

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 The formal due date for this report is June 15,
8 2013; however, the temporary add-on policies will expire
9 under current law at the end of the year. Therefore, the
10 Commission has been working toward giving the Congress the
11 information it needs to make a decision about whether to
12 end, extend, or amend these policies by the end of 2012.

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

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

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

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

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

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

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

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

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

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

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

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

1 9 percent with all the temporary add-ons, included; compared
2 with minus 8 percent to plus 5 percent without the temporary
3 add-ons. The wide range is a result, in part, of the
4 relatively small sample size, about 150, and the wide range
5 of costs reported in the sample.

6 Note that the population represented is suppliers
7 with no shared costs that were billing Medicare in 2003 and
8 2010 and still operational in 2012. It does not represent
9 suppliers that have entered since 2004, including many of
10 the for-profits concentrating on the apparently lucrative
11 BLS nonemergency transports.

12 Second, through a regression analysis, GAO found
13 that higher average costs per transport were associated with
14 lower volume (and they found an inflection point at about
15 600 transports a year), more emergency versus nonemergency
16 transports (which means that suppliers concentrating on
17 nonemergency transports have lower costs, hence higher
18 margins), and a higher level of government subsidy. We use
19 the finding about a 600-transport-a-year threshold in our
20 illustrative low-volume policy.

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

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

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

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

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

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

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

1 principle to see if it's feasible.

2 What we did was identify rural zip codes with a
3 population density of 20 people per square mile or less or
4 with a population of 4,000 or less. Those parameters were
5 chosen so that areas would be expected to generate less than
6 600 transports a year.

7 Looking at that set of zip codes, we find it is
8 better targeted than the rural short mileage add-on. The
9 new policy includes 78 percent of all rural zip codes.
10 Those included have an average population of less than
11 1,500. That size population is expected to generate well
12 below 600 transports a year, which is the low-volume
13 threshold. All together there were 550,000 Medicare
14 ambulance transports from these areas in 2011.

15 In contrast, the policy would exclude 22 percent
16 of rural zip codes. Those areas have an average population
17 of over 12,000 and accounted for 3 million transports in
18 2011. A population of 12,000 would be expected to generate
19 more than twice as many transports as the low-volume
20 threshold of 600.

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

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

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

10 Zach will now present the draft recommendations.

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

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

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

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

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

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

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

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

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

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

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

22 We have also observed wide variation in spending

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

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

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

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

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

1 transport services;

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

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

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

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

22 Okay. At this point we are happy to respond to

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

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

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

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

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

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

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

11 [No response.]

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

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

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

1 looks at the margins before and after.

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

6 MR. GLASS: There is.

7 MR. GEORGE MILLER: Just curious

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

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

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

14 MR. GEORGE MILLER: Right?

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

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

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

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

8 MR. GEORGE MILLER: Yeah, thank you.

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

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

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

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

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

3 MR. GRADISON: Okay.

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

7 MR. GRADISON: Thank you.

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

16 MR. GAUMER: What will happen --

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

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

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

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

21 MR. GAUMER: It's based on --

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

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

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

22 There was one other point there on this area, but

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

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

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

9 [Laughter.]

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

15 MR. GLASS: About 8 percent.

16 MR. GAUMER: There you go.

17 DR. MARK MILLER: Also, I --

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

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

21 MR. GAUMER: These are our --

22 DR. MARK MILLER: Right, right. Okay.

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

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

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

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

1 supportive of the recommendations.

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

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

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

17 [Hands raised.]

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

20 [No response.]

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

1 [Hands raised.]

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

3 Abstentions?

4 [No response.]

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

6 work.

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Perhaps the most important finding is that there
13 was significant variation in the performance of home health
14 agencies. The agency at the tenth percentile had a
15 hospitalization rate of 20 percent, while the agency at the
16 90th percentile had a rate of 37 percent.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 MR. ARMSTRONG: I don't have any.

6 MR. HACKBARTH: Craig.

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

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

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

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

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

13 MR. CHRISTMAN: I guess there's always some
14 judgment in this question. To give you an idea of
15 perspective, what we're talking about, the maximum penalty
16 under this illustrative policy would be an average of
17 somewhere around \$140 to \$150 on a typical home health
18 episode payment. You can imagine that a -- the last time I
19 checked, an average hospitalization clocked in at around
20 \$9,000. So the size of the penalty that some agencies would
21 bear, the maximum size, will be relatively small to the cost
22 the Medicare program incurs when that patient is

1 hospitalized.

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

7 MR. CHRISTMAN: Right. Right. So we've put out
8 five percent as an example. In 2010, the margins were about
9 18 percent. So you can see that that's a little less than a
10 third of the average agency. For the agencies in the top 25
11 percent of financial performance, the 75th percentile was
12 somewhere around 27 percent, so a quarter of agencies do
13 better than that. So that's kind of a little bit of the
14 challenge here and I think we were perhaps cheating a little
15 bit higher on the range of penalty we were suggesting. You
16 know, if you were to look at the providers at the high end
17 of performance, some might want a higher penalty amount.

18 MR. HACKBARTH: Clarifying questions. Jack.

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

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

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

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

22 From a practical perspective, this matters to us

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

13 MR. HACKBARTH: It --

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

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

18 DR. HOADLEY: Okay.

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

21 DR. HOADLEY: Right.

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

1 one.

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

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

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

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

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

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

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

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

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

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

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

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

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

16 Rita, clarifying questions.

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

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

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

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

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

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

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

1 issue.

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

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

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

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

1 MR. HACKBARTH: Okay.

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

7 If, for some reason, perhaps, there is some
8 question about whether they'll come back to that agency,
9 they could discharge the patient when the patient is
10 hospitalized and the agency would get a prorated payment of
11 the 60-day payment. So, for example, if they're
12 hospitalized on day 30, they'd get half, 30 over 60, of the
13 60-day payment. And then if the patient comes back after
14 that hospitalization, a new 60-day clock would start.

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

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

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

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

9 MR. HACKBARTH: Okay.

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

17 The second piece that mitigates --

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

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

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

1 when somebody rebalances a late at the national level --

2 MR. CHRISTMAN: Right.

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

4 MR. CHRISTMAN: Right, it --

5 DR. MARK MILLER: -- and there's a lot of it going
6 within any given category, that might eventually show up.

7 But the incentive in front of the person is not a real time
8 -- I mean, is --

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

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

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

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

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

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

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

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

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

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

10 MR. CHRISTMAN: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And then just to reinforce the Dartmouth part of

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

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

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

12 [No response.]

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

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

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

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

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

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

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

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

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

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

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

9 MR. CHRISTMAN: Right.

10 MR. GRADISON: Thank you.

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

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

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

3 MR. CHRISTMAN: Yes.

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

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

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

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

3 DR. DEAN: Really?

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

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

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

16 MR. CHRISTMAN: Right, right.

17 DR. DEAN: Okay.

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

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

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

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

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

9 MR. CHRISTMAN: Right, right.

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

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

18 DR. DEAN: I see.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 avoided.

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

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

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

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

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

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

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

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

1 community episodes.

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

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

14 DR. MARK MILLER: [Off microphone.]

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

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

19 MR. HACKBARTH: Does somebody want to verify that?

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

22 MR. GLASS: [Off microphone.]

1 MR. CHRISTMAN: It's primary care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 DR. MARK MILLER: [Off microphone.]

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

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

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

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

9 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

22 But there might be a couple other things that we

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

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

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

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

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

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

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

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

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

16 George.

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

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

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

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

1 MR. GEORGE MILLER: Hear, hear.

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

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

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

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

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

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

1 But that's obviously kind of an aside.

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

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

19 [Laughter.]

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

1 in the Southwest.

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

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

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

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

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

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

1 think that's good.

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

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

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

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

10 As an internist, I remember one patient that I had
11 that would come back to the emergency room constantly, but
12 it was dietary indiscretion. It was this whole notion of
13 this -- if I could have a medical home back then, you know,
14 30 years ago, that would have been a thing that would have
15 made a big difference.

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

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

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

8 [Laughter.]

9 MR. HACKBARTH: That's good.

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

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

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

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

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

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

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

3 MR. HACKBARTH: Just a couple concluding thoughts.

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

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

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

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

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

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

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

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

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

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

22 A last thought, related, at least distantly.

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

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

17 [Pause.]

18 MR. HACKBARTH: Seeing nobody moving towards the
19 microphone, we will adjourn for lunch and reconvene at
20 12:45.

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

1 AFTERNOON SESSION [12:44 p.m.]

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

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

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

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

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

1 October of this year. Some of the policies we've discussed
2 will expire at the end of the year. The Commission's final
3 recommendations today will be useful to the Congress before
4 their deliberations begin. The mandated report is due June
5 15, 2013, and will include a full discussion of the issues,
6 our analyses, and the final recommendations.

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

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

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

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

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

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

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

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

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

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

1 beneficiary and would then assume financial responsibility
2 for those services.

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

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

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

1 settings, such as SNF and home health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 services.

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

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

22 The spending implications of this third draft

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

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

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

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

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

22 MR. HACKBARTH: Thank you, Adaeze.

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

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

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

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

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

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

1 the framework that spending above baseline is appropriate
2 here.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 of those caps.

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

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

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

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

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

7 MR. WINTER: Sure. So in the final rule, where
8 CMS adopted a 25-percent cap, which is now 20 or -- sorry, a
9 25-percent payment reduction, which is either 20 or 25
10 percent in current law, depending on the setting, CMS
11 addressed the comments raised by many members of the
12 industry, among which were that the RUC has already
13 accounted for duplicate practice expenses when they valued
14 timed therapy services. And the contention is that the RUC
15 assumed that there were three services per visit for a
16 typical visit, two procedures and one modality, and that
17 they accounted for duplicate practice expense inputs for
18 those services.

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

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

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

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

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

1 is a good thing.

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

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

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

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

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

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

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

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

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

20 MR. KUHN: Nicely done.

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

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

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

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

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

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

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

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

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

1 know, \$40, the PE, practice expense, might be \$30 or \$35.

2 But I can get you more specific examples, and we can add

3 that to the text.

4 DR. DEAN: Well, I guess I was just trying to get

5 a sense of how big a hit this would take. But I think

6 that's reasonable.

7 Finally, to follow up on what Herb was saying, I

8 wonder about the whole manual review process given the

9 elimination of this improvement criteria. To me that is

10 probably the fundamental criteria that would be used in

11 those reviews. I would think without that -- and, again, it

12 doesn't really affect what we do here, but I would think

13 that that's going to make the review process much more

14 difficult. Does that make sense?

15 DR. MARK MILLER: When we had some discussion of

16 this, and declaring that I'm not an expert in it, what the

17 settlement will turn on is that there's a need for a skilled

18 service, so that would continue to be a criteria, and then

19 you would see presumably the MAC judging, you know, whether

20 there's an improvement or that's what would have happened

21 before the settlement. After the settlement, the MAC would

22 have to consider whether that skilled service was needed to

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

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

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

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

5 MR. GRADISON: Good [off microphone].

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

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

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

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

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

7 MR. GEORGE MILLER: Right

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

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

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

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

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

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

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

19 [Laughter.]

20 MR. GEORGE MILLER: Thank you.

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

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

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

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

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

15 DR. NERENZ: Case manager?

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

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

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

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

14 DR. AKAMIGBO: Probably, yeah.

15 MR. BUTLER: Probably.

16 DR. AKAMIGBO: I can't speculate as to why the low
17 -- so when you look at the distribution of spending for
18 HOPD, you find that the spending per beneficiary who uses
19 therapy services in hospital outpatient departments is
20 probably the lowest among all these other settings, \$500,
21 \$600, and highest --

22 MR. BUTLER: Hospitals are usually not the low end

1 of these things, too.

2 DR. AKAMIGBO: But these are outpatient
3 departments.

4 PARTICIPANT: I know.

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

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

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

12 MR. BUTLER: Right.

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

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

22 DR. AKAMIGBO: Yeah.

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

5 DR. AKAMIGBO: Yeah.

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

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

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

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

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

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

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

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

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

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

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

10 DR. AKAMIGBO: Other objections?

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

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

15 DR. REDBERG: But you addressed that, too.

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

19 DR. REDBERG: Right and that was my question.

20 DR. AKAMIGBO: Okay.

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

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

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

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

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

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

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

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

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

17 DR. REDBERG: Because that was really the choice.

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

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

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

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

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

19 [Laughter.]

20 MR. HACKBARTH: Right, a personal review.

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

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

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

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

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

9 MR. GEORGE MILLER: Yeah, yeah.

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

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

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

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

1 14 visits before they would be subject to any review.

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

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

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

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

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

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

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

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

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

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

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

18 DR. SAMITT: Great job. Very well done.

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

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

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

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

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

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

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

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

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

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

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

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

20 MR. HACKBARTH: Specific about what specifically?

21 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

20 MR. HACKBARTH: It might have.

21 [Laughter.]

22 DR. CHERNEW: Because the situation is so

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

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

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

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

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

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

20 [Hands raised.]

21 MR. HACKBARTH: No votes? Abstentions?

22 [No response.]

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

4 [Hands raised.]

5 MR. HACKBARTH: Okay. No votes? Abstentions?

6 [No response.]

7 MR. HACKBARTH: Number 3. All in favor of number
8 3?

9 [Hands raised.]

10 MR. HACKBARTH: No votes? Abstentions?

11 [No response.]

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

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

17 [Pause.]

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

20 Okay. Kevin, whenever you're ready?

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

22 The mandate for this report was in the Middle

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

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

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

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

1 again.

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

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

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

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

22 Factors that vary geographically and believed to

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

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

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

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

22 As you discussed at the September meeting, this

1 method for implementing the GPCI raises two issues.

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

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

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

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

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

22 Third, the work GPCI is highly correlated with the

1 hospital wage index.

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

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

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

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

1 impact on access. However, extension of the floor would
2 have a budgetary impact, a one-year impact in the range of
3 \$500 million.

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

15 The findings are:

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

22 However, the correlation of pharmacist earnings

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

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

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

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

22 This is consistent with the findings in the

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

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

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

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

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

3 The primary care incentive program also makes a
4 10-percent bonus to primary care services delivered by
5 providers in certain specialties who specialize in
6 delivering primary care services. The PCIP is along the
7 lines of the Commission's 2008 recommendation for a payment
8 adjustment for primary care services. And payments under
9 this program were about \$560 million in 2011, and the
10 program will expire in 2015. The Commission could undertake
11 further analyses of these programs to see how they could be
12 better targeted.

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

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

22 However, areas below 1 -- so those that are

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

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

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

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

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

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

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

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

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

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

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

22 To elaborate on that last point, if one wanted to

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

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

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

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

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

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

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

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

16 The implications of the draft recommendation are:

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

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

1 beneficiaries.

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

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

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

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

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

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

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

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

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

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

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

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

1 I would remind you, as both the recommendation
2 does and Kate did, that what we revert back to on January
3 1st is a one-quarter adjustment using the current GPCI
4 mechanism. It's not a full adjustment.

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

8 MR. BUTLER: I have no comments.

9 MR. HACKBARTH: Okay.

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

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

3 Thank you.

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

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

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

22 I guess as I read this recommendation one more

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

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

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

14 DR. MARK MILLER: You could --

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

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

19 DR. HOADLEY: You could do that, too.

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

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

1 yeah.

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

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

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

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

8 [Laughter.]

9 DR. MARK MILLER: What did I say?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 And so, the theory and the sort of spirit behind

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 Thank you.

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

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

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

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

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

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

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

18 DR. HALL: I support the recommendations.

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

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

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

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

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

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

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

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

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

22 And we try to sell all the amenities and the great

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

3 [Laughter.]

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

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

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

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

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

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

6 So I'll leave it at that.

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

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

15 DR. DEAN: Okay.

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

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

20 DR. DEAN: Right.

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

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

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

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

9 DR. DEAN: Right.

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

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

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

19 Okay. Anybody else?

20 Okay. So would you put up the recommendation?

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

1 [Hands raised.]

2 MR. HACKBARTH: All opposed?

3 [Hands raised.]

4 MR. HACKBARTH: Abstentions?

5 [No response.]

6 MR. HACKBARTH: Okay. Did you them all?

7 DR. MARK MILLER: I think so.

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

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

15 DR. STENSLAND: You got it right.

16 MR. HACKBARTH: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

1 premiums.

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

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

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

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

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

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

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

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

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

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

1 for-service rates.

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

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

11 So the natural question is, what is the difference
12 about the negotiation dynamics that allow MA prices to be 30
13 percent lower than other private insurer prices?

14 The first point is that MA plans must compete with
15 fee-for-service under the current system. If MA plans paid
16 commercial rates, they would have to raise Medicare
17 Advantage premiums. If this bid was above the MA benchmark,
18 then beneficiaries would have to pay more to join the MA
19 plan than they would to stay in fee-for-service. So, to
20 keep the prices beneficiaries pay competitive with fee-for-
21 service, MA plans must keep prices they pay hospitals close
22 to fee-for-service prices.

1 Second, MA plans are in a strong negotiating
2 position to keep the hospital payment rates close to fee-
3 for-service. By statute, if a hospital does not come to
4 terms with an MA plan, that MA plan only has to pay the
5 hospital Medicare fee-for-service rates for out-of-network
6 emergency services.

7 This is important because over half of Medicare
8 beneficiaries enter the hospital in-patient department via
9 the emergency room. Due to these emergency department price
10 protections, the plan is not at risk for high out-of-network
11 prices, and beneficiaries are not at risk for being balance
12 billed for full charges. And this is not always the case in
13 the commercial market.

14 The net effect of these two factors strengthens
15 the MA plan's bargaining position and weakens the hospital's
16 bargaining position relative to the position they are in
17 when negotiating commercial rates.

18 So this is just an illustration of how hospitals
19 have less of an incentive to negotiate with commercial
20 insurers than they do in the MA context.

21 In this illustrative example, you can look at the
22 first column, and this is the most extreme example -- a

1 closed HMO that owns its own hospital, such as Kaiser in
2 California. This type of hospital would have close to zero
3 scheduled admissions to outside hospitals.

4 So outside hospitals contracting with a Kaiser-
5 type HMO would only expect to get emergency visits and
6 emergency admissions. The hospital has very little
7 incentive to negotiate with the HMO. It could just bill
8 full charges for patients entering the ER and then balance
9 bill the patients to the extent the HMO does not pay.

10 Because charges are so much higher than negotiated
11 rates, the hospital may be better off just billing the full
12 charges of \$3 million, in this example, even if the portion
13 of the 3 million ends up as bad debt.

14 And this was a strategy some hospitals took in
15 California up until 2009. In 2009, the Supreme Court
16 interpreted existing California statutes as saying that for
17 emergency services the hospitals can only bill HMOs usual
18 and customary rates and are not allowed to balance bill
19 patients.

20 Other states, such as Florida, have offered
21 similar protections due to similar concerns. However, there
22 are many states where these protections are not available in

1 the commercial market.

2 Now, as you can see in the second column, a
3 hospital has a stronger incentive to negotiate with a PPO
4 plan, but the PPO plan still has some leverage if it can
5 bill full charges for ER services if the PPO fails to come
6 to an agreement with the hospital.

7 As I said, hospitals will still usually want to
8 negotiate due to concerns over bad debts if they bill full
9 charges, but this illustrative example should provide some
10 intuition as to why hospitals may be able to drive a harder
11 bargain with commercial insurers than they can drive with MA
12 plans.

13 The purpose of this next slide is just to show
14 that the importance to plans and to beneficiaries of
15 avoiding full charges is increasing over time. This is
16 because over the past 12 years, average markups on hospital
17 services increased from roughly 100 percent to over 200
18 percent. What this tells us is that the benefit to the
19 beneficiary from being protected against full charges for
20 emergency room visits is increasing and the price
21 protections may have a bigger and bigger effect on the
22 negotiating process.

1 So one question is whether MA plans could still
2 get the current levels of prices they're receiving from
3 hospitals even if there was not fee-for-service competition
4 and there was not any out-of-network price protection.

5 Would prices fall this much if there was simply
6 more competition amongst the hospitals? And the literature
7 shows that hospitals with large market shares tend to get
8 higher rates from insurers. So, if there was a reduction in
9 each hospital system's market share, rates would be expected
10 to decline.

11 In recent years, the FTC has had some success at
12 slowing down the rate of increase in each system's market
13 share, but I'm not aware of any actual movement seen toward
14 increasing competition.

15 To actually increase competition, that would
16 require either building more hospitals or breaking up
17 hospital systems. And I've not heard of anyone calling for
18 the construction of more hospitals as a mechanism for
19 reducing health care costs, and I've not heard of any calls
20 to break up any of the well known hospital systems either
21 that we're familiar with.

22 There has been some success with ACOs making

1 physicians more price conscious in their referrals, and
2 there has been some success with tiered networks making
3 consumers more sensitive to price. But there's been very
4 little success in actually reducing hospital systems'
5 dominant market shares.

6 Nevertheless, what if we could see an increase in
7 competition?

8 What would that mean for prices?

9 How much lower would average prices go if
10 hospitals markets are more competitive?

11 Our analysis in your paper indicates that hospital
12 prices are 9 percent lower on average in markets where
13 insurers have much more market power than hospitals. Our
14 measures of market power are imprecise, and so the 9 percent
15 measure we use is certainly imprecise, but I think the point
16 is that that's substantially lower than the 30 percent
17 differential we see in the data between the MA plan payment
18 rates to hospitals and commercial insurer payment rates to
19 hospitals.

20 So, in summary, provider rates affect insurance
21 premiums, as we all know.

22 Hospital prices are roughly 30 percent lower for

1 MA plans, on average, and this may be due to a combination
2 of 2 factors -- first, MA plans must compete with fee-for-
3 service, and second, MA plans and beneficiaries benefit from
4 out-of-network price protections. We cannot be sure which
5 one of these factors on its own could keep prices at their
6 current levels, if one on its own could.

7 Finally, competition tends to result in lower
8 prices, but it's not clear that we can generate enough
9 competition to bring market prices down to the level paid by
10 MA plans.

11 And now, we'd like to open it up for discussion.
12 Many of you have experience either working for an MA plan or
13 working with a provider who has negotiated with MA plans.
14 We'd like to hear your thoughts on how fee-for-service
15 competition has affected the rates MA plans pay providers
16 and the premiums charged by MA plans. In addition, we'd
17 like to hear your thoughts on how price protections that MA
18 plans have had for the past 25 years have affected price
19 negotiations between MA plans and providers in the past.

20 Now we'll open it up for discussion.

21 MR. HACKBARTH: Okay. Thank you.

22 Craig, do you want to go first?

1 And, here, we'll have our usual two rounds. So
2 first round is clarifying questions only. No?

3 Scott.

4 MR. ARMSTRONG: So somewhere in here is a
5 question. You talk about how market share influences the
6 ability to negotiate rates, either hospital share or insurer
7 share. And then, you talk about the concerns about a
8 difference between fee-for-service rates and the Medicare
9 program has kind of like ultimate market share or at least
10 authority to set rates.

11 We're wondering how can this future that looks
12 kind of more like MA compete effectively to manage these
13 provider rates, but we're comparing today's MA experience
14 with fee-for-service when MA is really only 20, 25 percent
15 of the overall market share. In this future we're talking
16 about, wouldn't these plans have much more market leverage?

17 And so, I'm just wondering if that's really a
18 great point of reference for us.

19 I told you somewhere in here was a question. I'm
20 not really sure how to get at it, but it really kind of
21 challenges the underlying concern about the 30 percent gap
22 that exists because it's comparing today's market dynamics

1 to a hypothetical future that would be very different.

2 MR. HACKBARTH: So a question that I think is in
3 there is, if the share of Medicare beneficiaries enrolled in
4 private plans were to increase substantially, would that
5 make it more difficult for private plans to command lower
6 rates or less difficult for them to command higher rates?
7 Lower rates, excuse me, from hospitals.

8 MR. ARMSTRONG: I think it would make it less
9 difficult. It would put the plans in a better position to
10 negotiate lower rates.

11 MR. HACKBARTH: Yeah. So sort of a standard
12 analysis might be that as they get more enrollees they've
13 got more leverage in the negotiation.

14 MR. ARMSTRONG: Right.

15 MR. HACKBARTH: All other things being equal, that
16 would equate to lower rates.

17 On the other hand, if they become a larger share
18 of a hospital's business and granting lower rates means a
19 more dramatic hit on the overall revenue coming into the
20 institution, it might give a low rate to a small fish that
21 you will find difficult to give to everybody would be an
22 alternative scenario.

1 MR. ARMSTRONG: Right.

2 MR. HACKBARTH: So I truly meant it as a question.

3 Which way does it cut as MA enrollment increases, Jeff?

4

5 DR. STENSLAND: I think we do have some data in
6 the paper. The stuff that we did on market concentration is
7 clearly crude measures, but we have the hospital market
8 share in there, and then we also have another thing I didn't
9 discuss in the presentation, of the insurer market share.

10 And, if we look at prices, when the hospital
11 dominates the insurer, we see they are about 9 percent
12 higher. If we look at prices when the insurer dominates the
13 providers -- and these are cases where they might have 80
14 percent of the market share in the state, the single insurer
15 -- we see prices, on average, that are 9 percent lower than
16 average. So you have this 18 percent spread there from
17 hospital dominance to insurer dominance.

18 So maybe we could get more than the 9, but I don't
19 know if we're going to get to the 30. And then, of course,
20 we're saying this is the prices the hospital pays.

21 Now there is some work by Daphny that suggests,
22 well, if the insurer has market dominance and they have 80

1 percent share, they might not pass all of those savings on
2 to the beneficiary in terms of their premiums. They might
3 keep some of that.

4 There's also the question of these are markets
5 where the insurer dominates by having an 80 percent market
6 share, and even if managed care as a whole has lots of
7 market share, lots of -- I mean lots of people are in MA
8 plans. The individual MA plans might not have big market
9 leverage on their own because they only each have a little,
10 teeny slice of it. So you might not see that full 18
11 percent that we saw in our regression results.

12 And I want to say again that, you know, this is --
13 I'm certainly not hanging my hat on 18 percent because our
14 measures of market concentration are really imprecise, but
15 that gives you some sort of a flavor for that differential.

16 DR. COOMBS: Yes, I was thinking about the cost
17 variation studies that the attorney general in Massachusetts
18 did, Martha Coakley, and just looking at the private market
19 and some of the indicators that they had that were outside
20 of just patient care.

21 You know, on your slide 8, I was thinking about
22 the whole notion of one of the impacts of the states where

1 there's no balance billing. How do you predict, you know,
2 if there was a CPC intersecting with the areas where you
3 have, say, a 60 percent private market from a single player,
4 almost a monopoly in terms of -- monopolistic, if you will.
5 How would that play with a new product like the CPC?

6 DR. STENSLAND: I don't think I'll try to
7 speculate on a new product, but we can look back at the MA
8 plans and see what we have learned from those.

9 And at least we do see -- when we looked at --
10 there are some markets where you have both big insurer
11 positions, like you're saying if an insurer has 60 percent
12 market share, like they might in Massachusetts, and some big
13 provider share. In some sense, those two things somewhat
14 offset each other in our data.

15 DR. COOMBS: That's exactly what it is. It's
16 matched by, you know, a dominant player on the provider side
17 and a dominant player on the insurer side.

18 DR. STENSLAND: In those markets, we tend to see,
19 on average, average market prices compared to the rest of
20 the country.

21 Of course, within the market, I think, as you
22 know, the attorney general said there are widely different

1 prices depending on the individual hospitals' market shares
2 and some getting much lower payments than others.

3 DR. COOMBS: Thank you.

4 DR. HALL: I think you may have answered this.
5 This is about market share. Let me just try one scenario
6 here.

7 What about a community that has a dominant
8 provider -- I mean a dominant hospital system, let's say,
9 and has -- at the same token, there's one dominant MA
10 program. How does this balance out?

11 I guess I'm thinking really more of, say, Florida
12 or certainly some parts of my state that have this
13 situation.

14 DR. STENSLAND: As far as we can tell, at least
15 from the people we talked to, if you're talking MA plans,
16 those MA plans are generally still following the prices that
17 fee-for-service pays. So even though it's a big MA plan and
18 it's a big hospital and a big insurer, they really are still
19 following those fee-for-service rates. And maybe that's
20 because they can't really move those much higher or they
21 lose their people.

22 DR. HALL: They can't move them. That was my

1 impression, right.

2 DR. STENSLAND: And there are some other nuances
3 in the rules that are in the paper that I won't get into,
4 but I think that's the general perception.

5 Now, of course, in the private commercial market,
6 it's going to be a different scenario, where those -- you
7 know, we certainly have examples of those must-have
8 hospitals extracting very high prices in certain markets.

9 MR. GRADISON: [Off microphone.] Fascinating.
10 Very fascinating. Thank you.

11 MR. GEORGE MILLER: Yeah, fascinating. You asked
12 the questions. We've had the experience. What you've just
13 described is normally the case in our experience, that --
14 not on the commercial side but on the MA side.

15 And one of our concerns, especially being small
16 rural hospitals, is if they will pay us what Medicare fee-
17 for-services would pay. So, fascinating.

18 DR. NERENZ: Yeah, it seems like if I'm following
19 this correctly the real meat of the discussion is near the
20 end of it, and I'm thinking particularly about slide 10
21 because other than that it's pretty straightforward. If you
22 assume that MA plans are going to have to pay higher rates

1 to hospitals, inevitably, the premiums go up. It seems like
2 that follows.

3 The question would seem to be, will they indeed
4 have to do that, or under what circumstances will they have
5 to do that?

6 And I think you've done a nice job of talking
7 about the leverage and market dynamics and negotiation.

8 I guess I'm trying to imagine the scenario a step
9 or two with the chess game further ahead. If we imagine
10 that fee-for-service has gone away; there is a set of plans;
11 they're negotiating. And let's say imagine that as a first
12 step they do indeed have to go up to what are currently
13 private insurance prices. I think the net immediate effect
14 I would just call a hospital windfall.

15 I mean hospitals are treating the same patients,
16 but now they're getting paid more money.

17 Now the question is, do you assume that there is
18 no additional market pressure of any kind that would then
19 result in some down pressure on those increases, or do those
20 windfall increase payments just ride forever into the
21 future?

22 DR. STENSLAND: I think that's pretty complicated.

1 The only thing I would add into that dynamic is
2 what we have seen in terms of our past work on financial
3 pressure is when that windfall money rolls in that money can
4 be spent because there's often the hospital system can think
5 of good things to do with that money. And then once they
6 start spending the money, then there's an incentive to keep
7 those rates up so you can keep on doing the things you're
8 doing.

9 DR. NERENZ: Understood. Understood. And I'm
10 just trying to think through those steps because up to that
11 point this is pretty straightforward. And I'm just sort of
12 asking you to speculate, because you probably have
13 speculated, about what that looks like.

14 The scenario you just described is certainly
15 possible, but I'm also wondering if somewhere then in the
16 resulting negotiating dynamics with whatever plans are
17 active, with whatever leverage they have, is there not some
18 power that produces some return back, meaning some later
19 reduction in those prices.

20 MR. HACKBARTH: Dave, can I ask a question there?

21 I'm not sure how we get to the scenario that
22 you're describing where the MA plan is paying much more than

1 Medicare fee-for-service rates.

2 DR. MARK MILLER: He said fee-for-service goes
3 away.

4 MR. HACKBARTH: Oh, I'm sorry.

5 DR. NERENZ: That's the number one assumption in
6 this whole discussion.

7 MR. HACKBARTH: So let me just make sure that I
8 understand. So your opening assumption was Medicare fee-
9 for-service goes away? Is that --

10 DR. NERENZ: I'm looking for the bullet point
11 where it I think makes that statement. Is that not the
12 hypothetical here?

13 DR. MARK MILLER: I mean, I took his -- I took
14 your question as this: Given this analysis, which does not
15 suppose that fee-for-service goes away, but you were saying,
16 given this analysis, if fee-for-service went away, the MA
17 plan payments to providers would go up. Just yes or no at
18 that point?

19 DR. NERENZ: Yes.

20 DR. MARK MILLER: Okay. And then, the second part
21 of your question was, would they stay up, or would there be
22 any countervailing pressure to bring them back down? And

1 you asked Jeff to speculate about that.

2 DR. NERENZ: Also, yes.

3 DR. MARK MILLER: Okay. And what I would have
4 thought Jeff would say was I do know a little bit about
5 this.

6 And, Jeff, it's the 9 percent point, I think.

7 To the extent that we've seen a countervailing,
8 you know, market pressure, an insurer-dominated market,
9 there might be some pressure, but it's not going to offset
10 that full amount.

11 DR. STENSLAND: The insurer situation would be
12 something that's already kind of baked into the baseline.

13 The only thing I could think of; I think the story
14 you're talking about might vary very much depending on the
15 different markets. If you're in a market where there's only
16 one hospital or two hospitals, you might really not see
17 anything happening, especially if maybe they dominant all of
18 the -- maybe they employee all the doctors in town also. I
19 think you wouldn't see anything happening, but I could see
20 maybe a little pushback in some markets.

21 And maybe Mike would have some opinion when this
22 flows around to him on places maybe like Boston, where if

1 you do have these extra higher profits available and you
2 have some ACO models or something where the physicians might
3 be able to, you know, leverage their influence over where
4 their patients go in terms of their referrals if someone
5 gives them a lower price. Maybe you could see some
6 increase, bringing that extra profit down a little bit
7 through that kind of mechanism, but I think it would really
8 depend on the individual market.

9 DR. NERENZ: Okay. Well, I just had to go back
10 through my own thinking. I may have made an assumption that
11 you actually didn't put in front of us, but as I look at the
12 bottom bullet on slide 3, that is the hypothetical you're
13 giving us -- if MA plans paid commercial provider rates.

14 And I was just trying to imagine under what
15 scenario would that actually happen.

16 And then, the scenario that came to mind was,
17 well, you pull the fee-for-service anchoring out of it, and
18 that's why such a scenario would occur. But perhaps that's
19 not why it would occur.

20 But then I would wonder why else would it occur.

21 MR. HACKBARTH: Yeah, yeah. So, just to be clear,
22 Dave, the reason for my question is the whole purpose of

1 this analysis is, in fact, to think about how the
2 negotiating dynamics and rates paid would vary under
3 different scenarios.

4 But I just want to be clear, though. We're not
5 assuming that Medicare fee-for-service goes away. That's a
6 scenario you can think through what the implications would
7 be, but we're not accepting that as a given in this
8 analysis.

9 DR. MARK MILLER: Can I just -- oh, I'm sorry.

10 So back to you, in your hypothetical, you're
11 correct. If that anchor is removed, you would expect on the
12 basis of this analysis that Medicare payments --
13 expenditures would go up because the rates that would be
14 paid to providers would go up and the premiums would have to
15 go up. And so do you see any countervailing force that
16 would drive them back down?

17 DR. NERENZ: That's why I asked for other smart
18 people who have been working on this to --

19 DR. MARK MILLER: [Off microphone.] And our last
20 slide was asking you guys --

21 DR. NERENZ: Well, but I just -- it just -- I was
22 just envisioning the scenario where you have multiple plans

1 and at a first step, their payments to hospitals have gone
2 up. But now, if that's true, then hospitals have received
3 what I'll call a windfall and now I'm looking for the next
4 year. Is there not some negotiating traction that at least
5 one or two of these plans have that would sort of have
6 selective contracting with one or two hospitals who are
7 willing to give back some of that windfall in return for
8 higher volume. And I'm just speculating on that kind of
9 dynamic, but I --

10 MR. HACKBARTH: So the dynamic would vary by
11 marketplace, and how many hospitals there are, where there
12 are must have hospitals, whether plans are prepared to go to
13 limited networks, whether they can sell limited networks in
14 that given market, and you potentially get all sorts of
15 different configurations based on those dynamics.

16 DR. NERENZ: All true. Very complicated.

17 MR. ARMSTRONG: Glenn, one quick point. So this
18 was behind my point earlier, was that if you shift so that
19 75 or 100 percent of the Medicare business is going through
20 these private plans. That also would really shift the
21 dynamic in that negotiation with the local hospitals. I
22 mean, I agree with your point. There are a lot of other

1 variables that would change this, too. But I think that is
2 one view.

3 DR. CHERNEW: But 100 percent in one MA plan is
4 different than ten percent in ten MA plans.

5 MR. ARMSTRONG: True, but going from 25 percent to
6 something closer to 100 percent will change regardless of
7 the hospital their relative position in those negotiations.

8 MR. HACKBARTH: [Off microphone.] Okay.
9 Clarifying questions.

10 MR. BUTLER: So I was going to drill down on this
11 nine percent thing, too, and ask if -- you made reference to
12 do the insurers that are able to extract nine percent lower
13 fees pass along the savings. You could look at medical loss
14 ratio. You could look at -- do you think there's data that
15 we could get at that would be able to give a reasonable
16 estimate of per capita spending under the commercial market
17 versus the -- so you get your answer to your question,
18 because that would be an important piece of information.

19 DR. STENSLAND: I think I'm not very optimistic on
20 how well we can do that. There is a paper out there by
21 Dafny, and I don't remember all the details, how basically
22 she was saying that they don't give it all back. But I

1 think if we actually went through that exercise of trying to
2 figure out what's happening in the commercial markets, I
3 think it would be a big exercise. I'm not sure we would
4 want to go there.

5 MR. BUTLER: You're always up for big exercises.

6 [Laughter.]

7 DR. CHERNEW: I think she says, in fact, that the
8 price -- if you consolidate amongst insurers, hospitals get
9 paid less, but actually, the customers get charged more,
10 which is loosely consistent with theory, incidentally.
11 That's what she says.

12 MR. BUTLER: So the total cost to society and
13 those paying the bills is higher --

14 DR. CHERNEW: Right, because you basically have a
15 monopsony in the market for the inputs --

16 MR. BUTLER: Yes, well that's --

17 DR. CHERNEW: -- and your monopoly in the market
18 that you're selling stuff.

19 DR. STENSLAND: And I just want to say, there's
20 not a -- at least, I didn't see a huge literature on this,
21 where there's a lot of other papers doing this. And it's
22 not the simplest paper, what she's doing. So I wouldn't

1 completely hang my hat all on this one study, but that is
2 the direction the one study goes.

3 MR. HACKBARTH: Rita, clarifying questions.

4 DR. REDBERG: Yes. I wanted to go back to Slide
5 9. I found this slide of mark-up of charges over cost,
6 because that's been quite an increase, it looks like, from
7 1998 to 2010, and did you have any more feeling for what was
8 going on there? I assume there was some geographic
9 variation, maybe States near the Gulf of Mexico but not
10 Oklahoma would be higher charges over cost, or other things.
11 What was driving that huge increase?

12 DR. STENSLAND: I could speculate on different
13 things, but there's wide variation across the country and
14 there's variation from hospital to hospital. Probably some
15 of the lowest mark-ups are in a lot of little teeny small
16 towns, and maybe you could see this. You know, you think of
17 a little small farming town where the farmers are on the
18 board of the hospital and they don't have insurance and what
19 are you going to do. Some of the biggest mark-ups of all
20 are actually in California. That's where they tend to
21 really have high mark-ups over charges.

22 And generally, I think, what people say was

1 driving a lot of this thing, the two main things we hear are
2 people still getting paid discounts to charges on certain
3 procedures, especially outpatient and thinking, well, we
4 need some more revenue. What are we going to do? Okay,
5 we'll move up our charges. And some people saying that, in
6 some cases, the hospitals are maybe willing to go along with
7 this because it makes it even more important for you to buy
8 insurance from them, because one of the services they
9 provide is they negotiate a price, and if their price is now
10 one-fourth of the charges, well, then that insurance becomes
11 more valuable because they've really been able to negotiate
12 a much lower price.

13 DR. REDBERG: California in all the systems, like
14 Kaiser and the private and nonprofit, or --

15 DR. STENSLAND: There's a lot of variation in
16 California, but, on average, the mark-ups are bigger. And
17 I'm not so sure about Kaiser. We don't have a lot of
18 Medicare data from the Kaiser people because they don't do a
19 lot of fee-for-service business. But in the other
20 nonprofit, for profit, both in California, they tend to be
21 some quite high mark-ups.

22 MR. BUTLER: If I could just ad quickly, you know,

1 virtually nobody pays these. It's like just a teeny part of
2 your business that you're still trying to squeeze what you
3 can out of somebody on a discount. And even those that
4 don't have insurance or are under even four times the
5 poverty level, typically, there are automatic discounts
6 against these charges. So this is a dying -- but it is
7 still some of the differences that you have been talking
8 about. It's not irrelevant by any means. It just looks a
9 little simpler than it is.

10 DR. STENSLAND: And just to reiterate what Peter
11 said, under PPACA, if you are under commercial insurance and
12 you are eligible for discounted care because you're poor,
13 under whatever level of poverty, the hospital can't charge
14 you full charges. It has to charge you a reasonable and
15 customary rate. But you could be somebody with private
16 insurance and you go into a market and you have an accident
17 there and there's no contractual negotiation with the
18 hospital. Then there's a potential that you might end up
19 having a really big price tag.

20 MR. GEORGE MILLER: That, again, like Peter said,
21 is so small. At my shop, for example, I'm 72 percent
22 Medicare and Medicaid, ten percent commercial, and about

1 five percent self-pay. So nobody -- very few of us, few
2 hospitals, get paid those type of numbers. I mean, we're
3 talking about ten percent of my total revenue, \$40 million.

4 MR. HACKBARTH: Okay. Kate, clarifying question.

5 MR. GEORGE MILLER: That doesn't mean they pay it.
6 That means I charge it to them. It doesn't mean they pay
7 it.

8 [Laughter.]

9 DR. BAICKER: Duly noted.

10 [Laughter.]

11 DR. BAICKER: So this is really interesting, and
12 understanding why they're paying less, why MA plans are
13 paying less, seems at the heart of the problem in
14 understanding what reforms are going to do. You mentioned
15 two factors, two potential explanations that are hard to
16 disentangle and I had a question about each of them.

17 One was the sort of back-end protection against
18 emergency charges out-of-network, and I didn't have a sense
19 of how big the magnitude of that might be. You know, if you
20 did sort of a bounding exercise and said, assume that that's
21 passed directly through, my intuition would have been that
22 that can't explain the majority of it, that it has to be a

1 fairly minority share of that. But it would be helpful to
2 know how big could that possibly be.

3 And then the second channel was because they still
4 have to compete with fee-for-service, then they have this
5 extra negotiating clout. That story seems to me, you know,
6 if we're going to believe anything about economic theory,
7 should only work in a world where they're negotiating in a
8 non-competitive market. But it shouldn't matter what --
9 that fee-for-service is an option if they're -- insurers are
10 competitive and hospitals are competitive, but they're not.
11 And so the nine percent number that you showed, I
12 interpreted to be overall in insurer-dominated markets,
13 payments were nine percent less.

14 But maybe an important complementary figure to
15 that would be the interaction effect between the degree of
16 competitiveness in the hospital market and the differential
17 between the MA plans and the commercial plans in the sense
18 that if the MA plans are able to exploit or able to use the
19 fact that their enrollees have an outside option, they
20 should be able to use that fact more in a situation where
21 negotiation matters as opposed to a perfectly competitive
22 market. So that wedge should be -- if that's part of what's

1 going on, I would think that the wedge effect would be
2 bigger in the least competitive hospital markets. Now, we
3 all know theory only works out 50 percent of the time, so
4 we'll see if that's actually true, but that's what I might
5 have guessed.

6 That's more of a request for more information than
7 a question, I realize.

8 MR. HACKBARTH: Cori.

9 MS. UCCELLO: My head is still spinning from her
10 question, so --

11 [Laughter.]

12 DR. BAICKER: Wasn't it perfectly clear?

13 MS. UCCELLO: Well, my head is not clear, so I
14 think that's the problem. So I'm not sure there's overlap
15 here.

16 I mean, clearly, the local market dynamics are
17 playing into things. But I know -- I'm going to channel
18 some other people, not necessarily me -- in thinking about
19 the role that cost shifting has in this and that 30 percent
20 that we're looking at, is that actually less than 30 percent
21 if there's higher --

22 MR. HACKBARTH: [Off microphone.] Which 30

1 percent --

2 MS. UCCELLO: I'm not sure. Thirty percent --

3 MR. HACKBARTH: [Off microphone.]

4 MS. UCCELLO: The 30 percent differential between
5 the pre-65 commercial and the fee-for-service. If the
6 Medicare rates kind of go up, if there's less cost shifting,
7 then we're looking at less than 30 percent.

8 My major question here is to what extent is cost
9 shifting an issue here, aside from the local market
10 dynamics, because I think there are a lot of people who
11 still think that cost shifting, the lower rates paid by
12 Medicare are increasing the commercial rates, which, again,
13 it's tied into the local market dynamics, but -- I'm sorry
14 this isn't clear.

15 DR. STENSLAND: Let me just -- the basic fact --
16 this is what people are telling us, that whatever your
17 commercial rate is, going up and down, depending on what
18 your market power is, the MA rate is sitting here at fee-
19 for-service. So if you have a little bit of market power,
20 fee-for-service is here and you're here. If you have a lot
21 of market power, you're up here and fee-for-service just
22 stays there.

1 So then the question of that cost shifting. I
2 think the way most academics talk about it is if there's
3 some exogenous shift in the Medicare price up or down, what
4 happens to the private prices if Medicare exigency has a
5 rule change and things go down? Do private prices go up?
6 And I think the evidence there is really mixed. Maybe it
7 does go a little bit of cost shifting, or some other studies
8 say, no. But really, they seem to be following Medicare,
9 like they kind of follow the lead of Medicare. So that's
10 mixed.

11 I think what's a lot clearer, at least from the
12 work that we did here a few years ago, is that it doesn't
13 look like people are charging the higher rates just because
14 they have to. This idea that I'm only going to charge these
15 high rates because I have to. If I don't have to, I'm not
16 going to charge them. And I think that part of the story
17 really falls apart when you look at the data, because you
18 look at the people that are really charging the high rates.
19 Those are people with lots of money in the bank. These are
20 the people, like, with the billion-dollar endowments. And
21 if you look at the people that are getting the lower rates
22 and have the lower costs, those are the people with the

1 eight-dollar endowments. And so I don't think it's the ones
2 that have no money that are the ones that are charging the
3 higher rates.

4 MS. UCCELLO: I think that there might still be,
5 maybe not in the community that is writing some of these
6 papers, but I think there is a perception out there that
7 that still is a big part of this. And so the extent to
8 which this work can kind of address that and maybe refute
9 some of that, I think would be helpful.

10 DR. MARK MILLER: Yes, and I think it is worth
11 repeating, and maybe for some of our new Commissioners we
12 can do this again in December. I don't know how much time
13 we have. But I believe you're correct. The perception is
14 very widespread and I encounter this in every room that I
15 walk into, which is no, no, no, this is about cost shifting.
16 Medicare doesn't pay enough. We have to charge more. And
17 we feel that we've shown pretty convincingly for many years
18 that that's not the case, that the people getting the
19 highest rates are the people who are engaged in this and
20 that that's driving costs up in the system much more broadly
21 and that, in a sense, it's almost the reverse problem, that
22 that cost makes Medicare margins look worse.

1 And so I do understand what you're saying and I do
2 understand that this perception is very widespread. We have
3 kind of rejected that argument, and I'll tell you, every
4 room I go into, I mean, I have to do it over and over again
5 because people are still carrying that around.

6 MS. UCCELLO: Yes, and I just want to be clear
7 that I'm not talking for myself. I'm just talking about
8 people --

9 DR. MARK MILLER: [Off microphone.] You said
10 channels --

11 MS. UCCELLO: Yes, other people --

12 MR. HACKBARTH: And on this issue -- I think Jeff
13 was alluding to this -- there's been a fair amount of
14 empirical research on this over the years, and Austin Frakt
15 from BU just did a review of all of the available empirical
16 research on cost shifting and his conclusion based on the
17 research was there may be some that exists, but it's way
18 less than that conventional wisdom that you're referring to
19 States, and that's broadly consistent with the sort of work
20 that we've done, as well. There's a lot of urban legend
21 here.

22 MS. UCCELLO: And I think the point here is that

1 as we discuss these kinds of things, using it as another
2 opportunity to highlight that would be useful.

3 DR. SAMITT: Round two. So I'm not sure what
4 question we're supposed to be answering, so if my answer
5 isn't right, just ignore it. But, you know, in the universe
6 that I'm in, in response to the specific question, if
7 Medicare fee-for-service did not exist, would we see rising
8 prices in Medicare Advantage, my guess is no. In the
9 universe that I'm in, I think we're hearing two phenomenons.

10 One is if you speak to most hospitals, many
11 hospitals, the prevailing perspective is that they will need
12 to learn to manage at Medicare reimbursement levels, that's
13 it, for all of their payers. So their presumption is they
14 need to bring their cost structure down to Medicare rates,
15 and I'm hearing that more and more and more. So I think
16 that while that chart shows rising charges, there is an
17 overwhelming sense that there is going to be no more
18 revenue.

19 The other phenomenon, though, is I think we've
20 just begun to see enhanced competition between providers for
21 quality and cost. So even in markets where there is mono --
22 it was a word you used, I'd never heard of it --

1 DR. CHERNEW: Monopsony.

2 DR. SAMITT: Monopsony -- even in an environment
3 where there's a monopoly, I don't think those will prevail
4 for long. I think there are organizations that are stepping
5 into the value path, and we've mostly concentrated on
6 discussions of unit cost whereas I think the greatest
7 opportunity to manage under an MA plan is utilization cost.
8 So I think there are going to be organizations that will
9 come in, will seek to focus on wellness and utilization
10 reduction, and aggressively compete as an MA plan, and
11 that's their mechanism of preserving reimbursement levels to
12 hospitals, because they're bringing the utilization cost
13 down.

14 So it's great to have a safety net of Medicare
15 fee-for-service to just assure that that doesn't happen, but
16 my prediction is we'll see bids come in lower than Medicare
17 fee-for-service because systems, hospitals and others, will
18 not be able to survive otherwise in an increasingly
19 competitive environment. That's -- you know, coming from
20 the commercial side, I think that's what we're seeing on the
21 commercial side. So why would we not think that would
22 happen on the Medicare side?

1 MR. ARMSTRONG: So I would actually just start by
2 echoing a point you just made, Craig, that this is a
3 conversation that's focused on price per unit of service
4 and, in fact, we do pay Medicare rates for MA hospital
5 services. We pay higher rates for commercial services. I
6 don't know if we are able to do that because of the presence
7 of those fee-for-service rates, but the market is changing
8 so much, as you said, that it's really hard to say for sure.

9 But we really don't look at those costs per unit
10 of service independent of the overall costs net of the units
11 of service. And, in fact, our model is much more focused on
12 get the rate and then manage the units of service as
13 aggressively as we possibly can.

14 One other point I would make about the plan I work
15 for. Beyond getting the Medicare Advantage rates in terms
16 of our hospital day rates, we also try to leverage a
17 relatively small market share, you know, 20 to 25 percent
18 market share overall, not just for Medicare, by
19 consolidating all of our hospital business in a single
20 hospital in each market. And so it's a great way for us to,
21 as a commercial plan, be able to do things that create
22 leverage that we wouldn't otherwise have. And I think just

1 one example of the kinds of dynamics that are variables that
2 come into this evaluation of what is that dynamic in each
3 one of these markets.

4 MR. HACKBARTH: Can I just jump in and ask a
5 clarifying question I should have asked a minute ago. I
6 want to make sure I understand the statutory provision that
7 gives a Medicare Advantage plan the opportunity to basically
8 command the Medicare rate for out-of-network services.

9 So does that mean that a Medicare Advantage plan
10 could go into a negotiation with Peter and say, look, we'd
11 like to include Rush in our network and you give us the rate
12 we want, whatever that might be, in the negotiation. And,
13 oh, by the way, if you don't agree and we exclude you from
14 the network, we're going to pay you the Medicare rate
15 anyhow, and it says here in Section 18 whatever of the
16 statute that we have the right to do that.

17 DR. STENSLAND: At least that's true for emergency
18 services. So if you're out of network and --

19 MR. HACKBARTH: But if they're out of network,
20 truly out of network, that's the only way a patient would be
21 admitted to that hospital would be through an emergency
22 service, right?

1 DR. STENSLAND: Unless it's something that they
2 don't offer at that hospital. But even if they don't offer
3 it and the -- the way it's structured is if the insurer
4 takes responsibility for that payment -- for example, maybe
5 you don't have anybody that's in network that does
6 transplant but somebody has to get a transplant and your
7 hospital doesn't have it, even if you're a Kaiser or
8 something. Then you're taking responsibility for that
9 payment. They're going to that out-of-network provider.
10 Because you're responsible for the payment, you can demand
11 that they take the fee-for-service rate.

12 MR. HACKBARTH: Peter, you were --

13 MR. BUTLER: But you're right. Fifty-eight
14 percent of the admissions come through the ER, is your
15 estimate, and those ones would be immune to anything -- I
16 mean, their Medicare rates is what you would get.

17 MR. HACKBARTH: So that's a pretty powerful
18 negotiating tool.

19 DR. CHERNEW: So, actually, I'm having a harder
20 time thinking through the sort of policy experiment that
21 we're trying to think about. So it sort of started with
22 what if fee-for-service went away. I can't envision it. I

1 probably can't imagine I would really support it. But in
2 any case, that seems to be sort of the exercise, to
3 understand what would happen, and I think that's challenging
4 for a number of reasons, because it's -- for example, if
5 fee-for-service went away, you'd have a hard time figuring
6 out what the benchmarks are. So you need to figure out what
7 the benchmarks would be, and then the benchmarks involve
8 some competition and potentially interaction amongst the
9 plans, depending on how you set it. And I think the answer
10 to all the questions that are being asked would depend on
11 the process that you put in for figuring out what the
12 benchmarks are and the extent to which you think that the
13 markets would be disciplined.

14 And I agree -- I have heard the exact same things
15 and I believe very much what Craig said, that hospitals are
16 trying to figure out how they're going to have to manage at
17 Medicare rates, but I think that's because they think
18 they're going to have to manage at Medicare rates. And in a
19 world where they didn't think they had to manage at Medicare
20 rates, it's not clear that the culture that has been -- I
21 perceive as a dramatic shift over the past five years is one
22 that they're so thrilled about and would remain, though it

1 might. But whether it did would depend on the exact set of
2 structures you put in place for how benchmarks went.

3 And I can envision in, for a worst case scenario
4 world, where you just wrote a blank check to everybody, that
5 there wouldn't be an incentive for the strong negotiation or
6 efficiency because people don't like networks and it would
7 be hard to enter to figure out how you would do that. But I
8 could envision other worlds that are much closer to the sort
9 of competitive ideal that Craig outlined.

10 So I think the one thing that this shows, and I
11 think is important to understand, and it pains me to say as
12 an economist who's generally very supportive of markets, is
13 markets are great, but they're not perfect and there's real
14 problems with competition in a whole variety of ways. And
15 understanding the dynamics of that competition is really
16 important and will depend on the institutional structures
17 that you put in place that folks are competing in.

18 But I think it's too simplistic to think that if
19 we just allow competition, that prices will all be driven
20 down. That clearly isn't happening in some markets. But I
21 think it's also too simplistic to say, if we set up a
22 competitive market, that it just would be a dismal failure.

1 And sorting out exactly what that experiment is that we're
2 trying to hypothesize about is really hard, and I think once
3 we do that, we might be able to be a little more concrete as
4 to how to help us figure out what would happen.

5 DR. COOMBS: I'm just taking this as a learning
6 session. Thank you.

7 [Commissioners passing.]

8 MR. GRADISON: I'm tempted to follow suit, but
9 years ago when I went to business school, we were told there
10 weren't answers to business problems, that the best you
11 could hope to obtain were currently useful generalizations,
12 so I'm going to reflect my current state of confusion by
13 stating some generalizations that I'm not totally sure I
14 would support, but they are just an indication of where my
15 head's coming from on this.

16 First is that, typically, in a situation like
17 this, if you're a purchaser and the goods or services you're
18 trying to buy are being in your mind overpriced, you
19 probably become -- you buy them out or buy somebody else or
20 start a new one, start a new hospital or buy out a hospital.
21 But there's a lot of evidence that combining insurance and
22 hospital ownership has not worked very well. I think Humana

1 was one of the examples that tried this and put it together
2 and then had to take it apart for a lot of reasons. So that
3 general principle doesn't seem to apply very well here.

4 At the same time, there is a truly symbiotic
5 relationship and these folks need each other. The hospital
6 needs somebody to pay their bills and the insurance company
7 needs somebody to provide services. So I don't see that the
8 financial deal in the long run can -- I don't see that the
9 arrangements that are worked out in the long run can be
10 based solely, and maybe not principally, on financial
11 considerations alone. I think that there has to be a longer
12 view of the relationships in an individual community.

13 A third point which sort of was mentioned here
14 already, and I'm not sure how it relates, but I do want to -
15 - I think it's a factor -- much of our discussion has to do
16 with what are the rates going to be for this year or the
17 next couple of years, something like that, which is sort of
18 a profit and loss consideration. Somewhere in here, I think
19 we have to enter the question of financial reserves, the
20 ability to ride out a couple of bad years. Kaiser almost
21 went under one year when they underpriced their insurance
22 and therefore weren't able to take care of all their

1 patients in their own hospitals and had to go out and buy
2 hospital care at top dollar. It was a very bad period. It
3 was about 20 years ago or something like that. It was
4 really -- I mean, over a billion-dollar loss as I remember
5 it in one year because of that imbalance. At the same time,
6 I read -- and I don't know what the numbers are -- the
7 partners has reserved some \$7.5 billion or something, I
8 mean, huge sums of money, and most hospitals, they get
9 along, but the matter of financial reserves does affect your
10 ability to negotiate in the short run and maybe in the long
11 run.

12 And, finally, just to show you how opinionated I
13 really am, I'm very skeptical of this argument of cost
14 shifting because it seems to me that what's actually
15 happening is a perfectly normal procedure where you segment
16 your markets. And you may have the same good and service
17 that you sell in one market for one price and another market
18 for a different price. We may think of it primarily in
19 international markets, where you might have a different
20 price for a drug in one country than another, but the same
21 thing can happen in other settings, as well. So the notion
22 that if you don't get paid enough by Medicare, you're

1 automatically going to shift it, may be. I'm not denying
2 the possibility. But it may be that you would charge that
3 higher amount anyway if you can get it. In other words,
4 you've segmented your market to the relationships, the
5 condition of the buyer and seller, in that piece of the
6 market, not the whole market.

7 As I said at the outset, I'm very confused.

8 MR. GEORGE MILLER: Yes, just general comments,
9 very quickly. For those of us who have Medicare and
10 Medicaid business above 50 percent, there's no such thing as
11 cost shifting. It just mathematically does not work. And
12 mine is only ten percent. I used the example.

13 A comment about what Scott said, that they
14 negotiate and direct all of their business to one hospital,
15 that's a very poignant point and I think he's using that as
16 a market strategy for him in Seattle, which makes perfect
17 sense. But if you're in a community like mine and, say,
18 someone like Scott decides to consolidate all their business
19 to one provider, that means, in my community, I would get
20 none of that business if those insureds live in my
21 community. All that business would go somewhere else. That
22 may be market forces. That may be the right thing to do.

1 But then that infrastructure of providing health care in our
2 community then will go away because the better-paying
3 patients and those that he can drive business to his one
4 hospital in that community then underpits what we're trying
5 to do.

6 When I was in both Fort Stockton, Texas, and
7 Jasper, Texas, the major insurer in Texas threatened to do
8 that to our facility if we didn't lower our rates well below
9 what Medicaid paid.

10 So I don't know the total answer, but these things
11 happen in the world. I don't know, unless you're a large
12 hospital system, I don't know how you get market domination.
13 I think it's the insurers that have the upper hand. Now, I
14 certainly could be wrong. Unless you're a part of a large
15 integrated delivery system. So, again, for those of us --
16 there are about 1,800 rural hospitals around the country --
17 we don't have that power to do those things. It is a
18 concern.

19 DR. NERENZ: Pass.

20 MR. HACKBARTH: This discussion has been
21 illuminating for me. You know, even six months ago -- oh,
22 I'm sorry. I'm sorry. Yes, I'm going to finish what I was

1 going to say and then I'll let Peter go.

2 MR. BUTLER: I do have something to say. This is
3 -- I have been in organizations where we've owned our plans
4 and where I am now, we don't. But I'll talk a little more
5 from the provider side.

6 First, when you talk about discounts, and I'm not
7 sure how you're looking at some of these, but the fact is,
8 actually, a lot of the rates have far less variation in them
9 than the contract language. All the money is in the
10 contract language, an amazing amount of how you define
11 outliers and carve-outs and, you know, what gets paid for.
12 It's really a huge percentage of the contract. So when you
13 look at your numbers, I don't know whether you just look at
14 basic rates or you look at the contract language, but there
15 are many days when I prefer a single payer system to get rid
16 of the billions of dollars that are tied up in both sides of
17 the equation here to haggle over the contracts and all the
18 apparatus required to keep it going.

19 With respect to how providers look at this and why
20 would they give Medicare rates other than the protection
21 that was mentioned, I think many payers will come in,
22 especially the national ones, with a book of business and

1 they'll say, I've got my PPO product or I've got my HMO
2 product and I've got my Medicare Advantage. And they will
3 say, you know, and the Medicare Advantage is not big, but
4 they say, you know, I really need my Medicare rates over
5 here. And I, myself, in contracting with you can help make
6 it up over on the commercial side, which might be easier to
7 pass through than the Medicare side.

8 So you look at your total book of business with
9 the insurer when you negotiate, not just the Medicare
10 Advantage in isolation. And because it's a small piece,
11 some providers might say, okay, I'll give you Medicare rates
12 for that.

13 Another reason is that in the -- I think if you
14 looked at the participants in Medicare Advantage, they would
15 be the ones that do have less clout in the market, that are
16 looking for additional volume, that may have lower costs so
17 they feel like they can live with the rate and feel that the
18 patients can be steered into their institution, so they see
19 that there may be a real pick-up in volume incrementally in
20 a kind of narrower network Medicare Advantage. So I won't
21 name names, but the big ad in the Chicago paper just two
22 weeks ago made the major insurer rolling out, here is our

1 Medicare Advantage, and you look who's in there and it would
2 fit the profile of those that, you know, they might be lower
3 cost. They definitely are looking for business. And
4 they're trying to play into filling some beds. Therefore,
5 why not give the Medicare rate? It doesn't look too bad for
6 us to do that.

7 Now, as far as the -- I actually come out the
8 opposite of Craig on the -- I think that you have higher
9 rates if you do away with the protection, almost for sure.
10 I would agree totally that the whole world is saying you've
11 got to live within Medicare rates, but as Mike pointed out,
12 is it because you're willing to give those? Now, they look
13 at their book of business and they say, okay, I've got 45
14 percent Medicare, 15 percent Medicaid, which is growing,
15 maybe 30 percent in the commercial, and five percent
16 uninsured, which is growing. And when they look at the
17 collective revenue stream and project it out five years,
18 they see the commercial market shrinking and not paying
19 those charges.

20 So I see the prices coming down for the commercial
21 market with greater transparency and I see the prices coming
22 up for Medicare. On balance, they might be -- in an

1 effective competitive market, you will have lower rates
2 overall, but I'm not sure that Medicare would get to have
3 the advantage they have now if you really kind of played the
4 whole thing out. So I do think it does provide protection
5 for sure for now and I wouldn't let go of that too quickly.

6 DR. REDBERG: I also found this discussion very
7 illuminating, but -- and I'm not an economist, but I find
8 health care to be a very funny market because it doesn't --
9 the usual supply and demand really don't apply. Prices have
10 no transparency. Peter corrected me and said, well, charges
11 have nothing to do with what people pay. I mean, that's a
12 little unusual for a market. Physicians can generate
13 demand. Hospitals can generate demand like those ads we run
14 in the paper. And so I think it's very hard to really
15 extrapolate from usual market principles to what one would
16 expect in the health care market because it's not really a
17 market and we certainly can't lose sight that Medicare is a
18 huge player, and for that reason, no matter what, has a lot
19 of influence, or should.

20 And then I would just say that to keep in mind our
21 framework, I think besides talking about costs, we should be
22 looking at quality measures here, too, and what are we

1 getting for what we're paying in all of these different
2 systems and really look at outcomes.

3 MR. HACKBARTH: Rita, as a physician, you
4 shouldn't be at all shy about intruding on economics because
5 our economists certainly aren't shy about intruding on
6 medicine.

7 DR. CHERNEW: That's so true.

8 [Laughter.]

9 MR. HACKBARTH: Now to Kate.

10 [Laughter.]

11 DR. HOADLEY: I mean, this is, I think, really
12 helpful, though it's big, complicated, and confusing. So, I
13 mean, I think that we're all taking more time to digest what
14 we're hearing.

15 I mean, I think the simple message out of the
16 analysis is that having pay-for-service Medicare makes a
17 difference. Even if you take it at that very simply stated,
18 it makes a difference, without even talking about the
19 direction, I mean, that's already saying something.

20 The other thing that -- two other things that at
21 least implicitly in this analysis is that balanced billing
22 rules make a difference. We don't talk as much about those

1 and I don't think most people who have talked about sort of
2 future Medicare design have necessarily thought that through
3 and what would you do with and without fee-for-service
4 Medicare. It's also something that the private market is
5 struggling with. I did a little bit of work on State laws
6 about balanced billing on the physician side, and a few
7 States have tried to do something, and none of them very
8 happily, feel like they've mastered how those rules should
9 work. And it does seem like it kind of is having some
10 really interesting effects here.

11 And the third, I guess, is in thinking about the
12 future of a world in which Medicare Advantage or whatever
13 we'll end up calling it someday plays a larger role, whether
14 it's just larger or 100 percent or whatever. I think
15 thinking through what we might expect the balance within
16 Medicare Advantage to be in terms of totally closed or
17 relatively closed network models versus much more open
18 network models. Obviously, PPOs in general in the under-65
19 market have a lot of popularity. There's clearly been a
20 niche for very closed network model plans, particularly in
21 some communities. But I think the way we think about all
22 these things and a lot of the comments people made, it's

1 going to sound very different if we assume that -- and
2 whether this is a question about what the public will accept
3 or what the market will offer -- it's going to make a lot of
4 difference whether that future is more heavily skewed to one
5 or the other.

6 And I guess my last comment is sort of a question.
7 Are we thinking of or are you working on anything to do a
8 similar kind of analysis on the physician side of things,
9 which is clearly a lot more complicated.

10 DR. MARK MILLER: Well, in this analysis, we
11 didn't play it up here, but if you go through the paper a
12 little bit in detail, the premium for MA is everything --

13 DR. HOADLEY: Right.

14 DR. MARK MILLER: -- and then what we entered or
15 what Jeff entered was the index for hospital and physician
16 services. And similar to hospital, you did not find a very
17 strong effect and it's certainly not what you would have
18 hypothesized or expected.

19 MR. HACKBARTH: You were talking about the
20 relationship between physician fee levels and MA bids.

21 DR. MARK MILLER: That's correct.

22 DR. HOADLEY: But then, also, thinking through

1 some of what other things in the literature would say about
2 some of the dynamics of market levels, it would be really
3 interesting --

4 DR. MARK MILLER: [Off microphone.] Yes,
5 absolutely. But I think just to note, for anybody who
6 missed it, that was --

7 DR. HOADLEY: Right.

8 DR. MARK MILLER: [Off microphone.] And I got
9 that right, Jeff, roughly?

10 DR. STENSLAND: Yes, roughly. I think the
11 physician story was, at least for HMOs, there was a little
12 bit of a relationship between the relative physician
13 commercial rates and the rates that HMOs were paying. The
14 sign actually flipped in the PPO thing and how you
15 structured your model. It wasn't really solid, like it
16 didn't just sit there. For an economist, you do these
17 models. You do another one, another one. It's always just
18 -- but the hospital thing, it's -- that's the story. It's
19 the end of the story. I think for the physician one, it's
20 not as clear, I think for a couple of reasons. One, because
21 it's not as big a portion of the pie. And another thing, I
22 think there also might just be a lot more complexity in how

1 you pay the physicians. Are you paying them some capitated
2 arrangement or some bonus arrangement? And it just might
3 not be as clean of a story as it was for hospitals.

4 MR. HACKBARTH: Cori and then Scott.

5 MS. UCCELLO: [Off microphone.]

6 MR. ARMSTRONG: Actually, you just made the point
7 I wanted make, in that throughout this whole conversation,
8 we haven't actually ever acknowledged that while fee-for-
9 service may always be kind of an important point of
10 reference, in fact, our organization is I'm sure not alone
11 in talking with hospitals about how we get way beyond a cost
12 per unit of service as a basis for reimbursement. And so we
13 just at least, I think, need to put that out on the table,
14 too.

15 MS. UCCELLO: So I changed my mind. I'm going to
16 say something.

17 [Laughter.]

18 MS. UCCELLO: So we've talked today kind of in
19 isolation about the provider prices and how that would work,
20 perhaps with or without the fee-for-service in there. But I
21 would suggest that other elements of the CPC can maybe
22 affect these things. And in particular, I'm thinking about

1 how the government contribution is set. If we're talking
2 about this and it's competitive bidding, that's kind of how
3 this discussion went. But if we're thinking about setting
4 the government contribution as a fixed amount that increases
5 by something --

6 DR. HOADLEY: [Off microphone.]

7 MS. UCCELLO: -- then would that kind of mechanism
8 be able to apply pressure in a way that maybe a competitive
9 bidding process wouldn't? So I think we just need to think
10 about these not necessarily in isolation but how the
11 different features of a CPC design could interact.

12 MR. HACKBARTH: Scott, on your point, back in the
13 1990s when I was involved in the health plan and medical
14 group business, at least in Boston, we did go through a
15 period where we started sharing the Medicare revenue on a
16 per member per month basis with at least select hospitals
17 because they wanted to assume more risk with the potential
18 of more gain by reducing utilization, et cetera. And those
19 arrangements blew up around the country and we sort of
20 reverted back to negotiated rates based on per diems or per
21 admission. But there was a period when we tried some of
22 these new mechanisms. I'm sure you remember that, as well,

1 Craig.

2 DR. SAMITT: The one other point I would add to
3 that, which is, I guess, a third dynamic, is clearly the
4 ongoing consolidation of the industry. And so the question
5 is who will really bid for these plans in the future. My
6 guess is many of them will be integrated systems that have
7 their own health plans. So in many respect, it's going to
8 be these integrated groups that already have internal
9 alignment that may very effectively be able to compete and
10 bid.

11 MR. HACKBARTH: Okay. Thank you. Very
12 interesting analysis, Jeff, and we'll be coming back to this
13 in the not too distant future.

14 Okay. We'll now have our public comment period.

15 MS. METZLER: [Off microphone.] I'm the only
16 brave soul --

17 MR. HACKBARTH: Yes, and let me just quickly
18 review the rules before you begin.

19 MS. METZLER: Yes, sir.

20 MR. HACKBARTH: So please begin by introducing
21 yourself and your organization and I'll give you a brief
22 amount of time. When the red light comes back on, your time

1 is up. And, as I always do, I remind people that this isn't
2 your only or even your best opportunity to provide input on
3 the Commission's work. You can place comments on our
4 website and, of course, interact with the staff, and that
5 latter one is your best opportunity.

6 With that, it's all yours.

7 MS. METZLER: Thank you. Christina Metzler. I'm
8 the Chief Public Affairs Officer at American Occupational
9 Therapy Association.

10 And thank you for that reminder about the contact
11 with staff and other opportunities to communicate to the
12 Commission, because we've taken advantage of that and have
13 been pleased during the recent few months about the
14 collaboration and the outreach from staff to AOTA, the
15 Occupational Therapy Association and the rest of the therapy
16 community. We thank you for that opportunity and we
17 appreciate that some of the thoughts that we have put
18 forward were reflected in the discussion as well as in the
19 recommendations.

20 But nonetheless, I have to say that we are
21 disappointed that the NPPR hammer was used. We don't
22 believe that this is a good approach and we opposed it when

1 it was first suggested by CMS, primarily on the basis of the
2 integrity of the AMA process that is used by -- used to
3 determine the value for -- across all of medicine and health
4 care and that using the NPPR invalidates what the AMA
5 process has done. And we don't think that that is a
6 sensitive way to reduce expenditures or assure appropriate
7 utilization.

8 Furthermore, I just want to point out the concerns
9 from a beneficiary point of view. Beneficiaries are really
10 in a bad state right now. Therapists are getting calls from
11 the beneficiaries because CMS has chosen to send letters
12 directly to the beneficiary underlining that they are
13 vulnerable to pay for therapy even if their therapist thinks
14 it's legitimate. And underscoring this creates fear,
15 confusion, and it puts a damper on people accessing therapy
16 that is legitimate, that is medically necessary, that they
17 are entitled to under Medicare, and that they should be
18 getting to perhaps improve their life but also perhaps to
19 save money down the road.

20 So I urge the Commission to watch what happens
21 with the communication to beneficiaries, that that scaring
22 of beneficiaries can be short-sighted and have negative

1 effects, especially on the quality of outcomes, as you were
2 talking about.

3 CMS, I want to state that CMS and its contractors
4 have always had the authority to do manual medical review.
5 It's only in this newest iteration that manual medical
6 review is now being interpreted as a prior approval process.
7 It's ironic in some ways to us because AOTA has suggested
8 several times that there be a prior approval process at a
9 certain level. We suggested it at the 95th or 90th
10 percentile. But CMS always said they did not have the
11 resources to do that, did not want to do that, would tell
12 Congress that that wasn't an acceptable alternative, and now
13 that's what we have. But I think we need to call it a prior
14 approval process so that beneficiaries and providers are
15 clear about what this process is.

16 I wanted to mention that the notion of the
17 improvement standard and this new ruling -- one of the
18 Commissioners, I think, talked about how this may bring
19 about a long-term care benefit. But I want to reiterate
20 what Mr. Miller said about the therapy services have to be
21 skilled. We're not talking about maintenance services.
22 We're talking about the skilled services that can help

1 people maintain function. And as we see people with more
2 chronic conditions, it's not just maintaining function or
3 restoring function. It's habilitating people to their new
4 status, whether they have a limited function from a stroke
5 or they have a progressive disease. That needs to be
6 remembered.

7 I also -- one last thing. Occupational therapy,
8 physical therapy, and speech therapy are three distinct
9 benefits and the functional status and any movement to
10 develop an episodic payment should be developed with the
11 awareness that they are distinct benefits and distinct
12 services that have different purposes.

13 Thank you.

14 MS. WORZALA: Good afternoon. Chantal Worzala
15 from the American Hospital Association.

16 Following on the comments about the multiple
17 procedure payment reduction, the AHA is very disappointed
18 that the Commission has recommended this 50 percent multiple
19 procedure payment reduction for outpatient therapy services.
20 We're especially disappointed that the Commission made the
21 recommendation without any independent analysis of the
22 number of visits per day or practice expenses. Instead, the

1 staff seemed to have referred to a CMS analysis on visits
2 per day and that actually was subject to a comment letter
3 from MedPAC that questioned the data as needing better
4 justification.

5 Some of the questions about the CMS analysis about
6 visits per day include the fact that they did not include
7 any institutional settings in their analysis. It was only
8 private practice. And they actually excluded from the
9 analysis any claim that had a single service per day. So by
10 definition it overstated the median services per day coming
11 to the four median services per day that were referenced in
12 the discussion.

13 Further, I'd just note that this payment cut for
14 practice expense is recommended at the same time that the
15 Commission is actually recommending increasing practice
16 expenses by asking for data collection on patient status. I
17 think everyone benefits from the collection of quality data
18 and functional status data. But collecting that data is not
19 free of cost and would, in fact, be part of a practice
20 expense, were that recommendation to be taken up by CMS or
21 Congress.

22 On the flip side, the AHA does greatly appreciate

1 the discussion of this balance between ensuring you
2 disincentivize inappropriate care or unnecessary care with a
3 burdensome manual review process. And when we think about
4 where that cap should be set, I think it is important to
5 think about the number of reviews that would be required and
6 the cost and burden of those reviews.

7 It looks like, from the materials on Slide 5, that
8 there are about 4.5 million beneficiaries that receive
9 outpatient therapy services each year. Therefore, that one-
10 third of beneficiaries being subject to the cap could lead
11 to as many as 1.5 million manual reviews per year. So I
12 think that's an important factor to keep in mind as
13 conversation continues about where to set the cap.

14 Thank you very much for your attention.

15 MS. McILRATH: Sharon McIlrath, AMA. I just want
16 to make a couple of points about the multiple procedure
17 payment reduction.

18 One is that the CMS, even if you accepted that
19 there were no problems in their study, the CMS study was
20 based on the overlap in a single session. The way this
21 thing is being applied is to a single day. So the kinds of
22 efficiencies that you get when you moved an imaging machine

1 from the abdomen to the chest, you don't find the same kind
2 of efficiencies when you have occupational therapy done in
3 the morning and speech language therapy done by a totally
4 different person in potentially even a different office on
5 the same day. So as a precedent for every time you are
6 going to be looking at multiple procedure payment
7 reductions, you need to distinguish between a single session
8 and a single day.

9 And then the other point about these is that this
10 is being applied, the exact same number, to every single
11 kind of service, where even the CMS study found a difference
12 of 28 percent to 56 percent. So it's way too high for the
13 procedures at the low end and way too low -- or not way, but
14 too low even if you accept that everything in their study is
15 correct.

16 MR. BUCCAFURNI: Hello. My name is Anthony
17 Buccafurni. I'm a physical therapist, an associate in a
18 large private PT practice, and I just wanted to discuss
19 briefly the outpatient therapy discussions that you had
20 today.

21 I'm in a private practice named Fox
22 Rehabilitation. We specialize in home treatments of the

1 older adult. Patient average age for us is 85 years of age.
2 Most of our patients have a multitude of medical
3 complexities, obviously.

4 I first want to thank you all for your stance on
5 the hard cap. Mary began the day by referencing the
6 patients and implications that hard caps would place on
7 access to care. You all echoed your concerns. I'm thankful
8 on behalf of my profession for that. This is a difficult
9 decision you all have to face and I'm thankful for the
10 extensive attention that you all have made towards it.

11 You referenced in your analysis today that 33
12 percent of patients are potentially impacted by the 2013
13 lowered therapy cap. In our private practice, approximately
14 90 percent are potentially impacted by the regulation you
15 have suggested. As a result, the most vulnerable of
16 beneficiaries who are in need of rehabilitation care will
17 have access issues to care due to the various roadblocks and
18 administrative obstacles providers are having to navigate.

19 In our current practice, with an MMR approval rate
20 of greater than 86 percent, we have submitted 2,309 reviews
21 to date. We have received a response on 581. But the
22 concern is that greater than 37 percent have exceeded the

1 ten business day threshold. In fact, earlier today, I was
2 working with a group of physical therapists in Delaware
3 County, Pennsylvania, who have submitted 40 MMR requests
4 that are in excess of 15 days.

5 As a provider, how do I direct my clinicians to
6 provide continuity of care and achieve optimal objective
7 functional outcomes, as you have suggested today, when we
8 have no idea when and if we'll receive the approval for the
9 ten visits? And you've gone into great length today to
10 discuss the need to make sure that Medicare has these
11 systems more efficient and user friendly to the providers.

12 But I wanted to read a quick note I just received
13 today from one of our therapists. "Anthony, this resident,"
14 I will withhold the name, "was on hold pending manual
15 medical review authorization. In the interim, she fell.
16 She fractured her elbow, went out to the hospital to the
17 emergency room, had a myocardial infarction upon return to
18 her assisted living, then went back to the hospital and was
19 admitted." So, unfortunately, the delays that are the
20 result of the administrative burden of these processes are a
21 significant impact to beneficiaries, and I have a dozen more
22 stories like this since the implementation of this process.

1 So, again, I understand the difficult decision you
2 all face, but from the field's perspective and our
3 beneficiaries and our patients, I just wanted to share that
4 information with you today. Thank you.

5 MR. HACKBARTH: Okay. We are adjourned until 8:30
6 tomorrow.

7 [Whereupon, at 4:07 p.m., the meeting was
8 adjourned, to resume at 8:30 a.m. on Friday, November 2,
9 2012.]

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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 2, 2012
8:31 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA

PAGE

Medicare Advantage special needs plans

- Christine Aguiar, Carlos Zarabozo

3

Addressing Medicare payment differences across
settings: Ambulatory care services

- Ariel Winter, Dan Zabinski

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Public comment

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1 P R O C E E D I N G S [8:31 a.m.]

2 MR. HACKBARTH: Okay. Good morning. We have two
3 sessions today, one on Medicare Advantage special needs
4 plans and the other on synchronizing payment rates across
5 settings. On special needs plans we will discuss some draft
6 recommendations that I am offering. They are draft
7 recommendations. And so for those of you in the audience,
8 no votes.

9 In terms of when we will come back on special
10 needs plans, in part that depends on how the conversation
11 goes, but have we scheduled time in the December meeting
12 potentially for this? No. So when would we come back, Jim?

13 DR. MATHEWS: This would be January.

14 MR. HACKBARTH: January, okay. So assuming the
15 discussion goes well and we see some either current
16 agreement or potential for future agreement, we'll be back
17 on this in January. And we'll hear in just a minute, I'm
18 sure, about the timing of the special needs reauthorization
19 and why it's important that we examine this issue now.

20 So who's going first? Carlos?

21 MR. ZARABOZO: Thank you for doing the first
22 slide.

1 [Laughter.]

2 MR. ZARABOZO: I'd like to add to that, at last
3 month's meeting, several Commissioners asked specific
4 questions about special needs plans, which we'll answer over
5 the course of our presentation. We will begin our
6 presentation with a brief review of the current status of
7 SNPs and then talk about each of the three SNP categories
8 and present the draft recommendations by SNP category. We
9 would like to thank Scott Harrison for his assistance in our
10 analysis.

11 We are examining SNPs at this time because the
12 statutory authority that enables such plans to enroll only
13 certain categories of Medicare beneficiaries expires at the
14 end of 2013 unless Congress acts to extend the authority.
15 Under current law, if there is no change in the statute,
16 special needs plans must decide by the first half of 2013
17 whether they wish to continue in the Medicare Advantage
18 program in 2014. If the statutory authority allowing
19 exclusive enrollment of special needs individuals does
20 expire, these plans can continue in the Medicare Advantage
21 program, but they will no longer be able to limit their
22 enrollment to only special needs individuals.

1 Here is a road map for the presentation. We'll
2 review information that was presented last month about SNPs,
3 using updated data; we'll discuss the differences between
4 SNPs and general MA plans in order to provide more clarity
5 about what those differences area; we'll review information
6 that we previously presented on quality in SNPs; and, again,
7 we'll present the Chairman's draft recommendations and the
8 basis of those recommendations.

9 Although the SNP program was not the subject of a
10 mandated congressional report, it is similar to the issues
11 discussed at yesterday's meetings in that Congress may take
12 action to modify current law as it applies to SNPs.
13 Therefore, the framework that you are familiar with for the
14 analysis in the mandated reports -- shown in the slide --
15 can be applied to the SNP program.

16 With respect to the impact on program spending, a
17 reauthorization of SNPs will increase Medicare spending. If
18 SNP authority expires, some beneficiaries currently enrolled
19 in SNPs will likely enroll in Medicare fee-for-service. If
20 SNP authority were to be extended and there was not a
21 movement of some enrollees to fee-for-service, that would
22 result in higher program spending because, on average,

1 Medicare spending on SNP enrollees and on MA enrollees in
2 general exceeds program expenditures for beneficiaries in
3 fee-for-service Medicare.

4 In terms of access, broadly speaking beneficiaries
5 have similar levels of access to Medicare-covered services
6 and to providers in general MA plans, in SNPs, and in fee-
7 for-service Medicare. We'll discuss quality-of-care issues
8 for SNPs in more detail during the presentation. In terms
9 of advancing payment reform and encouraging a more
10 integrated delivery system, both general MA coordinated care
11 plans and SNPs offer an integrated delivery system. Also as
12 we'll discuss in more detail, some D-SNPs encourage
13 integration between D-SNPs which are for dual eligibles,
14 encourage integration between dual-eligible beneficiaries'
15 Medicare and Medicaid benefits.

16 There are three kinds of special needs plans
17 permitted under the statute. The greatest number of
18 enrollees are in plans for beneficiaries who are dually
19 eligible for Medicare and Medicaid. These SNPs, the D-SNPs,
20 enroll about 1.3 million beneficiaries, or about 10 percent
21 of all MA enrollment. However, we would note that there are
22 about 900,000 dual eligibles enrolled in general MA plans.

1 As of the upcoming contract year, 2013, D-SNPs will be
2 available to about three-fourths of the total Medicare
3 population. By comparison, 99 percent of Medicare
4 beneficiaries will have access to at least one coordinated
5 care plan in their geographic area as of 2013.

6 C-SNPs enroll beneficiaries with certain specified
7 chronic or disabling conditions and have far fewer enrollees
8 and more limited availability.

9 The category with the smallest number of enrollees
10 are I-SNPs, which provide care to people in institutions or
11 who reside in the community but need an institutional level
12 of care. All SNPs function as MA plans, and they are
13 responsible for the full range of Medicare Part A and Part B
14 benefits for their members.

15 Now we'll talk about how SNPs differ from general
16 MA plans. The main difference between SNPs and MA plans is
17 that SNPs can design benefit packages that are tailored to
18 the special needs of the beneficiaries that they seek to
19 enroll. An organization can sponsor both a general MA plan
20 that appeals to the general Medicare population and a SNP
21 plan with a very different benefit design. SNPs also have
22 to report more quality data than MA plans, and SNPs submit

1 reports on their model of care and report on structure and
2 process measures. Rules on enrollment are also somewhat
3 different between MA plans and SNPs, as I'll explain in the
4 next slide.

5 One of the differences between SNPs and general MA
6 plans is the great ability of SNPs to enroll beneficiaries
7 outside of the October-December open enrollment period. Two
8 categories of Medicare beneficiaries can enroll in MA and
9 disenroll from MA on a month-to-month basis, as shown in the
10 two middle columns. The open enrollment right attaches to
11 the beneficiary status and not to the plan type. However,
12 because D-SNPs and I-SNPs specialize in these populations,
13 which are the dual eligible and those who are
14 institutionalized, they may be more likely to enroll such
15 individuals. For C-SNPs, a beneficiary that has the chronic
16 condition covered by the C-SNP has a one-time opportunity to
17 enroll in the C-SNP outside of the open enrollment period.
18 The right may not be exercised again after that, and the
19 person can only change status at the next open enrollment
20 period.

21 Glenn, at last month's meeting, you asked whether
22 we knew how much C-SNPs benefit from the year-round open

1 enrollment provision. We looked at the enrollment patterns
2 of two large C-SNPs in 2011 and found that they both had a
3 substantial level of enrollment outside the October-December
4 open enrollment period. For one of the plans, for example,
5 72 percent of its C-SNP new enrollment came from outside the
6 open enrollment period.

7 A couple of other items to note on this slide are
8 that general MA plans can enroll people year-round if they
9 have a five-star quality rating. Beneficiaries with end-
10 stage renal disease, or ESRD, cannot enroll in general MA as
11 new enrollees, but the Commission has a long-standing
12 recommendation that would allow such beneficiaries to enroll
13 in MA. There are a few SNPs specializing in ESRD, but there
14 are many more ESRD beneficiaries in other MA plans. About
15 10 percent of all Medicare beneficiaries who have ESRD are
16 enrolled in MA because they acquired end-stage renal disease
17 after having joined the plan.

18 Peter, you asked what we knew about enrollment
19 growth in SNPs and the nature of organizations sponsoring
20 SNPs. As indicated in the slide, D-SNP enrollment growth
21 has been similar to general MA growth. C-SNPs have had the
22 highest level of enrollment growth, and for I-SNPs, one

1 organization changed its status, causing a decline in I-SNP
2 enrollment in the last 12 months.

3 MA is dominated by enrollees in for-profit plans,
4 but both C-SNPs and I-SNPs have a much higher proportion of
5 for-profit enrollment -- over 98 percent for each category.

6 Scott, you asked what we knew about the financial
7 viability of C-SNPs. We looked at the stability of C-SNPs
8 over several years. Among the 136 plans that were operating
9 in 2010, about half will still be operating as C-SNPs in
10 2013, or the sponsoring organization will continue to have a
11 C-SNP. We also examined several publicly available
12 insurance commission filings of organizations that are
13 primarily C-SNPs, and in each case the medical loss ratio
14 was very low--at 82 percent or lower.

15 As we mentioned at the last meeting, it's also
16 true that C-SNPs have bids for the Medicare Part A and Part
17 B benefit that were on average below Medicare fee-for-
18 service levels.

19 An important question to ask about SNPs is whether
20 their special status enables them to provide better care to
21 the targeted populations, an evaluation that is difficult to
22 make in terms of comparing SNPs to general MA plans or to

1 fee-for-service.

2 To summarize what we discussed last month, using a
3 proxy method of comparing plans that are primarily or
4 exclusively SNP plans, we find that looking at a composite
5 measure that includes process and outcome measures as well
6 as beneficiary access measures and administrative
7 performance -- which is the CMS star rating system -- we see
8 that SNPs generally do not perform as well as other plan
9 types. For most of the currently collected process and
10 intermediate outcomes, SNPs on average do not perform as
11 well as non-SNP plans. However, there are exceptions which
12 we will point out as we discuss each SNP option.

13 Last month, we also noted that the industry does
14 not feel that the current rating system is appropriate for
15 SNPs. The industry also believes that new measures should
16 be developed that are more appropriate to the populations
17 that SNPs serve. Work is still underway to develop such
18 measures, which would be applicable to both SNPs and non-SNP
19 MA plans.

20 Mary, you asked a question about the status of new
21 measures emanating from the work of the Measure Applications
22 Partnership, or MAP. The MAP issued a report in June of

1 this year that included a recommended starter set of seven
2 measures and a revised core set of 23 endorsed measures for
3 dual eligibles. About half of each of those sets of
4 measures is currently in use in some form, but it will take
5 some time to have new measures in place. This would include
6 more outcome measures and certain screening measures such as
7 screening for depression.

8 On October 25th, CMS announced the testing of
9 several new measures, including continuity of information
10 and care from hospital discharge to the outpatient setting
11 and continuity between mental health provider and primary
12 care provider. But it will be two to three years before
13 these measures would be part of the star rating system.

14 Alice, you asked the extent to which certain
15 states are involved in the CMS dual-eligible demonstration
16 projects or have waivers under Medicaid. Of the 23 states
17 on the table that you were looking at, the majority
18 hopefully Medicaid waivers, primarily to offer home and
19 community-based services to certain populations. About half
20 the states are working with CMS to implement one of the
21 demonstrations on dual eligibles, with 11 of the 15 states
22 that are interested pursuing the capitated model. As you're

1 aware, Massachusetts has signed an MOU with CMS, and
2 Washington State recently signed an MOU to pursue the
3 managed fee-for-service model.

4 We'll now turn to two of the Chairman's draft
5 recommendations, which pertain to I-SNPs and C-SNPs.

6 This slide summarizes our findings on I-SNPs.
7 I-SNPs serve a very distinct, identifiable population with
8 specific needs resulting from their institutionalization or
9 their risk of being institutionalized. Enrollment in I-SNPs
10 is not large, and it is concentrated in urban areas,
11 primarily in two states. I-SNPs perform well on an
12 important measure of care for this population, the rate of
13 readmissions to hospitals, as well as on certain other
14 measures tracked at the SNP-specific level, such as
15 functional status assessments and pain screening.

16 The Chairman's first draft recommendation for
17 I-SNPs states that, "The Congress should permanently
18 reauthorize institutional special needs plans." This
19 recommendation would result in a small increase in Medicare
20 spending relative to current law, as explained at the
21 beginning of the presentation.

22 The draft recommendation will not have an adverse

1 impact on beneficiaries or plans. Current beneficiaries can
2 remain in their plans, new beneficiaries can be enrolled,
3 and plans no longer have the uncertainty associated with
4 being in a program operated under temporary statutory
5 authority.

6 Moving on to a summary of findings on C-SNPs,
7 these plans offer tailored benefit packages to beneficiaries
8 with chronic illnesses; however, the most frequently covered
9 C-SNP condition -- diabetes -- is common among the
10 population enrolled in general MA plans. The vast majority
11 of C-SNPs are offered through organizations that also have a
12 companion general MA plan. C-SNPs as a whole do not have
13 better quality results than non-SNP MA plans, with the
14 exception that several C-SNPs that are HMOs perform well on
15 a number of quality measures, though the measures are not
16 disease-specific measures. Enrollment in C-SNPs is
17 concentrated in the South, the enrollment is growing, and
18 the number of such plans being offered in 2013 suggests that
19 there will be additional growth.

20 With respect to C-SNPs, the Chairman's draft
21 recommendation reads: The Congress should:

22 - allow the authority for chronic care SNPs to

1 expire;

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

6 - and permit current C-SNPs to continue operating
7 during the transition period as the Secretary develops
8 standards but impose a moratorium on new enrollment in those
9 plans as of January 1, 2014.

10 What this draft recommendation does is to fold the
11 C-SNP approach into the general MA program by allowing all
12 MA plans to fashion alternative benefit packages and care
13 models tailored to a set of specific of chronic or disabling
14 conditions, and making the models of care that C-SNPs use
15 more widely available. This recommendation would increase
16 Medicare spending relative to current law, again, because
17 some beneficiaries would otherwise have been in fee-for-
18 service Medicare. We would expect a limited impact on
19 beneficiaries and a limited impact on plans in that we
20 anticipate that the large majority of C-SNPs will be able to
21 operate under the new rules after the transition period.

22 Christine will now discuss the D-SNP

1 recommendations.

2 MS. AGUIAR: I will now review our findings of
3 whether D-SNPs integrate Medicare and Medicaid benefits for
4 dual eligibles.

5 As a reminder, D-SNPs are the current managed
6 care-based vehicle in the Medicare program for the
7 integration of Medicare and Medicaid benefits. We found
8 that the best environment for integration with Medicaid
9 benefits occurs under two scenarios which are depicted on
10 this slide.

11 Under the first scenario, one plan -- the D-SNP --
12 covers both Medicare and Medicaid services. We refer to
13 these plans as financially integrated D-SNPs.

14 Under the second scenario, depicted on the right
15 side of the graphic, one managed care organization has both
16 a Medicaid plan and a Medicare plan, and the same dual
17 eligibles are enrolled in both plans. In this scenario, the
18 integration occurs across the two plans. It is not
19 necessary for the Medicare plan to be a D-SNP under this
20 scenario. However, the benefit of a D-SNP here is that it
21 can limit enrollment to dual eligibles and can tailor the
22 benefit package and supplemental benefits to those

1 beneficiaries.

2 Under both scenarios, the managed care
3 organization has the financial incentive to manage and
4 coordinate Medicare and Medicaid services because it is
5 financially at risk for those services. And under both
6 approaches, the managed care organization has the ability to
7 coordinate Medicare and Medicaid services because it covers
8 those services.

9 This chart shows our estimates of the number of
10 integrated and non-integrated D-SNPs. As you can see on the
11 second line of the chart, we estimate that there are fewer
12 than 60 integrated D-SNPs that collectively enroll
13 approximately 300,000 dual eligibles or about 24 percent of
14 all dual eligibles enrolled in D-SNPs.

15 However, as you can see on the last row of the
16 chart, the majority of D-SNPs are not integrated. These are
17 D-SNPs that are neither financially integrated with Medicaid
18 benefits nor are part of a managed care organization with a
19 companion Medicaid plan. We estimate that the majority of
20 dual eligibles enrolled in D-SNPs, about more than 75
21 percent, are enrolled in these non-integrated plans.

22 This slide summarizes our main findings on D-SNPs.

1 With respect to quality of care, we found that financially
2 integrated D-SNPs tend to perform well on star ratings.
3 There are fewer than 25 financially integrated D-SNPs, and
4 there is sufficient data to calculate star ratings on 15 of
5 them. Of these 15 plans, eight of them received star
6 ratings of 4 or 4.5 in 2013.

7 In terms of integration with Medicaid benefits, we
8 found that financially integrated D-SNPs or D-SNPs that are
9 part of a managed care organization that offers a companion
10 Medicaid plan are the only types of D-SNPs where Medicare
11 and Medicaid benefits are integrated. All other D-SNPs do
12 not integrate Medicaid benefits, but some of those plans may
13 try to coordinate them.

14 This brings us to the Chairman's third draft
15 recommendation. It reads: The Congress should permanently
16 reauthorize dual-eligible special needs plans that assume
17 clinical and financial responsibility for Medicare and
18 Medicaid benefits and allow the authority for all other D-
19 SNPs to expire.

20 Under this draft recommendation, financially
21 integrated D-SNPs and D-SNPs that are part of a managed care
22 organization with a companion Medicaid plan would become

1 permanent. These are the D-SNPs that integrate Medicare and
2 Medicaid benefits. As I previously discussed, we estimate
3 that there are fewer than 60 of these plans and that they
4 collectively enroll almost 25 percent of all dual eligibles
5 enrolled in D-SNPs.

6 Non-integrated D-SNPs would not be reauthorized
7 under this draft recommendation. However, to be clear, this
8 recommendation does not preclude those plans from working
9 with states to cover most or all Medicaid benefits and
10 operating as an integrated D-SNP. These plans would have
11 the option of working with states to become integrated or
12 converting to general MA plans. If the non-integrated D-
13 SNPs convert to general MA plans, they could still retain
14 their contracts with states.

15 With respect to spending implications, this draft
16 recommendation would increase Medicare spending relative to
17 current law. Integrated D-SNPs would continue permanently,
18 and spending on beneficiaries enrolled in these plans is
19 higher than fee-for-service spending. We do not expect this
20 draft recommendation to have adverse impacts on
21 beneficiaries. The dual eligibles enrolled in integrated D-
22 SNPs would be able to continue in those plans. The dual

1 eligibles enrolled in the non-integrated D-SNPs could remain
2 in those plans if they convert to general MA plans. We also
3 do not expect this draft recommendation to have adverse
4 impacts on plans. The non-integrated D-SNPs could convert
5 to general MA plans or could work with states to become
6 integrated. Integrated D-SNPs would benefit from this draft
7 recommendation by being able to continue permanently and
8 would no longer have uncertainty about whether they will be
9 reauthorized.

10 Returning now to an issue that we discussed in
11 October, we also found that there are administrative
12 misalignments between Medicare and Medicaid that are
13 barriers to integration. One of those is marketing
14 requirements. D-SNPs cannot describe the Medicare and
15 Medicaid benefits they cover in the same place on their
16 marketing materials. Another barrier is that Medicare and
17 Medicaid have separate appeals and grievances processes.
18 These barriers can be confusing and burdensome for both
19 beneficiaries and the plans.

20 Herb, to address your question from the October
21 meeting, the Secretary has authority to permit D-SNPs to
22 jointly market their Medicare and Medicaid benefits.

1 However, an aligned appeals and grievances process would
2 require congressional action to change the law.

3 This brings us now to the Chairman's fourth draft
4 recommendation. It reads: The Congress should align the
5 Medicare and Medicaid appeals and grievances processes for
6 D-SNPs that assume clinical and financial responsibility for
7 Medicare and Medicaid benefits. The Congress should direct
8 the Secretary to allow D-SNPs that assume clinical and
9 financial responsibility for Medicare and Medicaid benefits
10 to market the Medicare and Medicaid benefits they cover as a
11 combined benefit package.

12 This draft recommendation would align the appeals
13 and grievances processes and the marketing misalignments for
14 integrated D-SNPs. We do not expect this recommendation to
15 affect program spending. We expect this draft
16 recommendation to have a positive affect on beneficiaries
17 and plans by eliminating two administrative misalignments.

18 This slide presents a summary of the Chairman's
19 draft recommendations. This concludes the presentation, and
20 we are happy to answer your questions.

21 MR. HACKBARTH: Okay. Thank you, Christine and
22 Carlos. Well done.

1 As we proceed through the discussion, I would ask
2 the Commissioners to, if they can, frame comments in terms
3 of the framework that we've been using to assess these
4 reauthorizations. In other words, if we're going to
5 increase Medicare spending above the baseline, it should be
6 because we believe there's evidence that it will improve
7 quality, access, or aid movement to delivery system reform.
8 So if you can frame comments in that context, that would be
9 helpful to me in terms of moving forward.

10 Then I have a couple clarifying questions myself.
11 Could you put up Slide 7, please. So I want to make sure
12 that I understand this correctly. So as I interpret this
13 chart, duals and institutionalized beneficiaries can enroll
14 off-cycle in general Medicare Advantage plans, but
15 beneficiaries with chronic conditions cannot. Is that
16 correct?

17 MR. ZARABOZO: That's correct. The chronic
18 condition person has the one-time opportunity off-cycle to -
19 - so in July, if you have a chronic condition and it's C-SNP
20 available, you can enroll in that plan, but that's it.
21 That's your one-time opportunity, and to change status, you
22 have to wait until the next open enrollment.

1 MR. HACKBARTH: Okay. And so I'd ask people,
2 Commissioners, to also react to the possibility of a
3 recommendation that that same opportunity be extended to all
4 Medicare Advantage plans, so a beneficiary that has one of
5 the covered chronic conditions would have an opportunity to
6 enroll off-cycle in Group Health of Puget Sound. It
7 wouldn't be only a right to enroll in a C-SNP. Is that
8 clear, what I'm asking?

9 MR. KUHN: [Off microphone.] Can you say that
10 again?

11 MR. HACKBARTH: So there's a list of conditions,
12 chronic conditions, that C-SNPs are eligible to focus on.
13 The law says that if a beneficiary has one of those
14 conditions, they have a one-time opportunity to enroll in a
15 C-SNP off-cycle. And I'd ask you to react to a
16 recommendation that we extend that opportunity to all
17 Medicare Advantage plans. So if I'm diagnosed with diabetes
18 in July, I not only have the opportunity to enroll in a C-
19 SNP, but in any Medicare Advantage plan. Okay? Is that
20 clear?

21 DR. ZARABOZO: And I'd like to add, Glenn, that
22 right now, C-SNPs also have a slight difference in payment

1 from other plans in that for a person who's a so-called new
2 enrollee for whom there's no claims history because of that
3 condition, they can be coded as having that condition as
4 opposed to any other situation where you have to wait for
5 the claims history to catch up. So that would be a
6 companion piece.

7 MR. HACKBARTH: So perhaps also extend that
8 opportunity to any Medicare Advantage plan.

9 DR. ZARABOZO: Right. And it's by the -- the
10 authority is not specifically statutory, but it's under the
11 opportunities for open enrollment as determined by the
12 Secretary. So it's --

13 MR. HACKBARTH: Okay.

14 MR. ARMSTRONG: And just to clarify, you asked for
15 consideration of that extension to MA plans to coincide with
16 a recommendation that C-SNPs actually get brought into MA
17 plans in the future?

18 MR. HACKBARTH: Yes. So the idea would be, let's
19 do away with a special category of C-SNP but recognize that,
20 in fact, when a beneficiary receives a major new diagnosis,
21 like you have diabetes, that that's a significant event and
22 it may alter their thinking about their health care

1 arrangements. And the way the law works right now is, well,
2 you can say, oh, I have diabetes. Therefore, I want to go
3 into a C-SNP focused on diabetes. I think that maybe what
4 we ought to say is you can go into any managed care
5 organization that you think can help you better manage your
6 diabetes. It doesn't need to be a C-SNP. It can be any
7 Medicare Advantage plan. Or, of course, you can elect to
8 remain in fee-for-service, if that's what you wish. Is that
9 clear? Did I answer your question?

10 MR. ARMSTRONG: Yes. But to clarify, but our
11 recommendation is there won't be C-SNPs in the future --

12 MR. HACKBARTH: There won't be C-SNPs, but there
13 will be a general opportunity --

14 MR. ARMSTRONG: Yes.

15 MR. HACKBARTH: -- to enroll in Medicare Advantage
16 when you receive a significant new diagnosis off a list
17 established by CMS. Okay?

18 DR. MARK MILLER: The other way I've heard you
19 describe it is that the way it stands for I and D is that
20 the off-enrollment attaches to the beneficiary, not the plan
21 type.

22 MR. HACKBARTH: Right.

1 DR. MARK MILLER: And this would basically extend
2 the chronic condition to the beneficiary, and so the right
3 to enroll, or the opportunity to enroll off-cycle would
4 attach to the condition of the beneficiary as opposed to the
5 existence of the plan and, in a sense, normalizing the
6 situation across all three types.

7 MR. HACKBARTH: Okay. And then one last
8 clarification for me. Could you put up Slide 17, please.
9 So I think it might be helpful -- actually, maybe I've got
10 the wrong slide here. Well, leave it there. So the issue,
11 Christine, is that you say the non-integrated D-SNPs
12 coordinate benefits as opposed to integrate benefits. If
13 you could just be a little bit more specific about what it
14 means to coordinate benefits, that would be useful to me.

15 MS. AGUIAR: Sure. So, again, we spoke with a
16 range of managed care organizations, both those that were on
17 the chart that we showed that had the Medicare and the
18 Medicaid within the one plan and then those that had the
19 Medicare and Medicaid as two separate plans.

20 MR. HACKBARTH: Mm-hmm.

21 MS. AGUIAR: We also spoke with some plans that
22 just had the duals in their D-SNP but did not have them in

1 the Medicare product.

2 And so there's a range of coordination that is
3 going on under that scenario and it seems to -- I don't know
4 if I'd say it's up to the discretion of the plan. So on one
5 level, you'll have some plans that will assess the dual
6 eligible for their Medicaid benefits for what they're
7 eligible for, for what their needs are, and refer them,
8 refer those individuals to those services. And then what we
9 heard from those plans is because they don't provide those
10 Medicaid services, that's sort of where their ability to
11 help stops, is to make that referral. The responsibility
12 then becomes onto the beneficiary to do the follow-up. And,
13 there again, depending on the plan, there could, there could
14 not be some follow-up as to whether or not that beneficiary
15 is receiving those services are not.

16 Now, there are some other D-SNPs that we spoke
17 with that are also non-integrated that will take a further
18 step, that will actually try to make relationships with
19 community-based organizations, with the organizations that
20 provide those Medicaid services, and in addition to making
21 referrals will try to help the beneficiary, actually make
22 the referral for them, try to make sure that they actually

1 get that Medicaid service, and then do some follow-up on
2 that.

3 MR. HACKBARTH: Okay. So here's my question. If
4 non-integrated D-SNPs were to disappear, my understanding of
5 Slide 7, if you'd put that back up for a second, is that
6 even if non-integrated D-SNPs disappear, that duals would
7 retain the opportunity to enroll off-cycle in Medicare
8 Advantage plans.

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

10 MR. HACKBARTH: And so a Medicare Advantage plan,
11 they could also refer dually eligible beneficiaries to
12 providers for Medicaid services. There's no bar to them
13 doing that.

14 MS. AGUIAR: Right. That is correct. And I
15 think, from what we've heard, it really does sort of seem to
16 be the plan makes the decision to make those relationships
17 with the organizations in the community that could help
18 their dually eligible members, but that possibly could also
19 help their non-dual eligible members.

20 In addition to that, some of the same
21 organizations that we were speaking with that sort of take
22 that next step to make those relationships with the

1 community, they also are taking efforts to sort of build
2 much more of a primary care network, to build much more
3 clinical centers that could benefit their dual eligible and
4 also non-dual eligible members if they were to convert to a
5 Medicare Advantage plan.

6 MR. HACKBARTH: Yes.

7 MS. AGUIAR: So, again, there's nothing barring
8 them from continuing to do what they're doing now.

9 MR. HACKBARTH: Okay. So those are my
10 clarifications.

11 Let's see. Who looks ready to start the
12 clarifying round? I think Cori is primed to. Cori.

13 MS. UCCELLO: I'll jump in. So in terms of the C-
14 SNPs, I mean, my concerns are that plans get payments that
15 are commensurate with the risks that they're bearing, and so
16 there -- I'm just kind of thinking out loud here. I think
17 things are okay, but I want to make sure.

18 So if C-SNPs can't enroll new entrants, in a
19 regular plan, that would mean the risk in that plan is
20 devolving over time. They're becoming more expensive. I'm
21 not quite sure how that works with a C-SNP where they
22 already have conditions. But in any case, the plan --

1 because the payments to the plan are risk adjusted, that
2 that's going to make sure or ensure that the plan kind of
3 remained viable, right? For the plans --

4 MR. HACKBARTH: [Off microphone.]

5 MS. UCCELLO: Translator, please.

6 DR. MARK MILLER: What my colleague, Cori, I think
7 is saying, and I must remember she's speaking for her friend
8 from yesterday --

9 [Laughter.]

10 DR. MARK MILLER: I think what she's saying -- and
11 obviously, if this is wrong, say something -- there's a
12 natural -- if you stop enrollment, you have an aging of a
13 population so you have a devolving risk, okay, over time.
14 And so I think the potential concern you're expressing is,
15 well, wait a second. If we stop enrollment on these C-SNPs
16 for three years, do we potentially put the plan in a
17 financially not viable -- I'm not speaking well --
18 situation? Of course, counteracting that is that as their
19 risk devolves, the payments should also be going up because
20 there's some adjustment for risk. And the other thing I
21 would say is it's a relatively short period of time that I
22 think we're proposing. But I think that's what you're

1 saying.

2 MS. UCCELLO: Correct.

3 MR. HACKBARTH: In addition to that, they can
4 potentially convert to regular Medicare Advantage status and
5 enroll new --

6 MS. UCCELLO: Yes, and I was going to get to that
7 next, actually.

8 MR. HACKBARTH: Okay.

9 MS. UCCELLO: But I guess I'm just making sure
10 that from what Mark and I were saying, that there isn't a
11 problem, that my friend was saying.

12 DR. ZARABOZO: Yes. Your friend should be fine, I
13 think.

14 MS. UCCELLO: Okay.

15 [Laughter.]

16 MS. UCCELLO: So now, thinking about regular MA
17 plans who now in the middle of the year have to start
18 accepting people who are newly coming in with conditions,
19 how are the plans going to be appropriately compensated for
20 them? Is that what you were talking about, where they can
21 automatically do the risk -- note that in the risk
22 adjustment --

1 DR. ZARABOZO: Yes, but I think what you're
2 proposing is that if the plan chooses to do so, it can set
3 up a benefit package for diabetics, for example, and say,
4 this is open year round for people with diabetes. It's not
5 going to be the case that all MA plans would have to accept
6 somebody with diabetes, for example. They would say, we are
7 participating in this way, which is what used to be a C-SNP
8 is now a benefit package under general MA that is only for
9 these kinds of people and we will take these kinds of people
10 year-round.

11 MR. HACKBARTH: Okay. I'd like people to react to
12 both versions of that, in particular, people with experience
13 in the plan business. If you say this is a right that
14 attaches to the beneficiary, that would maybe indicate that
15 it isn't a plan choice and so I welcome comments on that
16 issue.

17 DR. ZARABOZO: The other point is that if
18 somebody, for example, has had diabetes for a year, let's
19 say, they decide, well, I feel like changing a plan, I can
20 do that because a year and a half ago I was diagnosed with
21 diabetes. I never exercised my right to do so, but I feel
22 like doing so now. So it's not necessarily a matter of on a

1 certain day you are diagnosed with this and therefore -- I
2 mean, that's a life-changing event thing. That would be a
3 little bit different from the current situation. So you
4 would also need to be specific about is that what you're
5 thinking about.

6 MR. HACKBARTH: And as I understand it, what
7 you're saying is that the current law for C-SNPs, it's not,
8 strictly speaking, a life-changing event. It's a one-time
9 opportunity that can be exercised on diagnosis or at some
10 later point.

11 MS. UCCELLO: But in any case, the diagnosis is
12 going to be attached to the person when the payment is made
13 to the plan.

14 DR. ZARABOZO: Under the current rules, yes.
15 Again, for the new enrollee for whom there is no history,
16 they would say, yes, you have been diagnosed with this. You
17 can now be coded with it.

18 DR. BAICKER: So following up on the C-SNP line of
19 inquiry, I'm disappointed that they didn't work on some of
20 these metrics, and do you have some sense about why they
21 didn't work and then how those factors would play out in the
22 new regime where we're sort of offering -- we're allowing

1 them to offer these kinds of benefits within the broader MA
2 umbrella.

3 DR. ZARABOZO: Well, I wouldn't necessarily say
4 that they didn't work because there's a lot of variation, as
5 was pointed out. Some of the HMOs that are C-SNPs do
6 actually pretty well. The regional ones do not do very
7 well. So part of the reason is to essentially broaden the
8 C-SNP model to other -- to a larger population, essentially.

9 MS. AGUIAR: I would just add to that. So some of
10 the C-SNPs that we spoke with, when they were talking about
11 what makes their model work, they were saying that it really
12 is focusing on changing the actual system of care, so making
13 that systemic change, you know, moving from an idea of an
14 insurer is just paying claims to one that's actually
15 changing the model of care.

16 And so the idea is that maybe -- and again, I
17 think as Carlos has said, there's been some consolidation in
18 the industry where some larger, broader MA plans have been
19 purchasing the C-SNPs with perhaps the idea to move this
20 model of care into a more broad base for the more general MA
21 population. And so when we have heard what works, it's
22 really been fairly consistently this notion of actually

1 being able to change delivery systems.

2 And then what we're thinking and sort of the hope
3 is that if we move that into the broader MA, that that could
4 perhaps push the broader MA plans to be thinking about
5 actually changing systems of care. That goes with more of
6 our framework of moving towards broader integration.

7 DR. BAICKER: So, obviously, we wouldn't want to
8 draw too much from a few case studies, but in the examples
9 of the more HMO-style C-SNPs that you said worked better,
10 are there innovations in the kinds of things that are
11 covered or in the way that services are delivered, or is it
12 -- do they look like examples of the kinds of innovation in
13 coverage that we were hoping this would spur?

14 DR. ZARABOZO: We would say yes.

15 [Laughter.]

16 DR. ZARABOZO: Cori's friend might say yes, also,
17 but I don't know her that well.

18 DR. MARK MILLER: What I'm trying to remember is
19 when we were meeting with some of them, as Kate was talking,
20 are there specific activities within that that you can
21 identify for them. And I don't want to put you on the spot,
22 because I actually was having a hard time kind of dredging

1 up from those meetings, too, the specific activities, and I
2 remember leaving the meetings thinking, yes, there were some
3 identifiable things that they were doing, but -- and I think
4 that's what you're fishing for.

5 DR. BAICKER: And part of the reason that I'm
6 fishing for that is not just to know, oh, do those kinds of
7 things work in this context, but then to make sure that in
8 the new regime we're discussing, those kinds of things would
9 still be fostered, and the fact that they would be open to
10 enrollment from people without those conditions necessarily
11 wouldn't be so much of a problem. So I just want to be sure
12 that the hope stays alive.

13 MR. HACKBARTH: So, Kate, there are at least some
14 C-SNPs that perform well for patients with chronic
15 conditions. There are regular Medicare Advantage plans that
16 also perform well for people with chronic conditions. And
17 so if you imagine a diagram with high performers, the plan
18 type does not seem to be the driving factor. The
19 performance is based on delivery system characteristics that
20 can be found in either plan type.

21 That raises the question for me, why perpetuate a
22 difference in plan type with different rules when, in fact,

1 what we're searching for is a change in care delivery that
2 can be readily found in other plan types. Plan type is not
3 the critical variable here. Care delivery system is the
4 critical variable.

5 DR. REDBERG: I think this question is trying to
6 get more to what is different about the successful C-SNPs or
7 what's different, because I think you said on Slide 4 that
8 the spending was higher in C-SNPs than in other Medicare
9 Advantage plans and I was wondering --

10 DR. ZARABOZO: They have lower bids, actually,
11 compared to fee-for-service, so --

12 DR. REDBERG: Okay. Was the --

13 DR. ZARABOZO: Spending is generally higher in MA
14 because the bid is on the Medicare benefit package and then
15 there are rebate dollars and so on, so generally higher in
16 MA.

17 DR. REDBERG: Do we have any -- my other question
18 is on Slide 9, in which we said that the outcome measures
19 are lower for SNPs than for MA averages and that the plans
20 were concerned the outcome measures weren't appropriate. So
21 I was just wondering, are the populations sicker? Do they
22 think that's why it's not appropriate? Or what was

1 different?

2 DR. ZARABOZO: Their main concern --

3 DR. REDBERG: I'm trying to get at --

4 DR. ZARABOZO: -- is socio-economic status, and
5 that's mostly for the D-SNP situation. These are the
6 intermediate outcome measures in HEDIS. And, for example,
7 for the C-SNPs, the SNP-level reporting, the only outcome
8 measure is really control of blood pressure across the
9 entire population. There is no disease-specific outcome
10 measures included in the SNP-level performance. So that's
11 why it's hard to judge.

12 You may recall there was a footnote in the reading
13 material that said, well, let's look at the diabetic
14 measures to the extent that we can.

15 DR. REDBERG: Right.

16 DR. ZARABOZO: And there, we didn't see
17 necessarily better performance by the C-SNPs on those
18 measures.

19 DR. REDBERG: Okay, because I'm just -- I'm still
20 not, I guess, clear on what is different about the care
21 delivery in the C-SNPs as compared to -- like, if I had
22 diabetes and I'm in the MA plan, I'm probably going to get

1 the diabetes counseling or the classes. So what would be
2 different if I was in a C-SNP that would theoretically be
3 better?

4 DR. ZARABOZO: Yes. The C-SNPs, for example, in
5 talking to one of them, they have -- in their general MA
6 plan -- this is both general and -- they have, even for
7 diabetics, they have cost sharing for diabetic supplies in
8 the general MA plan. In the C-SNP for diabetics, they do
9 not. And then the same with the shoes, they have cost
10 sharing. Not so in the C-SNP for diabetics. The provider
11 network appears to be the same. There does seem to be more
12 non-physician contact with the patients and more making sure
13 that they get to appointments. They have a better
14 transportation benefit for the people in the C-SNP to ensure
15 that they do get to appointments. So a lot of it is the
16 benefit package and much more -- a lot of family
17 involvement, for example, with the patients.

18 DR. MARK MILLER: My recollection from the
19 conversation, beyond the structuring of the benefit, is,
20 it's like much, much more engagement. I think if the C-
21 SNPs, or the ones that seem to be doing a good job, were
22 speaking, they would say, what we try and do is concentrate

1 our effort on a particular area and population and that's
2 why they want the C-SNP designation. I think that's what
3 they would say. There are different ways to look at it, but
4 --

5 MR. HACKBARTH: So what are the current barriers
6 to Medicare Advantage plans doing all of the things that you
7 just said?

8 DR. REDBERG: That's the question.

9 DR. ZARABOZO: Yes. Well, the interesting thing
10 in that case was that even for diabetics, in the general MA
11 plan, they didn't remove the cost sharing for diabetic
12 supplies, and the C-SNP --

13 MR. HACKBARTH: But my question is, is there any
14 statutory or regulatory barrier to a Medicare Advantage plan
15 doing those things?

16 DR. ZARABOZO: The barrier is you can do it if
17 something is specific to the disease. Like diabetic
18 supplies naturally only goes to diabetics. But if you
19 wanted to say, I would like to have no cost sharing for
20 primary care visits for diabetics but everybody else has to
21 have primary care cost sharing, that, you can't do.

22 MR. HACKBARTH: And I forget which draft

1 recommendation, what number it is, Carlos, but part of it is
2 to --

3 DR. ZARABOZO: Number two, right.

4 MR. HACKBARTH: -- yes, is to grant that
5 flexibility to general Medicare Advantage plans.

6 MS. AGUIAR: And I would just add, because we did
7 ask this very question of one of the better performing C-
8 SNPs and we said, you know, why is it that a general MA plan
9 couldn't be able to do this, and the answer that we had
10 received is it's more sort of the orientation over the
11 general -- not all general MA plans, but the one that we
12 were talking about specifically, where they sort of came
13 into the market thinking more as a typical insurer that pays
14 claims, perhaps just telephonic case management. So this
15 idea of really creating system change even in a sometimes
16 more localized area is just a shift in mentality, a shift in
17 sort of how they have to operate. And our understanding is
18 that there are some broader MA plans that are really
19 interested in adopting that more C-SNP model, if you will,
20 for their broader population. It's just it'll take time.
21 It's a change in how they've run their operations
22 previously.

1 MR. HACKBARTH: One argument that I've heard from
2 somebody who's involved with one of the very best of the C-
3 SNPs is that it permits you to develop a critical mass that
4 allows you -- it supports investment in certain types of
5 programs, and I understand the economic logic of that.
6 Would there be anything to prevent a Medicare Advantage plan
7 from saying, boy, we want to develop an outstanding program
8 in caring for diabetics and in order to get the necessary
9 critical mass, we want to do some targeted marketing to
10 diabetics, you know, calling out the fact that we've got
11 this outstanding program and perform exceedingly well?

12 DR. ZARABOZO: Not if it's general marketing. One
13 of the issues is how do you do provider marketing, and
14 that's kind of a sensitive issue, that --

15 MR. HACKBARTH: Say more about that distinction.

16 DR. ZARABOZO: Meaning that if a medical group,
17 let's say, is capitated and they have a program for
18 diabetics but they are selective about which diabetics they
19 refer to that, that's the issue that people have with
20 provider marketing, that to the extent that there's
21 financial risk involved and they may -- you know, the
22 possibility of selection of one patient is referred, another

1 patient is not referred as being too costly, that's the
2 sensitivity about provider marketing. I'm not sure what the
3 current rules are on the extent to which there can be
4 provider marketing, but there's always been a concern about
5 selection.

6 MR. HACKBARTH: Okay. I'm dominating the
7 discussion here too much, so maybe we can talk some more
8 about that.

9 Rita, did you have any other questions that you
10 wanted to ask?

11 DR. REDBERG: No. Actually, what you extended and
12 then you answered clarified my question. But now I'm just -
13 - would the difference between, then, caring for those same
14 patients in the regular MA plan mean that they would be less
15 desirable in a regular MA plan because they're going to be
16 higher and the costs will be higher for people with chronic
17 conditions in a --

18 DR. ZARABOZO: Well, of course, it's the risk
19 adjusted payment. So, I mean, I think the issue there would
20 be, well, in order to work within that risk adjusted
21 payment, we would rather have a program where we can do all
22 these things for these people, and so we actually do better

1 financially because of all the things that we can do by
2 targeting these people as opposed to being part of a broader
3 population where risk adjustment by disease as opposed to,
4 yes, we know how to do this for this particular disease and
5 we can really be successful financially by what we do.

6 MR. BUTLER: On page 8, slide 8. So I'm still
7 grappling with who these plans are.

8 My first question is on the I-SNPs that have
9 declined 39 percent in 1 year, I guess. And I know there
10 are only 48,000, but that's a big drop. So -- and you have
11 not disclosed who the entity is, but how did that happen, or
12 what changed status means?

13 MR. ZARABOZO: I think what is happening with this
14 particular organization is that previously you could be a
15 SNP if you had predominantly served a particular kind of
16 population -- the institutionalized, for example. So this
17 particular organization was in that category.

18 And then, the law was tightened up to say, no, you
19 had to serve exclusively these kinds of people. So this is
20 that organization that over the years has moved from I-SNP
21 status to not being an I-SNP.

22 MR. BUTLER: It just seems that you're making a

1 recommendation around I-SNP, and you said that 40 percent of
2 the members are gone in one year. It's a funny thing.

3 And then, I still have a feeling. I feel like
4 wasn't it Butch Cassidy when Paul Newman and Robert Redford
5 said, who are these guys?

6 I still feel that about this a little bit because
7 we've got 20 percent of the D-SNP enrollment in Puerto Rico,
8 half of the I-SNP in California and New York, and you get
9 some weird geographies.

10 And one side of me says, okay, you've got Humana
11 and United and the usual MA suspects. Are they somehow
12 selectively choosing where they think this will work?

13 And I said, I don't think it's so much that as
14 smaller, different plans, but that's what I mean.

15 I don't quite understand who are these guys quite
16 yet, and if you have more insights that would help me kind
17 of frame whether the motivations and the likelihood of this
18 spreading more successfully across the country rather than
19 in a fairly weird distribution of where these are taking
20 hold

21 MR. ZARABOZO: Well, in terms of the I-SNPs, it's
22 important to have contracts for the skilled nursing

1 facilities. So there's an issue there.

2 And you want kind of a different provider makeup.
3 So there's also a critical mass point there although they're
4 not very big.

5 But the I-SNPs -- the origin of the I-SNPs is from
6 the Evercare demonstration which was United HealthCare. So
7 United is still big in the I-SNP area.

8 And there's also actually Eriksson, which is now
9 part of United. It is a continuing care retirement
10 community. So they are also sometimes in the I-SNP
11 category.

12 MR. BUTLER: So how about D-SNPs because that's
13 where the vast majority of these folks reside?

14 MR. ZARABOZO: Many companies have been involved
15 in D-SNPs just because it's an opportunity to get enrollment
16 outside of the open enrollment period. But, as noted here,
17 there are many more not-for-profit organizations in the D-
18 SNPs, and about 5 percent of the enrollment is in public
19 authorities, like county health systems or like the Jackson
20 Memorial Health System.

21 DR. NERENZ: I just want to make sure I understand
22 the bullet points about implications for program spending in

1 the various recommendations.

2 And I want to make sure I clarify something you
3 said, and I think you actually said it when this slide was
4 up, but it's not on this slide. It's about the bids. It's
5 seems to me we've got a couple of comparisons, and this is
6 what I want to clarify. And then, you actually repeat it
7 again.

8 The bids that you describe, you said, are lower
9 than the regular MA bids?

10 MR. ZARABOZO: The C-NSP bids are lower, and this
11 could be a function of geography because a lot of the
12 enrollment is coming from Los Angeles, for example. The Los
13 Angeles area.

14 DR. NERENZ: Okay. And then, in the text
15 materials, there's also a similar statement, but it goes the
16 other way. It also refers to bids, and it says that the
17 bids are higher than fee-for-service. Are we talking about
18 the same bids?

19 MS. AGUIAR: Right. So the bids for C-SNPs, and
20 perhaps I-SNPs, are lower than fee-for-service, but total
21 payments are over fee-for-service.

22 DR. NERENZ: Okay.

1 MS. AGUIAR: So the bids for C-SNPs are lower than
2 fee-for-service. The payments are over -- are higher than
3 fee-for-service. Bids for --

4 DR. NERENZ: Payments by them to providers?

5 MS. AGUIAR: Oh, no, no, Medicare payments.

6 MR. HACKBARTH: You may need to explain the
7 benchmark system and how all the pieces fit together.

8 DR. NERENZ: Okay. I'm sorry if this is going to
9 get us into deep water, but it seems like it's essential to
10 the question of what the program spending implications are.

11 MR. HACKBARTH: Yeah, yeah, this is important.

12 DR. NERENZ: So I just want to make sure I can
13 follow it.

14 MR. ZARABOZO: It's the way that the MA payment
15 system works, which is plans present a bid for how much,
16 what revenue do they need to cover the Medicare A and B
17 benefits.

18 DR. NERENZ: Yes, yes.

19 MR. ZARABOZO: This is compared to an area
20 benchmark.

21 DR. NERENZ: Yes.

22 MR. ZARABOZO: And in many areas the benchmark

1 itself exceeds fee-for-service.

2 DR. NERENZ: Yes. Okay, I understand that.

3 MR. ZARABOZO: So then the bid is compared to the
4 benchmark. There's a rebate calculation that says you can
5 have some of that.

6 DR. NERENZ: Yes. Right.

7 MR. ZARABOZO: So, if you combine the bid for the
8 A and B benefit plus the rebate dollars-

9 DR. NERENZ: Yes.

10 MR. ZARABOZO: -- that's when you get over fee-
11 for-service in terms of payment to the plan.

12 DR. NERENZ: Okay, okay. I get that. It's
13 complicated, but I think I get it.

14 MR. ZARABOZO: Right.

15 DR. NERENZ: Okay, but if we go back to at least
16 the first part of this, the bids in the SNPs -- and it may
17 be different in the three different subtypes -- are lower
18 than MA for the comparable people? Is that --

19 MR. ZARABOZO: It is different in the three
20 subtypes.

21 DR. NERENZ: Okay.

22 MR. ZARABOZO: And what we were specifically

1 pointing out is that C-SNPs have low bids, relatively low
2 bids. The other plans are close to fee-for-service.

3 MS. AGUIAR: D-SNPs are.

4 MR. ZARABOZO: And D-SNPS are higher, yeah.

5 DR. NERENZ: Okay. So now just let me play it out
6 as if it were fairly straightforward.

7 If then, the C-SNPs were not reauthorized -- and
8 we are -- I think there's another little line of text. This
9 is on page 26 of the chapter, that says we are assuming most
10 of those enrollees then will just move into general MA.
11 Does that mean then that program spending will go up because
12 of that movement from the lower-bid C-SNP to a higher-bid
13 MA?

14 Is the logic as straightforward as that?

15 MR. ZARABOZO: Yes, that is a possibility. That's
16 a logical possibility.

17 DR. NERENZ: I mean, is that actually the basis
18 for --

19 MR. HACKBARTH: You'd have to do it on a
20 geographic basis. So, as Carlos indicated, a lot of the C-
21 SNP enrollment -- I think I heard you say -- is in Southern
22 California. And so, there high fee-for-service costs in

1 Southern California, and so they're coming in lower.

2 Now if -- I don't know how the general MA bids
3 compare to fee-for-service in Southern California. I
4 suspect that they may be lower.

5 And so, if you have a conversion within Southern
6 California of C-SNPs with below fee-for-service bids to MA
7 plans with below fee-for-service bids, you may not have a
8 significant budget.

9 MR. ZARABOZO: Although the point there, though,
10 is if like 100 patients are in the C-SNP and they cost less
11 because of the many things the C-SNPs can do, if they just
12 go to general MA and they suffer -- you know, they have
13 additional costs -- because they couldn't do what they did,
14 then that's the logical consequence.

15 DR. NERENZ: Okay. Well, that's essentially the
16 dynamic I was trying to understand with the question.

17 I know the bullet -- at least this is now slide --
18 I'm sorry I've got to flip through these. Top of 14
19 basically says that if the implication is increased program
20 spending. I just want to understand what the underlying
21 logic chain is to get to that point.

22 MR. ZARABOZO: The other point is that we expect

1 growth in the C-SNP area. So that -- because of they're
2 almost doubling the number of plans in 2013 and it would be
3 -- it is a broader geographic area.

4 DR. NERENZ: Okay. Fine. So the answer is
5 complicated.

6 MS. AGUIAR: It is.

7 [Laughter.]

8 MS. AGUIAR: And I would just add to it. When we
9 think about the bids, we've been thinking about them as how
10 much that plan is able to provide Part A and B services for
11 that beneficiary. So we've been thinking about if that
12 beneficiary's cost -- has a certain cost of A and B services
13 to them, if they were to move into MA, it should be about
14 the same.

15 The difference in increase in program spending is
16 not from whether or not these beneficiaries would move from
17 the C-SNP to the general MA plan. It's actually because
18 there is an assumption since C-SNPs are going -- since all
19 SNPs are going to expire in current law, there is an
20 assumption that a certain percentage of those beneficiaries
21 will go into fee-for-service.

22 And payments to C-SNPs, I-SNPs and D-SNPs are over

1 fee-for-service. So if they go into fee-for-service under
2 current law, spending on those beneficiaries will decline.
3 That's already in the baseline.

4 So, if we keep them in MA, whether in a C-SNP in
5 MA, in a D-SNP, that's -- so that's actually where the cost
6 is coming from.

7 DR. NERENZ: All right. Okay. So then I'll
8 elaborate my previous point; it's really complicated.

9 MS. AGUIAR: Yes.

10 [Laughter.]

11 DR. CHERNEW: I think that's the main effect.

12 Our recommendation actually keeps more people in
13 MA than otherwise might. And MA benchmarks are higher in
14 general. At least, they're assumed to be. And so, that's
15 why in the transition period as opposed to just getting rid
16 of them, it costs more.

17 DR. NERENZ: Yes. Thank you.

18 No, I didn't fully appreciate that dynamic until
19 we got into this discussion. Thank you.

20 MR. GEORGE MILLER: Yes. And mine has to do with
21 the reading material, and I really appreciate the
22 information on the demographic characteristics. Following

1 this line of questioning about C-SNPs, especially on page 8,
2 we project 21 percent growth in the last 12 months. But I
3 notice in the C-SNPs, in the reading, that 32 percent of all
4 C-SNPs are African Americans.

5 So part of my question deals back with the quality
6 issue, and that is, do you know -- have you done research
7 that the disparities are less or greater than the general
8 population of fee-for-service?

9 At least I thought around the table there's still
10 a concern about disparities in health care in general,
11 across the Medicare population. So do we know, in spite of
12 what you said about the quality for C-SNPs, if disparities
13 are less or if there's a better coordination of care with C-
14 SNPs being focused on the model of care to deal with that
15 particular disease process?

16 So is there a better quality, less of disparity of
17 care, or have you been able to tease that out?

18 MR. ZARABOZO: We're trying to look at that with
19 the person-level HEDIS data that we're working with. So
20 we're still looking at that data.

21 But I would point out on the distribution the
22 distribution matches the geography; that is, the reason the

1 proportion of African Americans is so high is it matches --

2 MR. GEORGE MILLER: Where they are.

3 MR. ZARABOZO: -- the distribution in the
4 geography.

5 MR. GEORGE MILLER: Okay. So it's not
6 disproportionate.

7 MR. ZARABOZO: Right. It does not --

8 MR. GEORGE MILLER: Okay. Got it.

9 Yeah. Okay. Thank you.

10 MR. GRADISON: I have two questions. I think the
11 answers to them are self-obvious, but I want to make sure.

12 I envision that at some point in time the
13 reimbursement rates to MA plans are going to actually move
14 towards fee-for-service rather than go north as they have
15 been with the star rating and the election and a few other
16 things going on.

17 So my first question in my mind has to do with the
18 viability of MA plans. If our recommendations are adopted,
19 I think the answer is it doesn't make any difference if you
20 have appropriate risk-adjusted payments. Is that right?

21 Shall I rephrase the question?

22 The question is, if we make these changes, will it

1 influence one way or the other the viability of MA plans in
2 an environment in which their reimbursement rates in general
3 are going down?

4 MR. ZARABOZO: That's more of a general MA
5 question. I don't think it is SNP-particular question.

6 DR. MARK MILLER: I think that's what he's saying.

7 MR. GRADISON: That's what I was -- that was my
8 impression, but I just want to make sure.

9 MS. AGUIAR: And I would just add to that. I
10 think, as we emphasized more in the mailing materials that
11 have been sent to you, you know, there are dual eligibles,
12 about 900,000 of them, in general MA plans already. You
13 know. So it's not just -- they're not only in D-SNPs.

14 And then the same thing with the C-SNPs. There
15 are beneficiaries with those chronic conditions, with many
16 of those chronic conditions, that qualify for C-SNPs already
17 in the MA plans.

18 So I think that we would not expect a greater
19 influx of individuals with those same conditions into
20 general MA, to have a negative financial impact on MAs,
21 since the risk adjustment system is -- you know, the risk
22 adjustment -- you know, the HCC scores attached to those

1 beneficiaries in the C-SNPs should be the same ones attached
2 to those beneficiaries when they're in the general MA plan.

3 Does that make sense?

4 MR. GRADISON: Yeah, that's from the plan point of
5 view.

6 MS. AGUIAR: Yeah.

7 MR. GRADISON: Same environment, let's assume
8 significantly lower reimbursements for MA plans. What may
9 be the effect of the beneficiaries who will be shifted into
10 the MA plans?

11 I assume what happens is that step by step the
12 premiums get higher, and the enrollment gets smaller. Maybe
13 it's more complicated than that.

14 But from a beneficiary's point of view I suppose
15 they are no more inconvenienced than anybody else that's
16 gone into the MA plan, but I just want to make sure, if
17 there are fewer options available among MA plans or the
18 plans kind of struggle along but with a declining enrollment
19 resulting from higher premiums.

20 MR. HACKBARTH: Do you see the higher premiums
21 being the result of general changes in the payment system
22 for MA plans, or are you saying as a result of this

1 migration of people from SNPs into MA?

2 MR. GRADISON: A general migration, yeah. My
3 sense would be that the reimbursement rates, as they move
4 toward fee-for-service levels, would probably force many of
5 the MA plans to try to shift more of the costs to the
6 beneficiaries.

7 MR. HACKBARTH: And so, the changes in PPACA that
8 happened to payment for Medicare Advantage plans also will
9 happen to the SNFs because they're basically in the same
10 payment system.

11 So, to the extent that lower Medicare payments to
12 MA plans results in higher increases in premiums for
13 Medicare beneficiaries, that will be true across the board.
14 That effect is general.

15 And then, what Christine is saying I think is that
16 because of risk adjustment, if SNP people with higher risk
17 scores migrate into Medicare Advantage plans, they will
18 bring with them higher Medicare payments.

19 MR. GRADISON: Yeah.

20 MR. HACKBARTH: And so, in and of itself, that
21 should not result in higher premiums for MA enrollees.

22 MR. GRADISON: Thank you. That was very helpful.

1 Thank you.

2 DR. DEAN: I had some of the same struggles that
3 Peter had, to try and figure out who these guys are,
4 especially the I-SNP, which seems like it might be a very
5 appealing approach because it really is a unique population,
6 more so maybe even than some of these others.

7 Do these organizations -- are they just -- do they
8 actually deliver care as well as pay for care?

9 I mean, do they -- are they delivery organizations
10 as well as financing organizations?

11 How do they -- how are they structured, and who
12 are they?

13 MR. ZARABOZO: They are MA plans. So, in other
14 words, they're responsible for the full range of A and B
15 benefits.

16 DR. DEAN: But I mean do they -- I understand
17 that, but do they actually employ caregivers, or do they
18 just contract?

19 MR. ZARABOZO: I think they employ, for example,
20 nurse practitioners that go into the facilities, and then
21 they have the contracts with the institutions. I don't know
22 whether, for example, the medical -- they use the medical

1 director of the institution or not.

2 DR. DEAN: And with the decline, is that something
3 that is expected to continue, or was that because of just
4 this one chain?

5 MR. ZARABOZO: That was that one organization.

6 DR. DEAN: And is there any prospects as to
7 whether there's -- what is the interest within the industry?

8 Is it likely that there would be more interest in
9 it because, like I say, in many ways this is a very
10 appealing structure?

11 MR. ZARABOZO: Yeah. I don't know the extent of
12 interest in expanding the I-SNP option.

13 DR. DEAN: Thank you.

14 MS. AGUIAR: I would just add to that that we call
15 them the duals office for short, within CMS. It does have
16 actually a demonstration going on now, which is sort of a
17 little bit more of a relaxed model of the I-SNP model that's
18 really sort of trying to bring -- you know, get interest
19 from nursing homes to participate.

20 I believe that they have recently kicked off that
21 demonstration. And so it's similar to the I-SNP model, and
22 it's really sort of trying to broaden, you know,

1 participation into that model because if you think about it
2 I think the I-SNP model is more or less that they'll embed a
3 nurse practitioner or they'll have a staff there.

4 They obviously are responsible for all Medicare
5 Part A and B benefits, but the real sort of value
6 proposition is that they'll be there to help medically
7 manage that patient there and then, ideally, to reduce
8 unnecessary hospital readmissions.

9 So, you know, you could see from a nursing
10 facility's perspective some of them have a financial
11 incentive to not do that.

12 DR. DEAN: Right.

13 MS. AGUIAR: And so, I think that could be
14 possibly why some of the I-SNPs have not been able to expand
15 it. But again, there are sort of other movements more
16 happening now to try to sort of broaden that concept, even
17 if not in the exact same structure of the I-SNP model.

18 DR. DEAN: And the program you mention, that's
19 completely separate from MA.

20 MS. AGUIAR: Completely. It's a demonstration.

21 DR. DEAN: Okay.

22 DR. HALL: Well, thank you for trying to shed some

1 light on this confusion.

2 We're spending a lot of time, it appears, on C-
3 SNPs right now, which recommendation 2 is suggesting we
4 should make a suggestion for deauthorization. And the
5 numbers are relatively small relative, say, to duals. It's
6 about 20 percent or -- it's over a million in duals and
7 about 200,000 plus in C-SNPs.

8 One thing you said, Carlos, I guess I want to make
9 sure I got this right. So we're seeing a decline in one
10 sense, but you mention that some of the carriers are
11 actually anticipating a large increase in enrollment. Could
12 you clarify that for me?

13 MR. ZARABOZO: In terms of the C-SNPs?

14 DR. HALL: Yes.

15 MR. ZARABOZO: Yeah, the -- a couple of the firms
16 have been bought by much larger firms that have C-SNPs. So
17 -- and the number of plans are being offered in 2013 is
18 almost doubled.

19 DR. HALL: Okay.

20 MR. ZARABOZO: So that's why we would expect a
21 growth in the C-SNP enrollment.

22 DR. HALL: So one would think that from a clinical

1 standpoint what's good for a diabetic in Alabama might be
2 good for a diabetic in Alaska. And yet, what seems to
3 happen in this marketplace is that the drivers have
4 relatively little to do with the rationale of clinical care
5 of the chronic illnesses being covered. Am I missing
6 something here?

7 Is this more a matter of profit-loss?

8 Why is this so regional, and how do you explain
9 this -- these discrepancies?

10 MR. ZARABOZO: Well, I think the current C-SNP
11 situation is partly the regionality of it, so to speak.
12 It's because one regional plan, or regional organization,
13 has entered this particular market. So that explains why
14 the southern emphasis in terms of the enrollment, but I
15 would expect that to change because of the larger entrance
16 now.

17 DR. HALL: And the reason it will -- if we were to
18 go to the major carriers, what would they say is the
19 rationale for wishing to expand this program, which has been
20 somewhat tenuous now over the years?

21 MR. ZARABOZO: Well, I think -- it's hard for me
22 to say.

1 DR. HALL: Okay. You said enough.

2 MR. ZARABOZO: No, I would say that the C-SNPs, I
3 mean, have been successful financially, it appears, and
4 therefore, the model may be appropriate to extend to more
5 people, essentially. And large organizations can also be
6 successful with that model, I think is the --

7 MS. AGUIAR: And again, we've also heard that some
8 of the reason for this acquisition is an interest in
9 adopting the C-SNP model for their broader, general MA
10 population.

11 DR. HALL: Right. That could be one possibility,
12 that it's a pilot study. But a crude analogy is that we're
13 moving from a very intense concentration on high-risk people
14 to more of I guess you'd say community rating if we move
15 back into MA, putting people with chronic disease back into
16 the general pool.

17 Okay. Thank you.

18 MR. KUHN: Quick question, kind of related to C-
19 SNPs but a little bit broader, but first, I do like the SNP
20 concept overall. I think the differentiated structure adds
21 some nice flexibility to the program, which I think is quite
22 useful.

1 When I thought about C-SNPs -- and I'm glad,
2 Glenn, you raised that question -- I've always thought a
3 little bit that you need large numbers of patients in order
4 to kind of bring together some of the -- it's easier to base
5 some of the interventions when you have a larger group
6 that's out there.

7 And Carlos mentioned the example about the benefit
8 package, but I also heard what you said, Glenn. So it's
9 something I want to think about a little bit more.

10 The real kind of question I have is kind of the
11 differentiation in terms of the variation of performance of
12 plans. We said we had some very high-value plans out there
13 in all categories but some that were less so.

14 So just kind of once again kind of an inventory of
15 the tools that CMS has now to kind of encourage innovations
16 for plans -- obviously, there's the five star. There's the
17 so-called quality bonus program. What are some of the
18 things that they have in their tool kit now to kind of drive
19 innovation, to drive higher performance of MA plans all over
20 but predominantly the SNP plans?

21 And is there anything that's left on the sideline
22 that might be helpful, that if they had those, it would be a

1 more robust opportunity to drive improvement?

2 MR. ZARABOZO: Well, as you mentioned, the primary
3 driver is the star system. And one aspect of the star
4 system is that SNP enrollees are rolled up into the star
5 ratings by the proportion of their population.

6 And the elements that are -- some SNP-specific
7 elements are included in the star rating system. They only
8 apply to the SNPs. So that's really the principle tool of
9 promoting better quality among the SNP plans

10 MR. KUHN: Is there anything that MedPAC has
11 opined on in the past or that others in the policy world
12 have talked about that if CMS were to add those, have that
13 in their portfolio, either through Congress and through
14 regulation, it would also help drive innovation?

15 MR. ZARABOZO: Well, we've recommended in the
16 report on -- the MIPPA required report on comparing quality
17 to have more outcome measures. I mean in terms of what is
18 the main interest in quality measurement, so to increase the
19 number of outcome measures. And CMS is working on that.

20 I don't know otherwise what additional approaches.

21 DR. COOMBS: Slide 16. In going over that slide,
22 for the integrated D-SNPs, you know, I'm noticing that for

1 the percentage -- and I hope I'm understanding this
2 correctly -- financially integrated was 5 percent, 65,000
3 enrollees and 25 approximate D-SNP enrollees. So, for the
4 non-integrated, it's a large number.

5 Was there some kind of impression you had in terms
6 of their way -- on their way to some kind of integration,
7 whether financial or the combined Medicaid integration?

8 MS. AGUIAR: Yes, this is a frustration that we've
9 heard from the D-SNP industry over the past few years.
10 We've heard of plans that very much so want to integrate, to
11 the extent that they perhaps -- even if not full, with full
12 Medicaid benefits, are really interested in integrating for
13 some or all of the Medicaid benefits.

14 And the just unfortunate limitation is that there
15 are just some states that are either just not interested
16 really in managed care and moving their long-term care
17 benefits into managed care. There's a lack of resources on
18 states, and so they can't right now.

19 Now since the demonstrations have come up -- CMS--
20 state demonstrations have come up -- a lot of the states are
21 sort of moving their focus on that and again less -- so this
22 is what we've been hearing from the industry on working with

1 the D-SNPs.

2 And then, another concern we've heard on the part
3 of the state was that the D-SNPs would be -- have to be
4 reauthorized every few years, and so it would quite an
5 administrative task on the part of the state to really move
6 towards a managed long-term care for a product that they're
7 not sure whether or not it was going to be able -- it was
8 going to last.

9 So, again, we have heard frustration from those
10 plans that want to become integrated and are just not able
11 to.

12 DR. COOMBS: So, Glenn, I was just thinking about
13 your recommendation in light of that and this large, you
14 know, quantity of D-SNPs that are involved.

15 And I know, speaking with Massachusetts's head of
16 the Medicaid and Medicare Services, that one of the
17 challenges is just that they felt apprehensive about the
18 state jurisdiction, and when the implementation grant came
19 about it allowed them to do some very innovative things.

20 So I don't know that there's opportunity for some
21 transition from the integrated -- the non-integrated to
22 progress to the integrated, and so I was just kind of

1 interested in that next leap.

2 MR. HACKBARTH: Help me out here, Christine. I
3 don't think the issue is states like Massachusetts.

4 DR. COOMBS: No, no, no.

5 MR. HACKBARTH: They're interested in the fully
6 integrated models, and they're using those plans in their
7 demonstration proposal. The issues about states being
8 reluctant to support full integration are other states that
9 don't share that orientation.

10 Let me ask this, which I think is a related
11 question. Alice, as I think you know, there are 26 states
12 that have expressed interest in doing demonstrations for
13 dually eligible beneficiaries.

14 DR. COOMBS: Right.

15 MR. HACKBARTH: Some of those states envision
16 using as the primary vehicle plans that they've worked with
17 under Medicaid. Is that correct, Christine?

18 MS. AGUIAR: That is correct, and that also is a
19 concern that we've heard from the D-SNP industry. Again,
20 according to CMS information that they have put out, from
21 what we've heard, it is supposed to be a joint selection
22 process between CMS and the states. There has been some

1 concern about whether or not in truth it actually will end
2 up that way in every state. There has just been some
3 concern about that. But there has been preference from some
4 states to work with the Medicaid managed care plans that
5 they already are working with. And you can understand, I
6 mean, they already have that set up with those plans.

7 Some of those plans in some states may already
8 offer a D-SNP or at least an MA plan, so then perhaps that
9 organization could still participate. But there has been
10 concern in some states that the D-SNPs that are not already
11 integrated -- and most of them aren't -- will not be able to
12 participate in the demonstrations.

13 MR. HACKBARTH: So several years ago -- I think it
14 was in PPACA -- the Congress included a provision requiring
15 that D-SNPs, to be eligible as D-SNPs, had to have contracts
16 with states, and that was based, at least in part, I think
17 on a MedPAC recommendation to that effect. And the problem
18 here is that you've got a program, Medicaid, with joint
19 federal-state responsibility, and the Congress can say, you
20 know, we want contracts for these plans. But unless the
21 states are eager to use these plans as vehicles, it doesn't
22 go anywhere.

1 DR. COOMBS: Right.

2 MR. HACKBARTH: And so many of the D-SNPs have met
3 with frustrations. We'd love to contract, we'd love to
4 financially integrate, but we don't have a willing partner
5 in the state, because in some states they're more oriented
6 towards using their Medicaid HMOs. And so, you know, it's a
7 byproduct of this shared responsibility between the federal
8 and state governments. Is that a fair statement?

9 MS. AGUIAR: I think that is, and I think, Alice,
10 part of your question was about innovation and are states
11 seeing the demonstrations as an opportunity to be more
12 innovative than they are when they work with the D-SNPs.

13 DR. COOMBS: Right.

14 MS. AGUIAR: Part of that, which the fourth
15 Chairman's draft recommendation tries to get at is to
16 address some of these administrative misalignments. You
17 know, so that was a sticking point for some states, and
18 understandably that was a barrier.

19 There are differences amongst the demonstrations
20 that you do not have in the current D-SNP system. Primarily
21 the states are able to share in the Medicare savings, that
22 they're not able to do so now when you have a D-SNP. And

1 the rates to the demonstration plans will be set below
2 current spending, and, again, that's not how it is
3 currently. And so I think part of what we've heard some of
4 -- because there really was quite a rush to the table with
5 the demonstrations around the states --

6 DR. COOMBS: Right.

7 MS. AGUIAR: -- was this opportunity sort of
8 force, try to force savings up front through these lower
9 capitation rates relative to lower spending. And then the
10 states will be able to share that, to share in that savings
11 in the beginning, you know, in year one of the
12 demonstration. Again, some of reluctance with states to
13 contract with the D-SNPs to be integrated is this concern
14 that from what they have told us that, you know, the first
15 year, sort of savings, if you think about it, tend to be
16 from acute care Medicare services with long-term care
17 savings coming later on. You know, we have argued that that
18 is not perhaps always the case in every situation. But,
19 nevertheless, under the demonstrations the states are -- you
20 know, there will be a -- in some states, like a 1-percent,
21 2-percent, 3-percent forced savings up front in year one,
22 and then that will be shared between Medicare and the

1 states.

2 DR. COOMBS: Right.

3 MS. AGUIAR: And so there's sort of a financial
4 flexibility there that doesn't exist under the current D-SNP
5 model, which I think has made these demonstrations more
6 attractive.

7 DR. COOMBS: To whatever extent we could, if the
8 Secretary could actually work with some kind of innovation
9 to work with the states locally, I think that would help us
10 tremendously with improved integration. I don't know how
11 that can happen.

12 MR. HACKBARTH: In fact, that's the intent of the
13 demonstration, is to bring the parties together and, you
14 know, flexibility around the roles.

15 DR. COOMBS: I think that's the next level for us.
16 Thanks.

17 DR. NAYLOR: So just following up on that, on
18 Slide 20, I'm wondering if -- you talk about the
19 administrative barriers in the context of better alignment
20 with the appeals and grievance process. Why can't we seek
21 just one process? I mean, for the beneficiary, they haven't
22 a clue that this is coming from this stream and this is

1 coming from this stream. So why not just recommend a
2 process?

3 MS. AGUIAR: Right. Well, I think that -- and
4 correct me, please, Glenn, if I'm misspeaking. I believe
5 that the intention of this draft recommendation is for there
6 to be an aligned. So one --

7 DR. NAYLOR: An aligned.

8 MS. AGUIAR: Right.

9 DR. NAYLOR: Okay, because I was reading it as
10 align the processes, but it sounded like there could be --

11 MS. AGUIAR: Right.

12 DR. NAYLOR: All right. On Slide 13, given the
13 conversation that we've been having, help me to understand.
14 If we're to take some of the lessons learned from the best
15 practices around C-SNPs, so around targeting and this
16 opportunity for flexibility and special service provision
17 and then risk adjustment payments accordingly, I'm looking
18 at the timeline here, and so the transition, if you were to
19 think about that, into an MA plan is a moratorium starting a
20 year from now, essentially, if we look at this again in
21 January, directing the Secretary, though, to think about
22 three years from now having assembled an opportunity for

1 benefit redesign that would allow to capitalize on best
2 practices and so on. And I'm wondering -- we lose something
3 here in momentum, especially given what you were talking
4 about in terms of increased interest and so on in that time
5 line.

6 MR. ZARABOZO: Potentially. I mean, if you would
7 -- yes, you would have fewer C-SNPs, presumably, during that
8 -- if it had been reauthorized, then you would have
9 presumably more C-SNPs. But the reason for the three years
10 is sort of an approximation of how long will it take the
11 Secretary to do this, because it would involve here are the
12 standards, here are the regulations that we would -- so
13 three years or less, hopefully. So it's within three years,
14 but setting it, you know, by the end of three years you will
15 have done all of this, hopefully it will occur sooner than
16 by the end of three years.

17 DR. NAYLOR: One other question. This talks about
18 the benefit design, but part of C-SNPs was also this set of
19 expectations around reporting process and outcomes. And I'm
20 wondering, does that have -- does this recommendation now
21 move those expectations into the MA plans generally for
22 those that take advantage of the redesigned packages?

1 MR. ZARABOZO: Yeah, that's a good question that I
2 think that part of the -- part of what is required of C-SNPs
3 is to have this model of care that explains how is it that
4 you're going to specialize in the treatment of these people.
5 And I would presume that we would say, yes, that needs to
6 continue, you need to show that if you're going to do this
7 specialization, you have to be capable of doing it and be
8 effective at doing it. So I think the reporting and the
9 standards would continue.

10 MR. HACKBARTH: Okay. Round 1, clarifying
11 questions [off microphone].

12 MR. ARMSTRONG: First, I just would disclose that
13 I work for an organization that has 80,000 Medicare
14 Advantage lives, and we started a C-SNP a couple of years
15 ago. It never grew -- I can't remember the enrollment --
16 to more than 1,500 patients. And we've decided to close
17 this effective January 1st. And I think that for us the
18 issue has been the distinctive value of that C-SNP wasn't so
19 great and different from what our MA plans had to offer, to
20 be frank. So that just influences my point of view on this.

21 I also just would say I really like the fact that
22 we're having a conversation about how we can organize these

1 prepaid, financed kind of plans to better match the special
2 needs of different populations of our beneficiaries. I wish
3 it wasn't a conversation forced by some deadlines and so
4 constrained.

5 So that leads to just a question. In a way it's
6 kind of rhetorical. I can't remember, but I think it's a
7 very high percentage of all Medicare beneficiaries actually
8 live with at least one chronic illness. Isn't that right?

9 MR. ZARABOZO: That's correct, and that's the
10 point that we're mentioning, that 15 percent of
11 beneficiaries have diabetes, for example. If you sum up the
12 top three conditions, I think 30 percent of the people fall
13 within, you know, the top three conditions.

14 MR. ARMSTRONG: So 30 percent of beneficiaries
15 have at least one of those chronic illnesses, and we would
16 expect that more and more of our beneficiaries are going to
17 be living with at least one chronic illness as we go
18 forward.

19 I guess the round two point I'll make is that I
20 like the idea of folding the chronic illness -- the C-SNP
21 kind of role into regular Medicare Advantage, because I
22 think that's what Medicare Advantage is going to have to be

1 all about.

2 But the other question I had is a little bit
3 broader, and that is, what we're proposing here leads us to
4 a place where basically we have two SNPs -- one focused on
5 the unique issues of dual eligibles, and, unfortunately,
6 that ends up becoming kind of a bureaucratic kind of web we
7 try to untangle, and that's too bad that gets in our way;
8 and the other is institutionalized patients.

9 I just wonder if -- there's a presumption that
10 those are two patient populations with special needs that
11 could be met better by a special program. I just wonder
12 what that tells us about what other populations or
13 beneficiaries might also benefit from special needs plans.
14 And I don't know the answer to that question, but my hope --
15 I guess my question is: Have we considered that? Is that
16 something MedPAC has put on the table in the past? And if
17 not, I would hope that that would be something that, as we
18 go forward, we might put on the table.

19 DR. SAMITT: Two questions. We haven't at all
20 discussed the materiality of the spending increases, so it's
21 described as minimal for the I-SNPs and in transition for
22 the C-SNPs and I assume more substantive for the D-SNPs.

1 Has an assessment or an estimate been done of what you'd
2 predict the increase would be relative to current law?

3 MS. AGUIAR: We have done our own internal
4 estimates. We're waiting now to hear CBO's to fact-check
5 them with CBO to see if they match their estimates.

6 I would say on the D-SNP side, because it would be
7 only the financially integrated and those that have a
8 companion Medicaid plan, which is about 60 plans, and then
9 the rest -- so the vast majority of the industry could
10 convert to general MA. The financial impact is not as large
11 as you sort of would assume if we were saying that all these
12 SNPs would be reauthorized.

13 I believe that for the -- when we come to the
14 final recommendations where you would vote on it, that is
15 when we would present our buckets, our estimates.

16 DR. SAMITT: Although can I follow up on that?
17 Would we estimate with the recommendation 3 that there would
18 be non-integrated D-SNPs that convert to integrated D-SNPs?
19 So it wouldn't just preserve those existing D-SNPs. I
20 assume there would be some SNP transition if they --

21 MS. AGUIAR: Right, exactly. So the difference is
22 sort of what we're modeling that's not current law. So if

1 it's under current law for all D-SNPs to expire and then the
2 issue is a percentage of those individuals and current law
3 have gone back into fee-for-service. So what their
4 recommendation would be changed and what we would be
5 modeling is the percent of beneficiaries in those
6 financially integrated D-SNPs that would have gone into fee-
7 for-service, were they to expire, that would remain in the
8 MA program. And so that's where the cost is coming from.

9 DR. SAMITT: And --

10 MR. HACKBARTH: So making the estimate a critical
11 variable is the assumption about how many go back into fee-
12 for-service versus MA plans, and also the geographic
13 distribution of those matters, because the gap between
14 Medicare Advantage rates and fee-for-service rates is not
15 uniform across the country.

16 DR. SAMITT: My follow-up question was really in
17 line with that as well. Do we envision, especially for C-
18 SNP and D-SNP, that we would see differential choices by the
19 beneficiaries in each of those two? So, for example, C-SNP,
20 would we envision that those beneficiaries would switch to
21 fee-for-service or other MA plans to a different degree than
22 those that are currently in non-integrated D-SNPs?

1 MS. AGUIAR: I believe -- and, again, I wouldn't
2 want to be quoted on this because we have to fact-check this
3 with CBO first. My understanding is that there is an
4 assumption, a particular assumption of the percentage of
5 beneficiaries in D-SNPs that would go into fee-for-service.
6 And I don't believe it differs by type of plan.

7 DR. SAMITT: Okay. Thank you.

8 MS. AGUIAR: But, again, that is something that
9 we're working with them now.

10 DR. SAMITT: Okay. Thanks.

11 MR. HACKBARTH: You would think -- and correct me
12 if my logic is flawed here -- that how many convert to fee-
13 for-service as opposed to another Medicare Advantage plan
14 would vary geographically. In the areas where Medicare
15 Advantage rates are well above fee-for-service, that gives
16 the Medicare Advantage plans an opportunity to offer
17 additional benefits that may make people in those areas more
18 likely to go to an MA plan as opposed to back to fee-for-
19 service. Where the gap is smaller, you might have more
20 migration back into fee-for-service. And so, again, the
21 patterns in how these things happen I think are critical for
22 the final estimate.

1 DR. MARK MILLER: And the only thing I would say,
2 just to lower the expectations as much as possible --

3 [Laughter.]

4 DR. MARK MILLER: Remember a few things. We won't
5 in any instances produce a point estimate because that's a
6 CBO job and that comes from legislation if somebody wants to
7 pursue this. So we have this process -- and you wouldn't
8 know this being the first time through -- where we estimate
9 things within buckets. And some of the precision we may be
10 talking about here will not influence that bucket, and so
11 CBO's approach to this in our world may be a little bit
12 different than when somebody shows up with a piece of
13 legislation.

14 The other thing I think CBO would say is a lot of
15 those dynamics are included in baseline types of
16 assumptions, and to the extent it's wildly different, they
17 might make a separate assumption. But if it's embedded in
18 the baseline, they might not. But, again, this is something
19 that is really their prerogative, and we're working with
20 them.

21 DR. HOADLEY: So a lot of what I was going to
22 raise has come up already in the discussion, but I guess I

1 want to ask about a couple of things.

2 On the C-SNP issues of -- and it really goes into
3 the recommendation on 13 of the things that the Secretary
4 might be able to do to change the current rules to make it
5 easier and which of those are secretarial authority and
6 which of those are laws. And you talked a little bit about,
7 you know, some of the cost-sharing rules and things, and it
8 seems like it would be really useful to figure out as much
9 of what that list might look like as possible so we can
10 think about it, and including leading down into the drug
11 plan side because since to enroll in a drug plan you have to
12 be in the drug plan affiliated with your MA plan, whatever
13 changes will flow on down into that part of the program.
14 And so, again, co-pay flexibility, the ability to do
15 differential cost sharing for the drugs for a particular
16 chronic condition might fit on that list.

17 But it seems like all that runs up against the
18 tension of sort of the general nondiscrimination policy.
19 You know, it's always been a thought that MA plans should be
20 able to market themselves, and we talked about this, you
21 know, because they're very good at treating people with
22 diabetes. The flip side is we want to make sure they're not

1 trying to avoid people with X or Y or Z. And in some ways,
2 this is -- you know, it's the two sides of the same coin.
3 So how do you adjust those rules without opening up another
4 problem it seems like is the real tension that we're trying
5 to work at there. So the more we could think about, you
6 know, sort of what those items might look like.

7 And then the other set of items it seems like
8 where secretarial authority doesn't help are the things
9 where -- and, Glenn, you talked about whether there was --
10 whether the label matters and whether the plan type matters.
11 Are there things -- and it seems like we've had a couple
12 examples of these where having the sole focus on one
13 population is allowing a plan to do some things that they
14 are less likely to end up doing when they have to worry
15 about not just the people with diabetes but the people with
16 cardiac problems and going down the list. And so are there
17 potential losses that we can't fix that come through a more
18 diluted focus? So those are some things that -- I guess
19 it's not really a question, but a sort of request.

20 And then on your other question that you posed to
21 us in the beginning about the sort of open enrollment or
22 flexible open enrollment opportunity, the first thing that

1 came to mind to me is what would the administrative issues
2 be. I mean, my understanding from when I've been on focus
3 groups is that the duals that have this opportunity now
4 often don't know they have that opportunity. Obviously,
5 they can learn about it, they can be told about it, and it
6 can be brought to them and they can act on it. So the
7 question of education and sort of understanding -- and there
8 was a distinction between the way you first phrase it as
9 newly diagnosed versus the current policy of sort of ever
10 diagnosed, ever diagnosed could be everybody, essentially,
11 or close to everybody. What does that do to education and
12 marketing? What does that do to the current notion of the
13 open season? You know, how do you regulate that? Do you
14 only allow the people to go into a plan that somehow has a
15 special component or is it truly wide open? And if it's a
16 special component aren't we just reinventing a SNP under
17 some different rubric?

18 So I see a whole bunch of administrative education
19 issues associated with that, which makes me skeptical about
20 the ability for that to be effective, even though the idea
21 might be appealing in some ways. And so, again, the more we
22 can understand what the administrative barriers might be and

1 sort of the education barriers that would help us think
2 through that option, I think. So I'll leave those requests.

3 MR. HACKBARTH: So you all remember how yesterday
4 I ran ahead of schedule all day long, right?

5 [Laughter.]

6 MR. HACKBARTH: Remember that. Right now we're 13
7 minutes over for this session, and we just completed Round
8 1. So I'm going to propose -- well, first let me ask a
9 question. We're currently scheduled to end at 11:45 after a
10 public comment period. If we needed to go to 12:00 would
11 that pose any big problems for people in terms of plane,
12 train reservations? Okay. We will be done no later than
13 12:00. Maybe at 11:45, but no later than 12:00.

14 So as opposed to going around one by one in Round
15 2, what I'm going to propose is that I'd like to see the
16 hands of people who have Round 2 comments that they really
17 urgent want to make at this point. And my slipping
18 "urgently" in there, I'm really not trying to, you know,
19 aggressively discourage comments. In fact, I need comments
20 so that we can figure out what to do for January. But if
21 you could really, you know, focus on being efficient in
22 terms of those comments, that would be helpful.

1 So who has Round 2 comments that they would like
2 to get in here? We have about seven or so. Okay. So let's
3 proceed with those.

4 DR. NERENZ: I think this is very quick. I'm
5 asking you to consider possibly adding a recommendation
6 about quality measures and whether this would be specific to
7 one type or all types. I know this has been done in the
8 past, and it seems to me that the recommendation is to find
9 more outcome measures, add more.

10 My new point would be just to consider a
11 recommendation that would recommend taking some quality
12 measures currently in the star system out on the basis of
13 there being not a high clinical priority for some of these
14 specific populations. I don't think we've been given a list
15 of those measures. I don't have a specific one to suggest.
16 I'm just raising the concept.

17 DR. DEAN: Yeah, just quickly, I just wanted to
18 reinforce what Scott said, that chronic disease is such a
19 big part of our challenge as a society that -- and we've
20 talked a lot about diabetes, and certainly there are a lot
21 of specialized and types of approaches that we know help
22 people that have diabetes. On the other hand, diabetes

1 rarely exists by itself. I mean, usually those folks will
2 have some other chronic disease as well, and I think that we
3 might even do harm to the care of these folks if we focus
4 too much on a few selected conditions.

5 So I think it makes good sense to -- chronic care
6 really ought to be part of the total part of coverage that
7 Medicare provides, and I don't think we should focus on
8 individual conditions that are so common.

9 Now, the possible exception to that might be -- I
10 see you listed, you know, HIV/AIDS. That is probably a
11 unique population, possibly the folks with ESRD. You know,
12 there may be a few within that, but for the most part, I
13 think a special program focused on "chronic disease" is
14 probably not appropriate.

15 DR. HALL: Similar comments, I guess. Chronic
16 disease never exists in a vacuum. These are incredibly
17 complex clinical cases for the most part. A lot of
18 decisions are made, room --

19 DR. DEAN: Weighing one against another.

20 DR. HALL: Right. Room for legitimate argument as
21 to whether highly specialized care is more effective. It
22 certainly isn't more cost-effective, that there's a lot of

1 uncertainty in all of this.

2 On the other hand, one thing I think we know for
3 sure is that the increase in the Medicare-eligible
4 population will be bringing with it an unprecedented amount
5 of chronic illness, unless there's some extraordinary series
6 of breakthroughs in medicine. But we know there's more
7 obesity, more diabetes, cardiovascular complications related
8 to that, more respiratory illnesses, et cetera, et cetera,
9 et cetera.

10 Now, the whole point of this is that these
11 diseases, for the most part, there are some reversible
12 factors and a huge number of preventable practices that are
13 not being utilized at the present time, certainly not for
14 pre-Medicare but also for Medicare patients.

15 I wonder if it would inform our discussion when we
16 come back to this if you might be able to give us a couple
17 of slides or data on a couple of things. One is maybe some
18 concrete numbers on the projections of what will the
19 composite Medicare population look like in 10 and 20 years
20 from now. I think it would be very informative. It's a
21 very different landscape than what we deal with now.

22 And the other would be, Are there any home runs

1 that you can point out to us within the C-SNP plans? I
2 don't know them that well. I'm not very familiar with them.
3 But is there something that would say somewhere here there
4 seems to be some light at the end of this tunnel that says
5 this highly specialization has some merit. It might inform
6 even how we modify recommendation 2. I'm not sure.

7 Just those two ideas.

8 MR. HACKBARTH: Bill, in answer to your second
9 question, one plan that has received a lot of publicity is
10 Care More. In fact, there are articles that have been
11 written in some journals that you could look up if you're so
12 inclined. And so they're one of the C-SNPs, in fact, I
13 think, one of the ones that has a very high rating under the
14 Medicare system.

15 MR. KUHN: Just quickly, overall, all the
16 recommendations, I'm pretty comfortable with the direction
17 we're going, Glenn, except for number two a little bit. I
18 want to think more about the C-SNP one. I was moved by
19 Scott's comment that they had been in this space but are now
20 exiting it. I listened to what Tom and Bill had to say.
21 But I want to think about that one as we go forward. So I
22 just wanted to let you know so no surprise when we get to

1 January.

2 DR. CHERNEW: So -- and I didn't have a round one.
3 I think the challenge in this area is to understand that
4 while it seems like we're restricting things, because we're
5 letting certain authorizations expire, in many ways, I think
6 our intent is to expand those things to broader populations.
7 And I think the broad philosophical line that we're trying
8 to walk is between the idea of specialization, targeting
9 things for particular people with particular conditions, and
10 allowing plans the flexibility to do that through benefit
11 design, allowing enrollment of people just when they get the
12 diagnosis, coordinating with other programs. And I think
13 that there's general -- I'll speak for me. I generally
14 support that type of specialization.

15 The concern is if you run a whole bunch of
16 different programs, so you're running the regular MA program
17 and you're running a SNP program and the SNP programs have
18 I-SNPs and D-SNPs and C-SNPs, it becomes administratively
19 complicated. So very much in the spirit of what Jack said,
20 I think that my hope would be that we could find a way to
21 administratively simplify this from the CMS perspective as
22 to what the programs are and allow this flexibility and

1 specialization. But any time you have specialization, there
2 is complication. And I think my hope would be that we could
3 do this in a way that we don't allow our opinion about the
4 average to drive out those that are good. The places that
5 are really doing good things shouldn't find recommendations
6 like this will prevent them from continuing doing those good
7 things.

8 And I think -- so I'm supportive of the
9 recommendation. I believe that I have not yet heard any of
10 the good things that we would be preventing in the way that
11 this is crafted. But if you have thoughts on that, I would
12 like to know.

13 MR. ARMSTRONG: So, generally, I just would echo
14 the sentiment that Mike just expressed. I think this
15 creates an opportunity for us to really think through how we
16 advance some of the reforms around payment policy that we
17 are constantly talking about.

18 I won't repeat what I said earlier, but I do think
19 that inside of here, this -- I support these recommendations
20 and the direction we're going. Inside, particularly, of the
21 C-SNP recommendations, this idea around eligibility to
22 enroll based on the patient's diagnosis rather than the

1 benefit type and so forth, I think is really an interesting
2 idea. I really like that.

3 And I also like, I think as a way, I think, a way
4 of dealing with the complexity, Mike, that you were
5 referring to, to really think through how within the MA
6 construct you can give more flexibility around benefit
7 design and then the development of a care model, depending
8 upon that patient's diagnosis. So I think that's a really
9 potentially powerful idea and a way in which we could help
10 the MA plans match better with the illness patterns that are
11 going to be evolving through our beneficiary groups in the
12 future. And so I'm enthusiastic about it. I feel like we
13 spend so much time on the details of fee-for-service
14 payment. I wish we could spend more time really sorting
15 through some of these ideas, and that's no surprise.

16 DR. SAMITT: So two quick comments. To echo what
17 Scott said, this is -- these recommendations, which I
18 support fully, including the modifications you added later,
19 I think are forward compatible with broader health care
20 reform and we should keep moving in that direction. For the
21 C-SNPs to recognize more specialization really isn't working
22 and getting us anything else. And for D-SNPs to really

1 encourage this alignment regarding duals, which we really
2 want to see alignment elsewhere.

3 The last comment that I want to make is about the
4 notion you heard from C-SNPs about critical mass. You know,
5 there are health care support organizations that are
6 blossoming and doing very well that are taking on sort of
7 the critical mass elements of this. So there are disease
8 management organizations that could help any number of
9 either commercial or Medicare plans manage complex
10 populations. So each plan in their own right does not need
11 to duplicate programs or services when there are support
12 organizations that these plans have access to that can do
13 that on their behalf. So, in short, I don't really buy the
14 argument that it's a critical mass reason why C-SNPs should
15 prevail.

16 DR. HOADLEY: I guess I'm still trying to sort
17 this through, and sort of like Herb, I'm trying to think
18 about the things that the last several people have all
19 talked about around the C-SNPs. It does seem clear that a
20 lot of them are accomplishing much. There may be some that
21 really are, and whether we can incorporate that -- I mean,
22 in the ideal world, the comments that Craig and Scott have

1 made make sense, that plans -- I'm not sure that all the MA
2 plans across the board are really doing a very good job at
3 doing that, and so those are the tensions, I think. So I'm
4 just putting that on the table.

5 MR. HACKBARTH: Thank you very much, Christine and
6 Carlos. Good job. And very good discussion. I'm sure we
7 could have gone on for much longer.

8 Okay. We are now moving on to addressing
9 differences in Medicare payment across different settings.
10 And you can begin whenever you're ready.

11 DR. ZABINSKI: We have a nice, light, non-
12 controversial topic to close.

13 [Laughter.]

14 DR. ZABINSKI: All right. But before starting our
15 discussion, we'd like to thank Jeff Stensland and Lauren
16 Metayer for their assistance on this analysis.

17 Okay. At the October Commission meeting, we
18 presented an analysis of narrowing or eliminating payment
19 differences across the OPD and physician office settings for
20 ambulatory services that meet a set of criteria, and today,
21 we'll review key features of those policies. Also,
22 Commissioners asked many questions at the October meeting

1 and we will address those today. In addition, we will
2 provide results of the combined effects of the policies that
3 we presented in October and equal payments across settings
4 for E&M office visits, which we recommended in our March
5 2012 report.

6 We have identified four criteria for services that
7 could have equal rates in OPDs and freestanding physician
8 offices. the first is that a service should be frequently
9 performed in a physician office, and we define this as
10 services where at least 50 percent of the ambulatory volume
11 occurs in freestanding offices.

12 The second is that the service should have a
13 similar unit of payment in both settings. This is a concern
14 because the outpatient PPS often includes much more
15 ancillary services in a unit of payment than does the
16 Physician Fee Schedule. Therefore, to be considered for
17 equal payment across settings, a service must have less than
18 five percent of its total cost from ancillaries under the
19 outpatient PPS.

20 The third attribute is that the service should be
21 infrequently provided with an ED visit when it is performed
22 in an OPD, which we define as less than ten percent of the

1 time.

2 And the final attribute is that there should be
3 minimal differences in patient severity between OPDs and
4 freestanding offices.

5 On this slide, we provide a summary of the two
6 groups of services we included in October's presentation.
7 The services in Group 1 meet all of the criteria from the
8 previous slide, while the services in group 2 meet three of
9 the four criteria but they miss on the criterion of minimal
10 packaging, as more than five percent of their total cost is
11 from packaged ancillaries in the outpatient PPS.
12 Ultimately, we have 24 APCs in Group 1 and 47 in Group 2.

13 For Group 1, we established equal payments across
14 settings for each service by setting the rates in the
15 outpatient PPS to the difference between each service's non-
16 facility practice expense rate and its facility practice
17 expense rate in the Physician Fee Schedule.

18 For Group 2, we allow for differences in
19 packaging. This results in the outpatient PPS rates for
20 each service being set equal to the difference between the
21 service's non-facility PE and its facility PE rates plus the
22 costs of additional packaging that occurs in the outpatient

1 PPS. This narrows but does not eliminate differences in
2 payment rates across settings.

3 Jack, you asked what percent of hospitals' revenue
4 from the outpatient PPS is included in the E&M office visits
5 from the March 2012 report and the APCs that are in Group 1
6 and Group 2 on this slide. We found that the E&M visits are
7 4.5 percent of total outpatient PPS revenue and the APCs in
8 Group 1 and Group 2 are 11.1 percent, for a total of 15.6
9 percent. I want to be clear, though, that this is not the
10 reduction in revenue from those policies, which we discuss
11 later, but it is the percentage of outpatient PPS revenue
12 that actually resides in those services.

13 George, last month, you expressed some concerns
14 over the idea that the OPD rate for APC 247, laser eye
15 procedures, would decline by 92 percent, to \$30. We want to
16 first point out that this is an extreme example of the
17 impact on OPD rates in the policies we discussed. On this
18 table, we have an example of an APC with more of a median
19 payment change among the services that we analyzed. This is
20 APC 698, level two eye tests and treatments.

21 The first column on the table shows this service
22 has a payment of \$66 if it is provided in a physician's

1 office, while the second column shows the payment if the
2 service is provided in an OPD. The physician receives \$27
3 and the hospital receives \$67 and the total payment is \$94.

4 The under the policies we covered in October to
5 make these payments equal across settings, the third column
6 indicates the physician would receive \$27, but the hospital
7 payment would decline to \$39 and the total payment would be
8 \$66, which is the same as when it is provided in a
9 freestanding office.

10 And George's concern over APC 247 brought us back
11 to examine the APCs in our analysis. We found that some
12 APCs, including number 247, have 90-day global periods in
13 the Physician Fee Schedule, and we also found that the 90-
14 day global periods include time for physician staff to
15 coordinate with hospitals and that cost is not included in
16 other services. And this additional staff time is similar
17 to the issue of additional packaging that occurs in the
18 outpatient PPS, which we have been able to adjust for in
19 Group 2 services. But we don't have adequate data to make a
20 similar adjustment for the additional staff time.

21 Therefore, we decided to exclude all APCs from our
22 analysis, including number 247, where more than five percent

1 of the volume is in services that have 90-day global
2 periods. And we found there are 15 such APCs, which reduces
3 the number of APCs in our analysis from 86 down to 71. It
4 also reduces the savings to the program and beneficiary cost
5 sharing from the \$1.2 billion that we mentioned in October
6 to about \$1 billion. About \$780 million of that would be
7 program spending and \$220 million would be beneficiary cost
8 sharing. The remaining results we discuss today exclude the
9 15 APCs eliminated on the basis of the 90-day global
10 payments.

11 At last month's meeting, we presented this diagram
12 that shows the relation between hospitals' 30-day episode
13 costs and their gain in overall Medicare revenue from the
14 higher OPD rates for the services in Group 1 and Group 2.
15 The point of the diagram is to illustrate that there is
16 little correlation between how much hospitals gain from the
17 higher OPD rates and hospitals' cost per episode. For
18 example, a regression of gains from higher OPD rates on cost
19 per episode has an R-square of just 0.07.

20 And Alice asked, where are the for-profit
21 hospitals on this diagram, and we indicated them by the red
22 dots on the chart. And the chart shows that among the for-

1 profits, there is little correlation between how much they
2 gain from the higher OPD rates and their cost per episode.
3 For example, for these hospitals, a regression of their gain
4 from higher OPD rates on cost per episode produces an R-
5 square of 0.11.

6 Okay. In October, we analyzed the effects of the
7 policies we presented on the hospitals that are under the
8 inpatient PPS. Part of this analysis compares the 100
9 hospitals that would be most affected by those policies to
10 the overall PPS hospital population. Relative to the
11 overall hospital population, the 100 most affected hospitals
12 tend to have much lower DSH percentages. They have a lower
13 percentage of major teaching hospitals, about the same
14 percentage of rural hospitals, and a much higher percentage
15 of proprietary hospitals. Also, we found that 53 of the 100
16 most affected are specialty hospitals.

17 And Craig asked about the profile of the 47
18 hospitals from the 100 most affected that are not specialty
19 hospitals. So when we eliminated the 53 specialty hospitals
20 from the 100 most affected, we found that relative to the
21 overall hospital population, the remaining 47 non-specialty
22 hospitals have a similar DSH percentage, a much higher

1 percentage of rural hospitals, about the same percentage of
2 proprietary hospitals, and no major teaching hospitals.

3 And Herb wanted us to look into hospitals that
4 have DSH percentages above the median for all hospitals and
5 that are among the 100 hospitals that are most affected by
6 the E&M recommendation we made in the March 2012 report and
7 among the 100 most affected hospitals we discussed in
8 October. And we find that in the E&M policy, there were 50
9 hospitals with above-median DSH percentages that appear in
10 the 100 most affected hospitals. And under the policies
11 presented in October, there are 24 with above-median DSH
12 percentages that appear in the 100 most affected hospitals.
13 And, finally, there are seven hospitals with above-median
14 DSH percentages that are in the top 100 most affected in
15 both studies.

16 Also in October, we showed you the effects of
17 reducing OPD rates for Group 1 and Group 2 at the hospital
18 level and for hospital categories, and the first column of
19 this table displays those results again. As we pointed out,
20 rural hospitals would face a greater reduction in revenue
21 than urban hospitals, one percent for rural hospitals and
22 0.6 percent for their urban counterparts. But these results

1 do not include the additional hold-harmless payments that
2 some rural hospitals would receive because of lower
3 outpatient PPS payments where the hold-harmless payments
4 provide additional revenue to small rural hospitals if the
5 outpatient PPS revenue is below the amount they would have
6 received under the cost-based system that preceded the
7 outpatient PPS.

8 And Glenn asked about the effects of including the
9 additional hold-harmless payments that would occur and the
10 second column of numbers on this table shows these effects.
11 In general, the hold-harmless payments have a nearly
12 negligible effect, but they would reduce the effect on rural
13 hospitals from a decline in revenue of one percent to a
14 decline of 0.9 percent.

15 We also looked at the effect of the additional
16 hold-harmless payments on the 100 hospitals most affected by
17 these policies. Once again, there is only a small effect of
18 the hold-harmless payments in general, but there is a
19 reduction in the number of rural hospitals appearing in the
20 number of most affected, from 29 down to 26.

21 Some Commissioners wanted to know the effects of
22 combining the policies we discussed in October with the

1 changes in payments for E&M office visits that we
2 recommended in the March report, and this table shows the
3 aggregate effects of this combined policy, including the
4 effects of additional hold-harmless payments that would
5 occur for the small rural hospitals.

6 The first column of numbers shows the aggregate
7 percent impacts on hospitals' Medicare OPD revenue. The
8 effect of the combined policy decreases hospitals' OPD
9 revenue by about 5.5 percent, and the two policies have
10 about equal impacts.

11 The second column shows the effect on hospitals'
12 overall Medicare revenue, and together, these policies
13 reduce overall revenue by about 1.2 percent.

14 On this table, we show the effects on hospitals'
15 overall Medicare revenue of the same combined policy on the
16 previous slide, but we disaggregate the results to hospital
17 categories. The effects vary widely across hospitals, as
18 ten percent would have revenue decline by 0.2 percent or
19 less, and ten percent of hospitals would have a decline of
20 2.7 percent or more. Also, rural hospitals would be
21 affected more than urban hospitals. Major teaching
22 hospitals would be affected more than other hospitals. And

1 government-owned hospitals would be affected more than
2 voluntary or proprietary hospitals.

3 On this table, we compare the 100 hospitals that
4 would be most affected by the combined policy on the
5 previous two slides to the effects on the general PPS
6 hospital population. It shows there are some important
7 differences between the hospitals that would be most
8 affected and the average overall hospital. The most
9 affected hospitals would have a much greater loss of revenue
10 from the combined policy. They tend to have lower DSH
11 percentages. They are more likely to be major teaching,
12 which is due to the effects of the E&M policy. They are
13 less likely to be rural because of the hold-harmless
14 payments. And they are less likely to be voluntary and more
15 likely to be proprietary. And they also have much fewer
16 beds, on average. Also, 30 of these most affected hospitals
17 are specialty hospitals.

18 So our next steps on this analysis include a
19 request from a few Commissioners to investigate a lower
20 threshold for one of the criterion for equal payments across
21 settings, that a service be frequently performed in
22 physicians' offices. The analyses we have done so far

1 requires that the service be performed in a physician's
2 office at least 50 percent of the time and we are currently
3 investigating the effects of dropping that threshold to 25
4 percent.

5 We are also open to analysis of any issue that is
6 of concern to Commissioners, and we are now ready for your
7 discussion and questions.

8 MR. HACKBARTH: Okay. I think George is ready
9 with his round one clarifying questions.

10 MR. GEORGE MILLER: Well, first, let me say thank
11 you for this analysis. I guess I've got a couple of
12 questions. The first one is, doesn't the hold harmless for
13 the rural hospitals expire at the end of this year?

14 DR. ZABINSKI: Yes, it does, but it has been
15 intended for sunset several times and it's always been
16 extended by Congress in one way or another.

17 MR. GEORGE MILLER: But for this analysis, we have
18 to assume it will expire because that's the current law,
19 correct?

20 DR. ZABINSKI: Correct. I was just going with a
21 request to include the hold harmless and see what the
22 impacts would be. As I showed, generally, they're not very

1 big, and obviously, because they focus on rural hospitals,
2 it has some effect on rural hospitals.

3 MR. HACKBARTH: So as Dan indicated, that was
4 something I asked for and we're not at the point of making a
5 recommendation yet. So we will likely know whether the hold
6 harmless is extended or not by the time we get to the point
7 of considering a recommendation.

8 MR. GEORGE MILLER: Okay. And I've got a lot of
9 round two questions, but let me use another one here on
10 round one. The assumption of this currently as presented is
11 that the payments to the hospital clinics will save the
12 Medicare program costs -- I'm sorry, by lowering the
13 payments to hospitals, will save the program costs. But in
14 the example we had when we had the gentleman from the Denver
15 clinic and Ron Anderson from Parkland is that they were able
16 to put together a whole network of clinics to provide better
17 care in the community. So the theory I got from that, they
18 provided great quality and that they were able to lower the
19 cost to the program for providing a medical home for the
20 patients in the community surrounding Dallas County and
21 Denver and provided a better structure. The impact of these
22 cuts may not allow them to do that and to have total

1 integrated care, which is the goal of the program.

2 So my question is, have you done the analysis that
3 just because you lower the clinic costs, would this then
4 lower the program costs for the Medicare program in the long
5 run?

6 DR. MARK MILLER: So the first thing I'd do, guys,
7 is put the correlation up.

8 DR. ZABINSKI: Right.

9 DR. MARK MILLER: And so do you want to take it
10 from here, or do you want me to?

11 MR. HACKBARTH: Well, why don't you talk about the
12 correlation, since you're better at that, and then I'll add
13 on a comment.

14 DR. MARK MILLER: Well, it's going to be very
15 brief, because that's an argument that a number of systems
16 are making --

17 MR. GEORGE MILLER: Yes.

18 DR. MARK MILLER: -- and say that it's worth
19 giving me these dollars because I'll save you money over the
20 long run. This shows that that's not going on.

21 And I think the second comment, which may roll
22 over to the Chairman, is even if you wanted to do that,

1 would this be the mechanism that you would do that. Is that
2 where you're going?

3 MR. HACKBARTH: And that would be my point, is
4 that I think we all believe that integrated care has the
5 potential to reduce total cost and we wish to encourage it.
6 Is higher outpatient department rates for all providers,
7 including those who are not engaged in integrating care, the
8 best way to accomplish that goal?

9 MR. GEORGE MILLER: Okay. I'll wait until round
10 two.

11 DR. NERENZ: As long as the slide is still up,
12 just a question of how we should interpret that, and I guess
13 I'm going back to Mark on this. It seems like the issue is
14 not that the dots, say, above 0.03 are lower. The question
15 would be, is it remarkable or interesting that they're not
16 higher than 1.0, the point being -- and this is, again,
17 right to George's point -- if these hospitals are receiving
18 a relatively high number of additional payments, would you
19 not expect, all else equal, the average on the 30-day
20 episode cost to be higher, and is it not then sort of
21 interesting and curious that they are not higher? The point
22 is not that they're lower. The point is they're not higher.

1 So I'm just asking a clarification. How should we interpret
2 this?

3 And then a very basic -- I'll just put this out
4 there. We can come back to this. The top of Slide 13,
5 average loss, 7.7 percent. That is 7.7 percent of what,
6 exactly? Is that of OPD or of overall Medicare?

7 DR. ZABINSKI: That is the average loss among the
8 100 hospitals that are most affected, 7.7 percent of their
9 overall Medicare revenue.

10 DR. NERENZ: Of overall Medicare.

11 DR. ZABINSKI: Right.

12 DR. NERENZ: Okay. Thank you. Okay. Then maybe
13 we can go back to that other figure, because I -

14 MR. HACKBARTH: So can I go back to the graph for
15 a second. So what we're relating here is the revenue from
16 OPD versus total cost and trying to examine whether there's
17 a relationship, and at least at a gross level we don't find
18 much of a relationship. Dave has offered sort of another
19 way of thinking about that.

20 I think what we know about the total cost per
21 Medicare beneficiary is that it's usually variable across
22 the country with a lot of regional, big regional differences

1 and I'm not sure how that factors into this. So it could be
2 that some of the places that have high OPD spending have low
3 total cost, totally unrelated to their investment in OPD.
4 They happen to be in areas of the country that have very low
5 cost. And everybody in those regions has low cost.

6 DR. NERENZ: But just so I make sure we're clear,
7 the vertical axis here is not overall OPD spending. It is
8 at least labeled here as gain in, what, gain in revenue
9 because of the provider-based payments. Is that -- so it's
10 not just overall OPD spending, right?

11 MR. HACKBARTH: Yes. Okay.

12 DR. BAICKER: So are you asking --

13 MR. HACKBARTH: How does that alter the question,
14 the answer to the question?

15 DR. NERENZ: Well, I guess I don't know how -- I'm
16 trying to just understand what the true dynamic -- I don't
17 know that regional variation is either reflected or
18 important in what we see here, and I also am just trying to
19 clarify the labeling of the vertical axis. I don't think
20 this is overall OPD spending, either, that it seems like
21 what I thought was captured here was -- it's labeled "gain,"
22 but it's basically the relative amount of OPD payments that

1 flow through this higher payment rate. I see Mark nodding,
2 so that's what it is.

3 MR. HACKBARTH: Yes.

4 DR. NERENZ: And then I go back to my question,
5 then. If that had the effect of raising overall program
6 spending, or in this case overall episode spending, all else
7 equal, would we not expect a shift to the upper right
8 quadrant, and is it not then remarkable that we do not see
9 such a shift?

10 DR. BAICKER: Just to make sure I understand the
11 question, I think you're saying that there's a mechanical
12 correlation built in potentially --

13 DR. NERENZ: We think so, yes.

14 DR. BAICKER: -- in which case the fact that
15 there's a component that's mechanically showing up on both
16 sides that should generate a positive correlation --

17 DR. NERENZ: Yes. Yes.

18 DR. BAICKER: -- the fact that we see it flat
19 means the parts that aren't mechanically positively
20 correlated must be negatively correlated to produce that
21 thing that's flat that should be mechanically upward
22 sloping.

1 DR. NERENZ: Exactly right.

2 MR. HACKBARTH: I think I understood that.

3 [Laughter.]

4 MR. HACKBARTH: Really. I think that was both
5 clear and helpful, Kate. I'm not being sarcastic there.

6 DR. BAICKER: [Off microphone.]

7 DR. REDBERG: We don't need to channel Cori's
8 friend.

9 [Laughter.]

10 MR. HACKBARTH: But unlike you two, I'm way out of
11 my element here in talking about this. It still seems to me
12 that what you'd want to do, if one of your variables is
13 episode cost relative to the national average, sort of
14 control for differences that may be regional or otherwise.
15 It seems like there's a lot potentially going on on that
16 bottom axis that doesn't necessarily relate to what's on the
17 vertical axis. And I want to do some sort of -- let me stop
18 there. Or am I just totally confused as a non-statistician?

19 DR. STENSLAND: So let's just start with the basic
20 of what that bottom axis is, and that bottom axis is 30-day
21 episode spending. So it's basically when you enter the
22 hospital and all that inpatient visit plus all the visits in

1 the hospital and your post-acute care and your post-acute
2 visits.

3 MR. HACKBARTH: Right.

4 DR. STENSLAND: But the inpatient visit is going
5 to be the bulk of it, and it's not going to be affected by
6 this at all.

7 MR. HACKBARTH: Right.

8 DR. STENSLAND: And then there's the visits that
9 the doctors do in the hospital during your stay. That's not
10 affected by this at all because there's no facility fee.
11 That's all wrapped up into the DRG payment. So that's not
12 going to be affected at all.

13 And then your post-acute payments won't be
14 affected at all.

15 So the only thing that's really being affected is
16 the difference between the post-discharge visits, like two
17 weeks after you get discharged from the hospital, you go see
18 your general practitioner, and do you see that person in an
19 office-based or a facility-based practice. So there will be
20 that \$30 difference or whatever it is. But that \$30
21 difference is just not going to be much relative to the
22 variation you see in this --

1 MR. HACKBARTH: In the inpatient costs.

2 DR. STENSLAND: -- in the episode spending.

3 MR. HACKBARTH: Sort of dominate here.

4 DR. STENSLAND: And then there is the regional
5 question, so we also did this two different ways. One way
6 was to say, well, how much does this 30-day episode spending
7 relate to basically how often you're seen in an OPD rather
8 than a physician's office, is basically what we're asking.

9 MR. HACKBARTH: Uh-huh.

10 DR. STENSLAND: Just raw, on average, is what
11 we're seeing here.

12 Another way I looked at it is to say, well, let's
13 look at what is the episode spending for you relative to
14 everybody else in your State. So is the people that are
15 high in their State tend to have high relative -- and again,
16 you see the same, almost no relationship whatsoever. So you
17 can pull out the regional effect and you still get almost
18 nothing.

19 There is that mechanical negative correlation that
20 you would expect, but it is such a small magnitude, I just
21 don't think it's going to move anything.

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

1 Jeff.

2 Peter, clarifying questions.

3 MR. BUTLER: So I really appreciate the staff
4 trying to assess the impact and provide additional data. It
5 suffers a little bit, because without the narrative, it's a
6 little hard to understand some of this. I should be an
7 expert on this and I feel like I still don't understand some
8 of it.

9 But on Slide 6, so we have listed two months ago,
10 I think it was the top 25, right, in the text? The top 20?
11 But this says there are now going to be 71 in the analysis,
12 it's suggested, right?

13 DR. ZABINSKI: Yes.

14 MR. BUTLER: I'm just trying to clarify.

15 DR. ZABINSKI: Yes.

16 MR. BUTLER: Okay. And then they have the --
17 you've shown the eye example, a different one on the
18 previous page, but so much was tied up, if I remember right,
19 in, like, the top three were half of the echocardiograms and
20 largely around heart and pain management and we still kind
21 of haven't -- and I said, boy, I kind of felt if we
22 understood that, particularly how it related to these

1 smaller for-profit probably heart and orthopedic hospitals,
2 we would have a better understanding of what's going on.
3 And then part of that is, too, are the physicians -- because
4 this all started with employing physicians too rapidly
5 because this was a mechanism to kind of help fund the
6 salaries. And I'm not sure that that's going on in the
7 smaller specialty hospitals. I'm not sure there is
8 employment, yet they're getting the facility fee at a -- I
9 just don't quite understand the dynamics in this, not the
10 E&M codes, but these set of tests.

11 And I don't even know if I'm asking -- I'm
12 obviously not asking the question quite right, but so much
13 of these APC volume and where the reductions occurred in
14 relatively few APCs that seem to be now skewing more towards
15 the for-profit smaller specialty hospitals, I just don't
16 quite understand what is happening there, and this data
17 doesn't quite get at it. Can you answer that -

18 DR. ZABINSKI: Well, would it be helpful -- I'm
19 wondering if it would be helpful if we looked just at the
20 cardiac imaging codes, APCs. As you pointed out last time,
21 they were the top two and they accounted for roughly, you
22 know, half-a-billion dollars in savings, program plus

1 beneficiary. If we looked at which hospitals, you know,
2 provided most of those services, or which would be the most
3 affected by the payment changes, and if we saw -- it sounds
4 like you're asking, is it really going to be the cardiac
5 hospitals that would be affected by this policy proposal or
6 other types of hospitals. So if we looked at it by category
7 --

8 MR. BUTLER: Well, that might help. But it did
9 strike me, like, half of the savings are coming from, like,
10 two or three APCs, and yet we're looking at 71 of them and
11 all this detail. Understanding those in particular, I
12 think, would help understand the bigger picture.

13 DR. MARK MILLER: There are two things that
14 occurred to me, and you were on to one of them, Ariel. What
15 if you ran this analysis for just those? That could be one
16 way to cut it. And the other way to cut it -- and I don't
17 know whether we're taking them out or just looking at them,
18 but I'm going to say it this way: take out the specialty
19 hospitals and see what it looks like. They were my two --

20 MR. BUTLER: That might be good, too.

21 DR. MARK MILLER: -- gut reactions to what you
22 said.

1 MR. BUTLER: Yeah, because one of my other
2 comments would be, you know, we look at the top hundred.
3 Well, if a bunch of them are these really dinky things, it's
4 a small part of the total hospital. So even those they're
5 smaller, it just explains part of the total spend that is
6 being impacted by the policies. I know there are many, many
7 ways you could slice the data, and you've been trying to do
8 that. But I still don't feel I quite have a handle on
9 what's going on on these high-volume APCs where the impact
10 will be the greatest.

11 DR. ZABINSKI: Some of the obvious things, you
12 know about them, you know, relative to the -- in the list of
13 71 APCs, they do have a high volume, and they also start
14 with a very high, relatively high payment rate. So, you
15 know, a lot of money as a share of the total is tied up to
16 them to begin with, and then you drop their rate, and they
17 do have -- in terms of their magnitude of their drop in
18 their rate is large. The percent drop is not unusually
19 large, but their magnitude is, and that's what really
20 matters here.

21 And we also do know that there's a fair amount of
22 shift in these APCs from free-standing offices to OPDs over

1 the last few years.

2 MR. BUTLER: I suspect, and I think most --
3 anecdotally you hear that the reductions in general for
4 cardiologists and how they're being paid and technical,
5 professional, et cetera, led to this rapid employment and
6 particularly in cardiology, and this was a safer haven that
7 provided more money than the previous model. And the more I
8 think we kind of understand the dynamics around, for
9 example, heart as just an area, I think the more we can
10 target this in the appropriate way to get at an underlying
11 issue.

12 I think it's a very different scenario, for
13 example, for primary care or maybe some of the other areas
14 that are less intense in some of these tests but have a lot
15 of E&M codes, for example.

16 MR. HACKBARTH: This is helpful, Peter. So the
17 impact analysis is showing a combination of three things.
18 One, as Dan says, these are relatively high priced -- these
19 cardiac things, they're a significant amount of money.
20 There's a lot of volume and a relatively high price. We've
21 got this move that Peter described that has occurred from
22 physician office into OPD, and then the specialty hospital

1 numbers, this is also an area where there has been a lot of
2 development of specialty institutions, the cardiac, and so
3 those three factors are showing up in these impact analyses.

4 MR. BUTLER: Now, there aren't new -- a lot of new
5 physician-owned specialty hospitals, but there have been
6 barriers to making that occur. So --

7 MR. HACKBARTH: But a lot of them existed before
8 the moratorium.

9 MR. BUTLER: Right. So there are different
10 dynamics going on here.

11 And then on Slide 13, I just think we need to --
12 this would be very tricky to kind of bring together what we
13 had in a previous recommendation, which was controversial by
14 itself, and then layer on another one and look at the
15 impacts on, you know, the 7.7 percent is a pretty big whack
16 of your total revenue. So I don't know how we need to start
17 thinking ahead. How do you kind of put that in the context
18 of the other reductions that PPACA has or updates? I'm just
19 trying to anticipate what obviously will be a tough
20 discussion to try to balance all of these things, because
21 it's hard to -- it's one thing to take an isolated issue and
22 kind of a principle that makes sense and then fold it into

1 the other dynamics of everything else that we do when we
2 make our recommendations and updates.

3 So I don't have a recommendation today other than
4 to suggest that obviously some institutions would be -- if
5 you did this all in one year, the way the data lays out, it
6 would be pretty darn tough.

7 MR. HACKBARTH: This is the combined effect of E&M
8 plus the new ones.

9 DR. ZABINSKI: That's correct.

10 MR. HACKBARTH: On the E&M calculation, does that
11 include our hold harmless features in there?

12 DR. ZABINSKI: Yes.

13 MR. GEORGE MILLER: That assumption is that hold
14 harmless will continue beyond this year in these numbers.
15 Is that correct?

16 DR. ZABINSKI: Correct.

17 MR. HACKBARTH: I'm actually talking about a
18 different hold harmless. I'm not talking about the hold
19 harmless in under-100-bed rural hospital. I'm talking about
20 the --

21 MR. GEORGE MILLER: I'm sorry.

22 MR. WINTER: Stop loss?

1 MR. HACKBARTH: Stop loss.

2 DR. ZABINSKI: It does not include any sort of
3 stop loss in it.

4 MR. HACKBARTH: Okay. So even on the E&M stuff,
5 those numbers that factor in here don't include our stop
6 loss --

7 DR. ZABINSKI: No, it does not.

8 MR. HACKBARTH: Okay.

9 MR. GEORGE MILLER: Well, if I could just follow
10 up, did we model -- I mean, the current -- if I remember
11 correctly from last year, the margins in HOPD are negative.
12 Have we calculated what this impact would be on those
13 margins as well?

14 MR. HACKBARTH: We can do that.

15 DR. ZABINSKI: Yeah.

16 DR. MARK MILLER: When we get into that next
17 month, George.

18 MR. GEORGE MILLER: Yeah. I would love to see
19 that.

20 DR. MARK MILLER: Actually, I just wanted to
21 finish off where I think Peter was. So the 7.7 is for the
22 top 100, just to make sure that we're tracking through that.

1 And what I can't remember on this one is when we do the
2 Group 1, Group 2, that top 100 had a lot of specialty
3 hospitals in it.

4 DR. ZABINSKI: Correct.

5 DR. MARK MILLER: And when you put it together
6 with the other policy?

7 DR. ZABINSKI: Thirty.

8 DR. MARK MILLER: Okay. I'm sorry. I had
9 forgotten.

10 MR. BUTLER: So, Mark, though, another way to look
11 at it is Slide 11, instead of saying, okay, the top hundred,
12 there is, you know, on average 5.5 percent reduction in
13 outpatient for hospitals in general and a 1.2 percent on
14 their total Medicare revenue, which is the average impact.

15 MR. HACKBARTH: But this also, I assume, does not
16 include the stop loss on E&M.

17 DR. ZABINSKI: No.

18 DR. REDBERG: Just to follow on from what Peter
19 said, besides looking at the non-specialty hospitals, for
20 example, on the top 100 and also in the most affected, you
21 would also look at the specialty hospitals specifically?
22 Because, obviously, it's a very diverse group of hospitals

1 that would be affected, or more affected, with very
2 different characteristics. So I just think it would be
3 interesting to break it out or helpful to break it out.

4 DR. ZABINSKI: [inaudible].

5 DR. REDBERG: And just the other point. Is it
6 possible to also, besides looking at the costs like you gave
7 us in Slide 7, to look at some of the quality measures, the
8 performance measures that CMS measures for inpatients? For
9 example, for the cardiac specialty hospitals, we have a lot
10 of inpatient performance measures. Can you compare quality
11 as well as costs and see if there's any correlations between
12 these payments and types of hospitals and quality?

13 DR. ZABINSKI: Sure.

14 DR. REDBERG: Thanks.

15 DR. HOADLEY: Just two small ones, and thanks for
16 the various responses from the previous questions.

17 On the answer to my question, the 11.1 percent on
18 this second group, was that before -- the total bucket that
19 was affected, was that before or after you made the APC
20 global period exclusion of those additional APCs?

21 DR. ZABINSKI: That is after.

22 DR. HOADLEY: Okay.

1 DR. ZABINSKI: Yes, after.

2 DR. HOADLEY: And I don't think you've given us
3 this, but it's sort of underneath several of the graphics.
4 How correlated are the two policies in their impact on
5 hospitals? I get a sense that they're affecting kind of
6 different groups, but I'm not sure I'm actually seeing
7 anything that shows that. Or maybe we don't know that right
8 now.

9 DR. ZABINSKI: Yeah, I did not look at that. Just
10 going by what I know and which hospitals fall in and where
11 they fall in the distribution, I would guess that it does
12 affect different groups of hospitals.

13 DR. HOADLEY: I mean, the Slide 9 that talked
14 about, you know, the DSH statistic sort of implies that the
15 list at least of the top 100 are different, but --

16 DR. ZABINSKI: That's definitely true, yes. The
17 top 100 list, there's not much overlap, but I think in
18 general --

19 DR. HOADLEY: But it would seem like it would be
20 useful to know if -- you know, because if the two policies
21 are reinforcing the impact on -- as opposed to one hits some
22 and the other one really hits, it's kind of an uncorrelated

1 set that's just useful to know, it seems like.

2 MR. ARMSTRONG: So I'm not sure exactly to ask
3 this, but we're looking at estimates that would reduce
4 revenues to hospitals by 5.5 percent or 7.7 percent for the
5 top 100. The question I have is: Given payment policy and
6 the changes that we've seen that have inspired these
7 policies, how quickly did the revenues go up by that much
8 over the last few years? Has this been a gradual thing over
9 the course of a decade? Or is this just...

10 MR. WINTER: Last year in our March report we
11 showed that the shift of E&M office visits from physician
12 offices to outpatient departments has been accelerating.
13 Correct, Dan?

14 DR. ZABINSKI: Yeah.

15 MR. WINTER: It has been accelerating over the
16 last couple years. We also looked at a couple of cardiac
17 imaging codes, like echocardiography and nuclear medicine,
18 and those have also been accelerating over the last couple
19 of years.

20 We have not looked at all of the 71 APCs in Groups
21 1 and 2, but that gives you a flavor for what we're seeing
22 in some of the really higher-volume, high-payment APCs where

1 there are big differences in payment rates.

2 MR. ARMSTRONG: Yeah, and I ask that because I
3 think Peter raises a good point, that on the one hand
4 there's kind of the discipline around the policy and does
5 the policy make sense. But then there's also the impact
6 operationally on changing the policy. But let's not forget
7 that while we would be taking revenues out, those are brand
8 new revenues that have been coming up. And so let's just
9 not forget that, too. If that's the right way to think
10 about that.

11 DR. COOMBS: So I was interested in if you were
12 able to get at a granular level with the disproportionate
13 share hospitals and the overlap with academic institutions
14 to see what the impact would be, especially for, you know,
15 inner-city urban teaching centers in terms of, you know,
16 their margins might be very different than the for-profit.
17 Thank you very much for answering my question, too, about
18 the distribution correlation.

19 DR. ZABINSKI: We haven't done anything on really
20 digging down to that level that you're asking about. That's
21 something we can do.

22 DR. COOMBS: My concern is the disproportionate

1 share hospitals that actually have a major mission for
2 teaching in the GME slots that are appropriate for what the
3 government has slated and what's necessary for them to
4 actually meet the demands of their surrounding communities.
5 Some of the institutions have actually increased the number
6 of GME slots on their own to kind of meet the needs of their
7 community, and so what would this do to them. And in that
8 same vein, we made an accommodation when we did E&M codes
9 for DSH hospitals, and I was wondering if we had been
10 thinking along those lines for this as well.

11 MR. HACKBARTH: That's certainly an option to do
12 some sort of special protection for the above average
13 disproportionate share hospitals.

14 MR. WINTER: And for the Groups 1 and 2 that we
15 talked about in October, Dan did model a limiting -- a stop-
16 loss policy similar to what we recommended for E&M, and I
17 think the impact was minimal, very minimal. Right?

18 DR. ZABINSKI: Yeah. It's much smaller than what
19 the impact would be under the E&M policy we recommended last
20 March.

21 DR. COOMBS: So could you do that as well for the
22 teaching institutions just to see the impact? Because I

1 think we just focused on the disproportionate share
2 hospitals.

3 DR. ZABINSKI: Yeah?

4 MR. HACKBARTH: I want to make sure I understood
5 what you said. So you're saying that for this second group
6 of services that the impact on the disproportionate share
7 hospitals is much smaller than for the E&M services.

8 DR. ZABINSKI: That's correct.

9 MR. HACKBARTH: Okay. Clarifying questions?

10 MR. KUHN: Yes, just one. Page 5 or Slide 5, just
11 a quick question to make sure I understand on the numbers.
12 So let's just take that top line, the fee schedule rates.
13 So the \$66 includes both the professional, the practice
14 expense and the malpractice. And then as we move forward,
15 then it goes to the 27. Is that the just the professional
16 and malpractice only?

17 DR. ZABINSKI: That's the three parts. It's the
18 professional, it's the malpractice, and it's the facility PE
19 for the physician.

20 MR. KUHN: Okay. In the 27.

21 DR. ZABINSKI: In the 27.

22 MR. KUHN: Okay. It would be interesting as we

1 look forward that, you know, if you think about this, you're
2 basically, you know, going into a hospital-based facility,
3 so it basically is the hospital's machinery, it's the
4 hospitals supplies, et cetera. So I would be really
5 interested to look at it as how we really separate that the
6 physicians are getting paid for what they are doing, that
7 is, you know, their professional, their malpractice, and
8 then the facility charges are separate. We might have a
9 different look at this if we had it that way. It just seems
10 like we're providing payment for services that aren't being
11 rendered, if you follow my logic here.

12 MR. WINTER: Would it be helpful if we broke down
13 the total fee schedule rate by the three components --

14 MR. KUHN: It might help us look at --

15 MR. WINTER: -- so PE, PLI, and work? Is that
16 what you're asking?

17 MR. KUHN: Yeah, I mean -- you know, I guess if --
18 well, I guess it depends where the locus of the practice
19 expense is. If it's all in the outpatient in the hospital-
20 based, then that's where all of the expense is. Or in the
21 example you have here, the physician is getting not only the
22 physician rate but also practice expense when they're using

1 the hospital's equipment. It's kind of a little bit what
2 George was talking about at the last meeting. It would be
3 interesting if we could break it out differently just to see
4 what it looks like.

5 MR. WINTER: Right, so -- and we can certainly
6 break it out in greater detail as we did with the E&M stuff
7 last spring, last winter and spring. There are going to be,
8 even for services performed in a facility, there are still
9 going to be some practice expense for the physician for
10 costs related to billing and if -- these are not 90-day
11 globals, but for billing and for perhaps coordinating the
12 service in the hospital, that sort of thing. So there's
13 going to be some -- there's going to be some costs --

14 MR. KUHN: Some costs.

15 MR. WINTER: And also just because of the way the
16 formula works for allocating the indirect practice expense,
17 that's based on the work and the direct practice expense
18 input. So even for codes that have no direct practice
19 expense inputs but do have work, so like surgical procedures
20 that are done just in the hospital, there's still going to
21 be indirect practice expense costs allocated for those
22 procedures. So, you know, there's always going to be some

1 practice expense on the facility side, even when the
2 procedure is always done in a hospital.

3 MR. KUHN: Yeah, and maybe the easiest way is to
4 kind of break out those three components so that at least we
5 can just see what they look like.

6 MR. WINTER: Sure.

7 MR. KUHN: Thank you.

8 MR. HACKBARTH: Round 2 [off microphone].

9 MR. GEORGE MILLER: Yeah, Herb covered one of my
10 Round 2 because that was the question I had last time, if
11 you remember, what component of the fee schedule for the
12 physician and then reduce the proposal -- last time it was
13 reduce that rate down to \$30, and I commented about that.
14 But to that point, once we break that out, it would be
15 interesting to look at that.

16 The other thing is you mentioned that the
17 physician office has to coordinate with the hospital. Well,
18 it looks like we're going to reduce our payments, but I
19 would imagine the same coordination would take place and the
20 same --

21 MR. WINTER: That's really an issue for the 90-day
22 globals, which we took those out for that reason, because

1 there are these higher costs, higher staff costs associated
2 with coordinating and scheduling the service in the
3 hospital. That's probably not going to be true for the
4 zero-day globals or the 10-day globals. But we can look
5 into that.

6 MR. GEORGE MILLER: Okay, great. And then just
7 for Round 2, I'm still concerned that -- although Scott
8 raised the question about how long we have been getting
9 that, and you said and quoted that there's been a recent
10 shift in certain areas, but for some of us, especially rural
11 hospitals, that have had employment of physicians and rural
12 clinics for a long time, the impact on the previous slide
13 shows that it's going to be pretty hefty on the rural
14 hospital. This is not a recent phenomenon for us.

15 And so, again, I'm concerned. Part of the
16 challenge for us, again, is the standby capacity that a
17 physician office does not have and that we have. Even our
18 infrastructure, especially in that HOPD, is in the hospital
19 versus a separate physician office, which I understand that
20 argument still requires us to do things that a physician
21 office does not have. And God forbid, what we just
22 witnessed and when I was in Jasper, Texas, when we had the

1 hurricane, everyone came to the hospital. Nursing homes
2 couldn't go anywhere else. They came to the hospital. And
3 that's part of that standby capacity. It's not just to have
4 an emergency room, but it's also to have a standby capacity
5 in case of disasters and floods and hurricanes or anthrax
6 threats. They come to the local hospital. So in my mind,
7 that's what some of these fees address.

8 We have a different mission than a physician
9 office, and it looks like what we're doing and discussing
10 has a limiting impact on what we first proposed, but I am
11 very concerned about the direction and the total impact.

12 I mentioned, and you said you would look at it,
13 the hospital outpatient departments have negative margins,
14 and I would love to see what the impact of this percentage
15 would be on those margins already.

16 DR. MARK MILLER: I just want to say one thing.
17 George, I do appreciate your comments last time. I think it
18 did lead to a deeper dive on this, and we've come to a
19 different place as a result of that. So I want to thank you
20 again for what you said last time.

21 [Off-microphone comments and laughter.]

22 DR. NERENEZ: This is a very broad question, I

1 think, about MedPAC philosophy and history perhaps, and I
2 ask it in that way because I'm new to this. If we just look
3 at the slide that's up, you know, you compare 94 and 66,
4 what's being considered here is dropping from 94 to 66. Or
5 perhaps if we look at the current thing, it's saying, you
6 know, what are hospitals doing with the difference between
7 66 and 94? And I can imagine many different scenarios, but
8 at least two clearly different ones. One is that the extra
9 \$28, if I'm doing my arithmetic right, essentially just goes
10 straight to the bottom line as profit or perhaps as
11 executive perks on the way to the bottom line, and we could
12 decide that maybe that's not such a good thing.

13 But, on the other hand, in other environments,
14 that could support community outreach. It could support a
15 safety net mission. It's basically an indirect subsidy of
16 other perhaps socially desirable things.

17 So my question is, in general, do we like indirect
18 subsidies like that because -- well, just -- but at least
19 I'd like a detailed answer.

20 DR. CHERNEW: [off microphone].

21 DR. NERENEZ: And I could think that the answer
22 could be simply because those area politically acceptable

1 ways, things that can pass to accomplish socially desirable
2 things. Or, obviously, the alternative is that as a matter
3 of principle, we do not like those things because they hide
4 or they mask or they somehow should be replaced by things
5 that are more specifically given their proper name. So I'm
6 simply asking, is there a broad philosophy that is being
7 applied here?

8 MR. HACKBARTH: Yes, there is, and it's to use
9 direct targeted subsidies to achieve policy goals, not put
10 out broad payments and then hope good things are done with
11 them.

12 DR. CHERNEW: I'm sorry. I didn't mean to
13 interrupt you before. I think the other thing to note is
14 the indirect subsidies have all other types of indirect
15 effects and distorting effects on prices and drive people in
16 ways that you might not want them. So it's not simply, oh,
17 we're giving you this money in some indirect way. We're
18 distorting relative incentives in ways that could really
19 affect behaviors in ways that we don't want. So it's not
20 just the indirectness. It's the price right versus price
21 wrong kind of thing where people get their care, where they
22 don't get their care, and a whole bunch of other

1 distortions, as opposed to just the money.

2 MR. BUTLER: Yeah, I think, Mike, you were the one
3 that last time said, you know, you aggressively apply a good
4 principle in one place, and then it balloons and pops out
5 somewhere else with some unintended consequences -- or
6 consequences that you have to deal with, and that's a little
7 bit of what we're dealing with here. And I've been
8 supportive of the direction that this has been headed, but I
9 angst deeply over those institutions that have a -- they
10 tend to be more urban, they tend to be the larger safety net
11 teaching hospitals that are providing access for patients in
12 these clinics that wouldn't otherwise occur. And just to
13 bring it a little more to light in a more personal way is
14 that, for example, in Illinois, we're now up to -- we're 25
15 percent of the residents, citizens -- 25 percent of the
16 people in Illinois are on Medicaid. And if you're not a
17 safety net institution as defined by the state, you are
18 looking at hospitals now that have 240 days in receivables.
19 Now, Illinois is unusual. We have a number of these clinics
20 on our campus, open for business to Medicaid patients to
21 come in and be served, to dual eligibles, to others, and you
22 have -- that's in contrast to some of these other private

1 offices that are off campus, may even be actually in some of
2 the same systems as the ones that have the on-campus ones,
3 that are suddenly getting new money for an office that
4 doesn't look any different than it was yesterday.

5 And then you even have some prominent,
6 progressive, integrated systems that we tout that may not
7 have much hospitals in their integrated system at all, and
8 also have a very low percentage of the Medicaid compared to
9 the population that, you know, overall is on Medicaid in the
10 -- so I struggle mightily with -- it is a subsidy, but I
11 struggle mightily with that very tenuous source of care for
12 particularly the Medicaid that -- where the doors aren't
13 open -- and some of these ones, by the way, if you could
14 determine if they flipped or they become -- they don't even
15 take Medicaid in their practice. The hospital may through
16 the emergency room, but some of these do not even take
17 Medicaid. If you could have a switch that says do you take
18 Medicaid or not -- and I know I really am mixing Medicaid
19 with Medicare, but -- and we did a pretty good job last year
20 of taking into account disproportionate share and phasing as
21 a way to kind of get at this. I wish we could get a little
22 bit more sophisticated around that to make sure we don't

1 have unintended consequences.

2 Thank you for listening to my passion.

3 MR. HACKBARTH: Peter, can you go one step
4 further? The DSH protection was an effort to get at this
5 issue. What might be different or better than that?

6 MR. BUTLER: Well, throughout the -- it would
7 really be interesting to know if these clinics are open for
8 Medicaid business or not. And I don't think there's a way
9 to do that, and you couldn't say -- they say, sure, I'll
10 take somebody that came through the ER, I'll do a follow-up
11 visit in my office. But if you looked at the underlying
12 nature of the business, they're really not in the Medicaid
13 business.

14 MR. HACKBARTH: Yeah.

15 MR. BUTLER: And I find even in some teaching
16 place some reluctance, they say we're going to cap, no more
17 Medicaid, for example. So you just have to think about what
18 might be other than DSH to get at it.

19 MR. HACKBARTH: So what I hear you saying is that
20 you think there are high DSH hospitals that have minimal
21 Medicaid commitment or declining Medicaid commitment.

22 MR. BUTLER: You could find a mismatch between the

1 DSH and the hospital versus what is occurring in the
2 clinics. I could site a couple of place in teaching even
3 that say no more Medicaid, we're not -- even though it's
4 coming through the ER.

5 MR. HACKBARTH: Yeah, let's think some more about
6 what the variables might be that could replace or supplement
7 DSH as a tool.

8 DR. BAICKER: Following up on the issue Dave
9 raised, I think we have -- ought to have a strong preference
10 against subsidizing some activity on the margin that's not
11 the activity that we want because it happens to
12 disproportionately benefit entities that are engaging in a
13 different activity that we want. I think we can -- I think
14 figure out where the impact of this is concentrated is
15 really valuable, and I can see an argument for smoothing the
16 transition more carefully for hospitals or departments that
17 are less able to weather the transition. But in the long
18 run, I think we have to move towards a system where we are
19 not using this very funny mechanism to subsidize an activity
20 that we don't think is particularly beneficial for patients
21 because it might have this correlated component that we
22 think is good.

1 DR. HOADLEY: I would second that sentiment, and I
2 guess the only thing I would add is that in the discussion
3 yesterday we had -- because of our time constraints on the
4 particular policy issues we were addressing, we had to say,
5 yes, we have to make a decision on one thing now, and the
6 targeted thing we will make a commitment to get to. To the
7 extent that we don't have the same time commitment, you
8 know, thinking about how to do them more in concert at the
9 same time seems valuable.

10 DR. SAMITT: I support the direction this is
11 heading. In fact, I would argue it hasn't gone far enough.
12 And so my comments are about the Next Steps slide. You
13 know, where should additional analyses be focused? We
14 currently looked at 50 percent. We talked about
15 investigating the 25 percent. I'm even wondering if the 25-
16 percent analysis will miss something. And so recognizing
17 the data's not available for Medicare Advantage, I guess the
18 question is: Can we look at another source like the
19 performance of the Pioneer ACOs with the lowest total cost
20 of care or the shared savings program ACOs with the lowest
21 total cost of care, and look within those organizations at
22 this question, this issue of what's being done in hospitals

1 versus what's being done in physician offices. I don't know
2 whether that data is available, but I'd be curious whether
3 it reveals additional opportunities that some of these high-
4 performing systems are exploring today.

5 MR. HACKBARTH: [off microphone] for Medicare
6 Advantage?

7 DR. MARK MILLER: I cannot believe how quickly
8 he's integrated right in [off microphone].

9 MR. ARMSTRONG: Thank God he did that, because I
10 was about to do the same thing.

11 [Laughter.]

12 DR. SAMITT: That's the advantage of going first
13 [off microphone].

14 MR. ARMSTRONG: I'm not sure we should be sitting
15 so close together, actually, but I was going to make a very
16 similar point.

17 First, actually I just wanted to say, you know, I
18 really understand the concerns that Peter has been
19 representing, and I think they are legitimate concerns. I
20 just don't think this payment policy is the way to deal with
21 those. And I like the direction that we're going with this
22 work. I think we should challenge, just as Craig said,

1 whether that 50-percent standard of services still remaining
2 in the physician's offices is the right standard, because so
3 much has already migrated, I think that's a conservative
4 standard.

5 I also just would say let's recognize that the
6 concern we have about just sort of the issues with the
7 policy for Medicare payment is one that's not limited to
8 Medicare. So much of commercial provider payment is based
9 on Medicare payment policy. And so this has an implication
10 that extends quite beyond just the Medicare program.

11 And I would just add a personal anecdote, and that
12 is that my organization recently sent letters to all
13 hospital providers in our network disclosing -- or informing
14 them that as of January 1st, we are no longer paying the
15 facility fees for the E&M codes for all patients. So we
16 just -- I don't just articulate my point of view here at
17 MedPAC, but we are actually in practice making these
18 changes. We're the only plan in the state that's doing this
19 so far. I know it will be controversial, but I believe it's
20 the right thing to do.

21 DR. CHERNEW: I only articulate my views here in
22 MedPAC.

1 [Laughter.]

2 DR. CHERNEW: I don't have anything else to do.

3 But, anyway, that's wonderful -- that's good to
4 hear, and let me say that it's important -- I guess with
5 Kate. I think it's important to realize that this fits into
6 a bunch of other things we do, like the updates and other
7 types of things. So I very much think that George's point
8 about standby capacity and stuff is valid. It's just paying
9 for standby capacity by putting incentives for people to get
10 services in places where it might not be the right way to
11 get services isn't right way to pay for standby capacity.
12 And I do think that we run the risk of undervaluing some of
13 the things hospitals do if we try to pay for every little
14 service at the margin because there's broader average things
15 that they do, and we need to take that into account without
16 a doubt in our payment system. And certainly we need to
17 worry about the populations they serve and the overall
18 health of our hospitals, which are essential.

19 It's just doing that in a way that distorts prices
20 strikes me as fundamentally the wrong way to do it, and if
21 we move to other payment models, it will become a little bit
22 easier, I think, to get right. But, nevertheless, in the

1 payment models that we have, I think we have to start by
2 trying to get the incentives right at the margin and not
3 undervaluing things that institutions provide that we value.

4 So I very much think that David's question was the
5 right question, and I, again, very strongly think that
6 indirect subsidies are a disaster, and if we really support
7 something, we should be able to stand up and say we support
8 standby capacities or extra care for these populations and
9 those types of things.

10 DR. NAYLOR: So I also support the direction of
11 these proposed -- of this policy change. I think that the
12 thing that has guided all of us all of these years,
13 depending on how long you've been on the Commission, is that
14 set of principles that -- and one here is equal payment for
15 equal services. I think that for the 71 APCs you're talking
16 about a \$1 billion potential savings, 780 to the program but
17 220 to the beneficiaries. And I think we've also had a
18 principle of really being sensitive to the impact of these
19 payment policy directions on the beneficiaries' pocketbooks
20 as well.

21 So I think that's it.

22 MR. WINTER: The other thing I just want to point

1 out is beyond -- we didn't say this in this presentation,
2 but beyond the reduced coinsurance, this would also reduce
3 Part B premiums for beneficiaries because they're paying
4 part of the payment for that.

5 DR. COOMBS: There's a couple of subsets, and it's
6 almost like -- as I listened to the discussion around the
7 table, I always think of the common thing we say in
8 Massachusetts: Not one size fits all.

9 Part of my concern is around the vulnerable
10 population, around the graduate medical education, and what
11 we do in terms of our trainees and how this would impact
12 them.

13 But the other piece of it is in practice, having
14 been an internist and now an anesthesiologist and ICU
15 doctor, I know that some procedures are done in the hospital
16 because there are certain things that need to be done a
17 little different than a doctor's office can provide. And so
18 that's one entity.

19 And the second entity is if you're in the hanza
20 coots [phonetic] where George lives, you might not have the
21 office of support, and you may feel that your comfort level
22 for doing certain things in your office invokes some element

1 of safety. And so I don't know how we could enter into this
2 discussion of the appropriateness of when to do it there and
3 not be penalized for it in the sense that -- I'm thinking
4 right now of an echocardiogram that's done in the hospital
5 and they call for one of us to come down and do anesthesia,
6 give a little propofol for someone with a low ejection
7 fraction and there's all these other problems that are -- I
8 was looking at \$39, I said, Oh, my goodness. It's a very
9 complex arrangement with a lot of co-morbid conditions.

10 So I think there's some reason for these things to
11 be done in the hospital, and there are the things that could
12 be done in the office, but it might be that it may be done
13 safer there, and the patient may go home right afterwards as
14 well.

15 So I'm thinking about that. I'm thinking about
16 just the whole nature of what we do for large
17 disproportionate share hospitals. You know, as Peter was
18 talking, I was thinking. You need a marker of missionary
19 dedication in terms of being dedicated to your community,
20 the surrounding community. And if you had to look at the
21 surrounding community that a hospital is located in, you
22 know, you have some hospitals that are located in

1 communities that are the vulnerable populations. I don't
2 know how we can get our arms around it, but I think that's
3 where we should go. I think that's a healthy way to
4 approach it.

5 MR. HACKBARTH: On both of those issues, I think
6 there's broad agreement, and so when we did the E&M version
7 of this, you know, we tried to build in protections for the
8 high disproportionate share hospitals, or some modification
9 that Peter will help us come up with could be included here
10 as well.

11 On the issue of patients having different risk
12 profiles and some procedures that are done either in the
13 physician office or hospital outpatient departments, that
14 the higher-risk people tend to migrate to the outpatient
15 department. There, again, you know, that's a legitimate
16 issue that we're trying to address. That was one of the
17 reasons why we started with E&M services because we thought
18 that those issues tended to be less significant. And you'll
19 recall in this case, with this new batch of services, what
20 we're trying to do is look at patient severity across
21 settings and identify things where the severity levels are
22 similar.

1 So my basic point is, you know, the issues you're
2 raising are valid ones that we're trying to wrestle with and
3 address, so help us do that.

4 MR. KUHN: Just looking at this through the lens
5 of kind of the criteria that we've been using on other
6 conversation over the last day and a half, let me start with
7 access. And I think Peter said it very well, and I think
8 the same kind of conversation came up when we were doing the
9 E&M. I think there's an issue here that we have to think
10 pretty hard on the access equation, so I think that
11 conversation will continue.

12 On the quality dimension, I don't think there's
13 any debate. I think the quality is basically the same. One
14 of the other -- although I think as was raised just before,
15 the whole notion of some higher acuity issues, you know, we
16 can continue to kind of grapple with that.

17 On the issues of integration, however, I think
18 there is an opportunity to further explore that one. I
19 appreciate the information that was up on Slide 7. I've
20 continued to look, like the rest of us, about the increasing
21 opportunity for care coordination, and provider-based is one
22 way to get to care coordination. And so now as we're

1 starting to get that, we're starting to say, wait a minute,
2 maybe we need to think about how the payment on that works
3 differently.

4 So I know there has been some interesting
5 conversation here about indirect subsidies, but I don't
6 think we can deny the fact that it is leading towards
7 integration, towards care coordination as part of the
8 process. So I want to continue to sort that out in my own
9 mind.

10 The other kind of issue that hasn't come up here
11 yet and what I'm trying to think more about is how this
12 could impact the issue of the readmission policy which began
13 on October 1. There are things people do post-discharge and
14 hospital outpatient department because the hospitals are
15 responsible for those patients under the 30-day
16 rehospitalization out there. And would this inadvertently
17 disrupt some of the feedback loops that go on as part of the
18 process and create more disruption in the readmission
19 policy? And so I'd like to kind of see if we could think
20 about or that explore that one a little bit further as we go
21 forward.

22 And the final kind of criteria we used is kind of

1 savings. Does it save the program more? Does it cost the
2 program more. Whatever the case may be. I think the way
3 we've looked at this is so far as a savings opportunity, but
4 it would be interesting to look at this as what it would be
5 like in a budget-neutral environment, because if I remember
6 correctly, last year, the Medicare margin for outpatient
7 departments was around negative 9 percent. We'll be looking
8 at updated margin information here in a month from now. If
9 this money was put back into the system, recalibrated across
10 other APCs out there, what it would mean in terms of overall
11 margin, that might be worth looking at as well.

12 DR. HALL: I'm in agreement with where we're
13 heading with this, and I guess I've grudgingly come to
14 understand the perverse nature of indirect subsidies. And I
15 guess by way of conflict of interest, I work at a teaching
16 hospital, and I get lots of feedback on this issue, probably
17 more than anything that I've gotten on any other issues that
18 have come forward.

19 So we can't tolerate indirect subsidies, but we
20 have to take at least some responsibility for the unintended
21 consequences of our decisions, it seems to me.

22 Now, maybe we have, but I don't think that has

1 been made very evident to some of the potential stakeholders
2 in this whole arena. So things that come to mind for me is
3 that -- I don't have the previous narrative in front of me,
4 as Peter mentioned, but have we really taken a very careful
5 look at what would happen if we dissected out all of the
6 non-campus-related facilities that are now considered part
7 of the hospital umbrella? If we took all of those out --
8 and maybe we can't; maybe we can only make an estimate --
9 what does that tell us? Does that inform us?

10 I think the rationale of trying to provide the
11 OPSS subsidy to a practice that one day is free-standing and
12 the next day is part of a university is probably subject to
13 a lot of criticism, to say the least. But also to point out
14 that we have been sensitive to the problem of teaching
15 hospitals through disproportionate share and stop loss.
16 That message, maybe it's been put forward, but I don't think
17 it's been received in a way that's constructive for these
18 hospitals to move forward. I think that's a real problem,
19 and I hope that we can spend a little more time on that
20 aspect of it.

21 DR. DEAN: I think this is a difficult issue, and
22 I guess the more I think about it, the more difficult it

1 becomes. I think the issue of we should pay a fair price
2 for a procedure that's done is pretty clear, and I think
3 we'd all agree with that. But there is a fear -- and I
4 certainly am sensitive to what George and Peter have said --
5 about the other less well defined services that are provided
6 by the hospital as an institution being there. And I think
7 the trend has been to whittle away at the ways to support
8 those services as we focus more on taking sort of almost a
9 Wal-Mart approach, we're just going to pay the very minimum
10 for each individual item of service.

11 You know, I was just thinking, you look at the
12 critical access hospital program where we realized that if
13 we didn't do something different, if we relied only on
14 payment for the individual care that those facilities
15 provided, they were gone. They just wouldn't be there. And
16 yet I think as a society the judgment has been -- and
17 certainly I've been wholeheartedly supportive -- that that
18 has been an extremely valuable program. I'm free to
19 acknowledge that there have been abuses, and there are some
20 that probably don't qualify and all that. But as a general
21 program, that has been an extremely valuable program.

22 I guess I really do worry that when bad things

1 happen, whether it's a hurricane or whatever, we do look to
2 hospitals to give us a lot of support, and we really are,
3 like I say, whittling away at the resources that they have
4 to provide some of these less well defined and less well
5 articulated kind of services.

6 So, you know, I think that I agree with the
7 direction that we're going, but longer term, I do worry.
8 Are we undercutting and weakening these really vital
9 institutions?

10 DR. MARK MILLER: I think we'll probably get into
11 some of this in December, and I don't know whether to take
12 your comment as, you know, the mission of the hospital as it
13 stands outside of Medicare or as it stands inside of
14 Medicare. But there's also other changes that are going on,
15 you know, DSH being redistributed to an uncompensated care
16 policy that's going on in the hospital that's trying to go
17 at some of these functions. So it depends on whether you're
18 talking about inside Medicare or outside Medicare, and we
19 can think through some of that in December when we start
20 walking through some of the broader changes that are going
21 to occur under PPACA with DSH and that type of thing.

22 MR. GEORGE MILLER: Mark, to your point, there are

1 things that Medicare requires us to do with standby
2 capacity, and that's why we're addressing the issue. And I
3 think Herb brought a point up that I failed to mention and I
4 want to just echo him on that. If this was redistributed --
5 I agree with everybody around the table about the philosophy
6 of where this should be paid for, but then if it's budget
7 neutral, then my argument would go away. If we redistribute
8 to other parts of the hospital through the APCs, we would
9 have no problem with this policy. But in itself, the way
10 it's presented is just -- in my view, is just taking money
11 off the table. And if that's the goal just to reduce the
12 spend level, not looking at access or quality and just
13 looking at the pure financial numbers to save money in the
14 program, then if that's it, I got that. But we have looked
15 at other things at redistributing and making sure it's
16 budget neutral. If we want to make it budget neutral, I'd
17 have a whole different opinion about this issue.

18 MR. HACKBARTH: Since we're already over, let me
19 call an end to this. Obviously, we'll be coming back to it.
20 So thank you, Dan and Ariel, for your work on this, and
21 let's now turn to our public comment period.

22 And so, let me, as always, repeat the ground

1 rules. Please begin by identifying yourself and your
2 organization. When the red light comes back on, that's the
3 end of your time and please conclude swiftly. And, as
4 always, I'll remind people that this isn't your only or your
5 best opportunity to provide input to the Commission's work.
6 The best opportunity is through the staff, but also letters
7 to Commissioners or you can post comments on our website.

8 MS. HUANG: Thank you. Good morning. My name is
9 Xiaoyi Huang. I'm with the National Association of Public
10 Hospitals and Health Systems. NAPH represents approximately
11 200 safety net hospitals and health systems across the
12 country that primarily care for the low-income, vulnerable,
13 and other underserved populations. So in addition to
14 primary care, our members provide the much needed specialty
15 care to the vulnerable populations through their clinics.

16 And NAPH continues to be concerned with the
17 potential consequences of these policy recommendations,
18 especially as they relate to vulnerable populations' access
19 to preventive, primary, and specialty care. With 2014
20 around the corner, these recommendations, if implemented,
21 would hinder hospitals' efforts as they are trying to
22 increase access to millions of patients. And safety net

1 hospitals, in particular, would be absorbing the impact of
2 these cuts on top of existing and scheduled payment
3 reductions and the ongoing costs of providing uncompensated
4 care. For some, with their already low or negative margins,
5 this may not be possible without reductions to service.

6 Thank you for the opportunity to comment.

7 MR. MYERS: Good morning, everyone. My name is
8 Tom Myers. I'm General Counsel and Chief of Public Affairs
9 for AIDS Healthcare Foundation. AHF is a nonprofit that,
10 among other things, operates an AIDS C-SNP in Southern
11 Florida and California. I think we're one of only two
12 entities that provides such services.

13 I was very much concerned about the proposed
14 elimination, clearly, of the C-SNPs. It seems to be
15 throwing the baby out with the bath water. Most of the
16 time, the debate and the discussion was over diabetes, which
17 apparently affects up to 15 percent of all Medicare
18 recipients. HIV affects less than one-tenth of one percent
19 of Medicare beneficiaries. It simply isn't the scale or the
20 number of people with HIV on Medicare to effectively fold
21 them into the Medicare Advantage. There's no incentive for
22 the Medicare Advantage plans to set up the quality and type

1 of care that the chronic care SNP does. The ability to
2 design the provider networks to specifically meet the
3 chronic condition, HIV experts, pulmonary care physicians,
4 high-volume specialists with experience with HIV, how to do
5 HIV, both HIV and heart, things like that, you know, the
6 incentive simply is not there in the larger Medicare
7 Advantage field.

8 So I haven't heard anything where doing this,
9 eliminating the C-SNPs, would be a benefit or would help
10 people who have HIV or AIDS and I would very much hope that
11 the Commission would look at the various disease states and
12 see which ones are perhaps worth keeping within the C-SNP
13 program.

14 Thank you.

15 MS. MIHALICH-LEVIN: Good morning. My name is
16 Lori Mihalich-Levin and I'm with the Association of American
17 Medical Colleges. The AAMC appreciates this opportunity to
18 speak to you about our ideas with respect to the Medicare
19 payment differences across settings, and specifically, we
20 have three recommendations for the Commission.

21 First, we strongly encourage MedPAC to release
22 additional draft information to the public about the 71 APCs

1 that have been selected. Specifically, we urge you to
2 provide a list of the 71 APCs as well as the detailed logic
3 that was used to select those APCs so that we can provide
4 informed feedback to the Commission in advance of any
5 recommendations.

6 Second, while we do not believe that the
7 Commission should move forward with these proposals,
8 particularly given the lack of thorough analysis about each
9 of the APCs that have been selected, we urge the Commission
10 to revisit the idea of a stop-loss or a carve-out that
11 actually protects access to ambulatory care services for
12 needy populations. The stop-loss that the Commission
13 recommended last year with respect to the E&M services did
14 not sufficiently address these important access issues and
15 would only have protected a very small number of hospitals,
16 particularly in the very first year of the stop-loss.
17 MedPAC could consider looking at factors including total
18 outpatient revenue losses from proposed cuts and not just
19 total losses, and whether, as Peter mentioned, the HOPD
20 routinely accepts Medicaid patients.

21 Third and finally, the AAMC urges MedPAC to
22 recommend to CMS that CMS collect better information on HOPD

1 clinics nationwide so that we all have more robust data to
2 better understand the policy implications of making payment
3 changes at the different sites of service.

4 Thank you for the opportunity to comment.

5 MS. CARLSON: Good morning. I'm Eileen Carlson
6 from the American Nurses Association.

7 With respect to hospital outpatient departments,
8 nursing costs are part of room and board in hospital and I
9 don't think anybody directly reimburses those. So we are
10 always concerned that any decrease in hospital payments are
11 going to lead to cuts in nursing staff and we think it's
12 very important that there's adequate and safe staffing for
13 every patient in the hospital.

14 But also to lend a little bit of clinical
15 viewpoint, I used to be a cardiac nurse in a hospital and
16 did some care coordination and triage, and I have to say
17 that I do think that clinics--in a cardiology clinic--
18 clinics in hospitals that are located right there are--it's
19 a different animal. I would schedule different patients to
20 come to the hospital outpatient department versus other
21 freestanding clinics, and some of those patients, we would
22 watch until all hours of the night and admit them directly

1 when if they had gone to another freestanding clinic or
2 outpatient facility, they would have had to go to the
3 emergency room. So I think that's something that you all
4 need to look at.

5 Thank you.

6 MS. WORZALA: Good morning. Chantal Worzala from
7 the American Hospital Association.

8 I very much appreciate your robust discussion this
9 morning about payment neutrality across ambulatory settings,
10 or at least across two of them, hospital outpatient
11 departments and physician offices. The AHA is extremely
12 concerned with the proposal to expand your recommendations
13 about pay equity across physician offices and hospital
14 outpatients to additional services. We're concerned that,
15 conceptually, these proposals do not account for the unique
16 role of hospitals. This includes emergency response, stand-
17 by capacity, complying with EMTALA, and meeting the Medicare
18 conditions of participation. Physician offices do none of
19 those.

20 And as an example of the unique emergency stand-by
21 role of hospitals, we can certainly look at what is
22 happening in the hospitals impacted by Hurricane Sandy. In

1 the midst of the devastation, hospitals have brought in
2 extra staff, paid extensive overtime, supplemented their
3 supplies and medications, and accepted large numbers of
4 additional patients who were evacuated out of skilled
5 nursing facilities.

6 I want to be very clear that hospitals do this
7 gladly and as part of their mission. The point is that we,
8 as a society, really need this kind of response capacity.
9 And you did talk about paying for this directly. Funding
10 for the Hospital Preparedness Program at the Federal level
11 has declined by 12.5 percent between fiscal year 2010 and
12 fiscal year 2012. Experience in the field is that these
13 funds are very much appreciated, but they come nowhere close
14 to meeting the costs of maintaining stand-by capacity and
15 actually responding in the event of a disaster.

16 When it comes to the specifics of the policy and
17 the recommendations, or the policies presented in the
18 presentation today, I want to be clear that this policy
19 would result in a negative 5.5 percent cut to hospital
20 outpatient departments where there is already a negative 9.6
21 percent margin. That would imply a negative 15 percent
22 margin, meaning that Medicare would pay 15 cents on the

1 dollar for care provided in all hospital outpatient
2 departments, which does include the emergency department.

3 The impact on rural was shown to be higher in the
4 slides, on average. You use 2010 data and the current
5 policy of a rural hold harmless, but that does, by law,
6 expire this year.

7 Maybe the underlying assumption from a policy
8 should be looked at a little more closely. It seems to
9 assume that the physician payment under Medicare is correct.
10 We have hospital cost data. It's provided every year by
11 hospitals as part of their overhead expenses. Physicians do
12 not provide cost data to Medicare. So we have hospital cost
13 data, but we don't have physician office cost data.

14 Also, the policy only addresses payments to
15 hospitals and it doesn't consider adjusting the practice
16 expense payment to physicians when they provide services
17 outside their own office. This payment is in addition to
18 the payment for the physician work and it's unclear why this
19 is not considered by the Commission as it is part of the
20 total payment that you're looking to equalize across
21 settings.

22 On this topic, the Commission discussed last month

1 whether a hospital could charge a non-employed physician for
2 the use of its facilities while also billing Medicare
3 directly for the hospital's facility fee. Our legal team
4 took a look at this and believes the practice would come
5 close to double-billing and could raise fraud and abuse
6 concerns, so that should not be considered a way to mitigate
7 the impact on hospitals.

8 Finally, we'd ask MedPAC staff to provide the list
9 of the specific APCs included in this analysis to the
10 public.

11 Thank you for your attention. I appreciate the
12 chance to comment.

13 MR. HACKBARTH: Okay. We are adjourned until
14 December. Thank you very much.

15 [Whereupon, at 11:52 a.m., the meeting was
16 adjourned.]

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