 nonfacility practice expense and the facility practice
16 expense. And just as a reminder, the nonfacility practice
17 expense is paid when the visit is performed in an office,
18 while the facility practice expense is paid when the visit
19 is performed in a hospital.

20 The physician still receives a payment of \$49.27,
21 just as they do under current rates. But the payment to the
22 outpatient department drops to \$19.70.

1 The rationale for reducing the outpatient rate is
2 to equalize the total payment amount across settings. The
3 option illustrated here appeared on the Commission's list of
4 savings proposals for the purpose of assisting Congress in
5 offsetting the cost of repealing the SGR. According to
6 staff estimates, this would reduce Medicare spending by
7 about \$5 billion over five years and by about \$10 billion
8 over ten years. And this slide simply puts this policy
9 option that we illustrated on the table before into words.

10 So there are some other issues we plan to examine
11 in future work. We want to address payment differences for
12 other services that are usually provided in physicians'
13 offices. In doing so, we'll consider the same issues we
14 considered in our analysis of E&M services, namely, patient
15 severity differences across settings that could affect
16 costs, hospitals' additional costs related to their unique
17 mission and the cost of meeting additional regulatory
18 requirements, and differences in the level of packaging
19 across settings.

20 We also plan to explore options for increasing the
21 level of packaging in the physician fee schedule so that
22 it's more comparable to the outpatient PPS.

1 So we have a couple of questions for your
2 discussion, ideas for your discussion. We would be
3 interested in getting feedback on the policy option we
4 discussed for equalizing total payment rates for E&M visits
5 across settings. In addition, are there other issues you
6 would like us to examine? And do you have additional
7 questions or requests for additional research?

8 Thank you very much.

9 MR. HACKBARTH: Thank you. Could I ask you to put
10 up Slide 12, the methodology for equalizing the rates? I
11 understand why you did this, but all of this money is going
12 to the hospital, right? To qualify under this, there aren't
13 separate payments made to the physician and to the hospital.
14 This has to be a hospital-owned unit to qualify for the
15 payment. So does this really -- the important thing is the
16 bottom row, not how you split out the dollars between the
17 professional piece and the facility piece, correct?

18 MR. WINTER: To be eligible for the outpatient
19 payment, the entity has to be owned by the hospital, and
20 there are other requirements that have to be met as well
21 under the provider basic rules.

22 MR. HACKBARTH: Right.

1 MR. WINTER: If the hospital employs the
2 physician, then it's getting the entire payment at the
3 bottom row. But in some cases, the hospital may own the
4 entity but contract with the physician, in which case the
5 physician could bill separately.

6 MR. HACKBARTH: I see.

7 MR. WINTER: Or the hospital could have some
8 arrangement where they pay the physician a portion of the
9 full physician fee. So it could vary depending on the
10 arrangement.

11 MR. HACKBARTH: Okay. Round one clarifying
12 questions.

13 DR. BORMAN: Do we know how this intersects with
14 teaching hospital status and payments in that not based on
15 data, based on some prior experience, and sort of a visceral
16 sense, there might be disproportionate representation of
17 academic practices in this model, and that might have some
18 bearing as we consider policy options? So if we don't know
19 that, it might be something worth pursuing before we get to
20 some endpoint on this.

21 I think the other thing I would ask is just as we
22 rightfully say that there are some less easily quantified

1 but, again, visceral feeling hospital mission costs, are
2 there some things on the flip side that sort of we'd have to
3 consider in fairness? That is, are there some things that
4 when the service is provided in a physician's office -- and
5 this doesn't hold so much for E&M because I agree with you
6 that they're pretty much apples to apples. When you start
7 to look at other things, do physician offices have the same
8 contracting power? Do they not perhaps increase the skill
9 level of their personnel in order to support the
10 eventualities that are uncommon but could happen in their
11 offices by virtue of doing some of these procedures?

12 So, you know, I start to be looking at intangibles
13 versus intangibles, or at least things I don't know how to
14 measure versus other, and so I'm a little less swayed by
15 that as an argument for higher rates in the HOPD. So if you
16 have anything that would help me think about putting a
17 dollar value to that and what the dollar value might be on
18 the physician side that's excess cost that they're shifting,
19 then that would be helpful.

20 DR. ZABINSKI: Yeah, well, you talked about the
21 disproportionate representation of the teaching hospitals.
22 Running the numbers, one thing we did find is that as a

1 percent of total outpatient department volume, the major
2 teaching hospitals have a higher share of these E&M visits
3 than basically all other hospital groups. There's a pretty
4 wide difference from one category to another, like
5 proprietary hospitals have about 5 percent of their volume
6 from office visits, while major teaching hospitals have
7 about 25 percent. So there's quite a bit of difference from
8 one hospital group to another.

9 MR. WINTER: If I can respond to the second part
10 of Karen's question, which is if an office is acquired by a
11 hospital and performs more intensive procedures, there's a
12 need to increase its skill level and maybe acquire other
13 resources. And so for the next set of services we want to
14 focus on after we get past E&M would be services that are
15 commonly provided in physician's offices, like more than 50
16 percent of the time, but may also be, you know, provided in
17 an outpatient department, and the volume may be shifting to
18 outpatient departments.

19 So it demonstrates that for many patients, at
20 least, the office setting is an appropriate and safe setting
21 for those services, so that might be the next level of
22 services to focus on.

1 DR. BORMAN: Just to be clear, my point was that
2 when it is delivered in the physician office, the physician
3 office may, in fact, have some things that it has to account
4 for, just as it would have to be accountable for in the HOPD
5 to make it safe that are costs that are sort of picked up in
6 that. So just as we say the hospital has a mission to do
7 all these things and has to do EMTALA and all those other
8 kinds of things, there may be things when the service is
9 provided in the office that, in fact, increase the cost in
10 the office so that this kind of increased cost kind of
11 happens in both sites of services, I think, although I'm not
12 sure what the differential between those two may be because
13 they're kind of a bit ephemeral costs to pin down.

14 MR. GRADISON: Can we get any information with
15 regard to how Medicare Advantage plans handle this same
16 issue and through that perhaps gain some insights into
17 alternatives that we should consider?

18 MR. WINTER: So we've talked to a couple of
19 private insurers, one of which had a Medicare Advantage
20 plan, and their policy really varies. Some insurers do pay
21 the additional facility fee for these kinds of visits when
22 they're performed in a hospital-based office or setting;

1 others do not. And so it does seem to really vary, but w
2 have only spoken to a handful. We have not done a really
3 broad survey. But we can try to expand our analysis in this
4 area and try to focus specifically on Medicare Advantage
5 plans.

6 DR. STUART: This is kind of a follow-up on that
7 from a slightly different angle. As I understand this, it
8 is simply where the service is provided, not who is
9 providing the service. So that if you had a physician who
10 had private offices but then also worked in an OPD and
11 provided exactly the same service, it would be reimbursed at
12 different rates, depending upon the setting. I know that's
13 true because it has happened to me.

14 And so one of the questions here is whether you
15 have looked at that in the data. In other words, if you had
16 the physician ID, you would be able to determine whether
17 this practice is common. And to the extent that it's common
18 and it's the same patients that are being treated and the
19 codes are the same, then that provides some pretty
20 compelling basis for doing the kind of policy change that
21 you're suggesting here.

22 MR. GEORGE MILLER: On this slide, can you tell me

1 if you've had the ability to determine if the \$19.70 covers
2 the cost based on what you talked about the unique mission?
3 Or did you just figure out the difference and just put that
4 number in?

5 The second part of the question is -- and I think
6 I asked this yesterday, but have we been able to measure the
7 impact of bad debt that may increase because of the current
8 economy and the unemployment, and if this number would cover
9 potential increase in bad debt because of the change in the
10 economy and unemployment.

11 DR. STENSLAND: We didn't arrive at the \$19.70 by
12 trying to accommodate the costs. The \$19.70 was arrived at
13 by trying to equalize the end payment rates to keep the
14 payments level. And so if indeed it does cost more to
15 provide the service in the hospital-based setting but we
16 don't appear to be getting anything additionally out of it
17 to go to that more costly setting, by making this policy
18 move we would be discouraging that movement toward the more
19 costly setting and keeping it in the less costly setting.

20 In terms of bad debt, we didn't compute that into
21 here. Of course, the bad debt -- in the physician's office,
22 if there's bad debt, they don't get paid any of that. They

1 absorb it. In the OPD they do get some bad debt
2 reimbursement. So, if anything, that makes the differential
3 and rates even bigger than what we're showing here.

4 MR. HACKBARTH: Let me introduce an idea of Bob's,
5 and then he can elaborate. One way to think about this is
6 we ought to equalize the rates, not worry about what the
7 costs are. As Jeff says, if they can cover their costs,
8 maybe they'll get out of the business or reduce their
9 activity.

10 Another way to think about it is that we really
11 shouldn't price differently for the same service based on
12 the type of provider. If we want to cover costs associated
13 with the unique role of hospitals, we ought to increase
14 payments where there are not clear, competitive substitutes.
15 And so you would put the money in the inpatient rates as
16 opposed to paying higher for E&M visits. Then, you know,
17 it's a continuum. You can do somewhere in between those two
18 and, you know, offset part of it in the inpatient rates.
19 So, you know, there are policy alternatives here, different
20 paths you can go down.

21 Anything you want to add on that, Bob?

22 DR. BERENSON: Yeah, that was the idea, is pay

1 outpatient rates comparable or have some narrow difference
2 for something, but close to the same or the same. And then
3 put those unique characteristics -- I mean, Glenn basically
4 said it. As I was listening to Ariel's presentation of what
5 those unique things are, they largely are not related to
6 outpatient services. Outpatient services aren't open 24
7 hours for the most part. Having stand-by capacity means the
8 OR is available, there's a trauma team on call, some of whom
9 are getting paid to be on call.

10 So it actually seems to reflect where those costs
11 actually are, is more in the inpatient capacity, the ER
12 capacity, and so formalizing it in a way by just that's
13 where the costs should be allocated to and we keep the
14 outpatient rates comparable or the same has some appeal, I
15 guess is what I'd say.

16 DR. CASTELLANOS: I'll have a lot of comments in
17 round two, but a clarification. Two issues that came up.
18 George, you just mentioned bad debt, and then you said
19 "some." Well, in the Medicare age group in the hospital, 70
20 percent of bad debt is reimbursed. In a critical access
21 hospital, as we found out, 100 percent of bad debt is
22 reimbursed. So it's not some. It's a significant amount,

1 and the issue here, again, is not in -- it's just in the
2 hospital setting, not in the doctor's office.

3 The other question just for clarification, Ariel,
4 you mentioned EMTALA does not affect the physician. I think
5 you may want to look into that and check with the AMA. They
6 have done some surveys. General surgeons, affected about 50
7 percent of the time, according to their survey, and ER
8 doctors, some ER doctors are private doctors working in the
9 ER, and that's about 95 percent of the time they're
10 affected. So I think EMTALA does affect the primary doctor
11 also.

12 DR. HALL: I'll also have some comments in round
13 two, but I just wanted to refer back to Slide 8, just the
14 statistic here. There are some metrics that there were 122
15 million office visits in free-standing practices. What's
16 the opposite number for hospital-based practices? Are we
17 talking about a 2-percent problem or a 25-percent problem?

18 DR. ZABINSKI: It's in here, but it's not coming
19 out.

20 [Laughter.]

21 DR. STENSLAND: It's about 7 percent.

22 DR. ZABINSKI: Right, 7 percent.

1 DR. HALL: It's sort of are we talking about
2 angels dancing on the head of a pin here. I don't think so.

3 DR. ZABINSKI: No, it's somewhere in the 15 to 20
4 million range.

5 DR. HALL: Okay, so it is quite a bit smaller.

6 DR. ZABINSKI: Yeah, quite a bit smaller.

7 DR. HALL: Maybe 10 percent or less compared to--

8 DR. ZABINSKI: Yeah.

9 DR. HALL: Okay. Thank you.

10 MR. KUHN: Two good questions. One, if I remember
11 right, what we're dealing with here is kind of the provider-
12 based rules, so basically one of these physician clinics or
13 offices has to be under provider-based in order to get the
14 higher payment rate. Could you just recap for us a moment
15 what are the criteria for provider-based? I think there's
16 like a 30-mile radius, just so we have kind of a grounding
17 of which facilities we're talking about and which ones we're
18 not.

19 MR. WINTER: Sure. We have a text box in the
20 mailing material that describes this in more detail, but
21 I'll just give you the high-level summary. There are rules
22 that apply to all hospital-based entities or provide-based

1 entities, whether they're on campus or off campus, and there
2 are five main criteria. One is that they have to operate
3 under the same license as the parent hospital. They have to
4 be clinically integrated with the parent hospital. For
5 example, the professional staff of the facility has to have
6 privileges at the main hospital. There has to be financial
7 integration, shared income and expenses. The entity has to
8 be held out to the public as being part of the parent
9 hospital, so if someone walks into the facility, they know
10 this is part of the main hospital. And if it's an
11 outpatient entity, it has to meet the general obligations of
12 an outpatient Department, like EMTALA and anti-
13 discrimination rules and some other things.

14 Then there are some additional requirements that
15 apply to off-campus provider-based entities, and the one you
16 referred to is that they have to be within 35 miles of the
17 main hospital campus. There are exceptions, including one
18 for rural health clinics that are part of a rural hospital.
19 Two other main requirements are that they have to be under
20 the ownership and control of the hospital. For example,
21 they have to be 100 percent owned by the parent hospital;
22 they cannot be a joint venture. And there also are

1 administration and supervision requirements, so the entity
2 has to be under direct supervision of the parent hospital,
3 and the administrative functions have to be integrated
4 between the entity and the parent hospital.

5 MR. KUHN: Thank you. That's a great overview.

6 Then the second question, kind of following up on
7 Bill's question when he was talking about the order of
8 magnitude here, 15 to 20 million visits per year we're
9 talking about. If you take the cohort that you're talking
10 about now of the E&Ms, what percent of that 15 to 20 would
11 be the E&Ms?

12 DR. ZABINSKI: Well, let's see. This is all E&M,
13 this slide here. It's the office visits.

14 MR. KUHN: I guess to rephrase the question, I
15 think you mentioned at the end that if the proposal that
16 we're talking about here would save \$5 billion over five,
17 \$10 billion over ten, you know, what's the total spend of
18 hospital -- of these procedures going to the hospital? And
19 which percent of that are we being impacted by the policy
20 option you're talking about now? Is it half? Is it even
21 half of what is going on in the outpatient department? Is
22 it -- you know, you mentioned earlier that 25 percent in

1 teaching, maybe 5 percent in proprietary. What percent are
2 we talking about here?

3 DR. ZABINSKI: It's about 12 percent,
4 approximately.

5 DR. BERENSON: Another statistics question. You
6 were sort of getting at this. What percentage of outpatient
7 revenues are E&M? Is that a number you know? You said
8 there was a range from 5 to 25, you gave earlier. Is it in
9 the middle somewhere?

10 DR. ZABINSKI: That's one -- I don't know that. I
11 want to know it, but I don't know it yet.

12 DR. BERENSON: Okay. The reason I ask is that I'm
13 interested in the future work when we go beyond E&M, I'm
14 sort of -- because I think some of what's going on in the
15 market now is related not to E&M services, like cardiologist
16 services, et cetera. So I'm just getting a sense of how
17 much of this problem we're tackling with this policy.

18 DR. STENSLAND: And I just want to be clear. This
19 5 to 25 percent we're talking about, that's just a simple
20 count of services. So it might be a \$60 E&M service counts
21 as one, and, you know, the \$600 MRI counts as one. So on a
22 dollar basis it's going to be much smaller.

1 DR. BERENSON: Right. It might be lower, so
2 significantly lower. Okay. I think that will be important
3 to help us decide how much we want to go into this area to
4 know how small of the problem we're tackling here.

5 The other thing I had to follow up on the
6 provider-based discussion has to do with how we're framing
7 this discussion and the policy solutions. Jeff, you
8 presented -- one of your slides, 4, was about acquisition
9 and the provider-based discussion is about when is a medical
10 practice part of an outpatient department and when is it
11 not. But the broader trend, as the paper talked about, is
12 just employment, regardless of how the employment occurred.
13 And the policy we're recommending seems to be about
14 employment, not about provider-based per se. Do we want to
15 -- you can comment on that, but the question is: Is there a
16 role for us to be also working on the provider-based
17 definitions, the whole list that Ariel went through, until -
18 - because I would anticipate getting this kind of thing in
19 place will take long, you know, an equivalence of payment,
20 then maybe some short-term fixes to the provider-based
21 definition.

22 DR. STENSLAND: I think this really just addresses

1 provider-based. Getting back to the two types of
2 acquisitions, sometimes the hospital will buy a physician
3 practice and continue to operate it as a free-standing
4 entity. So nothing changes in Medicare billing. All the
5 stuff we're talking about, nothing changes. It's just if
6 they decide to make it a provider-based outpatient
7 department, then the billing changes and then some of these
8 policies --

9 DR. BERENSON: What I'm suggesting is that there
10 are fully integrated practices in a teaching hospital.
11 We're not talking about -- they're on campus. They're in
12 the office building next door to the hospital. Everybody
13 agrees that they're provider-based. The policy we're
14 considering would reduce reimbursement for those physicians.
15 It's not like they're 10 miles away in their usual practice.
16 The policy we're recommending isn't about sort of the
17 nuances of the provider-based definition, right?

18 Mark, you wanted to --

19 DR. MARK MILLER: No, no, I'm just following the
20 conversation along. It's true what you said, this policy
21 would affect the reimbursement for that practice, too. What
22 I'm not following in your line of questioning, are you

1 saying that we should not be focused on that, we should only
2 be focused on the off-campus? Or were you asking --

3 DR. BERENSON: I'm asking whether we're, I guess,
4 addressing the two problems separately or we think this
5 problem solves the other problem?

6 DR. MARK MILLER: Here's what I would say. Follow
7 this closely. And don't hit Dan, okay? Don't hit him. We
8 got to stop all the hitting that's going on.

9 [Laughter.]

10 DR. MARK MILLER: This is what I would say: Once
11 you've cleared out the first case where you have a situation
12 where the hospital is involved but they just let it run as a
13 free-standing -- that's out of this conversation -- then in
14 a sense there's -- simplifying, there's two ways you can go
15 from there. I'm employing the physician or I'm engaging in
16 a contract. Okay? Sort of the exchange that we had at the
17 beginning. It would definitely govern both of those
18 situations because you just say the payment rate would be
19 the same. And if I happened to have either of those
20 arrangements, either on campus or off campus, it would
21 govern those arrangements. And the only thing I was going
22 to react to was you could kind of go into the provider-based

1 rules and say, okay, I want to start redefining them and
2 clarifying them. In a sense, this is a more direct way to
3 send a signal that says this is what we pay when something
4 is done in this kind of arrangement, regardless of whether
5 you're on campus, 20 miles away, whatever the case may be.

6 Did I get that roughly right?

7 MR. WINTER: Yeah, and just to point out, we can
8 certainly think about playing with the definition of
9 provider-based criteria, but we should keep in mind CMS'
10 ability to enforce, you know, the existing criteria or even
11 changes or more restrictive criteria. We've talked to the
12 regional office staff who administer -- who enforce these
13 criteria, and they don't have the resources to -- they tell
14 us they don't have the resources to do it really
15 effectively, and they have heard about abuses, and it's just
16 hard for them to police all the variety of arrangements that
17 exist.

18 DR. BERENSON: My only point -- and maybe this is
19 a round two discussion, but my only point is we're dealing
20 with E&M services here, and we do have all of those other
21 services in which we're not dealing with it and which we
22 still have major payment differentials. And whether there's

1 a -- we'll come back to that.

2 DR. MARK MILLER: And you are right about that.
3 [off microphone]. This conversation so far is only about
4 E&M, and we have some thinking on some of those other ones,
5 but we're not down that road yet. And so if you want to
6 give some direction, this is the right time.

7 DR. CHERNEW: So Bob and Herb's question are like
8 understanding this Level 103. I'm still at 101, so I have
9 some more basic questions about the stuff that's sort of
10 outlined in the text box where you talk about these things.
11 Let me just make sure I understand.

12 Our belief is that whatever's going on in this
13 discussion we were just having, no one is actually moving.
14 So when the hospital is buying the physician practice, we
15 don't believe the physician practice is now moving to a new
16 office building or doing anything that's physically
17 different. So when you said it's the same services, it's
18 more than just the same services. It's the same services,
19 basically we think it's happening in the same location. So
20 that's my first question.

21 DR. STENSLAND: They don't have to move.
22 Sometimes they might, but they don't have to to get the

1 extra money.

2 DR. CHERNEW: So, again, I guess my question is:
3 But generally do they? I know they don't have to, but
4 should I be thinking about this like they had an office
5 building wherever they had an office building, and then they
6 happen to be within the 35 miles, then they got bought, and
7 so we should worry about how many physicians are in- or
8 outside of the 35 miles? Because that would limit this
9 problem. In other words, if everyone within 35 miles
10 already did this --

11 DR. STENSLAND: I think my general understanding
12 is often they don't move, but I'd also caveat that to say
13 that if we changed the policy so that if they do move they
14 get the extra money, but if they don't move they don't get
15 the extra money, then we might see a lot of moving going on.

16 DR. CHERNEW: But that's the way the policy is
17 now. If they do move, they get the extra money, and if they
18 don't -- if they're --

19 DR. MARK MILLER: No, no, no -- [off microphone].

20 DR. CHERNEW: No, I take that back. If you're
21 outside the 35 miles you have to move.

22 MR. HACKBARTH: [off microphone] 35 miles.

1 DR. CHERNEW: Right, so that's what I was trying -
2 - right, so the sense is that they don't move. And then my
3 second question is: Are there places where there's the Bob
4 practices that he was just talking about that are in the
5 hospital that actually were set up not owned by the hospital
6 in a particular way, or are all those ones owned by the
7 hospital?

8 DR. MARK MILLER: [off microphone] So do you
9 understand the question?

10 DR. STENSLAND: I don't know about in the
11 hospital, but there's certainly practices like right next
12 door, you know, the hospital owns the building here, and
13 then there's the practice there, and they're not part of the
14 -- they're not operating as a hospital-based practice.

15 DR. BERENSON: That's pretty common, to have
16 practices in a medical office building very close to the
17 hospital, and they are owned by the practices, not by the
18 hospital.

19 MS. BEHROOZI: This is maybe just a hair on the
20 tail of the dog here, but urgent care clinics, which we like
21 to encourage people to go to rather than the emergency room,
22 I guess they would be billing like an HOPD. Is that right?

1 Billing Medicare.

2 DR. ZABINSKI: I would think so, yes.

3 MS. BEHROOZI: We wouldn't be able to distinguish
4 them -- I mean, you know, you were talking about the
5 problems that CMS would have in sorting all of these things
6 out. There's no particular distinction or add-on to the
7 code or anything like that?

8 MR. WINTER: Only in they're an emergency
9 department where they get -- can they bill for ED visits, I
10 think.

11 MR. BUTLER: So this is a topic I know a fair
12 amount about. I've lived in this world in various settings,
13 but I'll comment on the academic medical centers in round
14 two. But I share some of Karen's issues. I'm not sure we
15 know where this is really residing and where the incremental
16 change has been. I think these things have been around a
17 long time, and they've quietly just kind of existed and not
18 been a real issue until probably the last two or three
19 years. That's what I sense. And I sense that the real
20 growth is in the community settings, off campus, where
21 practices may, in fact, be doing pretty much the same thing
22 they were doing before they were converted to employment.

1 But I don't know if -- and so kind of moratoriums
2 around that kind of thing makes a lot of sense. Now I'm
3 getting into round two, but part of where to target this is
4 kind of like just understanding the base a little bit
5 better, because I am also told, but I don't know, that some
6 critical access hospitals in rural areas also have been
7 participants for some time in this kind of practice. But
8 that's my question. Other than the comments that you had
9 for Karen on the academic medical centers, is there any
10 other area that you know of right now where this is more
11 prevalent, disproportionately prevalent, like critical
12 access hospitals in rural areas or something? So if we
13 apply a blunt instrument we don't get unintended
14 consequences.

15 DR. STENSLAND: So what we're talking about today
16 would be just the PPS payments, and so critical access
17 hospitals would be in a different bucket, and they do get
18 cost-based reimbursement for whatever their costs are for
19 the facility part of the E&M cost. So if somebody goes into
20 the critical access hospital -- and it's often just one
21 building, and there's a little wing there where they have
22 their exam room -- they get to bill the costs of that exam

1 room and that time as a cost-based reimbursement. So that's
2 separate from this.

3 MR. BUTLER: They'd be exempt no matter what then
4 because they're getting cost-based reimbursement for all of
5 their activity.

6 DR. STENSLAND: And there's a separate kind of
7 rural health clinic which can be hospital-based, which also
8 gets cost-based reimbursement for rural health clinics that
9 can be off site, and that's a separate policy, too.

10 MR. BUTLER: Okay.

11 MR. WINTER: And, Peter, you had asked about to
12 what extent is the growth occurring in community settings
13 versus like on the main campus, and unfortunately, we don't
14 have the data to be able to distinguish.

15 MR. BUTLER: I'm sorry. I had one other question,
16 back on the slide that Glenn cited originally where he was
17 looking for clarification on the --

18 MR. HACKBARTH: [off microphone] 12.

19 MR. BUTLER: Okay. So what really surprised me
20 was when you said there are provider-based clinics where the
21 hospital owns the -- it's a hospital department, but they're
22 contracting for the physician piece and the physician isn't

1 even employed. But they're getting the provider-based --
2 that's a new one to me. I had not heard that. I guess
3 that's permitted.

4 MR. WINTER: It's permitted, and we don't -- all
5 we hear are anecdotes. We don't know to what extent that's
6 a small minority of the models or not.

7 MR. BUTLER: I can't -- I'm trying to --

8 DR. MARK MILLER: There might be a
9 misunderstanding here, and if I'm wrong I'm sorry. But
10 you're saying under contract you think the physician can get
11 the \$75?

12 MR. BUTLER: No. I was back on Glenn's. If you
13 imposed a policy, we recommended one rate, you know, the
14 hospital is going to sit there and just charge the physician
15 rate and not send out two bills. There's no reason to send
16 out two bills and one gets paid at \$19 and one at \$49. And
17 then they just abandon the -- they would abandon the split
18 billing and just take your rate. And I think your answer
19 was, well, not so fast, because in some cases there is a
20 physician that is an independent contractor that would get
21 the 49 bucks, and the hospital would get the 19, and that's
22 really convoluted to me. I don't know of any example where

1 that exists. And maybe it does. It's a question.

2 MR. WINTER: A hypothetical. That doesn't
3 actually exist in nature.

4 MR. BUTLER: If you talk about tightening up
5 rules, I'm surprised that that would be permitted.

6 MR. WINTER: Right. On the -- there are -- when
7 we've looked at the literature and articles about the recent
8 trend, it talks more about hospital acquisition of practices
9 and employing the physician. We don't hear about the second
10 model, the one you were asking about where they just
11 contract with -- so it may just be -- they may not exist may
12 be a very small minority.

13 MS. UCCELLO: I'm going to ask a very basic
14 question. The facility charge for the outpatient, can you
15 just tell me what that includes?

16 DR. ZABINSKI: Well, it includes the cost of the
17 hospital employees, the cost of the examining room, you
18 know, any -- there's a small bit of packaging, say if
19 there's a -- you know, the outpatient PPS has a fair amount
20 of packaging of sort of low-cost drugs. If there's any low-
21 cost drugs administered during that visit, that would be
22 packaged in. But packaging is pretty minimal on these

1 things.

2 MS. UCCELLO: So how much of this is a fixed cost
3 versus a variable cost?

4 DR. ZABINSKI: I don't want to venture a guess on
5 that. I would think that fixed costs are fairly high, but I
6 don't want to venture a guess.

7 MS. UCCELLO: Because thinking about, you know,
8 whether we want to move that back more toward inpatient
9 versus outpatient, I think that matters.

10 MR. HACKBARTH: Just say a little bit more [off
11 microphone].

12 MS. UCCELLO: Well, if we're thinking we only want
13 to apply some of these costs to the truly inpatient kinds of
14 services, to the extent that any of these are true variable
15 costs that do apply to the outpatient services, we don't
16 want to completely take that away.

17 MR. HACKBARTH: I see your point now. This isn't
18 going to come out very clearly, but there's two different
19 reasons that you may want to pay more for the hospital, one
20 that I think may have some validity and the other I question
21 the validity.

22 One is that through regulatory requirements the

1 hospital needs to provide certain services that cost money,
2 the path that Bob was describing, and most of those, I think
3 Bob is right, are related to the inpatient mission of the
4 institution.

5 The second thing is that they might have higher
6 overhead costs because of, you know, their location, they're
7 in downtown areas or, you know, they've got union contracts
8 for nurses that, you know, independent physician practices
9 may not have, and those increase their costs.

10 That I would be less inclined to say, oh, we ought
11 to cover that if, in fact, Medicare can purchase the same
12 services for a lower cost and alternatives. So I think it
13 matters what the reason for the higher overhead costs might
14 be.

15 MS. UCCELLO: I agree.

16 MR. ARMSTRONG: Actually, a couple of points.

17 First, I do work in a market where I am seeing a
18 lot of this happen, and I have seen different structures for
19 the employment of the physicians independent of the
20 ownership for the practice itself. So I think there are
21 variations on this salaried kind of theme.

22 Cori, I think actually your question is related to

1 the question that I would ask here, and that is, my point of
2 view on this seems different than several of yours, and that
3 is that one of the main arguments for this kind of
4 consolidation and acquisition is actually to lower costs.
5 There are economies of scale. There are ways of avoiding
6 redundant investments and information technology, and that
7 we're actually talking about how hospital outpatient
8 departments may be more expensive as kind of an underlying
9 presumption. And I actually think that it's good to pay
10 equally for equal services, but, in fact, the Medicare
11 program should be asking how does Medicare benefit from the
12 argument that acquisitions like this, in fact, are lowering
13 costs? And I just wonder if you've -- in your analysis you
14 talk about many reasons why the acquisitions are taking
15 place, but you never talk about the stated goal to, in fact,
16 lower the operating costs or the medical expense trends. Is
17 that something you're not hearing or should we pay more
18 attention to that?

19 MR. WINTER: There was an article in the New
20 England Journal in May by Robert Kocher and somebody else
21 which argued that hospitals incur large additional costs
22 when they acquire practices in terms of bringing them online

1 with their EMR and with their other systems and that the
2 physicians are billing for fewer services. And so they
3 argue that at least in the first couple of years there are
4 up-front investment costs. They don't talk about -- I have
5 not heard as much about, you know, the efficiencies. Jeff
6 might want to comment on that. But even if there are lower
7 costs and efficiencies, the point we're making is that
8 Medicare is paying more regardless of any efficiency gains.

9 DR. STENSLAND: I guess I'm not so confident in
10 either direction, and I think back to the 1990s when there
11 was a lot of physician acquisitions by some of these private
12 entities that were going to aggregate these things, and they
13 all told the doctors, "We can run your practice more
14 efficiently than you can. Sell out to us." And a lot of
15 those places just went bankrupt. And maybe the hospital can
16 do things more efficiently, maybe not, but I think the
17 general idea is that if we pay equally, we're not distorting
18 the incentives to do one way or the other, and people can
19 gravitate toward the more efficient model of the two.

20 It is kind of the solution for those who aren't
21 completely confident they know the answer.

22 MR. HACKBARTH: So I want to go back and just make

1 sure I understand points that I thought I heard Karen, Bob,
2 and Peter make about distinguishing between sort of the old
3 line, you know, academic practice, been in place for a long
4 time as opposed to the newly acquired, previously
5 independent practices. I thought I heard each of you
6 indicate that you think that that might be a potential
7 distinction for policy. I'm not sure that I understand why
8 we would want to make that distinction. In fact, I would
9 fear that if we made that distinction, we would start
10 skewing how the delivery system develops in the future in
11 ways that may not be intended.

12 So I think the environment that we see right now
13 is that both hospitals and physicians see an interest in
14 coming together in new ways, in integrated practice, salary
15 practice, and the like. And some of those physicians are
16 physicians that are currently in practice in independent
17 practice. Some are physicians that are in training in
18 thinking about their future career.

19 If what we start to say is that, oh, if you're
20 part of an academic practice or you're part of a practice
21 that's on the main campus as opposed to 10 miles away or 15
22 miles away, we're going to pay you differently given this

1 dynamic, this urge on both sides to come together, I think
2 what we'll just do is we'll encourage them to come together
3 in a particular way, in a particular location that may not
4 be in the long-term interest of the health care system or
5 Medicare beneficiaries or the most efficient model.

6 So I think that, you know, drawing distinctions
7 among types of practices and, you know, whether this has
8 been around for a long time or a short time could have
9 unintended consequences. I do think it's better to focus on
10 the principle, we pay the same for the same service
11 regardless of the location, and then if we have concerns
12 about, oh, hospitals have regulatory burdens and associated
13 costs, let's figure out another mechanism to pay them that
14 doesn't skew the delivery of, you know, basic E&M services.

15 So that's my round two comment.

16 DR. BORMAN: Well, first, my question was a little
17 more -- not necessarily having a clear endpoint of saying
18 that some sorts of practices should be treated differently,
19 because at the end of the day I think I come to the same
20 place you do about that we say that one of our goals is
21 accurate pricing, and I think that one of the things we've
22 tried is also to try and name some consistency of principle.

1 And so those two things would suggest that our default
2 position is that same services are paid in the same way.

3 Now, there's a lot of room for nuance there in
4 terms of is it really the same patient population or the
5 same service or whatever, and those may have to be captured
6 in different ways than we have traditionally captured them.
7 The appeal of this in evaluation and management services,
8 albeit Bob's point that it may be the tip of the iceberg is
9 a very well taken one, is it as something that it is more of
10 an apples-to-apples comparison and something that we could
11 act with principle, I think, sooner than we may be able to
12 act on some of the other pieces.

13 I share Bob's belief that the money is much more
14 in the other services. That's part of the reason they're
15 migrating as physicians and hospitals come together. These
16 services are migrating to the HOPD, and there's an awful lot
17 going on here that relates to a lot of other factors. The
18 inclination of today's residency graduates to be employees
19 rather than independent business people I think plays into
20 this in a huge way that, you know, certainly we shouldn't
21 account for in payment, but it's part of what is behind the
22 availability of physicians to do this kind of thing more so

1 than there was in the past.

2 I think that the reality is that probably this
3 double payment, if you will, is part of what's enabling at
4 least starting out with physicians not losing income when
5 they do this. And the reality is that if we change that,
6 the attractiveness of the model may go down. But a
7 corollary then is: Is this behavior of coming together
8 something we want to encourage as a way toward systemness.
9 And so we have a good goal and a perverse consequence sort
10 of meeting up here that I'm not sure we know the resolution
11 to. And I think that we have to be cognizant of what we're
12 trying to encourage or not in the context of doing policy on
13 this.

14 Another thing we have not talked about -- and I
15 know certainly at least in my generational group of
16 physicians a lot did this over the past five to ten years,
17 and they did it to some degree, to large measure, motivated
18 by economies of scale in their practice expenses and
19 particularly their ability to get a lower professional
20 liability rate by virtue of doing this. We haven't touched
21 on that at all, and that's a huge difference here in higher-
22 risk specialties -- OB, anesthesia, the surgical

1 disciplines, and in certain parts of the country. And so
2 that's a factor behind all this that we would need to
3 acknowledge, I think.

4 So we've got this big thing that I'm not sure we
5 can get around all the nuances quickly. I am led to believe
6 that if we look at this one small piece, E&M services that
7 don't have a lot of ancillaries bundled around them, that do
8 have a pretty much office visit to office visit, skills,
9 supplies kind of thing, and there is the ability by virtue
10 of levels within the service to capture or to generate a
11 higher charge because of the intensity of the visit and
12 resources consumed, that this is a reasonable place to act.
13 But as Bob rightfully points out, it's not the biggest piece
14 of the puzzle, and we need to dig some more on that to try
15 and get that right.

16 And my last comment would be that we talk about
17 patient selection, and you've appropriately mentioned
18 several times the right side of service to be safe for the
19 patient. I cannot emphasize too much how important it is
20 that we protect that. Just as an example, I was at the
21 American College of Surgeons meeting last week and went to a
22 session that was "Nightmares in the Ambulatory Surgical

1 Center," and they circle around that patient selection is
2 absolutely key. And that is a complex interchange of risk-
3 adjusting for the patient, but also what's the nature of the
4 procedure and what is the sedation or anesthesia or whatever
5 that needs to be done there, and to some degree how far are
6 attorney from a hospital? You know, this 35-mile thing is a
7 little bit scary, what you might be doing there versus what
8 you're doing if you're on the campus.

9 So I would say my bias would be let's move -- I
10 think we could continue to move forward on the E&M side. I
11 think there are some things we need to know on the bigger-
12 picture side, but that our principle, as you outlined,
13 Glenn, should be right pricing, accurate pricing, and
14 consistency, taking into account those factors.

15 MR. HACKBARTH: As you know, Karen, I really agree
16 strongly with your point about getting patients cared for in
17 the proper location is key, and moving into areas like
18 ambulatory surgery raises much more complicated issues, I
19 think, than E&M services.

20 MR. GRADISON: I may be repeating some of the
21 points which Karen just made so well, but to me personally,
22 the part of this that I wish I knew a lot more about is why

1 are we seeing these acquisitions take place and to what
2 extent is the issue we're discussing, the specific issue
3 we're discussing right now an explanation.

4 Certainly, a lot of hospitals were badly burnt by
5 their experience some years ago and are approaching this
6 acquisition matter in a quite different manner today because
7 of their experiences, which, as I understand them in talking
8 with some of them, was a significant drop in the
9 productivity of the physicians once their practices were
10 acquired.

11 Now, this has implications for us because it means
12 that there is, if anything, from the point of view of things
13 we talk about here all the time, an encouragement to do more
14 work, to do more procedures that is inherent in the hiring
15 decision, because to try to correct for what went wrong the
16 last time. That's just another piece of this.

17 But what I'm really suggesting is that it would be
18 helpful to me to know how important this -- and I know it's
19 a judgment call, but how important is this differential in
20 explaining the rather dramatic change that's taking place?
21 That's point one.

22 The other thing I want to mention is that I think

1 there are ways to deal with this in a more surgical manner
2 without even changing those numbers, with keeping the
3 present rate -- this is just a for-instance. You could have
4 a blended rate phased in over three to five years where at
5 the time for the first year when a doctor moves into doing
6 E&M under the hospital license rather than under their own,
7 they're paid four-fifths, of course, by the old rate and
8 one-fifth by the hospital rate, and phase it in, which would
9 take some of the juice out of this thing and not necessarily
10 require a change across the board. Whether that makes sense
11 in my mind would be determined, the way I would think about
12 it, a lot by trying to understand how important is this
13 differential in the decision, the strategic decision of the
14 hospital.

15 I mean, there are a lot of advantages in having --
16 from a point of view of comprehensiveness of care, in terms
17 of the patients, in terms of what you're trying to
18 accomplish here. And I don't think we want to stifle that
19 if we see benefit from it.

20 Those are the thoughts I have at this time.

21 MR. HACKBARTH: Peter and George, as people with
22 experience in this business, do you want to try to address

1 Bill's first question about the motives and how institutions
2 are approaching it differently this time than the '90s? You
3 and I were talking about that yesterday at lunch, Peter.

4 MR. BUTLER: Well, you know, I can't speak for all
5 hospitals, that's for sure. I think that the difference
6 this time is, first of all, they're not paying money for
7 good will. The most typical arrangement that is occurring
8 is that physicians may be guaranteed a salary for two years
9 that is comparable to what they're making now, and then they
10 move to a productivity-based kind of arrangement that, you
11 know, fluctuates up and down based on what they do and what
12 they see. So that's quite a different thing.

13 I think some of the motivations are the same in
14 the sense that I think the principal reason for employment
15 is they don't want to be left out, and they want to keep
16 their patients and be a part of something that's successful.

17 Another motivation that is more accelerated than
18 last time is kind of the administrative hassle factor of
19 running a practice has never been greater. So they're
20 looking at, I'll never be a meaningful user in my practice
21 the way I am now. I need help, and I need money to make
22 that happen. And, furthermore, all of these value-based

1 purchasing arrangements, it was one thing just to be part of
2 a contracting entity. Now I have to -- whether it's PQRI,
3 you name the initiative, I need help in making that -- I
4 want to be a part of something successful that can help me
5 with that, and let me spend most of my time still being a
6 doctor.

7 So I think a lot of the motivations are actually
8 pretty good on both the hospital side and the doctor side,
9 and, frankly, it is exactly what we want to see. I don't
10 see that free-standing private practices that have paper
11 charts and are doing things that they're just not in sync
12 with the kind of care coordination that is going to have to
13 occur.

14 So I think it is a different day, and
15 unfortunately, there are some -- I think in this particular
16 issue, in this particular case, I think we probably
17 overstated in the document this issue as being why they're
18 being employed. It's third or fourth on the list. It helps
19 facilitate employment, but it's certainly not the reason for
20 employment. They're the bigger issues that I just mentioned
21 that I think really are getting physicians so, okay, I want
22 to be part of something bigger, something that is going to

1 help me be successful and be a good doctor in the future.

2 MR. HACKBARTH: Peter, did you mention negotiating
3 leverage with plans being part of a larger organization in
4 your list? And if not, do you see that as a factor?

5 MR. BUTLER: Well, of course it's a factor.

6 Anybody who wants to be part of something -- you know, if
7 I'm out there on my own and I have got to negotiate on my
8 own, how am I ever going to be successful? But I don't know
9 that if a doctor themselves are thinking, I'm getting low
10 rates, I got to be -- I don't know if they're thinking about
11 it at the individual doctor level, no. Do hospitals think
12 about that? Do big physician groups think about that?
13 Sure.

14 MR. GEORGE MILLER: Yeah, very similar to Peter, I
15 remember I was in Texas in the '90s and the difference then
16 between now is that we were concerned about managed care and
17 capitated rates, and that's why we bought physician
18 practices. And as Peter indicated, we paid Goodwill or Blue
19 Sky for those practices, and we paid salaries. And the
20 concern then was productivity. They got the salary. I
21 remember one physician immediately took his 30-day vacation
22 back then.

1 Now the difference is, as Peter stated -- all of
2 my neighbors surrounding me are cardiologists, and I see
3 them in the driveway in the morning, and the hassle factor
4 of the practice, the cost of the practice, the malpractice,
5 all of the regulations they had to deal with with HR, with
6 documentation, meaningful use of EMR, all of those issues
7 now, they don't get the reimbursement issues, but all of the
8 cost factors. And then as I talk with physicians coming out
9 of medical school, they just don't want the hassle of
10 starting a practice.

11 So, again, I agree with Peter. The reimbursement
12 is not the issue. It's just the change. And the physicians
13 that are coming out of medical school, they say they want a
14 family, they want a lifestyle, they want predictability.
15 They do not want to start a practice up, particularly in
16 rural areas. They want to be employed. That is just a
17 driving factor.

18 MR. ARMSTRONG: One comment. We're not hospital-
19 based, but we're involved in acquisition and consolidation,
20 and I just think that a lot of these are going to fail like
21 they did in the mid-1990s. But I think that the ones --
22 this is partly based on my experience, and partly this is an

1 opinion. But in the context of an industry that sees the
2 value of integration, that's promoting ACOs, that really is
3 beginning to recognize that you can drive better quality and
4 lower costs, better value, and, in fact, it's probably the
5 best way to achieve those goals through the integration and
6 consolidation of practices. Those organizations that are
7 going into this with that mind-set I think are the ones that
8 are going to succeed, which is the reason for my point
9 before, that we're taking our payment policy into this
10 arena, and it's a very small little sliver, what we're
11 talking about today, and has little impact, but with the
12 mind-set that we're trying to defend against overpayment.
13 But, in fact, I think this is really just another
14 opportunity for us to reinforce the ideals of integration
15 and consolidation and that we shouldn't be silent on that.

16 DR. BERENSON: I'll just comment because I was a
17 co-author of an issue brief that was cited in the paper for
18 Health System Change and it was based on interviews with
19 hospital executives and physician groups. And what you
20 heard around the table are the multiple reasons why docs
21 want to be employed. And George is exactly right.
22 Lifestyle and predictability is all part of it. Some are

1 doing it for higher reimbursement. I mean, there's just a
2 mixture. But I just wanted to pick up specifically on the
3 point Bill Gradison was making, and it's absolutely correct.

4 Virtually without exception, every hospital who
5 was talking to us said they had made a mistake in the 1990s.
6 They took these hard-working, industrious docs, and they put
7 them on salary, and they went on vacation, sort of
8 figuratively if not literally. And so learning from that
9 lesson, they are all not only productivity but work RVUs.
10 The thing that gets published in the Federal Register, that
11 is something that we care about, which is part of the
12 Medicare fee schedule, is the tool that is used to determine
13 productivity, and that's how docs are getting paid.

14 So to Scott's point, simultaneously the hospital
15 folks would say we're aligning with docs so we can become
16 ACOs, so we can be part of new efficiency models and higher
17 quality, and then ten minutes later in the conversation,
18 we're putting them on productivity metrics to make sure that
19 we take advantage of the fee-for-service environment. And
20 how they're going to sort of turn a switch and turn that off
21 and turn on a new payment model is what I'm not so sure
22 about. I think most of those organizations haven't sort of

1 thought that through very much, and you're right, there are
2 some who have.

3 So I wanted to contribute that part.

4 MR. HACKBARTH: I need to get back into the queue,
5 and, Bruce, I appreciate your patience here, but Karen and
6 Bill I think were raising important issues, and we had some
7 expertise around the table that can help ground our
8 conversation in reality. So it seemed to make sense to take
9 advantage of that.

10 Let's continue with round two, and Bruce is up.

11 MR. GEORGE MILLER: Yeah, and Bob just reminded
12 me, the environment now, just to respond to what he said,
13 the difference between then and now is the ACO model and
14 bundled payments and trying to be more efficient, and
15 certainly, using RVUs as an emphasis for the physicians to
16 be much more productive.

17 I want to go back to Peter's question and ask it
18 from a rural perspective, rural hospitals, and that is, how
19 many of the outpatient departments in rural areas did you
20 find? And isn't there a difference, if I remember
21 correctly, that the payment -- outpatient departments in
22 rural areas include the cost of the drugs, but the

1 physicians that were not part of that can then bill
2 separately for the drugs. Am I correct about that? No?
3 The bundled payments for the outpatient department includes
4 the cost of the drugs, but the physician, if he's
5 independent, can then bill -- he gets his professional fee,
6 or she, and then can bill separately for the drugs, which is
7 different from the rural outpatient department. Is that
8 correct?

9 MR. WINTER: Okay. So, yes, the cost of drugs --
10 under what? Sixty dollars a day? It's probably higher than
11 that now.

12 DR. ZABINSKI: It's like \$80 a day.

13 MR. WINTER: Okay, \$80 a day. So those are
14 packaged with the associated service.

15 MR. GEORGE MILLER: Right.

16 MR. WINTER: Under the physician fee schedule, the
17 cost of drugs is billed separately outside the fee -- I'm
18 sorry. They're not paid under the physician fee schedule.
19 If the physician is providing the drugs, they get a separate
20 Part B payment.

21 MR. GEORGE MILLER: Right.

22 MR. WINTER: But I don't think that if the

1 physician is providing this service in an outpatient
2 department that they can bill separately for the drugs if
3 the outpatient department is submitting a claim. That would
4 seem to me to be --

5 MR. GEORGE MILLER: No, that's my point. They
6 can't do that, and so we don't have an apples-to-apples
7 comparison, do we?

8 MR. WINTER: That would be a concern for services
9 with a lot of packaged drugs, and we raised that as one of
10 the issues we will be looking at in the future. For E&M, as
11 Dan was saying, the cost of ancillaries is a very small part
12 of the payment under the outpatient PPS for E&M services.

13 DR. ZABINSKI: I found that about 3 percent of the
14 total costs of the E&M services in OPDs is for ancillaries,
15 including separately paid drugs -- or the packaged drugs.

16 MR. GEORGE MILLER: So 3 percent of the \$75 charge
17 or 3 percent of the \$19?

18 DR. ZABINSKI: It's 3 percent of the \$75.

19 MR. GEORGE MILLER: But then that's going to be
20 absorbed if you change the fee to \$19.

21 DR. ZABINSKI: Correct.

22 MR. GEORGE MILLER: And then there's a limit on

1 the drug costs. The package price for the drugs is limited.

2 MR. WINTER: Right.

3 DR. ZABINSKI: Yes.

4 MR. WINTER: If they provide a drug that is above
5 the threshold, they would still get paid separately for that
6 as under the current system. So that would be in addition
7 to the \$19.70, or whatever the rate is set at.

8 DR. CASTELLANOS: Thank you. I was a little
9 surprised that you asked all the hospitals why they're doing
10 it, but you really haven't asked the physician community why
11 they're doing it. And there's two sides to the equation.
12 Bob said some of the issues. I think you really need to
13 look at the root problem. Now, I joined a large group. I
14 did not join a hospital. But there's a lot of reasons I did
15 that, for some of the same reasons that Peter mentioned why
16 doctors are doing things today.

17 It's a different world today. It's a different
18 day. We do want to be part of something successful. We
19 recognize that the independent physician working in a small
20 office is very limited on his ability to negotiate. I think
21 you all remember John from Humana, and he and I went around
22 and around one time during a meeting where Humana was

1 offering me 85 percent of Medicare rates for a private
2 contract. And since I joined a group, I was able to
3 negotiate and got 120 percent. So it is a business model
4 that we're doing. It's not dollars. It's a business model.

5 We're looking at lifestyle. There's no question
6 about it. We're looking at less strain. We're looking at
7 trying to get away from the burdens of administration.

8 It's very similar to when we saw the concierge
9 practice. Why are doctors going into concierge practice?
10 For a better lifestyle, for doing what they were trained to
11 do, to be able to spend time with patients.

12 So it is a different day, and I think we really
13 need to look at the root problem of why not just hospitals
14 are doing it, and they're doing it to fill their panels,
15 which you need. They're doing it for coverage. They're
16 doing it also for financial reasons. And I think physicians
17 are doing the same.

18 I remember Bob Reischauer, one of the most
19 important point I remember him ever saying is it's not the
20 site of service that's important, it's what's most
21 appropriate for the patient. I'm switching to another side.
22 So I really believe that it is more expensive to see a

1 higher-risk patient in the HOPD. We saw it, for example, in
2 the material that was given to the Commission with
3 colonoscopy. There's no question it takes more time, it
4 takes more skill, it takes more appropriateness, but it's
5 paid the same.

6 So I think sometimes we need to pay on a risk
7 adjustment basis rather than a site-of-service basis, and
8 there's just no question that as we go down this cycle, that
9 when we get into outpatient facilities, et cetera, that we
10 may want to consider that.

11 I have no problem with the present. I think there
12 is some rationale for trying to make payments equal on the
13 E&M side, but I do have some problems as we go further down
14 in the cycle. And my suggestion is we go very slow on this
15 and we try to get input from as many people as we can.

16 Again, I congratulate us for addressing this
17 problem. It has been a problem that has been a difficult
18 situation for physicians in the community and for the
19 hospitals, but also for the clinics. There are a lot of
20 large clinics or practices that do it. I would strongly
21 suggest that we do this very, very slowly.

22 Thank you.

1 DR. NAYLOR: So others around the room appreciate
2 the complexities of this much more than I, so I'm just going
3 to reflect on the great report I read and this conversation.

4 I do think evaluation and management is a pretty
5 predictable service. We know what we are looking for, and
6 we actually have really good measures of -- we know when we
7 get it. So if there's any opportunity to think about
8 getting to equitable payment for the same service, I think
9 this represents a really important starting point. And I
10 think it is absolutely consistent with our efforts to get to
11 thinking about the most efficient provider, so if we're
12 going to be internally consistent in trying to work toward
13 that.

14 I also appreciate that people are at different
15 risk, and the E&M service allows for that. As Ariel and
16 others, Jeff, said, you can lengthen the service and get
17 paid for a longer service to accommodate people of different
18 needs.

19 So in this case, I think that there's an urgency
20 to capitalize and take advantage of this opportunity to, in
21 some ways, to move a service or a payment for a service in a
22 way that also capitalizes on our interest in moving toward

1 community-based care. And I think it promotes continuity,
2 it promotes integration when it all can happen in the right
3 way.

4 I do not think access to the Medicare
5 beneficiaries will at all be affected by this change. And
6 finally, I think the costs -- really, this slide, Slide 8,
7 which says that if we were to increase by 50 percent where
8 we sent these services to outpatient departments, the cost
9 growth which could happen, not just to the program but to
10 the beneficiaries, is dramatic. And here's an opportunity
11 to really go the other way, \$10 billion savings in ten
12 years.

13 So to me, I would say, I think this is exactly
14 where we need to be going because we know this service, and
15 it's a great one to move on in terms of equalizing payment.

16 DR. HALL: I'm not going to repeat some of the
17 arguments that have already been very well stated.

18 Look, I think what we're talking about here are
19 E&M services -- just to sort of constrict this down, because
20 part of our conversation is confused by we can't have the
21 same conversation about a lot of technologically-based
22 services and E&M, but let's just look at what we've been

1 looking at, the 222 million E&M office visits, ten percent
2 or so of which are now in hospital-based practices.

3 So let's take the viewpoint of the patient. So
4 I'm 75 or 80 years old or whatever and I get my primary care
5 from Dr. X and his associates. It's not clear where I live.
6 I might live in a large urban area or a rural area. But in
7 either circumstance, I'm probably going to be best served if
8 I can go to a practice that knows me, that has consistent
9 physicians and health care providers, and in all probability
10 in the vast majority of instances that's going to be in what
11 we now think of as a freestanding ambulatory facility. It's
12 not going to be in a larger hospital where the primary care
13 geriatrics clinic is squeezed between the MRI machine and
14 the lithotripsy machine. And we're also very concerned, as
15 we were last month, about preserving primary care.

16 So if I'm that primary care doctor and I feel
17 threatened by a hospital coming in and setting up something
18 else, I think the principle is that for the same service,
19 the same fee ought to be paid. Otherwise, I think, as Mary
20 has alluded to, we're really sort of speaking out of both
21 sides of our mouths in terms of our desire to promote a
22 medical world that will have primary care services that are

1 efficient and amenable to our Medicare population. So I
2 think that helps me in that situation.

3 But the flip side of this is that under Medicare
4 rules, I am required, no matter where I work, to comply with
5 certain requirements of Medicare. Let's just take a very
6 recent one, as of today or that's coming up today, is that
7 physicians are now under meaningful use supposed to have a
8 certain percentage of their prescriptions submitted
9 electronically. Now, I can tell you that any hospital-based
10 practice is probably already at 100 percent because it's
11 built into the infrastructure that presumably is paid for by
12 these extra fees. But in many parts of the country, only
13 about 25 percent of practices are going to be compliant, in
14 which case presumably they're going to be penalized, then,
15 in their Medicare reimbursement.

16 So, if you will, equal pay for equal work, but
17 let's also remember that maybe the overhead involved in
18 these practices may not be enough at this point to allow
19 them to do the work. So there may have to be not just
20 moving down to where the primary care fee schedule is, but
21 some compromise somewhere along the way to allow them to
22 continue to practice in that environment.

1 MR. KUHN: Thanks, Glenn. This has been a good
2 discussion about a site-neutral payment system for the
3 ambulatory side, and obviously we're talking just one part
4 of that site-neutral and that is the E&M codes that are out
5 there.

6 So when you look at Slide 15 where you ask the
7 Commission discussions and you had those three dot points up
8 there, I thought I would just talk about the latter two,
9 about future issues to examine and additional questions and
10 research, and I have kind of three general areas that I
11 thought would be helpful for me as we continue to move
12 forward.

13 The first would be kind of the rural impacts. As
14 Ariel walked us through the discussion of provider-based,
15 I'd like to kind of get a better understanding of how this
16 might be impactful in rural areas, rural systems that are
17 out there, critical access. Jeff, there might be some
18 portability in terms of some of the work that you're doing
19 on that report that we're looking at for Congress next year,
20 so hopefully not a lot of new work, but maybe, again,
21 there's some portability in the work out there. So that
22 would be kind of one area of impacts that would be helpful.

1 The second area of impacts would be kind of what
2 we've talked a little bit about here that both Karen and
3 Bill and Bob have talked about, and that is kind of what's
4 the order of magnitude that we're talking about here. You
5 know, we've got this 220 million codes. What subset is the
6 E&Ms? And then also stratify, if we can, by types of
7 facilities that are out there. You know, Karen asked the
8 question about teaching. You talked a little bit about
9 proprietary, rurals, just community hospitals, so we can
10 kind of get a sense of the order of magnitude.

11 And then the third issue a little bit came up,
12 and, I guess, when Ariel was again walking through the issue
13 of the provider based, when these facilities do become
14 provider based, they then become under, as you kind of
15 indicated, all the requirements that hospitals have, and you
16 talked about EMTALA, but I assume also -- you didn't mention
17 it, but I assume also the COPs as part of that. So I'd like
18 to understand a little bit about the impact of the COPs, and
19 from two areas specifically.

20 One is what might impact this beyond access? For
21 example, under -- you know, we know physician offices have
22 no COPs that are out there. But on the hospital side, if

1 you take Medicare, you're also required to take Medicaid, as
2 well, and since E&Ms are largely the primary care codes that
3 are out there, if we did this, would this create an access -
4 - could this create an access barrier in the future for some
5 folks who can't access a physician in Medicare or Medicaid,
6 in a physician office, but if it's through a provider-based
7 facility that's attached to a hospital, would that limit
8 their access on a go-forward basis. If there's anything out
9 there that can kind of help us understand that.

10 And then picking up on Bill's point when he was
11 talking about EMRs, I think from what I've seen in Missouri
12 is that those that have become provider-based tend to be
13 ahead of the game in terms of not only the EMRs he
14 mentioned, but also in the whole realm of care coordination.
15 And so if we were to do this, does this slow down the care
16 coordination effort or does it just -- would it continue
17 with the other incentives out there? I'd just like to know
18 the interaction of those two things together, I think would
19 be helpful to understand better, too.

20 DR. BERENSON: Okay, just a few points. First, to
21 address the point you made in your comments, I think some of
22 us have distinguished the provider-based issue from the

1 overall payment because we're right now distinguishing the
2 services we're considering policies to. If we were able to
3 have a policy that extended across all services, then I
4 think those distinctions should disappear because I
5 basically agree with you that we wouldn't want to, by our
6 rules, determine what these particular configurations of
7 doctors and hospitals are going to be. So I see this only
8 as a transition until we get to a full policy.

9 Second, I think we can move more quickly than Ron
10 maybe suggested. You know, the Deficit Reduction Act acted
11 overnight in saying that doctors wouldn't get imaging
12 services in doctors' offices for MRIs, PET and CT would be
13 the same as outpatient, without an awful lot of thought, and
14 that's actually worked out pretty well as far as I know,
15 that policy. I'm not saying we should do it exactly that
16 way because I think we do need to do a little more evidence-
17 based work.

18 I would very much like to move quickly to
19 considering the whole universe of services that are provided
20 both in an outpatient department and in the doctor's office,
21 but I think we do need to understand more about whether
22 there are systematic differences in severity of illness

1 which would be presumably manifested in different variable
2 costs, which I would consider in that case a legitimate
3 variable cost difference if it's reflecting more staff or
4 something that you need for sicker patients.

5 I don't know how complicated that would be, but I
6 think that would help me decide whether we want to go to a -
7 - I said in my first remarks that we should either pay the
8 same or small differences. Right now, we have differences,
9 according to the table you provided in our handout, as much
10 as 400 percent payment differences for removing actinic
11 keratoses. I can't imagine you need a major severity
12 illness adjustment for doing liquid nitrogen applications to
13 the skin, but maybe you can justify five or ten percent on a
14 systematic basis. If we had differences on that magnitude
15 which reflected real differences in severity, we wouldn't be
16 distorting the market. When we have differences of 200
17 percent, 300 percent, we are creating distortions.

18 So I don't know that it has to be the same
19 payment, but I think if we have differences, they need to be
20 -- there needs to be a basis for those differences other
21 than what we've currently got.

22 And then, finally, I would, consistent with the

1 discussion earlier about applying the extra -- the hospitals
2 into the unique hospital-provided services, I'd like to
3 understand a little more about these particular obligations
4 that hospitals have, as Herb says, including the COPs and
5 seeing where those costs can be attributed, and know just a
6 little bit more if there are any of these sort of special
7 obligations that legitimately are attributable to outpatient
8 services rather than as, I think, largely inpatient or
9 emergency department services.

10 DR. CHERNEW: Thank you. This is a fascinating
11 topic, and sometimes I think we get so caught in the
12 details, we sort of miss the headline, and I think the
13 headline here is that the fee-for-service system is loopy.

14 [Laughter.]

15 DR. CHERNEW: And I think that transcends just
16 this discussion, but it goes through a whole series of
17 discussions we have, that if you listen to the discussion,
18 you're, like, really? We're really having this discussion?

19 [Laughter.]

20 DR. CHERNEW: So my general view is that, as a
21 baseline, we should pay the same rate for the same service.
22 There's a question about what that rate should be, and what

1 hasn't really been said here is part of the reason this may
2 be going on is that the physician office rate was just too
3 low for a bunch of reasons and so people wanted -- so we
4 don't know what the right rate is. I think, in general, it
5 should be the same rate.

6 I agree 100 percent with Bob that maybe it should
7 be risk adjusted. Maybe we need a little difference of five
8 or some percent. But the rates we have now just clearly are
9 not right, and all the cost arguments you make are great in
10 the level, but they can't explain what's going on in the
11 same practice. They're switching from one to the other and
12 they're doing the same thing because their costs weren't
13 changing to justify what was going on.

14 I am worried in some ways, of course, because I
15 believe that we have to move on to a better fee system, that
16 some odd inadvertent aspect of this is encouraging
17 integration, which is basically the way we want to go
18 because integration encourages and facilitates different
19 types of fee schedules. My general view is that, despite
20 that, this shouldn't be the mechanism to encourage that
21 level of integration. We need to find some other way to
22 think about that as opposed to having the -- you don't want

1 a system where we've set the fees wrong just because it
2 helps us get somewhere we want to go. I think you want to
3 set the fees right and find some other way to get to where
4 we want to go, and I think some of our other recommendations
5 in other sessions have sort of led to that.

6 I will say that when we did our evaluation of this
7 alternative quality contract in Massachusetts where they put
8 physicians in a bundled payment, one of the things you saw
9 was there wasn't huge changes in utilization, but the
10 physicians shopped around and got better prices. They saved
11 their money by finding cheaper settings to deliver the same
12 services. And I think you would see that type of stuff
13 going on.

14 I also agree with Bob that I am on the side of
15 expanding and moving quicker to investigate this and doing
16 so in the spirit of trying to get us to a reasonable fee-
17 for-service system as we transition away from a fee-for-
18 service system.

19 MR. HACKBARTH: Mike, can I ask a question about
20 your evaluation of the alternative quality contract? I read
21 your piece and heard you make that point before that, at
22 least initially, the most significant savings were not from

1 reduction of utilization, but going to lower-cost providers
2 of the services. When you looked at that in Massachusetts,
3 were you able to distinguish between hospital-owned
4 practices as opposed to practices that were part of an
5 organization under the quality contract?

6 DR. CHERNEW: No. We weren't able to distinguish
7 that, or the extent to which they were going from one
8 outpatient facility that was just more -- had a more
9 expensive rate to another one. One of the challenges in the
10 private sector, of course, is there's huge variation in the
11 rates that are different than just driven by the site. So
12 they have variations that you could look exactly the same
13 and there could be this variation of rates. So you could go
14 from one hospital outpatient to another hospital outpatient
15 if it's cheaper.

16 So you've seen anecdotally in Massachusetts, for
17 example, large groups, some of which you have been
18 affiliated with, suggesting that they're moving some
19 referrals from one large center to another large center,
20 those that have the exact same ownership if you tallied them
21 up in our data, the same type of ownership -- they're both
22 big academic centers -- it's just one had a lower rate than

1 the other. And so we don't have in our data the ability to
2 do exactly what you asked and I think more of some of the
3 other --

4 MR. HACKBARTH: So a Harvard Vanguard can respond
5 to the alternative quality contract by moving services from
6 the Brigham to the B.I. Deaconess system.

7 DR. CHERNEW: Right.

8 MR. HACKBARTH: But if it's a Brigham-owned
9 practice, moving their services to the B.I. Deaconess is
10 probably not an option for them.

11 DR. CHERNEW: Right. No, exactly, and we'll see.
12 I mean, of course, the other thing they can do is they can
13 send some services out, and one of the things we're looking
14 at going forward is a very complicated, under the
15 alternative quality contract or any bundled payment system
16 more broadly, there's a complicated make or buy system, and
17 you have to think about what the marginal cost of providing
18 it versus what the actual fee is when you're doing it
19 internally. So it's a complicated --

20 MS. BEHROOZI: So we're looking at it from the
21 point of view of the payer wanting to pay the same thing
22 across services, and I firmly believe in that. I think I

1 said last time that we don't pay the facility fee. We just
2 pay the physician fee. We don't pay a split lower HOPD rate
3 plus facility. What we often get is the bill for the
4 physician services plus the facility fee, so looking for a
5 real premium on both, even what the HOPD rate would have
6 been, and we just say, no, we don't pay that facility fee.

7 But we also pay ER visits that are coded at
8 levels, you know, where the diagnosis code is really worthy
9 of an E&M visit, we pay an office visit rate to ERs. One of
10 our more unique, I guess, situations is that we have
11 employers, who happen to be hospitals who happen to have ERs
12 who have, in many cases, eliminated their employee health
13 services and so they're sending people to the ER when they
14 have a stomachache or whatever, and so we've had to be very
15 vigilant about that. So we pay ERs, urgent care centers,
16 HOPD - well, leave the HOPD out for a minute, but just
17 hospital-owned physician practices or hospital-contracted
18 physician practices, we pay the same thing across the board.

19 But where Medicare is paying more for an ER visit
20 for something that they would then pay an urgent care center
21 less, then you may have -- because Medicare is such a large
22 payer, obviously, we're not going to influence things no

1 matter how big we are in Europe, we're not big enough to
2 influence -- you may have a disincentive for institutions,
3 hospitals in particular, to set up urgent care centers,
4 which are a better alternative than an ER for people who
5 really don't need emergency services but can't get to a
6 physician office because it's after 5:00 p.m., for example.
7 And they do have a little bit higher overhead because they
8 are operating longer hours and they are making -- they are
9 trying to keep more services available.

10 So I have a little bit of a concern looking at it
11 from that direction of trying to keep available or make more
12 available less than emergency-level services but more than
13 what a regular physician office can provide. As Mike says,
14 maybe the physician office visit isn't the right price or
15 maybe there's different gradations to make sure that you
16 don't eliminate some middle swath of services that you
17 otherwise need and drive things to the high and low ends.

18 MR. BUTLER: Several comments. I can't resist to
19 go back to Bob's comment on RVUs being counter to the -- I
20 go back to my Henry Ford Health System days when we felt you
21 couldn't get a private practice doctor into a meeting and
22 you couldn't get a group practice doctor out of a meeting --

1 [Laughter.]

2 MR. BUTLER: -- and we struggled, whether they
3 were flat salaries, we had all this capitation, but you
4 still wanted to get work effort out of them and you had to -
5 - so, you know, how do you do that? And so percentage of
6 time to get an appointment, all kinds of other things. How
7 do you get it down at the ground level, you know, a sense of
8 energy and work effort, and RVUs isn't.

9 So in our contracting, we do have a lot of pay-
10 for-performance in our contracts that does reward the kind
11 of things that this Commission would like to see rewarded
12 and disproportionately favors the primary care. I think
13 we're getting there, but these are complicated -- as you
14 know, these are very complicated when you start having all
15 these measures in there to create behavior and you're only
16 putting, say, ten percent of salary at risk. You just kind
17 of throw up your arms sometimes and say, is this all worth
18 it? So that's just a comment.

19 A second comment, generally, Scott's about we
20 should be looking at lowering costs for Medicare and not
21 maybe justifying higher costs. I agree. I would say,
22 though, that the ambulatory sites, I think, are going to be

1 more expensive than they are now. Forget about this one
2 particular issue. When we employ somebody, we put in the
3 EMR. We sometimes upgrade the staff. We try to create
4 greater participation in coordinating care. We put
5 extenders. And, you know what? It is usually more
6 expensive on a per unit basis, but it's where the care is
7 being coordinated, so that it's worth it because all of the
8 rest of the system can benefit from that because we put more
9 effort into the site that really is instrumental to making
10 other things happen. So it's kind of hard to look at the
11 costs on just site by site. If the goal is lowering the
12 widget cost per unit of service in an ambulatory site, I'm
13 not sure that's going to be the right answer, necessarily.

14 Now I'll get to more substantive -- those are
15 substantive, but not specific to the proposal on the table.

16 So one comment now on the academic medical
17 centers. Here's where I really get great angst, and I will
18 say that I can support the principle. I think it's how can
19 you not really kind of support the principle? It's just
20 what are the consequences, how do you do it, and how fast do
21 you do it.

22 So academic medical centers, the ones that I know

1 of got into this long ago, and, yes, maybe the clinics were
2 primarily on campus, primarily for teaching, and had a high
3 percentage of either uninsured or Medicaid, and you could
4 say this is a way to prop them up. Whatever it was, it has
5 existed in a reasonable fashion and is not where the big
6 growth in this is occurring.

7 But I do look at -- there's many millions of
8 dollars for some institutions, so I do look at -- I look at
9 one of our own clinics in a Hispanic neighborhood. It has a
10 pilot medical home and has electronic medical records.
11 We're working on diabetes in particular. And it has a fair
12 amount of Medicaid. And so I try to look at the outlet for
13 Medicaid patients, which is, you know, when they're all
14 supposed to be covered here in a few days and I say, how
15 many places are there that are willing to kind of do this,
16 and there aren't many. And if you look at some of the newly
17 employed that are sitting out there in their community, they
18 are not taking Medicaid now. So it's more of the system
19 impact that I'm worried about, because I think not all
20 academic medical centers by a long shot, but I know of one,
21 for example, that already is quietly kind of weaning
22 themselves of the commitment to Medicaid, and so this is

1 where a lot of that care goes on and it's -- again, we're
2 looking out after Medicare, not Medicaid, but just that
3 unintended consequence, I'm not sure.

4 I can support the principle. I don't know about
5 the execution, though. I can't just say, okay, next year,
6 let's just flip the switch. Whether we have a moratorium,
7 which is one way to go which would be one way maybe to
8 address this, or some transition, I don't have the exact
9 answer, but I think this is a bigger impact on some
10 organizations and some communities than maybe some think.

11 DR. BAICKER: It seems pretty clear that, in
12 general, the big picture principle of paying the same thing
13 for the same service delivered to the same patient makes a
14 lot of sense, and what we're struggling with is how are we
15 defining the same patient and how are we defining the same
16 service. And factors like a clinic being open 24 hours a
17 day is in some ways a different service on the margin, but
18 that is bound to be small relative to a 400 percent
19 difference in the price, that around the margin, the
20 features of the setting may, in fact, make us think about
21 the service slightly differently.

22 And then the other piece of that is getting the

1 patient adjustment right, that clearly we want patients
2 treated in appropriate settings so different patients may be
3 appropriately served in different places, and that's about
4 getting the risk adjustment right and about getting the
5 patient characteristics that should affect the service
6 entering, where as those that shouldn't not, and that, to
7 me, then makes a lot of sense to start with E&M because it
8 seems less susceptible to subtle differences in patient
9 characteristics.

10 Now, then getting that price right, okay, so there
11 should be one price for one uniform good that's hard to
12 describe, defined to one uniform patient that's hard to pick
13 out, what that price should be. It then gets to Mike's
14 point of if you dial it too high, you get too much of that
15 service, and if you dial it too low, you get too little of
16 that service, and that's something we struggle with more
17 broadly. But then layering in that price differential seems
18 to make all of those problems worse. So it doesn't solve
19 the problem of what's the right price for us, but with those
20 two component sticks, then it seems like we've gone a long
21 way there. At least you've reduced the problem to something
22 we can get our hands around a little better.

1 MR. ARMSTRONG: I just very briefly and simply
2 would say I believe I support the policy option as you've
3 talked about it. I think it's really pretty
4 straightforward. We're paying -- you know, I see this as a
5 commercial payer, too. I'm paying 200, 300 percent of what
6 I used to, same service, same setting, different structure,
7 and so I think it's kind of straightforward. Frankly, I
8 think it's conservative, and to the degree we could start
9 this Monday morning, I would.

10 MR. HACKBARTH: Okay. Thank you. I think this
11 was a very good discussion and appreciate all of the insight
12 and thank you guys for the good work on this.

13 So our last session for this meeting is a
14 discussion of a mandated report on Medicare coverage of and
15 payment for infusion services.

16 DR. SOKOLOVSKY: Good morning. This morning we
17 want to continue our discussion of the Congressionally
18 requested study on home infusion. I won't dwell on this,
19 but I wanted to briefly remind you of the issues that
20 Congress has asked us to examine for this report.

21 Today we're going to be focusing on the third and
22 fourth bullets there, looking at payment methodologies and

1 issues surrounding abuse of a home infusion benefit. We
2 want to tell you about the results from our interviews with
3 plans and providers on how home infusion is provided and
4 paid for in the private market and under Medicare.

5 Interviewees described factors that make home
6 infusion appropriate or inappropriate for particular
7 products and particular patients, how plans manage and pay
8 for home infusion, and the decisions that confront the
9 Medicare beneficiary if infusion therapy is required post-
10 hospital discharge. Finally, we'll describe the next steps
11 we plan for this analysis and look for input from you about
12 other steps to take.

13 First I'd like to begin answering the questions
14 that you posed in September. Bob, you asked about whether
15 providing home infusion affects Home Health payments. And
16 the answer is that yes, it can. Providing home infusion
17 benefits increases your points, which can bump you into a
18 higher case-mix. However, I do want to emphasize that only
19 a small percentage of Home Health episodes involve infusion.

20 We'll be responding to some of your other
21 questions during the course of this presentation. A
22 Medicare beneficiary needing infusion therapy can get it in

1 a number of different settings, including hospital
2 outpatient, physician offices, ambulatory infusion suites,
3 and skilled nursing facilities and the home.

4 Medicare coverage for home infusion, as we
5 discussed in September, is limited and spread across
6 different payment silos. Recall that coverage for infusion
7 drugs is split between Part B and Part D. If the drug is
8 covered under Part B, the DME benefit, generally payments
9 will include the cost of equipment and supplies.

10 And also, by special statutory provision, Part B
11 covers intravenous immune globulin, IVIG, in the home, but
12 only for beneficiaries with primary immune deficiency. Part
13 D covers drugs not covered by Part B if the drugs are on the
14 plan's formulary and they meet any prior authorization
15 requirements that the plan may have.

16 Nursing visits are covered under the Home Health
17 benefit if the patient is homebound. Some supplies will
18 also be covered under that benefit.

19 In September, we provided data on payments for
20 home infusion for Medicare beneficiaries. In order to find
21 out how private payers and Medicare Advantage plans are
22 covering, managing, and paying for home infusion, we

1 contracted with NORC to conduct interviews with health
2 plans, home infusion providers, and hospital discharge
3 planners.

4 Staff have also conducted interviews with
5 physicians, home health agencies, beneficiary advocates,
6 CMS, and the VA, as well as other stakeholders, and these
7 interviews are ongoing. We cannot independently validate
8 the accuracy or generalizability of the information they
9 provided, but our findings are generally consistent with the
10 previous GAO report on home infusion and, in the case of
11 Medicare beneficiaries, the data that we previously
12 analyzed.

13 As you asked in September, Ron, we have included a
14 discussion of the GAO report in our mailing materials. In
15 the next few slides, I'll try to take you through how the
16 decision is made that home infusion is appropriate for a
17 patient and how the resulting care is managed.

18 It's important to note that there's a whole lot of
19 variation. However, the most common scenario begins in the
20 hospital. The decision to provide home infusion begins with
21 a conversation between the physician and a hospital
22 discharge planner. In the case of antibiotics, which are

1 the most commonly prescribed product, the patient may be
2 suffering from an orthopedic, joint infection, bone
3 infection, or some other post-operative infection.

4 If oral medications won't work, the physician will
5 probably give orders for infusion therapy in the hospital.
6 Then the physician works with the patient and the discharge
7 planner to determine the most appropriate site of care
8 following discharge. Both physicians and health plans
9 generally said that home was the optimum setting, but a
10 number of factors determine if home infusion is appropriate.

11 First are the clinical factors. A physician must
12 consider the risk profile of the drug, for example, are
13 there likely dangerous side effects, how stable is the drug,
14 does the patient need more than one different kind of drug
15 each day. And then he has to consider, along with the
16 discharge planner, the specific patient.

17 Since the goal of home infusion is usually to have
18 patients or care givers learn to self-administer the
19 medications, and there are some exceptions to this, they
20 look at whether the patient or care giver is both able and
21 willing to self-administer.

22 And then they look at other factors like does the

1 home have reliable refrigeration, electricity, water supply.
2 Does the patient have a history of IV drug abuse? Is there
3 reliable transportation to get to the hospital if there are
4 adverse effects? And does the patient have multiple co-
5 morbidities and be too medically complex for this home
6 infusion to happen in the home? Yeah.

7 Next, the discharge planner looks at insurance
8 coverage. Private payers tend to have broader coverage of
9 home infusion than fee-for-service Medicare, but coverage
10 varies by drug. Does the plan think that this drug is safe
11 and cost-effective for home use? And will the plan approve
12 nursing visits? All play into whether home infusion will be
13 prescribed.

14 In the private sector, before home infusion
15 begins, plans must approve coverage. And all plans we spoke
16 to use prior authorization, although not for all drugs.
17 Plans ask the physician to provide the diagnosis, the
18 prescribed drug, the dosage, and the expected duration of
19 therapy. The plan will have to determine whether the drug
20 is on its formulary.

21 In the case of Medicare Advantage plans and stand-
22 alone Medicare drug plans, they may also have to determine

1 whether the drug is covered by Part B or Part D. And if D,
2 whether the beneficiary is in the coverage gap.

3 In answer to your question, Herb, we looked at
4 this B/D overlap issue briefly, and, in fact, although
5 everybody told us that the prior authorization process was
6 generally pretty smooth and took less than a day, the B/D
7 overlap issue did create an administrative burden and could
8 slow down the process.

9 Home infusion providers said that the coverage gap
10 could also be a problem for Medicare beneficiaries. Some
11 plans limit prior authorization to expensive drugs, and they
12 may require, in the case of antibiotics, a consultation with
13 an infectious disease specialist.

14 All plans also do retrospective reviews of home
15 infusion with the number and intensity varying basically --
16 if they're very intense on prior authorization, there's less
17 post-review. But when they do it, they look for outliers
18 like an excessive length of therapy or an excessive number
19 of nursing visits.

20 For example, one physician told us that IV
21 antibiotic therapy lasts longer than eight weeks, it should
22 raise a red flag. Some integrated plans take primary

1 responsibility for coordinating care and they may have their
2 own infusion providers and nurses.

3 The interviewees we spoke to from health plans
4 each said that abuse of home infusion benefits was no more
5 prevalent than abuse of other services. They believe that
6 their utilization management activities help deter and
7 prevent abuse. However, some interviewees questioned how
8 these activities would be accomplished under a fee-for-
9 service system.

10 The kind of problems that they did mention
11 included double billing for a drug under both the pharmacy
12 and the medical benefit. Our claims analysis also found
13 some questionable claims that could bear further scrutiny.
14 For example, we found more beneficiaries receiving Part B
15 home infusion pumps than beneficiaries receiving Part B home
16 infusion drugs.

17 [Laughter].

18 DR. SOKOLOVSKY: Once a physician has determined
19 that infusion is indicated, care coordination requires
20 continued interaction among multiple individuals, mostly
21 nurses and organizations. If the physician that orders home
22 infusion remains in charge of the patient's care following

1 discharge, the home infusion provider and home health agency
2 will communicate directly with the physician's office.

3 In some cases, the patient will come to the office
4 once a week for a nurse to do blood work, change dressings,
5 and check the catheter. If another physician takes over the
6 patient's care, we were told that there were sometimes gaps
7 in coordination.

8 Hospital discharge planners have primary
9 responsibility for care coordination while the patient is in
10 the hospital. They check to see if the plan has a preferred
11 home infusion provider or home health agency, and then they
12 make a referral.

13 And finally, one of their most important jobs,
14 they make sure that the patient is not discharged until both
15 the needed drug and a visiting nurse can be assured to be at
16 the patient's house before the next drug administration is
17 needed. But after discharge, they have no further role.

18 The home infusion provider gets insurer
19 authorization for the needed medications. The check health
20 plan coverage. And this may include working with the
21 physician to change the drug regimen to a drug on the plan's
22 formulary or to get an exception. They prepare and deliver

1 the drug to a patient.

2 If they don't have their own nurses, they make a
3 referral to a home health agency for a visiting nurse. And
4 they told us that they share responsibility for educating
5 the patient on how to administer the drug and how to detect
6 dangerous side effects.

7 Nurses from home health agencies, when required,
8 educate the patient, draw blood for lab work, monitor and
9 clean lines and catheters, and check for any medication
10 errors. They also communicate any concerns to the
11 physician.

12 Now Kim will discuss how plans pay for home
13 infusion.

14 MS. NEUMAN: We asked health plans and home
15 infusion providers how commercial insurers and Medicare
16 managed plans typically pay for home infusion. While there
17 is some variation, the most common methodology is a three-
18 component payment structure.

19 Under this approach, there would be one payment
20 for the drug, there would be a second payment, which is a
21 per diem fee typically, to cover supplies, equipment,
22 pharmacy services like compounding, and other non-nursing

1 services like care coordination. We heard varied reports
2 about the typical plan payment for the per diem. For
3 example, for antibiotics, interviewees cited typical per
4 diems ranging from \$75 to \$150 per day.

5 DR. SOKOLOVSKY: We must have lost the connection.
6 I think you should go on.

7 MS. NEUMAN: Okay, the slides. Okay. So as I was
8 saying, for antibiotics, interviewees cited a typical per
9 diem ranging from \$75 to \$150 per day. It's important to
10 note that some of the things covered by the per diem, for
11 example, pharmacy services, are currently covered by
12 Medicare Part D through the drug payments.

13 The third component is nursing. If nurse visits
14 are needed, many plans make a separate payment for each
15 visit. Karen, in September, expressed interest in bundled
16 payment approaches. While much less common, we have heard
17 that some plans pay in broader bundles, but maintain a per
18 diem structure.

19 So, for example, some plans include nursing in the
20 per diem for supplies. We also heard instances of certain
21 drugs being bundled in the per diem for supplies. However,
22 none of these bundles are for episodes. They're per diem

1 bundles.

2 We also spoke with a few plans that used a
3 capitated approach, paying a per member per month payment to
4 a home infusion provider or a medical group to cover all
5 infusion services their members might need.

6 Mary, you asked in September for more information
7 on the beneficiary's experience accessing home infusion. As
8 we've discussed, Medicare covers some or all components of
9 home infusion depending on the circumstances, and our
10 analysis in September showed that many Medicare
11 beneficiaries, more than 100,000 in 2009, received home
12 infusion drugs covered by Medicare.

13 From the interviews, we heard that dual eligibles,
14 beneficiaries with employer-sponsored supplemental insurance
15 that covers home infusion, and beneficiaries in some
16 Medicare Advantage plans have the easiest access to home
17 infusion services. For other beneficiaries, we heard a
18 really mixed picture and it's difficult to generalize.

19 Overall, we heard that out-of-pocket costs for
20 home infusion influenced site of care for some
21 beneficiaries. But interviewees gave varied accounts of the
22 type and amount of out-of-pocket costs and the extent to

1 which they lead beneficiaries to seek care in alternate
2 sites.

3 For example, some interviewees said the cost of
4 the per diem supply fees left most Medicare fee-for-service
5 patients without other coverage to seek care in alternate
6 settings; while a few other interviewees said that the per
7 diem did not typically influence site of care because some
8 providers would offer a reduced rate, a payment plan, or
9 charity care.

10 Some discharge planners mentioned the Part D
11 coverage gap as being a significant issue affecting access
12 to home infusion, while others told us the coverage gap was
13 not much of a factor. We heard less about out-of-pocket
14 costs for nursing being an issue. Discharge planners said
15 that most beneficiaries who receive IV antibiotics meet the
16 homebound criteria and can receive Medicare home health.
17 That may be less the case for other drugs.

18 In terms of where patients receive care, if the
19 financial costs of home infusion were prohibited, we again
20 heard a mix, with some interviewees saying all or most such
21 patients went to SNFs, others saying most went to outpatient
22 clinics, and still others saying it was a mix between those

1 two settings.

2 So this brings us to next steps. We have two
3 remaining issues to examine that were part of the study
4 request from Congress, and we'll address those in March.
5 First, we'll do an assessment of sources of data on the cost
6 of home infusion that might be available to construct a
7 payment system.

8 Second, we'll do an assessment of the cost
9 implications for Medicare of providing infusions in the home
10 versus alternative settings. This will be based on
11 information from the interviews, a literature review, and
12 we'll also do our own analysis where we'll develop
13 illustrative scenarios of situations where home infusion may
14 generate net savings or additional costs for Medicare.

15 We'll also pursue any additional issues based on
16 your deliberations. And as far as your discussion today, to
17 the extent that in your work you've dealt with issues
18 related to home infusion, we think we would benefit from
19 hearing that perspective to help inform the research.

20 So with that, we conclude our presentation and
21 look forward to any questions and your discussion.

22 MR. HACKBARTH: Okay, thank you, Joan and Kim.

1 Scott, I think you're up, Round 1 clarifying questions.

2 Cori.

3 MS. UCCELLO: Do we know if home infusion is used
4 more frequently in MA plans versus fee-for-service?

5 MS. NEUMAN: So we looked at that with the Part D
6 data that we have, and the one caveat is that this would not
7 reflect any Medicare Advantage plans that provide drugs
8 bundled together with the services under Part C as a
9 supplemental benefit. So taking those MA plans out, what we
10 saw actually was a higher use of home infusion drugs among
11 Part D enrollees and PDPs on the fee-for-service side than
12 we found in Medicare Advantage.

13 The driver of that is low-income subsidy
14 enrollees. We see higher use of home infusion drugs among
15 LIS enrollees in PDPs than LIS enrollees in MA-PDs. We
16 don't see a difference between PDPs and MA-PDs for the non-
17 LIS.

18 DR. CHERNEW: I have a question. The tone that I
19 got was that the idea was that home infusion would be
20 efficient because it could keep people out of other
21 settings. And my question is, in some settings like
22 inpatient, if you shorted the inpatient stay, that savings

1 wouldn't be captured unless the DRG rate was adjusted one
2 way. In other words, it wouldn't be captured by the system.

3 But others like if you shortened a nursing home
4 stay, because the bundling is per diem or something like
5 that, you would save?

6 MS. NEUMAN: That's correct. It really depends on
7 how the payments are structured in the hospital versus the
8 skilled nursing facility, and as you said, Medicare pays a
9 DRG for the hospital, and that's different from what a lot
10 of other private payers do. They often pay a per diem.

11 So they could get potentially more savings on the
12 hospital side than Medicare might. But as some point out,
13 you see lots of doctors when you're in the hospital, so
14 there could be some savings on the hospital side from
15 reduced doctor visits, possibly. That would obviously be
16 offset by how much it costs to do this in the home.

17 So it gets complicated and we're hoping to be able
18 to draw this out for you more in March and come up with some
19 scenarios, because clearly, things depend on what kind of
20 setting you're shifting them from.

21 DR. CHERNEW: Right. And so, my second sort of
22 related question is, and you said some of this in your

1 comment about the pumps and the drugs. I didn't get a very
2 good sense of how much potential for over-use you think
3 there is in home infusion. If you think that it's something
4 where no one is getting home infusion when they shouldn't or
5 whether it's something that if you just encouraged it a lot,
6 there are going to be people using it when they really
7 shouldn't be getting any treatment.

8 DR. SOKOLOVSKY: I don't think we can answer that
9 yet. I think we're a little -- I mean, some of the points
10 are what we're seeing in the claims, the idea that there
11 wouldn't be the same kind of management in MA. One of the
12 drugs that can be covered by home infusion is pain
13 medication. That might be an area that you would really be
14 concerned about. But I don't think we really have an answer
15 yet. We're hoping to dig into it more.

16 MR. KUHN: I have two real quick. One is, given
17 the conversation we just had on the prior subject matter of
18 a site neutral payment system on the ambulatory side, how
19 much is there a variation in terms of payments for infusion,
20 whether it's in the home or in the outpatient department,
21 physician office, or whatever the case may be? Do we also
22 have variations across different settings here as well?

1 MS. NEUMAN: So that is something we're planning
2 to break out for you in March where we can show how much it
3 costs to do drug administration in the hospital versus the
4 physician's office, and then you'd have to think about what
5 Medicare might be doing in the home. And so, we don't have
6 that for you now, but we do intend to have that for you in
7 March.

8 MR. KUHN: Okay, thank you. And the second
9 question is, we talked about the different kinds of drugs
10 that are part of home infusion, and I think I've read
11 recently, and maybe you can tell me or some of the
12 clinicians around the table, are we starting to see
13 oncology, chemotherapy drugs starting to be used in home
14 infusion? Is that being migrated to the home yet or is that
15 starting to occur? Do we know?

16 DR. SOKOLOVSKY: We heard from some providers that
17 they were doing chemotherapy in the home. I would say that
18 it was still a very small minority in the interviews that we
19 did.

20 DR. HALL: Well, you know, a lot of infusion is --
21 almost all infusion is done on an ambulatory basis now. But
22 a lot of it's done at centers, particularly biologics and I

1 think there are a lot of reasons for that in terms of
2 handling of a product, and there are some facility fees that
3 go along with that. I haven't seen a huge infusion of
4 infusion therapy in the home.

5 MR. KUHN: Okay, thanks.

6 DR. NAYLOR: So I don't want to misread, but just
7 based on what -- thank you for all the efforts to update us
8 on different components, especially on that kind of the
9 beneficiaries' experience with this, and I know that that is
10 a limited database around this.

11 But is the work suggesting so far, not just with
12 the kind of silo payment, but also with the way services are
13 delivered, at least the potential of a capitated approach?
14 You say that a few places are beginning to use this.

15 I'm wondering if just even doing a little bit more
16 digging with whomever is using that approach to see if some
17 of the challenges that are being uncovered and reported in
18 your interview data may or may not be mitigated by having a
19 more comprehensive approach to addressing the service needs
20 of this population.

21 MS. NEUMAN: We can look more at that. My sense
22 is that it's a minority that are doing a capitated approach

1 and it tends to be an integrated kind of system, health plan
2 together doing it. So it's not the norm, but we can get
3 more details on the folks that are trying to do it.

4 DR. NAYLOR: And will you by -- you mentioned some
5 network of a couple hundred home infusion agencies that are
6 providing or generating quality data. Do you know if we'll
7 have any of those data before the March report?

8 DR. SOKOLOVSKY: I don't know. Some of those
9 providers that we spoke to who are involved in this network
10 have spoken to us about getting data to us, but I don't know
11 how quickly or how soon that can be done.

12 DR. NAYLOR: All right, thank you.

13 MR. GEORGE MILLER: Yes. On Slide 8, you said
14 that the plans said the abuse of home infusion benefits are
15 no more prevalent than other services, and I'll focus in on
16 home care. We thought there may have been just a little bit
17 of abuse there. So are we talking about the same magnitude
18 of home services or just in general we don't think there's -
19 - I'm just trying to get a picture of where we think that
20 potentially could be. Or do you know?

21 DR. SOKOLOVSKY: They said in general --

22 MR. GEORGE MILLER: In general, okay.

1 DR. SOKOLOVSKY: -- that they didn't see that as
2 being an issue for them.

3 MR. GEORGE MILLER: Yeah. I didn't know if this
4 was more ripe for that type of abuse than other services.
5 The second question I have is just, do you have demographic
6 information on what the characteristics demographically of a
7 patient that has home infusion looks like? Or can you get
8 that from the data? Can you pull the demographic
9 characteristics?

10 MS. NEUMAN: You mean from the Medicare claims --

11 MR. GEORGE MILLER: Yes.

12 MS. NEUMAN: -- that we've paid for home infusion
13 drugs?

14 MR. GEORGE MILLER: Yes.

15 MS. NEUMAN: Yeah, we have. We have looked at
16 that. I think we had a little bit more detail on that in
17 September.

18 MR. GEORGE MILLER: I don't remember.

19 MS. NEUMAN: And my -- the one difference, it was
20 either with B or D -- I can go and dig it out -- there was
21 one category where there were differences across racial and
22 ethnic groups. Let me just go look. And then there was

1 also higher use among beneficiaries with ESRD used home
2 infusion drugs, both B and D, more commonly.

3 Older beneficiaries, I believe for Part D, were
4 more likely to use them. And then as I said, I think racial
5 and ethnic minorities, there was a difference on the D side.

6 MR. HACKBARTH: Can I follow up on George's first
7 question? The way I interpreted that first bullet is that
8 this is in the context of private plans that pay for home
9 infusion. The context might be different there depending on
10 the type of plan. There may be a payment structure or
11 oversight mechanisms that would not necessarily exist in
12 fee-for-service Medicare to limit potential abuse.

13 DR. SOKOLOVSKY: And we did have several
14 interviewees who pointed that out.

15 MR. HACKBARTH: Yeah, yeah. Okay. Bruce. Bill.
16 Karen.

17 DR. BORMAN: I just wanted to touch on the more
18 pumps than drugs, which certainly seems so counter-intuitive
19 to being reality, and my only question would be, do we have
20 a sense whether that potentially could be a combination of
21 fluids, hydration, and drugs? Because there are some drugs
22 that are not compatible with various things and you might,

1 in fact, need a separate infusion to follow on that drug, or
2 in terms of hydrating in anticipation of that drug, but you
3 couldn't mix it with the drugs.

4 So I suspect that most of these times it is a good
5 marker for something's funny, but that there could be some
6 clinical circumstances where potentially that more pumps
7 than drugs maybe could make sense. So I just throw that out
8 as just being a little bit -- you know, we just need to be
9 sensitive to the clinical context when we pick markers.

10 MS. NEUMAN: And we're sort of following up on
11 this point and looking at it a little bit more. It's
12 actually more beneficiaries getting pumps than getting
13 drugs. So the more product possibility wouldn't be driving
14 this result.

15 DR. BORMAN: Would just an electrolyte or fluid
16 solution be considered a drug?

17 MS. NEUMAN: We'll be capturing --

18 DR. BORMAN: I guess would be my question. Would
19 you capture it? That would be the only --

20 MS. NEUMAN: Yeah, we'll check.

21 MR. HACKBARTH: Round 2, Scott.

22 MR. ARMSTRONG: Just briefly, I would say I'm

1 impressed with the analysis. I think the direction that
2 you're going in makes terrific sense. It's very consistent
3 with many of the other policy directions that we've been
4 heading in. In my own experience in a care delivery system
5 that is really expanding the use of home infusion and other
6 home services, for our payment policy to reinforce that, I
7 think, is the right direction.

8 DR. BERENSON: I just want to say that I agree --
9 I'd better not talk -- you're approaching this very
10 systematically, you're going in the right direction. I just
11 wanted to be on record as saying I think this is going
12 exactly right.

13 DR. HALL: In the course of your analysis, you
14 know, I think the 90 percent/10 percent rule will probably
15 prevail, that 90 percent of the services are bunched in 10
16 percent of the patients. I'm not sure that's going to be
17 true for Medicare, but it would be well worthwhile looking
18 at that.

19 DR. CASTELLANOS: Kim, you asked if we express any
20 personal experience that you have. Obviously with urinary
21 tract infections, this is a big field for us. Quite
22 honestly, we don't do it. We do it as a referral to an ID

1 doctor. I know that's more expensive for the system, but
2 it's so complex, there's no uniformity, and if I stress
3 anything that you can do, is really try to get a uniform
4 policy and try to make it a lot simpler.

5 Herb, you asked about oncologists. Yes, they do
6 it. I think ID doctors are the main ones. Rheumatologists
7 are doing it now and GI doctors are doing it.

8 George, you talked about abuse. A big thing in
9 Florida is home infusion, outpatient infusion fraud. That's
10 a big, big topic, but I think that's been dealt with
11 separately, I'm pretty sure. You mentioned that, too, Mike,
12 I think.

13 But if I could suggest anything, it's just make it
14 a lot of simpler, more uniform, and make it something that I
15 don't have to refer to somebody because it's so complex.
16 I'm sorry to say this. I don't have a lot of time and it
17 costs me more time and energy to do it.

18 The other concern I have is that -- and it really
19 isn't a concern -- it's the SGR issue with Part B drugs. As
20 you remember, that Part B drugs were a big issue in SGR, was
21 taken out. We want to make sure if we keep them in Part B,
22 that they're taken out of the SGR, that is. Thank you.

1 MR. GRADISON: Just to say thank you for helping
2 to make a more orderly -- I mean, have such an orderly
3 analysis of really such a complex subject. I'm can only
4 think of one with so many moving parts.

5 DR. BORMAN: Just a couple of questions and
6 thoughts. I do have some experience with a fair number of
7 patients. I'm getting mostly antibiotics, but occasionally
8 some other drugs.

9 And my first question is a little more to Glenn
10 and Mark. Do you sense we have boundaries on where we can
11 go in this report in terms of if we said in the end this is
12 crazy and there should be a clearer, simple uniform way that
13 has to cut across all this business of this one is B and
14 this one is D? Is that within our purview to recommend? Is
15 that sort of out of scope in this particular report?

16 MR. HACKBARTH: Go ahead.

17 DR. MARK MILLER: Of course, we would never say
18 anything that's crazy. I think there is -- I think as
19 usual, we could take a fairly wide latitude here. I think
20 in part the way I think we're approaching this is they
21 structured some questions for us and we're trying to fit in
22 behind those questions.

1 I think there's this general thought, and some of
2 this came up here, Oh, if you just do this, it's more
3 efficient and it saves money. I think what this report is
4 going to show is that that question is highly dependent on
5 not just the payment system changes or what payment system
6 is coming into and going out of, but the drug in question
7 and that type of thing.

8 And so, at least so far -- and this is still a
9 ways off so I hadn't thought of a really hard deadline or a
10 real hard finished product for us -- is we could go to here
11 is the response to the mandate, this is the information you
12 asked for, here's where it seems to work, where it doesn't
13 seem to work, where you might have an advantage and you
14 might not, and be done there.

15 I don't think there's anything that restricts us
16 from going further from that, but I think we have to
17 minimally do that.

18 DR. BORMAN: Okay. Then just briefly, do you have
19 a sense why we have this mismatch? Is there some piece of
20 history here that we're missing that causes us to regard
21 this as very difficult to deal with? Is there some
22 underlying rationale that we're all missing that's explained

1 by knowing the history of how this came together, or is it
2 truly just different things happened at different times and
3 nobody was pulling it all together, do you think?

4 DR. SOKOLOVSKY: Yes.

5 [Laughter].

6 DR. BORMAN: I was trying to find a polite way of
7 saying it. Then in terms of the point that Mike Chernew
8 brought up, I think, about how you would determine what the
9 DRG piece of this is that might unfairly remain if you
10 encourage all this home infusion.

11 I think it's going to be hugely problematic to
12 figure out unless you went for maybe the most common reasons
13 to do this, the most common diagnoses, and say that this is
14 so much of the business that this is most likely to be the
15 impact. Because I think it's going to be all in the length
16 of stay primarily, that if you put a week out of the length
17 of stay, there's going to be a pretty big incremental value
18 on the hospital side, maybe a bit less so on some of the
19 drugs and some of those kinds of things.

20 But it's going to be in that length of stay.
21 That's going to be really tough, I think, to tease out and I
22 don't think we could begin to address that question.

1 MR. HACKBARTH: And I agree with that, Karen.
2 Mike's analytic point, conceptual point is exactly right.

3 DR. BORMAN: Right.

4 MR. HACKBARTH: I don't think it leads to a policy
5 of trying to figure out the precise amount by which to
6 reduce the hospital inpatient rates to offset this.
7 Instead, I think what we would do is what we always do, look
8 at the overall relationship between what we pay hospitals
9 for inpatient services and what the costs are that they
10 incur in the aggregate and try to keep those numbers in
11 balance.

12 But we wouldn't want to adjust rates to offset
13 somehow this transition to another setting.

14 DR. BORMAN: Right. And then my last two things,
15 I would absolutely support what Bill Hall said in terms of,
16 I think the real mover and shaker in this general topic is
17 doing this infusions in HOPDs or other infusion centers and
18 much less so in this -- maybe in the home infusion market
19 now.

20 I think home infusion has helped us think about
21 it, but then has led to doing so much of this in a more
22 center because of the relatively higher side effect profile

1 and complexity of handling the drugs in administration that
2 needed to be done in a center rather than in the home. So I
3 think that really, at the end of the day, it might be this
4 is a smaller piece of the question about infusion therapy.

5 And then from a personal standpoint, the other
6 group that I would say, and it seems counter-intuitive, that
7 at least in some hospital systems or care systems that has
8 pretty good access to home infusion are the under-funded,
9 and that's because there isn't all this complexity of going
10 around and figuring it out.

11 It's pretty clear for a given system, that they're
12 going to get this patient who's under-funded out of the
13 hospital days earlier with X savings and they can easily
14 afford to put that into the home infusion piece.

15 So in addition to sort of the MA and some of those
16 people you had there, there's kind of a counter-intuitive
17 piece where the under-funded, in fact, benefit, and it tells
18 you it's a back-handed comment on the system we have for
19 Medicare, I think.

20 MR. HACKBARTH: Yeah, yeah. So let me pick up
21 with that. This interests me because I think it's an
22 example of a broader set of policy issues, that things

1 migrate from inpatient settings to outpatient settings or
2 even the home as technology changes, as clinical practice
3 changes.

4 And part of that migration is where you move into
5 settings where there's less institutional control, less
6 formal oversight, and if you combine that with some
7 subjectivity in whether the service is needed, you have the
8 potential for misuse, overpayment, and the like.

9 In a system like Scott's, this isn't much of an
10 issue because they are organized in a way to provide ongoing
11 clinical oversight and they have financial responsibility
12 for the whole thing. And so, their decisions are presumably
13 guided by all of the right factors.

14 But in a disaggregated care delivery system paid
15 for on a fee-for-service basis, you don't have everything
16 lined up. And, you know, as long as stay in fee-for-service
17 and as long as technology and clinical practice continues to
18 change, I think we can be sure that the general direction is
19 going to be down this path towards more things moving out of
20 tight institutional settings into looser settings.

21 It's a problem we're going to face repeatedly.
22 That doesn't mean I have a solution to it, but this is an

1 example of a much bigger phenomenon.

2 Okay, thank you, Joan and Kim, for your careful
3 work on this.

4 We'll now have our public comment period. Please
5 begin by identifying yourself and your organization, and let
6 me do my usual statements about your best opportunities to
7 provide input to our work are actually not through this
8 comment period, but rather by engaging in conversation with
9 our staff, and also using our Web site where you can file
10 comments as well.

11 When the red light comes back on, that signifies
12 the end of your time. Thank you. Go ahead.

13 MS. CARLSON: Hi. I'm Eileen Carlson from the
14 American Nurse's Association. I'll just be really brief.
15 I'm also a registered nurse. On the home infusions, this
16 may be totally off base, but one of the possibilities is
17 that insulin pumps may have been counted, which obviously
18 insulin is not counted as an IV med. So that's one thing to
19 look at.

20 I just want to say that I'm really glad to see you
21 all looking at the costs and possibilities for paying for
22 home infusions, and I'd like to see some attention drawn,

1 and perhaps this is really the fundamental reason this is
2 being looked at, at the -- it's the quality issues involved.
3 I guess I shouldn't say quality, but health care associated
4 infections. That's really one of the major reasons for
5 going to home care and having infusions at home.

6 Don't quote me specifically, but I think there's
7 recent data showing that three out of ten patients in a
8 hospital have some kind of error or suffer some kind of
9 condition. So obviously, when you go in the home setting,
10 as long as it's a good environment, that can be a good thing
11 in and of itself, and maybe saving costs that you wouldn't
12 ordinarily look at, at home. So I just want to emphasize
13 the need to do that.

14 And then with respect to ambulatory care, once
15 again we're really glad to see you all looking at this, and
16 I just wanted to mention that -- and I'm really glad to see
17 that you pointed out that staff nurse costs would be
18 possibly a part of the payments made to hospitals in
19 outpatient departments.

20 And one of the things that ANA has been looking at
21 is, as you're probably well-aware, staff nursing costs are
22 usually part of the room and board and are not identified

1 separately. We have a health care economist and we've been
2 looking at trying to pull those out and identify them, and I
3 think if that was done, that might be very helpful to you
4 all.

5 So if there's anything we can do in that respect,
6 there's a dataset called Nursing Intensity Weights that was
7 used in New York State for Medicaid, and one of the purposes
8 was to ensure adequate staffing per patient. And that's
9 been developed pretty in-depth. So that's one dataset that
10 might be helpful. Thank you.

11 MR. PLUMMER: Good morning. It is my
12 understanding that the MedPAC is providing information to
13 the super committee that is studying the reduction of health
14 care costs to reduce the deficit in the United States. And
15 I'm a hospital CEO. I'm a CEO of a 25-bed hospital,
16 critical access hospital, and I have some information that I
17 believe the MedPAC should look at when they make
18 considerations and provide information to this committee so
19 that accurate information is being provided to the
20 committee, and that we need to look at all aspects of health
21 care and all aspects of critical access hospitals in the
22 United States.

1 And critical access hospitals were designated by
2 Federal legislation and that designation was given to the
3 rural community in which these hospitals are located. When
4 these hospitals or when these communities decided they could
5 no longer support their local hospitals and turned them over
6 to systems or larger hospitals for operation, I believe that
7 they should have gave up their critical access status at
8 that time, or not maybe gave it up, but in the regulation,
9 they should have -- it should have been taken away from
10 them.

11 Information that we have discovered through
12 research and development shows that systems that take over
13 critical access hospitals have what they call home office
14 expense that they are reimbursed on that brings and drives
15 the costs of that critical access hospital up and puts that
16 money back into the coffers of the system that now owns that
17 hospital.

18 That money is not spent in that rural community in
19 which that hospital is located, but is spent maybe in the
20 bigger city or the metropolitan area where the system is
21 located. And I believe there's a lot of savings out there
22 and I think that MedPAC should look into this and provide

1 that information to this committee.

2 We've provided it to many members of the
3 committee, but we think you need to do some research and
4 look into that if you would. I am from Pennsylvania. My
5 name is Carey Plummer. I'm the CEO, President and CEO of
6 the hospital in Jersey Shore, Pennsylvania. Who could I
7 give this to? Thank you.

8 MR. HACKBARTH: Okay, thank you very much. We are
9 adjourned.

10 [Whereupon, at 11:08 a.m., the meeting was
11 adjourned.]

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