MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 6, 2012
9:28 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
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:28 a.m.]

MR. HACKBARTH: Okay. It's time to begin. Welcome to our guests in the audience. This is, as you know, our first session of a new MedPAC cycle with new Commissioners.

On today's and tomorrow's agenda, we have three sessions that are related to reports that Congress has specifically requested from us. Those pertain to the geographic adjustment for the work value in the Physician Payment System, payment for ambulance services, and the outpatient therapy benefit under Medicare.

In addition to those three issues -- which will reappear repeatedly through the fall with the goal of our making recommendations in response to the Congress' request before the end of this calendar year. In addition to those issues, we will over the next two days discuss our annual chapter on the Medicare context spending trends and the like, bundling for post-acute care services, hospital readmissions, and what we refer to as "competitively determined plan contributions."

As always, we will have a public comment period at the end of each session, so there will be one at the end of

our morning session before we break for lunch, then one at the end of the day, then another at the end of tomorrow morning's session. And when we get to those, I will remind you what the ground rules for the public comment period are.

Let's see. Our first topic is the context chapter, context for Medicare payment policy, and Kate and Kahlie are going to lead the way. Who is going first? Kahlie?

MS. DUFRESNE: Good morning. So Kate and I would like to start by reviewing the Commission's congressional mandate and how this presentation fits into our annual work cycle.

Each year, the Commission is required to review Medicare payment policies and the health care delivery system, to make recommendations on those topics, and to review the budgetary ramifications of those recommendations.

As a part of its work to fulfill that mandate, the Commission's March report contains a chapter describing the context for Medicare payment policy, and in fact, it establishes the Commission's understanding of the environment in which it makes recommendations. This involves reviewing the current and future challenges for the

Medicare program in light of the federal budget and the health care system as a whole.

In today's presentation, we will discuss each of the items listed on this slide. Due to time constraints, we will keep our narrative brief; however, there is bountiful detail in your mailing materials, and we're happy to flesh out any points on question.

In addition to each of these items, we'll take a quick look at some of the policy changes that are taking effect at the end of this calendar year, including the federal budget sequester and changes to physician payments under the SGR, as well as a few more.

First, Kate will start us off looking at health care spending growth.

MS. BLONIARZ: Health care spending growth has grown on a per capita basis faster than economic growth for many years, rising from 9 percent of GDP to nearly 18 percent of GDP in the past 30 years. However, the past two years saw a rapid slowdown in health care spending. There's a lot of conjecture about why this slowdown occurred and whether it's permanent.

Potential structural factors explaining the

slowdown could include the changing pace of technology, changes in care delivery models, or cost pressures driving individuals and employers to seek out more efficient health care. There are also cyclical factors, such as the recent recession and financial crisis.

Even if the changes are structural, there is still the potential for a reacceleration of health care spending growth. For example, during the late 1990s, low medical inflation and managed care kept health care spending at very low levels, but then it rapidly reaccelerated in the early 2000s. And whether that pattern will be repeated here is still an open question.

Some recent evidence include CBO's statement, in their August 2012 budget outlook, that they were revising downward their Medicare projections for 2012. But both CBO and the Medicare actuaries assume that Medicare spending will rebound somewhat over the next ten years, but not to historical highs.

In the private market, investor indices of the health care sector show the slowdown continuing into 2012 but forecast a rebound, and some insurers have noted an increase in outpatient and doctor visits.

Medicare combines this larger trend in health care spending with enrollment and legislative changes that also affect spending. Medicare's share of GDP has also tripled from 1980 to 2010, and Medicare's share of federal spending more than doubled over that time frame.

Enrollment growth will start playing a more significant role as the baby-boom generation attains Medicare eligibility. For example, the Medicare population is projected to double by 2050. As the number of workers supporting the program through payroll and income taxes will shrink and the share of individuals of retirement age will increase, the worker-to-beneficiary ratio will drop from 3:1 today to 2:1 in 20 years.

This figure shows Medicare's spending growth broken down between per beneficiary growth, which is the top bars, and enrollment growth, which is the bottom bars.

During 2007 through 2009, growth per beneficiary was around 4 to 6 percent per year, and you can see the significant slowdown in 2010 and 2011, corresponding to a similar slowdown in health care spending more broadly. Enrollment growth was generally around 2 percent over this time frame.

Over the next decade, enrollment growth will be higher, the number of beneficiaries rising more than 3 percent per year, and even 4 percent in the coming one. And while the story in prior years was more about per beneficiary growth, over the coming decade both enrollment and per beneficiary growth play a role.

You can also see that the Medicare actuaries assume that per beneficiary spending will start to rise again towards the end of the ten-year window, on the right of the slide, due to a projected economic recovery.

The Medicare program receives financing from a number of different sources. Starting from the bottom of this chart, the hospital insurance payroll tax makes up about 40 percent of revenue today. Then taxes on Social Security benefits and a fee on drug manufacturers make up about 3 percent. Next is the Part B monthly premium that beneficiaries pay, and that's about 13 percent. Transfers from states for the cost of drugs for dually eligible beneficiaries is next; that's about 1 percent. And then the next largest share in yellow is transfers from the general fund of the Treasury. In 2010, this was about 44 percent of the program's finances -- the largest single share. And it

is projected to grow to about 50 percent in 2040.

The top line is Medicare's total spending, and the difference between that line and the sources of revenue is the hospital insurance trust fund deficit. The large and growing share of Medicare's financing coming from general revenues means that the government's budget picture is an important consideration in the Medicare program's financial outlook.

So what is that financial outlook or that budget outlook? By the end of this fiscal year, debt as a share of GDP is projected to be 73 percent -- the highest level since 1950 and about twice what it was at the end of 2007, before the financial crisis and recent recession. Medicare, Medicaid, and Social Security are projected to grow significantly over the next quarter century -- totaling 16 percent of GDP by 2040. In contrast, the entire federal government over the past 40 years has amounted to around 18.5 percent of GDP.

Under the Budget Control Act of 2011, spending for all other parts of the budget other than Medicare, Medicaid, Social Security, and interest payments on the debt are projected to be flat in real terms over the next ten years.

A final consideration when talking about the fiscal picture is the changes in taxes and spending scheduled for this year.

As you all are well aware, the sustainable growth rate formula, or SGR, is projected to take effect at the beginning of calendar year 2013, reducing physician payments by about 30 percent. There are also other Medicare provisions that will expire at or around the same time frame, and Congress has requested that the Commission look at three of these: the exceptions process for the caps on the outpatient therapy benefit, payment adjustments to ambulance providers, and the floor on the work GPCI for physician payments, all of which expire at the end of this calendar year. And as Glenn mentioned, you'll be talking about this today and tomorrow.

Also occurring at the same time frame are a host of other policy changes scheduled to go into effect at the end of this calendar year that cut spending and increase taxes. In total, these provisions are projected to reduce the federal budget deficit by between $500 and $600 billion in 2013 alone. These include expiring tax rate reductions for individuals and the sequester of government spending

under the Budget Control Act of 2011.

So these are the things that Congress may contend with at the same time that the SGR is scheduled to go into effect.

I am not going to turn it back to Kahlie to talk about the effect of health care spending growth on families and beneficiaries.

MS. DUFRESNE: Growth in health care costs has the most direct impact on individuals and families. Median family income has been stagnant over the past ten years. Some evidence points to health costs as a significant roadblock to family income growth as the increase in premiums has far outweighed changes in average wages.

Medicare beneficiaries are not exempt from these financial challenges. Premiums and cost sharing for Parts B and D are consuming an increasing share of the average Social Security benefit, and the growth in premiums is set to outpace the growth in those benefits.

With the recent economic downturn, adults under the age of 65 have seen more unemployment and decreasing home values, and many will have seen their retirement savings take a financial hit. As such, adults approaching

Medicare eligibility may have smaller assets and income, and they are more likely to participate in the labor force after age 65.

As the baby-boom generation ages into Medicare eligibility, the Medicare population is projected to grow by a third within the next ten years. With this expansion, the population attaining coverage will differ in key ways from the current Medicare population.

First, the average age of Medicare beneficiaries will slightly decline over the next two decades when nearly a third of all beneficiaries will be between the ages of 65 and 69. In addition to a shift in age, the Medicare population will become more diverse. Over time, the program will see increasing shares of Hispanic, African American, and Asian American beneficiaries.

Second, adults approaching Medicare eligibility are at heightened risk for chronic conditions than preceding generations. For example, baby boomers are more likely to be overweight or obese and will have spent more time overweight or obese over the course of their lives. The prevalence of obesity could spark heightened risk of chronic diseases like type II diabetes, heart disease, certain

cancers, and possibly even mental health challenges like Alzheimer's.

Third, soon-to-enroll Medicare beneficiaries experienced a different private insurance market than their predecessors, so they will be more familiar with different types of insurance products. For example, more will have been insured under a high-deductible plan -- a plan type that has only been available since 2005. Even more, premiums and cost sharing under private health insurance have steadily increased over the past ten years -- experience that will affect rising beneficiaries' financial stability and expectations for health care cost sharing.

So as we discussed on the previous slide, the prevalence of chronic conditions in Medicare may increase as the at-risk baby-boom generation ages -- possibly putting more budgetary pressure on the Medicare program.

One piece of information that you have asked us about was the prevalence of and spending for chronic conditions in the current Medicare population. We reviewed the prevalence and cost per beneficiary of a few common chronic conditions.

In this table, you can see that chronic kidney

disease is by far the fastest growing chronic disease in terms of the number of beneficiaries who have it -- growing at 9 percent per year. In contrast, while the incidence of congestive heart failure has declined, the cost per beneficiary has grown 9 percent per year.

There is evidence that some of the dollars spent on health care may be misallocated or inefficiently spent. First, different regions consume widely varying amounts of health care services that do not correspond to higher quality, to higher satisfaction, or to better outcomes.

Compared to countries in the Organization for Economic Cooperation and Development, the level of health spending in the United States is notably higher. This is likely a reflection of the higher prices for services in the U.S. and not significant differences in utilization.

Second, many experts question the value of health care spending. Researchers believe that while the aggregate increase in health spending has produced value, the marginal value of health spending is decreasing over time. Utilization of improper or improperly applied services also puts beneficiaries at health and financial risk and results in inefficient spending.

Finally, despite years of attention to health disparities, outcomes are still worse for individuals who are of racial or ethnic minority and those who are low-income. Further, some compelling evidence suggests that these beneficiaries often receive care from poorer-quality providers.

So that concludes our presentation. As I mentioned in the beginning of our talk, the point of this chapter is to establish the Commission's understanding of the environment in which it makes its recommendations. So in light of that goal, Kate and I would appreciate your guidance on the scope, substance, and tone of the chapter, and, of course, we are happy to answer any questions.

MR. HACKBARTH: Okay. Thank you very much, Kate and Kahlie. Let's begin with a round of clarifying questions. For the new Commissioners, just a reminder what we mean by that is, "Slide 8, second column, what does that number mean?" is a clarifying question. Once we go through our clarifying questions, we will have another round where people can make broader comments and suggests.

DR. SAMITT: My only question is: As it pertains to the slowdown in spending, do we have more information on

whether there's any variability in the slowdown of spending by market or by any other type of distinguishing feature?

MS. BLONIARZ: So we have some aggregate information right now about the slowdown, but, you know, in the fall, when Kevin does some of the analyses of physician payment, we'll be able to break it down by imaging versus procedures and things like that. Actually, a lot of the action has been in outpatient settings, so physician and other ambulatory settings, so we'll have more information on that as the fall proceeds.

DR. SAMITT: Thank you.

MR. BUTLER: Slide 12. You have this also expressed in the draft chapter in dollar terms, and if I add it up, it was something over $400 billion in these chronic diseases. So I want to understand if I'm interpreting this right, recognizing you may have more than one of these, but it looks like 86 percent of beneficiaries are associated with a chronic disease, and if I look at the dollar numbers, it looks like about a similar amount of dollars in Medicare are spent on beneficiaries with these chronic diseases. Is that the right conclusion?

MS. BLONIARZ: So it is key that this is not

unique -- these are not unique categories. People can be in multiple categories, and so you can't add them up. And what I'd intended to do --

MR. BUTLER: What do you mean? I just did, maybe not --

[Laughter.]

MS. BLONIARZ: What I intend to do over the next couple of months is pull out some common combinations so you can see that chronic kidney disease co-exist with congestive heart failure, and for that group of kind of very complex individuals, the spending is this. But that's why it adds up to, you know, 80 percent of the spending or 80 percent of the dollars. It's because people are in different categories, and so you can't really add them together to get a unique count.

MR. BUTLER: Where the overlap occurs is important, too, but it does reinforce the point that if you don't have -- well, now I'm making round two.

DR. CHERNEW: Can you go to Slide 6? Are these numbers inflation adjusted?

MS. BLONIARZ: They are not.

DR. CHERNEW: They're not, so they're nominal. So

do you know what the -- when I look at, say, the 3 percent, which is the gap above -- the 3 percent growth in spending above the number of people, so that would be sort of the per person spending is 3 percent. But that's nominal, so the real amount would be less inflation. And then if you knew what GDP was -- and I don't know if you do -- a lot of times people think in terms of excess spending, beneficiary growth above GDP. And I'm trying to put this in that real -- relative to GDP. And I think 3 percent is really low. Three percent nominal is a really, really low number.

DR. MARK MILLER: Just to be clear, 3 percent is the enrollment.

DR. CHERNEW: No. I'm looking at the 2012 number. That was my --

DR. MARK MILLER: Oh, 2012. I'm sorry. I thought you were looking at --

DR. CHERNEW: There's a lot of numbers. I apologize, and many of them are 3.

[Laughter.]

DR. CHERNEW: I'll try and be clear. The gap, the yellow part I think is actually pretty low if you think about it in terms of historically the way we think about

excess spending growth, which is relative to GDP growth. And I just wanted to make --

MS. BLONIARZ: So from a process standpoint, we could take out, you know, either CPI or some other measure of inflation, we could take out GDP. Generally the ten-year projections are around GDP growth, maybe a little higher, and I did want to note that this is not assuming that the SGR takes effect. If you assume the SGR takes effect, the projections are actually a little below GDP growth over the next ten years. But we can do all that and kind of give that to you if that's helpful.

MR. HACKBARTH: Let's focus on that 2012 per beneficiary growth number of 3 percent. I think most forecasters are projecting GDP growth of less than 2 percent for the year.

DR. CHERNEW: Real [off microphone].

MR. HACKBARTH: Fair enough. And so probably about equal -- so the 3 percent is about equal to nominal GDP growth for 2012, roughly.

DR. CHERNEW: So in the GDP plus X framework of thinking about spending growth, we're at about, at least for many of these years -- even ignoring the SGR footnote part,

we're at about zero. I think. That's what I was trying to figure out.

MR. HACKBARTH: Yeah.

DR. NERENZ: Same slide actually that's up there. Just a couple of sharp discontinuities. I'm curious if we know anything more about their meaning. There's the per beneficiary growth change from 2009 to 2010 and then the enrollment growth from 2011 to 2012. Is there a story there that we should be paying attention to, either one of those?

MS. BLONIARZ: So the 2010 per beneficiary growth, this also tracked with what happened in the private sector where demand for health care was very, very low, and GDP growth actually over the 2008-2009 period into 2010 was negative. It was about negative 3 or negative 4 percent. So you saw a big slowdown in health spending across all payers.

On the bump-up in 2012 for enrollment, I think that's just a baby-boom effect, and there's just a lot of variability across years and the number of people turning 65 in that year.

DR. HALL: Going back to page 12, the prevalence numbers, are these changes from 2006 to 2010 in keeping with

historical trends before that period of time? Or is there some reason that you picked that particular segment of time? Is this an exception or are we looking at an aging population or a change in coding philosophy? I'm trying to see the underlying meaning of this.

MS. BLONIARZ: It was more a convenience sample because we had a uniform definition of incidence using the Medicare claims. We will look into what we can say about trends over a much longer time period.

DR. HALL: Okay. Thank you.

DR. NAYLOR: Slide 10. On the issue of the economic downturn and continued participation in the labor force after 65, we also have -- well, maybe you should tell me. Do we have a significantly higher rate of people unemployed in their 50s, early 60s who enter Medicare in poverty?

MS. DUFRESNE: So we can't answer that right now, but I think we can answer that going forward.

DR. NAYLOR: Okay.

MS. DUFRESNE: The general trend, it has been increasing over time that more people over the age of 65 are participating in the labor force. So that trend is just

expected to continue to increase. In terms of how many have been unemployed like approaching Medicare eligibility, we can find out for you.

DR. NAYLOR: I think that is really important, especially as the use of Social Security dollars to support health care and other things increases.

On the same slide, 12, you mention in the report the numbers of people obviously living with multiple conditions, and you're going to go deeper into that. But I hope that we can also in doing that not just look at clusters but how many people have multiple conditions and how that increases over age over time, because I think that that will help us to get to the complexity of the challenges.

MR. GEORGE MILLER: Yeah, two questions. The chapter did a very nice job of saying that we've got both sides of the position on the slowdown in health care spending. But I'm wondering if the slide on page six -- what it would like if it reflected that health care spending may be permanent versus it may rebound.

So is this slide showing the rebound? Or what would that slide look like if the chapter mentioned that the

recent slowdown could be permanent? How would that look?

MS. BLONIARZ: So this chart is based on what the Medicare trustees assume.

MR. GEORGE MILLER: Oh.

MS. BLONIARZ: They assume an economic recovery, which is why you see the number going up towards the end of the decade. I don't believe that over the long term they assume that Medicare spending will go back to its historical highs. So I think they have a mix of --

MR. GEORGE MILLER: So this is --

MS. BLONIARZ: -- some recovery, but not to the peaks that have been seen in the past decades. And maybe Mike wants to jump in, too.

DR. CHERNEW: No. We should talk about it.

MR. GEORGE MILLER: Okay.

DR. CHERNEW: I'm happy to talk about it, but it's probably better elsewhere.

MR. GEORGE MILLER: All right. And then, secondly, on Slide 13, do you have any quantifying numbers for the third bullet, the persistent disparities in care, what that costs the system? If minorities were to get the same level of care as the others in the population, what is

that delta? What's the difference? What does it cost the Medicare program for the fact that disparities persist in, obviously in a profound way, since they persist.

MS. BLONIARZ: We can look -- we'll look at that and see if somebody has quantified that. It would be the interaction of a bunch of different variables, but we can look into that.

MR. GEORGE MILLER: Okay. Thank you.

MR. HACKBARTH: So can I just pick up on George's first question about the future trends and whether there's going to be a bounce back and if so, how much. There was a piece in the New England Journal of Medicine within the last few weeks that tried to look at the historical data and identify if the slowing of the rate of increase in cost was concurrent with the recession or whether it began before, and unfortunately, I'm blanking on who the authors were, but the gist of the article was that there was evidence of a change in the trend dating back to 2005. I didn't see that piece cited here, and there may be reasons for that, but it seems quite pertinent to this question of whether this is a recession-only phenomenon or a reflection of preexisting changes.

DR. DEAN: I guess this is round one, but it's more general, because we constantly cite things in terms of a percentage of GDP and we sort of take that as a measure of health care costs, and yet GDP fluctuates, too. So you've got fluctuation in the denominator and it's -- and I've always wondered how reliable those numbers are. Do they really tell us what we think they tell us?

MS. BLONIARZ: Well, and actually going to the point that Glenn just made, in this paper in the New England Journal, they talk about how GDP growth just varies very much, and so health care spending as a share of GDP can look low or high for multiple reasons, either the numerator or the denominator. So I think we're generally just using it kind of as a benchmark, but there are issues around it and we can clarify that.

DR. DEAN: It's usually used as kind of the standard measure, either of what we do or what's done internationally, and yet it just always troubled me. Is that really a reliable -- does it really tell us what we think it tells?

MR. HACKBARTH: Your point is absolutely right, Tom. I think some people use it as a way of assessing,

albeit crudely, affordability, you know, what percentage of our nation's wealth are we investing in this activity. And so, of course, it is influenced by what's happening with the denominator, but as a measure of where we're spending our money as a society, I think it has some utility.

DR. DEAN: As a sort of general, broad indicator, I'm sure that's true. If we measure it year to year, I wonder.

MR. HACKBARTH: Yes. I have another clarifying question. This one pertains to the paper as opposed to the slides. On page 21 in the paper, there's a heading, "Medicaid Dominates Many States' Fiscal Outlooks." In the first sentence there, it says Medicaid accounts for almost 24 percent of all State spending. And my question is, is that just the States' share alone, or does that include the Federal match?

MS. BLONIARZ: I believe that's just the States' share alone. We can double-check.

MR. HACKBARTH: Okay. Can we check that?

MS. BLONIARZ: Absolutely.

MR. HACKBARTH: Thank you. I appreciate that.

Okay. Round two comments, beginning with Scott.

MR. ARMSTRONG: Yes, just very briefly, I wanted to acknowledge that this is excellent work and creates context that I think is going to be very valuable to MedPAC. Given that this does create a context for the work that we're going to be doing, the only feedback I would have is I feel like -- my sense has been that, reading this, the tone is a little rosier than it should be, and that here, we're talking about some of these projections and so forth, but the truth is that the trust fund is depleted in the future. The only debate is which year is it depleted at.

And I think that this chapter becomes an opportunity to create an imperative for the work that we have to be doing going forward in that even just -- I don't want to pick on words, but in the very last sentence, we talk about we need to ensure that Medicare is a wise purchaser of health care. Well, I think what we need to ensure is that the Medicare program and MedPAC's role in this is driving transformational change, because if not, this is going to go bankrupt. So I just think there is a tone that we could put into this that creates an imperative that will help us to drive forward more quickly some of the work that we have going on our agenda in the coming year.

And then the last comment I would make is just that nowhere in the report do we acknowledge that the Medicare program and the payment policy and its financial effectiveness actually has an impact far beyond just Medicare, but also on the commercial and Medicaid and other aspects of the health care industry, and I think that that's an important point to make in this chapter on the industry context for the work that we do.

MR. KUHN: I, too, want to thank Kate and Kahlie for a job well done. My only comment or observation is on page ten of the written report where you start the conversation about growth in Medicare spending and a couple of good points. You look at those areas that are coming down, notably, at least in 2009 and 2010, hospital inpatient and physician, but those areas that we're seeing some sizeable growth. One would be hospital outpatient, which makes sense. If inpatient is coming down, outpatient will probably go up, which is probably a good thing. Hopefully, migrating to lower-cost settings is part of the process.

So that's about all we say about those. So I was wondering if two things we might be able to look at a little bit more. One is, are there any projections in the CMS

Actuaries Report that gives us a sense of where some of these trends might be going in the future, because as you said, this paper sets the context for our work, so if we could get a sense of where they think those particular areas, whether it's SNF, physician, hospital, inpatient, outpatient, whatever the case may be. And then if we could also maybe get some context for some historical growth in those areas.

I don't know whether that fits in this paper or whether that would be each in the individual chapters when we do the updates in December, but having that information, I think, would help set context better. Thanks.

MS. UCCELLO: I think this is a fantastic chapter. I think, every year, it is a fantastic chapter. I want to agree with Scott that I think one of the key take-aways from this is that still more needs to be done to improve the long-term solvency and sustainability of the program.

And if we go back, and kind of building off what Mike was saying from Slide 6, if these projections -- I mean, these are short-term and they include the productivity adjustments and there is some question about whether in the long-term those are going to be sustainable, and we've

talked a lot about this. Mike can correct me if I'm misstating things. But in the Medicare Technical Panel, it talked a lot about how these can be more sustainable in a system that moves more toward alternatives to fee-for-service. And I think as a Commission, we can really help provide and encourage and provide insights on how to do that, how to move away from fee-for-service to more cost effective ways of delivering payment.

MR. HACKBARTH: Could I just pick up on Cori's comment, because I think it's an important one. So take the issue of physician payment. If your unit of service is, you know, the 15-minute office visit, the opportunities for improving the production of the 15-minute office visit are limited. If, on the other hand, your unit of production is a physician, an internal medicine physician that cares for a panel of 2,000 patients and you're not looking at just individual office visits but you're providing care over a year for a defined panel, there are many more opportunities for improving the production of that physician's services. So the unit of payment really does, I think, strongly influence the opportunity for productivity improvement.

DR. MARK MILLER: Can I just add one quick point?

I understand what you said. I agree with it. I'm not trying to disagree. But there's also the other argument that we've run across in the hospital setting where what you pay on a unit basis does influence what the cost growth is over time. So there's sort of a couple of different evidence points on this issue. So if we get into it, we'll probably have to paint a little bit of a, on the one hand, on the other hand, kind of thing.

DR. SAMITT: I think this was a compelling overview. Thank you. I want to tag onto Scott's comments. I think he must have been in a better mood than I was when I read this, because this kind of depressed me.

[Laughter.]

DR. SAMITT: It didn't seem rosy. And the part that I was looking for that I would suggest is I was hoping for something at the end that would pull me out of my depression. I don't think it talks about opportunity. And so the slide that I think really points to opportunity is Slide 13. I'm very curious about -- and intrigued by variations. And so I wonder if we would benefit from elaborating on the value of the variations. So if we really eliminated the variation or diminished it, what is the

potential there for the regional variation, the international variation, the disparity variation, the declining value. Maybe we want to point to and suggest that while the picture isn't very rosy, here are some of the avenues and paths that we could take to improve the situation based upon a more in-depth analysis.

DR. COOMBS: So I know with the private insurers and patients who are covered in that venue, there were a lot of patient benefits designed, and I wonder if you could correlate this with some of the things that were happening in the private sector, as well, because it may be that, as many of my colleagues have expressed, that a copay change or some micro dynamics that occurred with more, as they say, patient skin in the game impacts may result in less cost per beneficiary. So I was thinking about some of the other things that might contribute to what we see on the Graph 6. Thank you,

MR. BUTLER: So if you could put 6 on one more time, Slide 6. So just for a reminder, if this comes to pass, is it -- this is like a round one question, I guess, but IPAB would not be necessary, is that right? I know in the short run, so IPAB would not --

MS. BLONIARZ: I believe right now it takes effect in the last year or the last two years of the budget window.

MR. BUTLER: Okay. So then the other point is that in the chapter, we begin by saying the lower-growth projections are largely due to savings policies in the Patient Protection and Affordable Care Act. So embedded in this numbers is PPACA savings, and, of course, there's all kinds of noise in the -- everywhere. Maybe by the time this chapter is published in March, everything will be a lot clearer. But we don't articulate anywhere in our charts the savings attributable in this due to the PPACA cuts, which, you know, this famous $700 billion is mostly reflected in here.

So one could argue in the other slide on the legislative things happening at year end, what would be the impact of a repeal of PPACA and everything associated with it? These numbers would go up significantly. Now, nobody thinks that all of those provisions are going to be abandoned, but, you know, we don't really kind of peel out that piece of -- we talk about SGR and other things, but not the PPACA provisions as something that is at least going to be debated.

MR. HACKBARTH: Just on Peter's first point about IPAB, just a clarification for people who haven't followed that really closely. The trigger -- IPAB goes into effect, as it were, if there is a target that is exceeded and it's GDP plus one percent. So the point that Peter was making is that in the first part of this window, the projected growth would be under that threshold. You know, it would only be towards the end of the window that we would be above the target, is that right, Kate? Okay.

DR. CHERNEW: Yes, so two things. First, just to say something about Peter's comment, you didn't take the real current law. You took the alternative current law. But it still is a current law projection. I think in the chapter, it would be useful to note that they're not making projections in the way that people think about projections. They're doing it under the rules that it has to be done, which is current law. Even when they use the alternative, as you footnoted, they only are changing some very specific legislative aspects of current law. But that's minor.

The bigger point is, you mention this in the presentation, it's not emphasized at all -- in fact, I had a hard time finding it when I went back in the chapter -- this

issue of the number of workers relative to the number of beneficiaries. And there's a tendency to present some of that information as just, oh, by the way, this is what's going on, the three-to-one versus the two-to-one number. But, in fact, I think it would be useful to put that into some very basic mathematical context, which is if we want to give people the same amount of benefit -- if we want to give the beneficiaries the same amount of benefits but we're cutting the workers per beneficiary less, by definition, in a pay-as-you-go system, and I know we have trust funds, so there's some play here, but at least in a pay-as-you-go system, by definition, the current workers have to pay more.

And that's -- there's a lot of opportunities and policy stuff we could try and do to become more efficient, but if we don't, the math is what the math is because of that and it's not a policy -- in some ways, it's a great policy success that we have more beneficiaries still alive, you know. But it does create some financial challenges and I think the chapter could put that math part in starker contrast, because the per beneficiary spending growth portion is only a small portion of the basic demographics challenge that we face.

DR. BAICKER: I was just going to build on that, that I think it's really useful to think of the total growth in spending as decomposed into the different parts, and I thought it was really helpful to have the increasing disease burden and the aging of the population and understanding all of those underlying trends because we have different policy levers to act on them. We're not going to slow time, although that would be nice. But we are possibly going to improve the disease state at which people enter the program and how those diseases are managed. So that breakdown is really helpful for thinking about policy levers.

But the total spending, and I kind of like the "as a share of GDP measures over the long run," taking Tom's point, that in any given year, the denominator is changing and that makes it hard to interpret. But over the long run, it's the total spending that drives the share of GDP that has to go to finance the program and the sustainability of that and the implications for the Federal situation. So I like having that as the overarching backdrop, that there's this enormous spend under the current program and it breaks down into parts we can effect and parts we can't effect and let's focus on the parts we can effect and try to change the

program in a way to improve the value of care that's delivered through those avenues so that then the total picture will be sustainable going forward. I thought that was -- all the useful pieces were there and I'd encourage us to continue with that framing.

DR. CHERNEW: Yes. Again, I'd repeat some of the thanks, comments about the clarity of the chapter. It's very well written. The points are made very succinctly and I certainly appreciate its main focus on the content of the Medicare program itself.

If there's just one other request or suggestion, it might be to say a little more, if you can, about the delivery system context or what's happening outside Medicare. If the goal of the chapter is to talk about context, I think we just have to recognize that for providers, Medicare is one payment stream among several, and if there are major trends that are out there, either in the private insurance arena or in Medicaid or anywhere else, it may be worth just mentioning those. I don't have a specific suggestion, but just raise the general point for your consideration because the Medicare decisions eventually in some way or other take into account what's happened outside

the Medicare system.

And also, just some of the structural changes you do mention in delivery systems, you know, integration, formation of ACOs, things like that may be worth saying just a bit more about because I think they do make up an important part of the context.

DR. HALL: Again, kudos on the chapter. Just to reemphasize what Scott brought up, I think the chapter has to end on a slightly different note than it does. Wisdom is in the eye of the beholder and I think that that particular term is open to any kind of connotation that you might like. And I think what you're really trying to say here is that Medicare has to be vigilant in terms of ensuring cost effective high-quality care or something of that nature and leave the "whys" part out of that. That's a little bit of wisdom from me.

[Laughter.]

DR. NAYLOR: Kudos. Just terrific report. A couple -- some take-aways that I have, briefly. You make so clear what's happening in terms of demand for services in both the insured and uninsured, and yet prices are not falling commensurately. So hitting home that critical

opportunity here and need to have transparency and prices, I think it's there in two different places, but it may be to link them together.

I would really, if you could, focus on complexity, that we have -- you mentioned three million people that are going to be over 95 at some point in time. I mean, we're talking about really needing to prepare for people living with, long-term, with multiple complex conditions that will require services. And so the notion -- and everybody has all of these records of 20 percent of the population consuming 85 percent of our resources and so on. Now we're going to see one percent consuming a huge amount of resources, et cetera.

The declining value statement, I think, is a really important one. You might want to add Craig's point about all the evidence that we don't have the value, but there are opportunities out there and so that might give that a more balanced view.

And the last thing is, I really think the beneficiary cost issue associated with paying for premiums and coinsurance and the rise that we're going to see of ten percent in 20 years of Social Security benefits in a

population that's poor and relying entirely on Social Security benefits for the other things that give us health is a really important factor.

So I also walked away depressed, but feel that this is a really critically important context for our work. Thank you.

MR. GEORGE MILLER: Yes, just to echo the kudos. It's an outstanding chapter, very informative reading. I just want to highlight a couple of things very quickly. I, like Craig, am very concerned about the variation in utilization, especially regionally for the same services, why Medicare pays so much differently from one part of the country to the other.

And Mary mentioned in her earlier comments about the different quality factors in the government dealing with the quality that we may consider using evidence-based medicine as a driver for really reducing the variation and increasing the quality, and I would suspect there's enough continuity with those different quality players that we could use that really to make a huge difference in the -- like Mary, I'm concerned about the rise in premiums with the percentage of folks on fixed income, Social Security, and

therefore, we've got to increase the value.

MR. GRADISON: My compliments, as well. Three points. We've talked about the two-to-one ratio, which was largely a ratio of people who are in the workforce and those who aren't. I've sometimes found it more helpful, or at least additionally helpful in an additional way, to take a look at the dependency ratio with adding on the youngsters, as well as those who are retired or potentially retired, as compared to the number of workers. It doesn't make the picture any prettier, but I think it does put it in a broader budgetary context because there are legitimate concerns in our society today about the resources that we're devoting to the young versus the old. And since I'm in the latter category, of course, I have an opinion on that, but I won't express right now. But then having nine children, I guess I have to take account the effect on younger people, as well.

The second point I want to make, and I don't mean to be piling on, but I'm going to pick up on Slide 6. Scott and Craig and others have spoken about this. None of us know what the GDP is going to look like in the future. With what's been going on, at least speaking for myself, I think

it would be what Shakespeare would call a consummation devoutly to be wished if we had three percent growth, real growth, at least, on a long-term basis in GDP. Now, what that says to me is that even if there were no growth in the per capita cost, per beneficiary cost, which isn't going to happen, but even if that were the case, this program alone would be increasing its share of GDP, modestly compared with what we've experienced, but increasing it nonetheless with, I think, very significant implications in terms of what I want to make as my third point, which is there's an urgency to this.

It's so easy sometimes -- not only we're doing this, but it's so easy to say, well, you know, we've got another X years before the HI Trust Fund goes broke and what's the big hurry. And I, having served in the Congress, I'm well aware that it's sort of a crisis to activate an organization, and in the case of Social Security, and I was there then, and part of it, it was only when the trust fund, the OASDI Trust Fund was about to -- literally did go broke, it had to borrow money from the HI Fund to get the checks out in the spring of 1983 -- that some action was taken. And I don't see anything in the exact mix here that would

trigger that kind of an action.

All I'm saying is that since it takes years to phase in the kind of changes that might be necessary to provide a more sustainable future for this program, I wouldn't want the fact that the next few years, let's say, in this Chart 6, the first four years say, wow, you know, our kind of total -- our total share is actually going down right through 2015. What's the hurry? I don't read it that way.

DR. DEAN: I guess most of the thoughts I have have already been articulated. I would share, it was a very interesting chapter and a great perspective. But I think there really is a concern in what Bill just said, that we could kind of lull us into the idea that, well, things are holding steady and we'll be okay for a year or two, but the changes that we need to make are very -- I see as pretty fundamental and just don't happen very fast and we really do have a crisis looming not that far down the road. And I think it's important that we recognize that and try to communicate that. So thank you very much, and it's a big challenge.

MR. HACKBARTH: So I want to pick up on Bill's

comment, and it goes all the way back to Scott's initial comment, as well. A crucial issue is how urgent is the situation in a lot of different ways that you can look at the numbers. But if you put up Slide 8, so bullet two, I'm sure, accurately -- I'm not saying this is inaccurate, but it chooses one sort of metric. It says, let's look at Medicare, Medicaid, Social Security, and those three combined will be 16 percent of GDP in 25 years, and 16 percent of GDP is a significant number because it's nearly the size of the total Federal Government over the last 40 years. All of that is true.

Yet for me, at least, 25 years is way out there in the distance and tends to have that effect that Scott alludes to, that, well, a lot of stuff is going to happen in 25 years. We'll probably have all new elected officials by that time and let's not worry too much about this. We have good news in the short term. The rate of increase is slowing.

So I try to look at the numbers using a shorter time frame, and so a number that has caught my eye in the CBO projections is that within ten years, you know, the current budget time window, if you look at the health care

entitlements, Medicare, Medicaid, and the plan subsidies under the PPACA, Social Security, and interest on the debt, just those components of the budget -- health care entitlements, Social Security, interest on the debt -- CBO projects that within ten years, those components alone will be more than 16 percent of GDP.

Then you add in defense spending, you know, even at the lower levels envisioned by the Obama administration, and you're up to over 19 percent of GDP for the four components of the Federal budget within the ten year window. And Federal taxes have averaged about 18 percent of GDP in the post-war period. So just four components of the budget will basically consume all of our historical level of resources within ten years, leaving nothing for FDA, CDC, NIH, other health care-related institutions, education, infrastructure, research, you know, you name it, FBI, Homeland Security. Ten years is not all that far away.

I think that there are ways to look at the numbers that are entirely consistent with these that create a much greater sense of urgency about the issues, so I'll stop on that.

Okay. Thank you very much, Kate and Kahlie.

We will now move ahead to the first of our discussions on reports that Congress has requested for this fall. This one is on geographic adjustment of the work value in the physician payment system as well as the payment system for other health professionals.

DR. HAYES: Good morning. So, Glenn just said what our topic for this session is.

The mandate for this report was in the Middle Class Tax Relief and Job Creation Act of 2012. It directs the Commission to consider whether certain payments under the physician fee schedule -- payments for the work effort of physicians and other health professionals -- whether those payments should be adjusted geographically.

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

The Commission's report on these matters is due June 15th, 2013. However, as I will explain in a few

minutes, there is a temporary floor on the current adjustment. That floor is due to expire on December 31st of this year. Therefore, we wanted to address the topic early in the report cycle so that Congress would have the Commission's ideas and analysis before the end of the year.

For today's presentation, I will first provide background on the geographic adjustment for work effort. Second, drawing on the work of one of our contractors, I will summarize arguments for and against the adjustment. And, third, I will outline for your consideration next steps toward fulfilling the mandate.

The current adjustment for work effort is one of the fee schedule's three geographic practice cost index, or GPCIs. In addition to the GPCI for work effort, there's a GPCI for practice expense and a professional liability insurance GPCI.

I will explain the purpose of the work GPCI in a second, but for now, let me note that the practice expense GPCI is an adjustment for the costs such as rent and staff wages that are incurred in operating a medical practice and known to vary geographically. The PLI GPCI is an adjustment for the premiums that physicians and other health

professionals pay for that type of insurance.

The GPCIs scale payments up or down depending on whether an area's input prices are higher or lower than the national average. So, in this example, the work GPCI of 1.04 scales the relative value unit for work of 0.97 up to an adjusted relative value unit of 1.00.

Note also that in the example the work GPCI adjusts just under half of the payment for the service. So, 0.97 represents 47 percent of that total unadjusted RVU for this service.

And, that's characteristic of the fee schedule overall -- that work payments represent, on average, about 48 percent of fee schedule payments.

As a geographic payment adjuster, the work GPCI is intended to adjust payments for costs that are beyond a provider's control. Specific to the work GPCI, what are those costs?

In the late 1980s, a Medicare contractor identified the relevant costs as an area's cost of living adjusted for the area's amenities. Thus, the GPCI would account for housing, food and other costs specific to an area. Amenities could include professional factors such as

access to quality colleagues and personal factors such as availability of good schools. Amenities can offset at least some of the cost of living differences among areas.

I'll have more to say about these issues of the rationale for the GPCI in a minute when we talk about arguments for and against it.

The payment areas for the GPCIs are called localities. There are 89 of them. Thirty-four localities are statewide; that is, each one is an entire state. Other states have more than one locality. Pennsylvania, for example, has two -- one for the Philadelphia metropolitan area and one for the rest of the state.

While not the issue in the mandate, you should be aware that there have been proposals to reconfigure the localities. At the April 2006 Commission meeting, staff presented alternatives. Most recently, the Institute of Medicine in a report last year recommended moving to the 440 metropolitan statistical areas and statewide non-MSA areas that CMS uses for payments for institutional providers.

Putting aside for the moment a floor that has been established for the work GPCI, the GPCI can have a range of values. The national average is a GPCI of 1.00. Without

the floor, the GPCI for Puerto Rico would be lowest, at 0.908. The locality with the next lowest work GPCI is Montana, at 0.945. At the other end of the scale, Alaska has a work GPCI of 1.50, a value specified in the statute and not shown on the slide. Otherwise, Santa Clara, California has the highest work GPCI, at 1.077.

Given the value of the work GPCI in each locality and the locality's volume of services measured in RVUs, we can estimate the effect that the GPCI has on spending for fee schedule services. A GPCI generally has effects on locality spending that are in a range from -2.9 percent to 3.8 percent. The exceptions are Puerto Rico and Alaska. Puerto Rico's work GPCI impact is -5.4 percent. For Alaska, not shown on the chart, the legislated work GPCI increases the state's fee schedule spending by 25.6 percent.

The work GPCI has a temporary floor. It was established initially with the Medicare Modernization Act of 2003 and continued with a series of temporary extensions since then. The floor suspends the GPCI in localities with costs below the national average. In other words, if a locality's GPCI would be less than 1.00 without the floor -- say, it's 0.95 -- with the floor, the locality's GPCI

becomes 1.00. Given the floor, the GPCI's effect on spending is limited to the 34 localities with above average costs.

CMS constructs the work GPCI with Bureau of Labor Statistics data on the earnings of professionals in seven reference occupational categories, including in one category, architecture and engineering; another category is computer, mathematical, life and physical science.

If the GPCI were constructed with data on the earnings of physicians and other health professionals, there would be four issues:

One is circularity. Practices receive revenues from various payers, including Medicare. Therefore, revenues are partly a function of the work GPCI. Practices also make decisions about the share of revenues going to the earnings of physicians and other health professionals. If data on those earnings were then used to construct the work GPCI, there would be a circular relationship between the work GPCI and data used to construct the GPCI.

This circularity is an issue some of you will recall that the Commission considered when making recommendations on an alternative method for computing the

hospital wage index.

The second issue is return on investment. CMS notes that the earnings of physicians and other health professionals can have two components -- wages and a return on investment from owning and operating a practice. Calculating the work GPCI with data on those earnings would assign higher GPCI values to areas where practices are more profitable.

In other words, we can take what CMS is saying to mean that if the GPCI were based on the earnings of physicians and other health professionals it would be partly a function of more than just costs that are beyond the control of those professionals.

The third issue is geographic variation in the volume of services. The earnings of physicians and other health professionals are partly a function of the volume of services they furnish. Indeed, the Commission is among those who have documented variation in the volume of services. A work GPCI based on those earnings would be higher in high volume areas and lower in low volume areas.

And, a fourth issue is market factors. In some geographic areas, health professionals have a strong

position -- bargaining position -- relative to insurers. As a result, those professionals can command higher payments with the payments possibly acting as an important determinant of earnings in some areas.

The question about whether to have a work GPCI is a longstanding one. When Congress first considered legislation for the fee schedule in the 1980s, there were concerns about equity and ensuring access to care in areas less desirable to professionals. In response to those concerns, the Congress put constraints on the work GPCI.

First, the fee schedule legislation passed in 1989 limited the GPCI to one-quarter of the relative cost of professional work effort in a locality compared to the national average. For example, if in a given locality the earnings of professionals in the reference occupations were 20 percent above the national average the work GPCI, instead of being 1.20, would be limited to 1.05, or 5 percent above the national average. This limit was established after research had shown that a work GPCI without the limit would range from about 28 percent above the national average to about 16 percent below the national average, a degree of variation perceived by the Congress as too high.

The second constraint is the floor I discussed earlier. It was extended most recently with the Middle Class Tax Relief and Job Creation Act of 2012 mentioned earlier. This is the legislation that included the Commission's mandate for this report. Without further legislation, the floor will expire at the end of 2012, this year.

So, at this point, we've covered the background on the work GPCI. I'd like to shift gears now and say a few words about how the Commission might go about fulfilling the mandate.

Toward that end, we've been working with a contractor for review of relevant economic theory, characteristics of the labor market for physicians and other health professions, and arguments for and against the GPCI.

The relevant economic theory here is called the theory of compensating wage differentials. According to this theory, geographic factors can affect wages in an area, and those factors are the cost of living and local amenities. Amenities include such things as climate, cultural activities and recreational opportunities. And, as I said earlier, these factors can -- these amenities can

offset the cost of living.

So, for example, in high amenity areas, employers can pay workers less relative to the cost of living than in areas with low levels of amenity. That's the general theory.

Now, if we were to think about how it might be applied to this market in particular, you know, and to the question at hand about whether there should be a work GPCI, there are some features of the labor market for physicians and other health professionals to consider. We touched on some of them when talking about the reasons why the data on earnings of these professionals are not used to construct the work GPCI -- for example, the business about self-employment and return on investment, about market power.

A third factor not discussed earlier is that we could expect input prices in this market to be affected by the availability of factors of production that are either complements to, or substitutes for, the work of health professionals. Relevant factors might include hospitals and other institutional providers in the area, providers of medical technology and specialists to whom a professional can refer patients. All such factors can influence the

earning potential of health professionals, and of course, all of them can vary geographically in their availability.

Let me now say a few things about arguments that have been made for and against the GPCI. And, I'm not going to go through all of these, but let me just say a few things about the first two.

The first is the assumption that -- and this may be the most important argument in favor of the GPCI -- is that cost of living varies across areas. The assertion is that it's a cost that's beyond the control of physicians and other health professionals; the payments for the services they furnish should be adjusted accordingly; consistent with the theory, the adjustment should account for an area's amenities.

Another argument in favor of the work GPCI is about access. Some say that a work GPCI protects beneficiary access in high cost areas. According to this argument, if payment rates for fee schedule services do not reflect local cost of living and amenities the supply of physicians and other health professionals will not be sufficient in those areas -- in high cost areas -- and beneficiary access to care in those areas will suffer.

Arguments against a work GPCI are drawn from positions of stakeholders who have argued at least for a floor on the GPCI if not outright elimination of it.

The first argument is that work is work. In other words, some would say that the work of physicians and other health professionals is the same in all areas; so why should work be paid for differently across areas? Essentially, this is an argument of equity.

Another argument against the work GPCI is that the labor market for physicians and other health professionals is a national market. For example, practices in rural areas with low work GPCIs assert that they compete against urban practices, and practices in different regions compete with each other, to hire health professionals. Therefore, rural practices argue that payment rates should be uniform everywhere.

And, a third argument concerns the characteristics of rural practice. Some representatives of rural practices claim they have to pay more to hire physicians to locate in rural areas. The reasons cited include the extra demands and costs of rural practice, such as greater on-call time and travel.

One more argument against the work GPCI concerns the inadequacy of earnings data used to construct the GPCI. Some say that the labor market for physicians and other health professionals may be different from the labor market for the professionals in the reference occupations. The data used to construct the GPCI, of course, omits these differences.

So, as you can see, the slide lists a few other arguments. I won't go into those, but if you have questions about them, of course, I'll try to answer.

To take one step further toward fulfilling the mandate, we thought you might also wish to start thinking about policy options. Given the background on the work GPCI and the arguments for and against having one, two options present themselves.

One option might be to retain the one-quarter GPCI but without the floor. The rationale for this option is that having the GPCI is consistent with theory. However, as just discussed, the earnings data for the reference occupations have limitations, and the prudent course may be to limit the adjustment to one-quarter of relative costs.

At the October meeting, we will present our

contractor's empirical analysis of geographic variation in physician compensation. This analysis includes investigation of the correlation of geographic variation in physician earnings with geographic variation in the earnings of professionals in the work GPCI's reference occupations.

We're still reviewing the contractor's work, but the conclusion so far is that geographically there is no correlation between the earnings of professionals in the reference occupations and the earnings of physicians.

Another option might be to eliminate the work GPCI and make the change budget neutral. Here, the rationale would be that the labor market for physicians and other health professionals has some unique characteristics, such as things I mentioned earlier about self-employment, return on investment, market power, that kind of thing. All of these factors are likely to vary geographically.

And, the question then would be: Are these factors kind of overshadowing or more important than the costs that are measured by the GPCI?

And then, of course, with this, there's kind of the stronger version of the point about how the data just do not support -- may not support construction of an accurate

index.

So, that concludes the presentation for today.

Our hope is that you will discuss the mandate and the arguments for and against the work GPCI and that you will give us guidance on policy options you wish to consider.

At subsequent meetings, we will present the contractor's empirical analysis. We will also present analysis of the work GPCI's impacts, including impacts on access to care.

MR. HACKBARTH: Okay. Thank you, Kevin.

So, Tom, do you want to begin round one clarifying questions?

DR. DEAN: Kevin, the bit about cost of living and amenities available, I didn't quite follow. Do those move in opposite directions?

I mean, in general, high cost areas tend to have more amenities. So, with that, do they potentially cancel each other out, or how do they measure amenities? I didn't quite follow that.

DR. HAYES: So, the answer to your first question would be that in general amenities and cost of living move

in opposite directions.

So, you could imagine that in a high cost area -- and we'll pick Manhattan just as an example -- there would be -- in addition to there being a high cost of living in an area such as that, there would also be, you know, a lot of cultural amenities. There would be opportunities for a spouse to gain employment and all that kind of thing.

DR. DEAN: Right.

DR. HAYES: And, I've been trying to think of examples where they kind of work in the same direction, but I haven't come up with anything yet, but there may be some examples like that.

So then, your second question had to do with, well, okay, how do we measure this. You know, these two components.

And, there are ways, methodologically and through collection of data on prices for things like housing and food and so forth, that you could measure cost of living and how it varies geographically, and there have been some attempts to do this. Some commercial companies actually sell data on this. But, the amenities are kind of an intangible. You know. And so, it's, how do you get a fix

on that?

And so, the contractor that developed the idea of the GPCIs back in the 1980s said, well, you know, we're not going to measure this explicitly. We're not going to be able to measure cost of living and amenities as two things specifically. But, what we can do is kind of look at indirect evidence of what this is, and the way to do that is to look at the earnings of these professionals in the reference occupations -- the architects and engineers and lawyers and so forth.

And so, the theory is that, well, by looking at variation in those earnings you will be capturing the effect of both things together -- cost of living, net of amenities. And, by constructing a GPCI with data of that sort, you'd have an approximation of what it would be and that that would serve as a justification for the GPCI.

DR. DEAN: And then, to follow up on that -- and, obviously, I have some biases here -- there seems to be the assumption that if you don't do this you do create access problems. Has that ever been -- is there any evidence to support that assumption?

DR. HAYES: That if you do not have an adjustment

there would be access problems?

There -- I mean, the problem would be that there -- no, the short answer to your question is no.

One could imagine doing such a study. The difficulty would be that there's lots of things that influence access. So, to say, well, okay, it's this that did it would be a pretty hard thing, a pretty hard study to do.

DR. MARK MILLER: The only thing I would add to that -- and I'm saying it this way because of where you're coming from and that you've expressed your own bias already.

If you think of it as urban and rural, you know we just went through the urban and rural report and did not great differences in utilization and satisfaction between the areas although the issue really is broader than that. It's really about high cost and low cost areas, which can be urban or rural as they break across that continuum. But, at least in terms of urban and rural, you know the work that we just went through on that front.

MR. GRADISON: Yes, I think number 9 would probably pinpoint my question. If you have the floor, then this becomes more costly than if you don't have the floor

because there aren't some -- is that correct?

I mean, how does this work out in terms of budget neutrality if you have the floor versus not have the floor? Maybe that's the best way to phrase the question.

DR. HAYES: For the next meeting, we want to kind of lay all of that out.

MR. GRADISON: Okay.

DR. HAYES: But, our first pass at this would be that there are more work RVUs subject to the GPCI in the floor areas than there are work RVUs generated in the areas above the floor.

And then, it becomes a question of, well, okay, and then how much are those RVUs adjusted, right? And, that will give you the number that you're after.

And so, my first pass at this, it look like there are -- that it would be -- how to say this. Maybe I shouldn't say anything, but I'll --

MR. GRADISON: I can wait until the next meeting if you --

DR. MARK MILLER: Kevin, just to cut through it, we expect that if you continue the floor, it's cost.

DR. HAYES: Oh, yes, that -- certainly.

MR. GRADISON: Try that again. Sorry. I missed that.

MR. HACKBARTH: So, just to build on that, so when the floor was enacted in MMA it was scored as having a cost. It was not done on a budget neutral basis. It cost money.

DR. HAYES: Certainly.

MR. HACKBARTH: So, if you allow the floor to go away, then the question is: Well, what does the baseline say?

Well, the baseline says that it goes away. And so, if you just allow it to go away, that's budget neutral. There is no score attached to that.

But, if you say, well, keep the floor, there will be a score attached to that. It will cost money to keep the floor given the way the --

MR. GRADISON: Because it's an expiring provision that's current law.

MR. HACKBARTH: Exactly.

MR. GRADISON: Thank you.

MR. GEORGE MILLER: Thank you.

On slide 14, could you help me understand your definition of characteristics of a rural practice?

You said arguments against the work GPCI, so you mentioned the characteristics of a rural practice. What are the issues here of the characteristics of a rural practice that argue against a GPCI?

DR. HAYES: These would be what you might think of as items that are not adequately accounted for by the fee schedule's RVUs. They are things that one could -- the argument would be, well, these are things that there -- for which there should be some kind of adjustment.

And so, the arguments that were outlined by our contractor, the arguments that have been made by stakeholders in this area have been that, well, in rural practice -- in rural practices, physicians and other health professionals are -- have greater responsibilities for on-call, for being on call than their urban counterparts, that they travel more, say to get to the hospital to see patients, that there are fewer resources available in the hospital, you know, in terms of technology and so on to turn to given the needs of a patient. And, a fourth thing would be just fewer -- more difficulty in referring patients to specialists just because there may be some more travel distance -- travel distances involved.

Off the top of my head, those are the ones that come to mind.

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

And then, should the floor go away and we kept the GPCI, so that would be budget -- well, it wouldn't have an impact on the budget because it would expire. What would that do to access, particularly in rural areas?

Or, have you measured what it may potentially do to access -- may be the better way to phrase it.

DR. HAYES: We have not measured that, and we would have some difficulty doing that. I mean because it would be -- you know.

It goes back to Tom's earlier question about well, you know, is it isolating the effects of just the change in the GPCI. It would be difficult to do.

DR. MARK MILLER: But, we do have some information on this.

So, your question again is urban-rural? Is that your question?

MR. GEORGE MILLER: Yes, it is. It really is.

DR. MARK MILLER: So, we have to data points that we can look at.

Again, in response to Tom's point, we just finished our work on the rural report that was published in June, and again, utilization rates and satisfaction are comparable. And, we also did that report 10 years earlier, and the same conclusion was reached. So, that's at two time points -- one in which you didn't have a floor and one in which you did have a floor.

Now, those are decades apart, or a decade apart. So, I get that. But, there has been sort of a recent examination in the presence of the floor and an earlier examination in the absence of the floor.

MR. GEORGE MILLER: Okay. Well, a quote -- well, I'll wait until round two. Okay. Thank you.

DR. MARK MILLER: I think the other point I want to draw out of that interaction is, in arraying these arguments, what we're trying to do is capture what people have said. In some cases it's analytical arguments; in some cases it's alternative arguments. And one of the confusing things about the characteristics of the practice is it's not really addressing the GPCI. It's sort of saying, well, the GPCI's out there, I should be, you know, compensated for these other things. And why it's confusing is it's not so

much a GPCI issue. It's sort of other issues.

MR. GEORGE MILLER: Right, okay.

MR. HACKBARTH: Just picking up on George's and Tom's question about the effect on access, obviously that's linked to how much this influences the dollar value paid per unit of service. I can't remember, Kevin, there being any place in the paper where you quantified that. We are, after all, talking about a work adjustment, which represents roughly half of the fee, and we're talking about a one-quarter adjustment, which is what the law provided.

So in terms of, you know, how much would this affect the fee for a typical office visit would be a critical question in examining the likely effect on access, whether in an urban or a rural area. But it is important to keep in mind that it's just the work portion of the fee, and it is one-quarter of that amount.

DR. NAYLOR: So I'm wondering if you could comment on the work of the IOM related to this reported in July and some of their recommendations related to maintaining GPCI but also needing to rely on other strategies to get to the issue of access rather than this as a central one.

DR. HAYES: Sure. The IOM has issued two reports

related to this matter -- one last year and one just this past July. The report last year, I think it's fair to say that the biggest recommendation related to the GPCI in general was just the one that I mentioned earlier about the reconfiguring of the localities going from the current 89 localities to 441 of them.

The other thing that they focused on was just the accuracy and I guess you could say validity of the data from BLS on the reference occupations and that whole idea of constructing a GPCI around the earnings of professionals in those reference occupations. And they recognized the need to not construct the GPCI with data on the earnings of physicians and other health professionals because of the circularity and the other things that I mentioned. But at the same time, just from the standpoint of having an accurate, valid index, they saw some value in doing the kind of correlation analysis that we've asked a contractor to do to see, well, okay, you know, how well do the earnings of those professionals match up to the earnings of these health professionals. And so that was one other thing that they recommended, and pursuant to that was the idea that, well, okay, and if you could do that successfully, you know, that

would be an opportunity as well to explore this issue of, well, what kind of -- how big an adjustment -- if there should be an adjustment, if there is a correlation, how big an adjustment should it be? Should it be, you know, a quarter? Should it be the full thing? What? You know. So that was -- in a nutshell, that was last year's report on this.

Then the report this year was partly, you know, some simulation analysis of what would happen if you go to the 441 localities, and I had a little summary of that in the paper about how well, you know, the -- it would be plus 5 to minus 5 percent change in payments, depending on -- for 96 percent of -- the areas where 96 percent of the RVUs are generated. So that was one thing that they did.

The other point that they made -- and these made it into, in one form or another, recommendations -- was that if you're going to -- if you have concerns about things like access, that there are ways to deal with those issues, mechanisms to deal with, policies to deal with those issues, those concerns that are outside of the payment adjustment, the geographic payment adjustment of the type that we're talking about here that weren't GPCI.

So, for example, we have, as you know, currently a 10 percent bonus is paid for fee schedule services billed from a health professional shortage area. And so their recommendation in that regard was that, you know, concentrate on those types of policies.

The other thing that they mentioned along those lines was that focusing in particular on primary care and recognizing that the nation faces some difficulties, you know, in supply for those services in the future, they talked about the different types of professionals who can furnish those services. So it is physicians and it's nurse practitioners and it's PAs and so forth. And they talked about the limitation -- you know, as we all know, the licensure of these professionals is all subject to state laws. Those state laws vary quite a bit in terms of what professionals can do and can't do and so forth. And so they made some points in their recommendations about allowing -- remember Karen used to make the comment about practicing to the top of their license, and so to paraphrase what she said, they made recommendations along those lines as well.

There may be others, but that's --

DR. NAYLOR: No, that's great. That's very

helpful.

DR. HAYES: That's pretty much what I remember.

DR. NAYLOR: Thank you. Thank you very much.

DR. HALL: Kevin, you did a great job at, I think, making at least partially understandable a very complex metric here.

I've been trying to sort of get more concrete on this and get some sort of idea of how big a deal this is. In looking at pages 7 and 8, the graphs there, it appears that --

DR. HAYES: Bill, you're talking about slides, right?

DR. HALL: Yeah, slides, sorry.

DR. HAYES: 7 and 8.

DR. HALL: It looks like sort of the mid-range would be that overall there's plus or minus about a 2 to 4 percent difference in allowable charges based on the GPCI. Is that right? Am I getting that --

DR. HAYES: Yeah, it's -- the range in general, excluding Puerto Rico, the range I think was minus 2.9 to plus 3.8.

DR. HALL: Okay, so it's not in the 15 or 20

percent range.

DR. HAYES: No, no.

DR. HALL: Or something like that, in some other areas we've talked about. So do we have any idea how the current distribution of GPCI's correlates or doesn't correlate with the largest concentration of Medicare-eligible individuals in the United States? Does it have any relevance to the population we wish to serve?

DR. HAYES: Let's see. Well, let's see. If we go back to this map, we can say that the areas where the payment impacts are in the positive range are primarily California and the Northeast corridor, running roughly from the D.C. area up to Boston. And there are a few pockets elsewhere -- Chicago, Detroit, I think Atlanta, Dallas, you know, some of those higher-cost areas in Texas, those are the areas where the impacts -- so this is a heavy concentration on the coasts and some pockets in between. Does that help you?

DR. HALL: I think what it says is there probably isn't any direct relationship, the two are apples and oranges.

DR. HAYES: Yes.

DR. HALL: I'm not sure that's the right way we should be approaching this in the future, because we know demographically where older populations are likely to reside in greater concentrations in the future. Okay.

DR. NERENZ: Two related questions about the map so it's good that this slide is up. What we see here is basically an effect of large cities, but we don't see all large cities. Minneapolis, Cleveland, Denver, Pittsburgh sort of come to mind. Is there any insight to be gained by that? Is there anything that we can learn about these phenomena because of the fact that some large cities do not show up here?

DR. HAYES: Let's see. Those large cities are in the statewide localities primarily, if not entirely -- well, no, primarily. So that's one insight.

The other thing I can say is that we've ended up with 34 --

DR. MARK MILLER: Can we just make sure everybody catches that? So localities, you know, there's a certain history, which I won't go through, on how localities get drawn. Some states have opted to put the entire state into one locality and have one GPCI value for it so that the

cities in that instance wouldn't be different than the rest of the state that --

DR. NERENZ: Okay. I'm sorry I missed that point. So this is something a state can decide to do?

DR. MARK MILLER: There is a rather sordid and complicated history here. Yes, some states decided to do that.

DR. NERENZ: Thank you. I didn't --

DR. MARK MILLER: State medical societies decided.

DR. NERENZ: I didn't appreciate that. Okay.

DR. MARK MILLER: Is that, at least for a short answer, without like torturing him --

DR. HAYES: Absolutely.

DR. MARK MILLER: -- with 20 years of --

DR. NERENZ: No, no. That helps. Thank you.

DR. MARK MILLER: You don't want that.

DR. NERENZ: Okay. That may get me very quickly then in and out of the second question. If we look then at the map that appears on page 15 in the report -- I don't think you have a slide -- I was just surprised to see that then a couple of the large city areas actually appear to be under because they're not affect -- the floor affected, and

I'm thinking of Miami/South Florida, for example. Does that mean that that metropolitan area that does appear here is actually then under a state average? Does that follow?

DR. HAYES: It would be under the national average.

DR. NERENZ: Under the national average, okay. Just a little surprised, that's all. Anything we learn about that?

DR. HAYES: So the reason for this would be that that's what the BLS data for the reference occupations led to in terms of a result.

DR. NERENZ: Fine.

DR. MARK MILLER: The only other comment that might help is, remember, it's all relative to one another. So it doesn't mean that, you know, somebody in -- I don't know this factually, but South Miami is earning more than, you know, whatever you might have expected in some other part of the country, but relative to some other parts of the country, their cost of living is less.

DR. NERENZ: Yes, got it. Okay. Just making sure I understood.

DR. BAICKER: So it's interesting that a lot of

the problems we have in coming up with the right reference here seem analogous to the problems for coming up with the right references for spending on particular services where we're always looking for a comparison that's the right comparison. When you set prices in the absence of price signals from the market, you have to come up with some number. And so I was very interested in the composition of what the reference group is and how we compare to the reference group and what we can learn about the correlation of -- from the correlation of physician spending and the reference groups. So I wondered if the report that you're going to get will do a couple of things.

One, the other reference professions that were listed in the report, some of them include health professions like nursing that you might think would be similarly subject to the non-market wage determination Medicare factors. So it would be interesting to see, if you take them out, what's left with the rest and what other professions might we think should be in there now that we might not have thought would be in before or that weren't in before, you know, lawyers -- I don't know what else, but other groups that we think might be a reasonable proxy for

capturing what you would expect if we weren't trying to make up these wage adjustments out of thin air. So I'd like to see other reference groups, excluding the health ones, and adding in other ones that might be missing. And then I'd also love to see how that correlates not just with overall physician earnings but with some subset of physician earnings that we think are less muddied by these decisions that we're making now. And I realize that it's almost impossible to disentangle because the whole physician pay structure is not unrelated to what goes on with Medicare payments, but what they're paid from, you know, commercial plans or what they make for non-Medicare patients or what MA is paying them or some other measure. We want to see total income because that's going to capture some of these compensating wage differentials and amenities of different areas and things like that, but we'd also like to see a part that is slightly less contaminated by the idiosyncrasies of this process.

That's a question.

[Laughter.]

DR. HAYES: There are a couple questions in there that I can take a pass at.

The contractor did look at the components of the reference occupations, the individual reference categories, and I haven't looked at the data, the results carefully enough to tell you what that says, but there is some potential for us to report on that.

On the muddiness of the data, the one thing that the contractor tried to do -- I'm not sure whether they were successful or not -- there was a hope going in that we would be able to focus on employed physicians as opposed to the combination of employed and owners. But there, again, I'm not -- and the third thing -- and this is probably the most important thing, I would say -- is that, you know, in no way, shape, or form would I want to overpromise what we can do here. I mean, as a metric, as something to try to measure physician compensation, the compensation of any health professional is notoriously difficult to get under any circumstances, and here we're trying to do not just that, but to do it geographically. And so it's just that you've run into some really, really nasty data constraints here in terms of sample size and the whole thing. It's really a --

DR. BAICKER: [off microphone].

DR. HAYES: And we're running into top coding where the BLS, you know, caps, tops out the annual earnings number at something like $190,000, which works for a lot of -- but not -- you know.

MR. HACKBARTH: So let me just pick up on Kate's line of inquiry. Would you put up Slide 10, Kevin? I want to make sure I understand the framework correctly.

The idea that is embodied in the current GPCI is this notion of competitive wage compensation theory that you referred to at the outset, and the significance of that is it says that a market wage is a function of the cost of living and amenities. And so that's what took us down this track of saying, oh, we're not going to just simply measure the cost of living differences that physicians face in different parts of the country, which we have pretty well established mechanisms for doing. We need to identify reference groups of professionals to construct the work GPCI.

The decision was made, for reasons that seem logical to me, not to use physicians because of the circularity issues and others, so the task then was to identify other professionals that could be the reference

group, like architecture, engineering, et cetera. So that's how we got on this track.

I'm not sure I think that this whole thing about amenities is a good track for us to be on. I understand the theory, but the reality is that we're having great difficulty in data issues operationalizing the theory. And, you know, as I think about amenities, to me they're in the eye of the beholder. So you think about -- take New York City as an example. On the plus side of the ledger, it would be, you know, culture and lots of professional colleagues for physician opportunities, career opportunities for spouses, and the like. On the other hand, there would be congestion and traffic and crime. And how one weighs those things is entirely a matter of personal preference. And the idea that, well, we need to build our whole construct here in order to somehow not just look at cost of living but look at amenities that we can't measure and are inherently subjective, I feel like we're getting tangled in our underwear. But I'm missing something. Kate's going to tell me what I'm missing.

[Laughter.]

DR. BAICKER: I hate to jump in on that note, but

--

[Laughter.]

DR. BAICKER: Just to react wearing my labor economist hat. I keep one of those stored away for use. I think in some ways calling it "amenities" is labeling something we don't need to label. In a way, it's a broader measure of cost of living that we're trying to capture by just acknowledging people, you know, of similar professional training in New York are paid more than people in another city. Why is that? We don't know. You can call it just cost of living; you can call it because people want to live there, or don't want to live there and that's why they're paid more. You know, you can call it whatever label you want to put on it, but the idea is if we want the wages that Medicare pays physicians to be comparable to what other people with similar training get paid to live in the same location, we need some way to benchmark that. And why they're paid more in some places than others is not so important, I think.

MR. HACKBARTH: And I think I understand that, but then the problem you encounter that Kevin alluded to in his presentation is that, in fact, each of these professions has

their own distinctive characteristics in how their markets work. And so trying to compare the physician market to the engineering market, you end up comparing apples and oranges in important respects. And so you still end up at a dead end trying to pursue this theory as opposed to just say let's do cost-of-living adjustments, we got the data on that, the methods and sources are reliable. And so I just want to open that as a way of thinking about this. That's not a conclusion, but I think we're bumping up against data issues because of the theory that we're trying to embrace. However great the theory is, we don't have the data to do it.

MR. BUTLER: So we're going to hear more I guess maybe next month on the floor issues and impact, and it was referenced that the scoring for CBO I guess would -- you know, this is one that goes away -- the floor goes away unless Congress does something. So I'm trying to still understand. It's the son of SGR or what is the potential pot of money that we're talking about here that would, if we don't -- if Congress doesn't intervene, what's the size of the pot, roughly?

MR. HACKBARTH: So you're saying what would it

cost if we say, oh, continue the floor? If nothing happened, there's no budget effect because the baseline assumes the floor goes --

MR. BUTLER: Correct. I understood your point. So, you know, reinserting the floor has a cost, and do we have any idea how much?

DR. HAYES: It's going to be several hundred million dollars, but I'd want to kind of reserve --

MR. BUTLER: Million, "M"?

DR. HAYES: With an "M," yes.

MR. HACKBARTH: Per year.

DR. HAYES: Per year.

MR. HACKBARTH: And then there would be a ten-year score.

MR. BUTLER: Okay.

DR. MARK MILLER: We're doing that. We don't like to throw these numbers around and then people write them down and run off --

MR. BUTLER: I know you don't.

DR. MARK MILLER: And so we're doing that.

[Laughter.]

DR. MARK MILLER: But, I mean, it would be the

kind of thing where if somebody said, okay, do it, it would be fine, what's your offset, and it wouldn't be -- you know, it wouldn't be just, oh, you can write a check for that, that type of thing.

MR. BUTLER: Okay.

DR. MARK MILLER: You personally write a check.

[Laughter.]

DR. COOMBS: Has there been any hospital indexing for the geographic index for hospitals and providers, any models to look at that?

DR. HAYES: I'm sorry. Ask the question again, please.

DR. COOMBS: Hospital geographic indexing, is there any correlation with that and the providers?

DR. HAYES: No, not that I know of. And the thought, just if I may, the thought would be that there might -- it would be a useful correlation to explore?

DR. COOMBS: Yes.

DR. HAYES: And just to take that one step further, the hospital index that we're talking about here is a wage index, so there would be -- you know, what's driving that would be the earnings of workers in hospitals.

DR. COOMBS: And then one other question, maybe Tom might know this, or Bill. When the floor went into effect, there was probably -- there's some data about workforce in rural areas, so there might have been a jump-up or there might have been no change. Has anyone looked at that transition from pre-floor to floor and looking at the workforce in rural areas?

DR. HAYES: No, no one has done that, and so the workforce that you're talking about would be the workforce -- the physicians and other health professionals billing Medicare, and was there an uptick at that point.

DR. COOMBS: Right. Specifically in the rural areas.

DR. HAYES: I have not seen any numbers on that, no.

DR. UCCELLO: I'm not sure this is helpful, but is there -- in the work that's going to be presented later on, is anyone not going to look at whether or not these different occupations are correlated, not just with the physician stuff but with each other? And you can imagine that the amenities -- the perception of those is going to differ by occupation and area, but kind of how much does

that really matter? And then you can in a sense almost back out what we're thinking the amenities are if we know what the cost of living is, and you can kind of figure out, well, how big of a deal is that really?

DR. HAYES: Part of the rationale for the IOM's recommendation that there be some kind of an analysis here was to see, well, are there some occupations that are more correlated with the earnings of physicians than others, just to that point that maybe it depends on what reference occupational group you're looking at. So we'll look at the contractor's work and see if it helps us with that.

MR. KUHN: Just a couple here. Kevin, is there anything in the literature that shows that a physician chooses a place to practice based on the work GPCIs?

DR. HAYES: There was a GAO report about this, and I'm thinking it was somewhere in the 2004 kind of time frame, and so they didn't really look at -- as I recall, they did not look at numbers. It was more an issue of speaking with recruiters and asking them, well, okay, when you try to place a physician in a particular type of community, what difficulties do you encounter? What response do you get? What feedback do you get? And so the

answer back was that, well, there are some -- financial considerations are part of it, but the more important things have to do with the kinds of things we've been talking about in terms of, you know, employment opportunities for the spouse and recreational opportunities and climate and all that. So GAO kind of came away downplaying the importance of the GPCI as an issue for purposes of placement, Pakistan location decisions.

MR. KUHN: Okay. And the second question is have is kind of coming back to something that two or three people have kind of raised, but it's kind of the order of magnitude. Let me just see if I can get a little bit of a finer point so I can get a sense of this.

Last year, when we spent a lot of time talking about the issue of provider based, a lot of presentations on the CPT code 99213, you know, the general office code. And if I remember right from those conversations, it was $60, $70, or somewhere in that range about what that code paid. So if we didn't have a work GPCI, how much would that impact that code? $5? $2.50? What's kind of the sense of the space we'd have on something like that?

DR. HAYES: You can get an idea -- I mean, we can

do that, you know, kind of in a systematic way, but you can get an idea just by looking at this example that we had on Slide 4. This is a mid-level office visit, and, you know, the specific code here would be the 99213, the most frequently billed service in the fee schedule. And so, you know, without a GPCI, you're looking at -- with no work GPCI at all, you're looking at that 0.97 being the RVU for the service, right? So it's not going to have a big impact.

MR. KUHN: Thank you.

DR. HAYES: And we had -- these numbers, too, also kind of give you a sense of what that -- across the board on average for all services in the fee schedule, that this is what the range looks like, depending.

MR. HACKBARTH: So, Kevin, for our next conversation, if you could just give us a few of those examples for very common services, what the fee would be with and without work GPCI, that would be helpful.

Scott, clarifying questions?

MR. ARMSTRONG: I have one, but I don't think I'll ask it, but if I did, it would be --

[Laughter.]

MR. ARMSTRONG: -- with all due respect to

Congress, why they think this is a good use of our time. So I won't ask that question.

MR. HACKBARTH: Okay. Tom, round two comments or questions.

DR. DEAN: I guess to begin with, I'm just troubled by the semantics of this. We're putting a lot of things under the heading of work which really don't have anything to do with work. And it would seem to me that if we really think these issues are important -- and I have some serious questions about that -- it really belongs in a separate category, whether it has to do with -- and the thing is that we have -- there are a lot of other programs -- and Kevin alluded to one, you know, the 10 percent bonus that's paid, the HPSA issues, and all the complexity of trying to design those, and we're sort of trying to duplicate that within this process in what seems to me a pretty imprecise way. It just seems to me that there's enough difficulty in trying to establish what really goes into the pure work measurement. That's hard enough by itself. And there's a lot of argument about how you construct that. And to add all these other things in on top of it just to me makes it less and less meaningful.

So I guess, you know, that's pretty obvious, I just think that this kind of an adjustment, if it's done at all, belongs in a separate category. It really makes the idea of a -- to call it work just simply is not accurate. And it seems to me that if we were to pursue this, there are much more direct ways to try to get the information. I think talking to recruiters, it makes -- that's a much more direct way to get real-time data and not base it on a whole lot of assumptions that -- and I think it has come out in the discussion. We really don't have -- that really don't seem to me to be very reliable. I guess so be it.

You know, and in terms of the other comparative professions, you know, thinking of my own situation, we don't have any architects or engineers in my area. We do have computer programmers. We've got several fairly sophisticated computer programmers in my little town of a thousand people. But in terms of, you know, comparisons, it just doesn't work for me.

MR. GRADISON: I guess I will be piling on. Even before Glenn spoke, I had made a note to myself to use the phrase about beauty being in the eye of the beholder. I've been troubled, as I gather that others are, by this term

"amenities." At one point I thought, well, maybe I'm missing something, that it's just a matter of terminology, that there's perhaps a more solid way to describe it. But the more I think about it and listen to the discussion of my colleagues, the less opportunity do I see to rationalize it away.

I'm trying to be careful in my thinking because I don't want to suggest that everything that we're asked to do around here can be resolved through objective versus subjective distinctions. I don't want to be in that category of people who know the price of everything and the value of nothing. But having said that, there are two sides to all these things. A lot of people would rather not live in Manhattan, and a lot of people I know would love to live in Manhattan, even if they could just scrape by, because of those special factors that make it attractive. But I don't know how to manage that in a fair way. So if you're looking, at least from this Commissioner, for guidance for the next round, I'd say that unless we can find reasons that haven't been educed so far for the use of what is broadly described here as amenities, I would be inclined to try to find some way to move away from it.

DR. MARK MILLER: Can I just ask you this about that, Bill? Would you still make a cost-of-living adjustment? Or it's just the amenities piece that kind of -- -

MR. GRADISON: Yes. Yes, precisely.

MR. GEORGE MILLER: If I could quote one of my colleagues, living in the real world, for recruiting positions and to Herb's point, I've never had a discussion trying to recruit a physician, especially in a rural area, wanting to know what the GPCI is and how that would impact his or her payment. And so like Tom, I'm troubled by the amenities part of this as well. It probably was a great idea when whoever thought of it thought of it at the time, but to quote someone else, that time now has passed. And I would think that we would want to look at things -- and Tom hit the nail on the head. There's published data from recruiters, and national recruiters, who have this data I think that's more relevant and more current than this mechanism right now.

MR. HACKBARTH: There are probably people here that are users of that data in addition to George and Tom. My experience, which is now pretty dated, was that, yeah,

there are lots of surveys, but they don't necessarily yield consistent results. You know, one of the constraints that you have dealing with a public program is that there are unique pressures put on the data, and that's the reason we're having this conversation. Are these reliable, accurate data? And data produced by various recruiting services may not be able to withstand that test?

MR. GEORGE MILLER: But I think to your point, Glenn, though, at least what I get is a composite from 10, 12 different firms in one document that shows a range of salaries that have been paid so you can compare the -- paid in the last year, and then you can compare them. So not taking just one company but a whole range of them and trying to find the right number for our community and for the things that are offered.

DR. NAYLOR: I don't know that I have much to add. I think to the extent that the work that's being done can help us to understand what are the opportunities to get to improved payment accuracy and equity, and certainly to have no negative effect on access, and so I think it's going to be important because it might be that we now have an opportunity to really say there's a simpler way. Maybe we

don't have to go from 89 to 441 localities to do these -- I don't know but I think that that is exactly the direction that would -- the kind of data that they would present that helps us to understand is there a simpler way using cost-of-living adjustments that are available to everyone and are transparent and so on, that would be great. So I look forward to the data.

DR. HALL: Kevin, can we go back to Figure 1, which is page 6 of the handout, the map of the fee schedule payment localities? It's the map, the figure, the map of the United States with the fee schedules in it. Yeah, that's the one.

We talked about the mostly urban areas. I guess what I'm trying to do is to see whether there might be some justification around the country for continuing the GPCIs that we haven't looked at before.

So in addition to the large metropolitan areas, there are scattered areas around the country where less metropolitan sites, like in Texas and Louisiana, where for some reason these have been carved out as areas with a higher payment -- or higher GPCI adjustment. So just taking an area that I'm a little familiar with, and with apologies

to David who can correct me if I'm wrong on this, if you look at Michigan, which is the state -- for those of you who don't travel much, it's the state in the middle there that looks like a hand, a right hand -- I'm sorry, left hand. If you go over where your little pinky is and go way up in the state, notice there's just a dot, one little area up there in what is the Lower Peninsula of Michigan, and that's called Traverse City, Petoskey, an area that I grew up in. I was surprised to find that that was a high GPCI area, although it does have amenities such as really terrific fishing and hunting and clean air and drinkable water.

MS. UCCELLO: [off microphone] but I think that map is just showing what the localities are, and that's different, I think, from the map that shows what areas are getting more. There's a map in the paper, and I think --

DR. HALL: There is a map in the paper --

MS. UCCELLO: -- that particular area I don't think is a high --

DR. HALL: No, it is. The one at the end of our reading material. Yeah, there's a different map there. So this has no relationship to GPCI?

DR. HAYES: This is the locality boundaries.

MR. HACKBARTH: So this simply says that that is its own locality as a metropolitan area. It doesn't say whether it's high or low.

DR. HALL: I'm sorry. So --

DR. NERENZ: It doesn't go away [off microphone] -- sorry. It does not disappear on the floor-related map on page 15. So that would suggest, I guess, that it's high and not low. I think.

DR. HALL: That's what I thought.

DR. HAYES: All right. Let me just clarify one thing here. So for the state -- you know, in Michigan, there are two localities. There's Detroit and there's the rest of the state.

DR. HALL: Okay.

DR. HAYES: The work GPCI for Detroit is 1.022. The GPCI for the rest of Michigan is 0.991.

DR. HALL: Okay. Then I guess I have to withdraw -- I guess what I was trying to think of, are there some smaller metropolitan areas where at least part of the justification might be that if you've got a concentration of physicians in these areas, that it has important value to Medicare patients, specifically being high concentration and

outreach programs that would justify it.

DR. HAYES: To that, I would say that, you know, just to provide some clarification, that kind of reminds me of the kind of thing that the IOM was talking about when they said, well, you know, there are certain things for which you want to use the GPCI, you know, or a geographic adjuster in general, you know, measurable input price differences among geographic areas. If there are other policy goals to pursue, then you could consider some of these other things more targeted. So that would be a way to deal with the issue that you're talking about.

DR. HALL: Okay.

DR. REDBERG: To sort of echo Mary's comments that I think evaluating the data and simplifying and really looking at what are we getting, because it seems to be a lot of work involved and a lot of adjustments, so that simplification, if we were able to reduce the work and achieve the same goals I think would be overall excellent.

DR. NERENZ: Just an observation. This is actually an extension of Alice's point the last time around. If we just took for discussion purposes the assumption that the full GPCI adjustment was right and fair, and then we

observed that there's the floor effect that's laid on as well as this 25 percent only, it would seem then that we have a situation of a bit of a natural experiment where theoretically then some physicians are underpaid relative to what we have assumed is fair and right and others are overpaid. We could then look at access measures or physician supply measures and just see if any of that at all hangs together. I suspect there's a very weak signal, if any at all, and there's a lot of noise, but at least one might be able to look.

DR. BAICKER: This may be an unreasonable simplification, but it seems like what we're trying to do is see if the COLA is right. Is the cost-of-living adjustment -- what we want to have is a wage that reflects local cost of living. If we just had a COLA that was absolutely correct, we wouldn't have to worry about the GPCI. But then maybe there's some aspect of the cost of living or what needs -- the compensation that needs to be paid to keep things parallel for physicians that's different from everybody else so that the -- and national average or the state average COLA is not appropriate, we need some extra add-on, and that's why we're looking at some subgroup of

professions that we think is most comparable or most adequately captures the labor market that those physicians face. And that's part of why in the first round I was focusing on who's in that comparison group, what are we comparing, because we need some reason to think that the COLA is not adequate. If it is adequate, we should be done, and there should be no GPCI. If it's not accurately capturing the labor market in a way that will ensure adequate physician presence and adequate access for the Medicare population, then we need to do an additional adjustment, and we need to figure out what that right adjustment is by in some way capturing the labor market for a group of people that doesn't face a real labor market. And that's the challenge there.

But I'd love to get away from thinking about whether that adjustment is capturing this aspect of why people are locating there or that aspect. Is it amenities? Is it practice style? What is it? Really I think we don't care why, if we could adequately capture labor market parameters that are hard to extract.

MR. HACKBARTH: So help me, Kate. I'm trying to understand what that may mean in terms of analysis. One

comparison would be if we just used a straight COLA, cost-of-living adjustment, and compared that to the values produced through the GPCI, how do they relate to one another? What are the differences? Is there a pattern in those differences? That would be one type of analysis.

DR. BAICKER: Yeah, so you could see how do wages for different professions compare to an aggregate COLA, and does that seem to capture excess variation?

MR. HACKBARTH: If we were to find -- I don't know what that analysis would show. If we were to find that -- and perhaps you've already done this, Kevin, or the contractor has. If we were to find that, in fact, there's a pretty strong correlation between a straight cost-of-living adjustment and the GPCI using the reference professions, that may make it easier to say, well, let's get out of all of these complex data problems with the reference professions and just use a COLA for which there are established data collection mechanisms, and we'll get similar, more reliable results.

DR. BAICKER: And the answer --

MR. HACKBARTH: And if they're different -- they could be very different, and then what do we do?

DR. BAICKER: And they could be different in at least two different ways. They could be different by just saying -- you know, say the COLA looks like this and the GPCI adjustment makes it steeper but sort of in a highly correlated way, so it's not that they're the same but that the correlation coefficient is similar, the slope is different, you could add a multiplier to the COLA. Or if it's idiosyncratic, some places are higher and some places are lower and it's not systematic, then maybe you say the COLA's not adequate and you need some micro area level adjustment.

MR. HACKBARTH: Let's stipulate for the sake of discussion that there are important differences and, you know, they're idiosyncratic, they're not just uniform, in some areas the COLA is close to the reference profession index, in some cases it's far away. Then the question to me is: Well, which of these two is actually better for adjusting Medicare payments to physicians? Do we believe so strongly in this theory of the reference professions because it's capturing not just cost-of-living differences but amenities and other factors that we want to override the COLA and say, no, we've really got to use these reference

professions? Or alternatively, do we say the reference profession index is problematic because they all have different market dynamics than physicians anyhow, why would we want to tie our wagon to this reference profession index?

DR. BAICKER: I think we would first want to be sure we all agreed on what the goal was. In my mind, at least right now, the goal is to try to capture the market wage that you would need to pay to make it equally attractive to be a physician here or there. You're just trying to capture what the right wage is. And the question is: What's the best adjuster for the right wage? We know the right wage is different in, you know, Mississippi than New York for lots of reasons. Some of those things are captured in the traditional cost-of-living adjustment, but that's flawed, too, or it's imperfect. So the question is: What's the right way to construct the counterfactual of what the wage would be if we weren't setting it ourselves?

MR. HACKBARTH: Yeah, I agree with your formulation, so that is the question. Which of those two approaches -- straight COLA or reference profession -- is getting us closer to that? The problem is there's no way of knowing -- since we don't know what the true market wage

would be for physicians, we have difficulty judging which of those two is producing the right information.

DR. BAICKER: And one thing people have been focusing on is how big a factor is this, and the GPCI adjustment is fairly small.

MR. HACKBARTH: Right.

DR. BAICKER: It adds up to a lot of dollars in the end. But the percentage adjustment is relatively small. It might be interesting to say how big that is relative to just a COLA adjustment.

MR. HACKBARTH: Right.

DR. BAICKER: You know, so that we know we're fiddling around the edges here. And you could say, well, we're fiddling around the edges in a way that's not necessarily so full of information so we just shouldn't do it, or it's as close as we're going to -- we'll make it as close as we can and say it's imperfect but as close as we can get but it's going to be different than the COLA. And I don't have an answer to that myself.

MR. HACKBARTH: So I'll pass the baton to Mike here in just a second, but one other idea that has been mentioned that I just want to link here is that, you know,

one approach would be to say we do a COLA-only adjustment, recognize that there are things that may not capture, but couple that with a shortage specific type adjustment. So if our fees are dramatically out of line and there are real shortage issues as a result, we make a targeted adjustment for the shortage as opposed to fiddling with reference professions and the like.

DR. MARK MILLER: Can I just say one thing before you go on? And I'm not presupposing that that's where people move to. But if we move to that, we'll also probably have to say something in the recommendation about the Congress continuing with what it currently has until a new measure is constructed, because we can do the analysis and say, well, do these things look like each other, how close are they, but then they'll have to go through some process of actually building it and putting it out on the street. So just keep that in mind. So the recommendation might have this is what you do for now, this is where we think you should be going, that kind of structure. Sorry to --

DR. CHERNEW: That's all right. So I actually think we're making decent progress on this. I see three broad paradigms. One of them is the one we've just been

discussing, which is what I'll call loosely an "econ paradigm." We're trying to approximate what wage we would get if there was a real market, which there isn't, and we need to think about how to get the data. So that's one.

I think there's other important paradigms. One of them is there's a fairness paradigm that sometimes gets discussed, and I think that's just a different view of things.

And the third one, which is actually in some ways the one I like, which relates more probably to the econ one, sort of an access paradigm, which is we need to make sure there's good enough access in a given place, and we don't have to worry about all the theoretical stuff as much as we do, we just want to make sure we get access right. And I like that in some ways because I think that whatever we're going to do when we make a recommendation, we should have what I would sort of think about through a program evaluation lens, which is if we recommend -- make a recommendation, whatever that is, what's the impact going to be? And that has to be judged relative to some status quo.

I think one of the problems that we face in this, an increasingly frustrating problem, is we suffer from

status quo confusion. And what I mean by status quo confusion is we have a status quo which has the floors. Current law has a different status quo, which is no floors. And so if we do nothing, you would think that means we maintain the status quo. But, in fact, that's not what happens. If we do nothing, we revert to some new change. And so understanding the impact of our action or inaction becomes important, and I think the right way to think about that, my personal view, is as much as this is going to pain me to say, is I think the status quo that we should think through is a current law status quo, and I think we should ask ourselves, if we deviate -- if we make a recommendation that deviates from current law, do we think we're going to make the world better, and if so, by how much? Or if we don't make that recommendation, you know, will the current law put us in a really bad place? And until we know the answers to those questions that I think are hard to know the answers to, I think we should give some deference to the current law status quo, regardless of whether we think -- you know, so we'd have to think that the fairness paradigm was going to override that or the economics paradigm was going to override that, and we're going to have big

deleterious consequences if we don't make a recommendation.

So I sort of come down on a status quo current law bias until shown otherwise.

MR. HACKBARTH: And just to be clear, the status quo is the floor is eliminated and we revert to the one-quarter work GPCI adjustment.

DR. CHERNEW: Which is not what we actually have now, so that's --

DR. MARK MILLER: Correct.

MR. BUTLER: So I'm going to raise the issue up a higher level when you want to get to the detailed technical level, at least that's what Congress seems to want. So whenever we make decisions or recommendations here, I try to adhere pretty much to the principles that I think we have, and that is, first, is it reforming the system in the way we want it to be reformed? And this is not that issue. This is a fee-for-service one. So that's not one of the criteria we're going to use on this recommendation. Second, how is it impacting Medicare expenditures? Which is relevant relative to the status quo. Third is quality, and fourth is access. And then fifth might be do we need to transition in some way to kind of -- and we kind of -- so I think whatever

-- it's not too soon to think ahead to remind ourselves as well as those we're making this recommendation to that those are the kind of principles -- it's not fairness, it's not some of the other criteria we're throwing out there. It's really some of these things that we're trying to do as a Commission. So I think that will -- I hope that will help guide some of our thinking, and I do think that the access one and the expenditure one do definitely play a role here in terms of how we're going to come forward with our recommendation.

MR. HACKBARTH: So, Peter, that's helpful, but let me just take it to the next step. So on the expenditure one, Kevin will be able at some point to give us a pretty solid number on what the budget impact would be of not going to the status quo of eliminating the floor.

The access one, if I understand the conversation that's transpired to this point, it's going to be really difficult to reliably assess the access implications of one path versus another. And so what you end up with is a solid number on expenditures and questions in all of your other boxes.

MR. BUTLER: We'll just talk to the recruiters

again or whatever. Right. But at least we should acknowledge that and say we use that filter, but our tools at this point in time to measure that is limited.

MR. HACKBARTH: Yeah.

DR. COOMBS: David said exactly what I wanted to say. I'll take off on your number four, which is access, and if we had a wish list and we could actually tailor what we really want is to be able to look at the impact across the living and then say, okay, in these areas the cost of living -- it's not going to make a difference. But in an access shortage area, you might want to tailor it so that you have an incentive to say, okay, let's really design a system where we could not make these areas disparate in terms of being at a distinct disadvantage in terms of workforce. We have some information on workforce -- physician/population ratios in different areas. We have the data for rural, we have the data for urban and suburban areas. What we are having a hard time getting our arms around is actually care maps in terms of what doctors take care of what type of patients in what areas, and that's something that occurs at the micro level. But I think you have to make some assumptions that if you have a very, very

low number of doctors distributed over large populations, that's going to be an area of significant need.

And so I like the idea of some kind of broad uniformity with some tailoring and designing systems where you say these are critical service areas that show true shortages.

MR. HACKBARTH: So, Alice, we have, in fact, done some work on the relationship between physician-to-population ratio numbers and actual access to services, and the two don't correlate very strongly. There's much less variation in the access and utilization of services than there is in the physician-to-population ratios.

DR. COOMBS: I think that's particularly true when you get to the academic centers because you have such large numbers dispersed over a smaller population. When you get into the rural areas -- and primary care specifically is a harder place to get your arms around.

MR. HACKBARTH: The other major finding was that actually the urban/rural distinction was not that important, and what we found was in terms of access and use of services, much more regional variation than there was urban/rural variation. So in low-use parts of the country,

both the urban and rural tended to be low use. In the high-use parts of the country, both the urban and rural tended to be high use of services. And so the urban/rural distinction is not as powerful as one might think.

Craig.

DR. SAMITT: So I can mostly talk about personal experience. So I've worked in a market that is well above the floor and now I work in a market that is below the floor. And I think my remarks would be the same in the former and the latter. In fact, some of my best friends are in above-the-floor markets.

[Laughter.]

DR. SAMITT: But what I would say is when I was in Boston, I recruited physicians from a national marketplace, and in Wisconsin, I'm recruiting physicians from the same national marketplace. And our compensation methodology is identical. And to make an argument when you're recruiting physicians that we're going to pay you less than the offer you're going to get from other markets because cost of living is lower in our market, it doesn't work. The physician accepts the position based upon compensation without adjustment in their own head for cost of living.

And interestingly enough, even within our own markets, so our organization is in urban, suburban, and rural areas, and you need to know that we need to pay our physicians in rural areas higher than in the urban areas to retain them and for the reasons that we described earlier, that the lifestyle is quite distinct. And the cost of living is lower in the rural areas, and yet we need to pay the physicians higher in those areas to retain them there and to preserve access.

So I do question the relevance of the GPCI methodology. I think my preference would be to not have a GPCI. But if we are going to have a GPCI, I do question the relevance of using these occupational groups, and it's in serious doubt. And while I understand the concerns about the circularity issue, how is irrelevant input better than that? So I think if we were to come up with a new methodology, I wouldn't be in favor of a COLA methodology because in my experience that doesn't correlate, either. I would find a way to use real and viable inputs, and the question is, is there a way to control for it, control for the four areas that were identified that are areas of concern.

So, for example, if we use total physician compensation, maybe we should just look at employed physicians or not non-profit organizations and what compensation is for physicians there, because the circularity issue is not an issue. The return on investment issue is not an issue. Likewise, we can adjust for or modulate for volume by looking at total cost or total income per volume as a way to mitigate the potential concerns and risks about volume.

So I would shift and I would look at something other than a COLA if we are going to preserve the GPCI because I don't think that there's a relevant correlation with the experience that we have in our markets as we actually incur those costs. And the same, frankly, would be true not just of physicians, but nurses and other professions which tends to also seem to be more like a national market.

MS. UCCELLO: I feel like over the past couple years, I get some mixed messages on some of these issues regarding access and payments. So we've been hearing about how, yes, when you're recruiting, how much you're going to pay really matters, and that makes sense to a great extent.

But on the other hand, when we had a rural panel here a couple of years ago, they talked about recruiting and how payments weren't really the problem. It was, I'm going to say, amenities.

So I think we need to -- and maybe that was just a rural or even frontier kind of issue, but I think as we think about some of these things, we need to consider what things really are payment-related and what things aren't that maybe we need to get at in different ways.

MR. KUHN: As I look at this and I think about the fact that there's still a body of technical folks out there who make the argument that Pope and Welch and Zuckerman all made in the late 1980s, that it's necessary that we apply the GPCI to physician work, so that's still out there. But then also we know as this discussion today and others that there's a policy body out there along with a pretty good set of rural advocates that argue more equal pay for equal work. Just get rid of the GPCI entirely.

And so we can see Congress has intervened a couple of times on this by the fact that they just put a quarter adjustment. They didn't agree with Pope and Welch and Zuckerman for the full adjustment. They just did a quarter.

And the fact that in 2003, they put in that floor. So it's pretty clear Congress has intervened to kind of modulate that somewhere in the center.

So having said that, and I'm kind of in the camp a little bit -- of the camp of equal pay for equal work, I think what my recommendation or where I'd like to see us think, look about, is really incorporate that policy objective into the basic design of the fee schedule. Let's get rid of the GPCI for the work adjustor entirely. I don't think it makes any sense anymore as we go forward.

But what we do then is you have a set of recommendations where you put specific separate targeted payment adjustors to deal with the other policy objectives, whether it's access and whatever you need to accomplish, and I think this does two things for us. One, I think it's a lot simpler than some of the other things that are out there right now. But also, it's much more transparent because you then see with those targeted payment adjustments really what are the policies you're trying to achieve and you can see the exact results of whether it's accomplished or not as you go forward.

So I think you simplify the basic fee schedule.

You get rid of that GPCI. You put in -- like I said, I think it's simpler, and I think if more targeted, then I think it's more transparent in terms of the process that's out there.

The big issue that we're going to have to -- the conundrum that we're going to deal with here is how do you then pay for it as you go forward because there would be some adjustments here, and I don't know all the baselines that we'd have to deal with, but I just think in that regard there are some folks, as we can see on those schedules, that will come down in terms of their payment if you moved in that direction. And so then, of course, you need to think about appropriate transitions, however you would want to get to that stage.

So that's kind of where, as I've looked at this issue for several years now and -- I think that's where I would feel most comfortable kind of talking about in the future on this.

MR. HACKBARTH: So, the equal pay for equal work approach would differ from current law, going back to Mike's framework, by saying that not only would there not be a floor, but there wouldn't be any above-line adjustments,

either --

MR. KUHN: That's correct.

MR. HACKBARTH: -- and so understanding what the budget impact of that would be relative to the current law baseline would be helpful.

MR. KUHN: Right. I mean, basically, what it -- there is that body of argument out there, which I subscribe to, I mean, physician work is work. I mean, regardless of whether you're in a rural area or not. I mean, the adjustments are in the practice expense and then the area of liability.

DR. CHERNEW: I need to say something at least about the economics of the notion that work is work and pay is pay. When you're giving someone a wage, you're really trying to give them something that proxies for a certain amount of goods and services that they can buy. So if you were really going to do this, you would give them those what goods and services are. And the idea behind the adjustment is you're trying to make the amount of money you pay them to be equivalent in terms of the goods and services that you're transferring to them as opposed to some nominal amount of things. You would never -- if this was Lira -- or there

aren't any more Lira. Maybe there will be soon. But in any case --

[Laughter.]

MR. HACKBARTH: There may be in time.

DR. CHERNEW: Right. Exactly. But whatever the case may be, if the currencies were just different because they were -- you would never say, well, we're going to give you one dollar versus one Euro and say, well, work is work so it doesn't matter. You would worry about the amount of goods and services that that would buy.

So I think the work is work argument pushes you towards a cost-of-living adjustment as opposed to away from one because you're equating the amount of goods and services they're getting as opposed to some fictitious amount of money that you get into your bank account.

DR. MARK MILLER: Can I answer on a more narrow basis? This is a different point. So given what Kevin said earlier about the dollars that lie below one and above one, if you say, I eliminate it, it probably has a cost. But you could also as a matter of law say, I eliminate it in a budget-neutral way in which case you could make that cost go away. But, obviously, you are bringing people down and

people up.

MR. KUHN: Right.

DR. MARK MILLER: The distributional consequences don't go away,.

MR. KUHN: And my thought was, right, you eliminate it in a budget neutral way, and that's why I was mentioning a transition, because there are some redistributional issues that would play in that. So I think it would be one scenario that's worth looking at.

DR. MARK MILLER: And then, again -- I guess this is obvious, but I'll just say it -- and if you transition, then you are probably incurring some kind of a cost because you're presumably protecting people from the impacts.

MR. KUHN: There could be. You know, I guess it would just look what those glide paths look like and how you construct them.

MR. ARMSTRONG: So, you're last and you run the risk of just reiterating points people have made, so I'll be really quick. First, I do feel, back to my previous comment, a little like we're rearranging deck chairs and ignoring the icebergs on this one, and I guess that's part of our mandated work.

I think this is a decent policy issue and the actual payment structure that's evolved is dated. And this discussion about COLA or other alternatives, I think, is the right way to go. But what's working or what we have here, we need to change.

I guess the one point I would make beyond all that is I thought Peter's point about we care about access, we care about quality, we care about the cost and short-term and long-term viability of the program. Frankly, whatever the investments we're making through this policy, I think it's a fairly poor return on our investment and that our job is to identify the 20 or 30 other examples like this and find much better ways for us to use the program resources than these resources are being used to achieve the overall goals of the Medicare program.

I just found it kind of interesting, in some of our conversation we're saying, well, you know, is the data sufficient for us to know what the impact would be if we didn't spend this money? I would reverse that and say, is the data sufficient to convince us that there's a return on our investment of that money? And I would say, given what we have talked about, the answer would be no.

So beyond that, I think many of the points about specifically what kind of proposals we ought to evaluate and so forth, I would reinforce those points.

MR. HACKBARTH: So let me just pick up on that, Scott. So, like Peter, you're sort of creating, at least implicitly, a framework for evaluating options, and given your take on how important this is in the grand scheme of things, it seems to me that there might be a couple implicit implications. One is that you would avoid options that cost a lot of money to fix a problem. And two, you may want to avoid a lot of redistribution, you know, a lot of hassles and fighting over something that you don't think is very important in the grand scheme of things. So your framework would highlight those factors.

MR. ARMSTRONG: And the quality and access criteria are also --

MR. HACKBARTH: Yes, although as I said in response to Peter, I think assessing the quality and access implications of any of these alternatives is just about impossible to do.

Tom, and then we'll move on.

DR. DEAN: Just a quick point, that I think we

don't want to get lulled into the idea that if we're talking about access, whether it be rural, urban, wherever, any place where it's difficult to recruit professionals, dollars only go so far and there are a lot of other issues that determine whether, in my particular situation, whether we can recruit somebody. If we can -- the amount that we're willing to pay is an issue, but there's a whole lot of other issues that are going to affect that person's decision. And I was advised quite a long time ago by somebody who -- I don't remember who it was, but it was wise advice -- you need to be careful, because you can pay too much, too. And if you only -- if you recruit somebody based only on their interest in how much money they're going to make, we're going to get the wrong people.

And so that if we're really concerned about access, we really need to take a much broader perspective than just the dollars. I don't mean to say they're not important. They really are important and we've got to be competitive. But if we're trying to make up for other big deficiencies, whether it be in the support structure or the colleagues or the communication or whatever, you can't do it with that and you may get yourself in trouble.

DR. SAMITT: The one other quick comment is that we've had a lot of discussion about this and we're still talking about tweaking the fee-for-service world. And I guess my question is, is how compatible is this with where we ultimately feel we need to go, which is a value-based orientation. You know, what role does the GPCI play, no matter how you define it, in the world of value? And I would hope that whatever it is we decide is forward compatible with where we ultimately feel we need to bring this.

DR. CHERNEW: I wanted to say one thing about that. This is a somewhat more technical and mundane version of a much bigger, maybe forward-looking issue about how payment rates should vary across the country just broadly for everything. And one thing I do think we have to think about, per Peter's first criteria about how this moves us forward -- and I agree with everything you said, Peter -- is that what we do here has ramifications for, potentially, what fee-for-service spending is and how that varies across the country, and you might imagine a world in which that becomes a benchmark number for how other payment rates may or may not vary across the country.

So without saying anything about that, this technical issue will potentially set a benchmark that may under some states of the world matter, so it's worth some thought. But I agree. I'm actually where Scott is. How much thought and how much fighting and how much you want to get into is a separate issue.

MR. HACKBARTH: In fact, you know, under the ACO shared savings program, you still have the underlying fee-for-service infrastructure still very much in play --

DR. CHERNEW: Right.

MR. HACKBARTH: -- and so that's a new payment system that is influenced by decisions on these fee-for-service issues.

Okay. Anybody else want a final comment? Seeing none, we will conclude this for now. Obviously, we will take this up at the next meeting, working towards our recommendations in November.

And now we'll have our public comment period.

The ground rules for the public comment period -- well, I'll wait to see if there's anybody who wants to go to the microphone. If not, I'll spare you the ground rules.

Seeing none, we will adjourn for lunch, and

reconvene at 1:15.

[Whereupon, at 12:13 p.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:21 p.m.]

MR. HACKBARTH: Okay. It's time to begin our afternoon session and the first topic is responding to a specific request from the Congress on Medicare payment for ambulance services. John.

MR. RICHARDSON: Good afternoon. This session is the second installment of our work in response to a mandate from the Congress to report on Medicare payment policy for ambulance services.

In April, we presented background information on Medicare coverage and payment for ambulance services and the results from our initial data analysis, literature review, and meetings with industry experts. Staff have continued to work in all of these areas over the summer and today we will summarize our updated analysis and present policy options for the Commission's discussion.

In February of this year, the Congress directed the Commission to conduct a study of the Medicare ambulance fee schedule and submit a report no later than June 15, 2013. The Commission was specifically directed to examine three temporary add-on payments that are used in the ambulance fee schedule, including their appropriateness and

their effect on ambulance providers' and suppliers' Medicare margins. The law also directs the Commission to consider whether there is a need to reform the ambulance fee schedule, and if so, what those reforms should be, including whether the add-on payments should be included in the fee schedule's base payment rates.

While the formal due date for this report is June 15 of next year, the temporary add-on payment policies will expire under current law at the end of this year, which means that the Congress will want to have the Commission's advice as it makes a decision about whether to end, extend, or amend these policies by the end of 2012.

In today's presentation, we will provide you with a brief refresher on Medicare ambulance coverage and payment basics. We will then walk you through the updated information we have prepared since the spring on our various trend analyses and discuss the key policy issues that arise out of those analyses. We will also summarize the existing research on ambulance provider and supplier costs and margins and then briefly review the ambulance benefit program integrity issues that the HHS Office of Inspector General has focused on over the past several years. Last,

we will present you with an array of policy options to discuss.

This slide and the next outline Medicare's ambulance coverage policies. Since we went over this material in the spring and the details are in your mailing materials, I will only touch on a few essential points.

Ambulance services for both emergency and non-emergency transports are covered under Medicare Part B, and as a Part B covered service, each transport generates a beneficiary coinsurance liability along with a Medicare payment. When covered, Medicare pays 80 percent of the ambulance fee schedule amount and beneficiaries are liable for the remaining 20 percent.

The key coverage requirement is that the beneficiary's medical condition must be such that the use of any other method of transportation is contra-indicated, that is that the beneficiary cannot be transported by any other means from the origin to the destination without endangering the individual's health. Several other specific conditions for coverage are listed on the slide.

Ambulance trips during a Part A covered hospital or SNF stay generally are not separately payable under Part

B, but there are a few specific exceptions to this policy, such as the non-emergency transport of a SNF resident to and from a dialysis facility.

For non-emergency trips that are regularly repeated, such as routinely transporting a beneficiary from their residence to a dialysis or other outpatient treatment facility and back, Medicare requires the ambulance supplier to obtain a signed physician's order certifying that the use of any other method of transportation is contra-indicated. An exception to this general rule is that Medicare currently does not require a physician certification statement for non-recurring non-emergency transports from a beneficiary's residence to a treatment facility.

Zach now will review the basics of how the ambulance fee schedule works and highlight the results of our updated data analysis.

MR. GAUMER: Good afternoon. First, I want to provide you with a brief reminder of how the Medicare ambulance payment system works. Medicare's ambulance fee schedule is similar to other Medicare fee schedules. This fee schedule has a base payment and a mileage payment. The base payment consists of three distinct pieces: A relative

value unit, which is the weight that determines the relative intensity of the ambulance transport; the national standardized conversion factor, which converts the RVU into dollars; and the practice expense GPCI, which is the geographic adjustment factor used to adjust payment for geographic differences.

The mileage payment consists of the provider-reported mileage of the transport multiplied by a national standardized mileage rate.

As you can see in this example, the components of the base payment are multiplied together to yield the base payment of $386 in this particular case. Then this is added to the components of the mileage payment, which amount to roughly $34, to generate a total payment of about $420. This example does not include the add-on payments that likely apply.

There are five ambulance add-on policies active in current law. These add-ons are supplemental to the fee schedule, and mechanically, how this works is that they increase the base payment and/or the mileage payment. Three of these policies are specific to ground ambulance transports and two are specific to air transports.

In addition, these policies are either temporary or permanent and they are additive of one another where it is applicable. The temporary add-ons, highlighted in yellow, expire at the end of 2012, and the permanent add-ons were implemented along with the ambulance fee schedule in 2002.

The first ground ambulance add-on, going from top to bottom on the slide, is permanent and increases mileage rates by 50 percent if the distance of the rural transport is between one and 17 miles.

The second is temporary and increases the base payment and the mileage payment by three percent for rural transports and two percent for urban transports.

The third is also temporary and increases the base payment by 22.6 percent for ground transports originating in zip codes classified as super-rural.

The two air add-ons are linked somewhat. The first is permanent and increases the base payment and the mileage payment by 50 percent if the transport originates in a rural zip code.

The second is temporary and extends or grandfathers the rural air add-on to a specific group of zip

codes that were reclassified from rural to urban back in 2006.

Moving on to the results of our trend analyses, first, we'll talk about the add-on policies. In 2011, the five ambulance add-ons increased payments to ambulance suppliers and providers by approximately $360 million, which amounts to approximately seven percent of all ambulance payments. The three temporary add-ons in particular, those highlighted in yellow, accounted for $200 million, and the two permanent add-ons accounted for $160 million.

In 2011, over 11,000 entities billed Medicare for ambulance services. Overall, the number of these entities increased by about 0.8 percent per year from 2008 to 2011. Six percent of these entities were institution-based providers, such as hospitals and skilled nursing facilities, and the number of these providers decreased approximately 4.6 percent per year during this period. Ninety-four percent of the ambulance entities billing Medicare were non-institution-based suppliers, such as local fire departments, public EMS agencies, or private for-profit and nonprofit companies. The number of suppliers increased 1.3 percent per year during this period.

But using a different source of data, we observe that the number of for-profit suppliers grew more than twice as fast as nonprofit suppliers, at 4.2 percent per year versus 1.6 percent per year during this period.

In addition, private equity made a significant entrance into the ambulance industry in 2011. Three different private equity firms acquired the two largest private ambulance companies and two other large regional suppliers.

Glenn, you asked in April why private equity firms entered the ambulance industry, and some analysts maintain that their motivation was brought about by recent insurance coverage expansions, the aging of the baby boom generation, and their interest in coordinating lines of service across clinical silos.

Now, overall, the Medicare program made $5.3 billion in payments for ambulance services for about 15 million Medicare Part B claims in 2011. This is a little over one-third of the industry-wide ambulance revenue and one percent of total Medicare spending. Medicare payments per fee-for-service beneficiary for ambulance services increased at an average annual growth rate of 5.2 percent

from 2007 to 2011. About half of this is accounted for by claim volume growth and half by growth in payments per claim.

In addition, we observed the slowing of ambulance transport utilization in 2010 and 2011, both in terms of payments and claims. But we also observed continued growth in the number of claims per user. Individually, users of ambulance services had an average of three transports each in 2011, and overall, 15 percent of Medicare beneficiaries used at least one ambulance transport.

To identify if there were problems with beneficiary access to ambulance services, we evaluated trends in Medicare utilization, conducted a general literature review, and spoke with a number of ambulance industry advocates. None of these sources indicated that Medicare beneficiaries lack access to ambulance services. In particular, Medicare claims data suggests a steady increase in utilization rather than a dip or decline.

You can see from the slide above that there has been an increase in the number of ambulance claims per beneficiary, the number of Medicare ambulance users per beneficiary, and the number of ambulance claims per

ambulance user over the time period.

In addition, we specifically looked at the annual growth rates of ALS emergency transports originating in rural and super-rural zip codes and found that both were above average, growing at 2.9 percent and 3.5 percent per year, respectively.

From 2007 to 2011, ambulance transport volume increased by approximately ten percent overall. On a broad level, basic life support transports grew faster relative to advanced life support transports. On a service-specific level, basic life support non-emergency transports grew faster than other service types that account for a large share of claims. And the growth in BLS non-emergency was also more pronounced for transports originating in urban zip codes, which increased 12.5 percent.

Now, further analysis into the BLS non-emergency growth revealed two key additional facts. First, in 2011, 16 percent of suppliers and providers, or approximately 1,000 entities, devoted 90 to 100 percent of all their transports to BLS non-emergency. This group of suppliers and providers accounted for 27 percent of all BLS non-emergency transports. And we also found that the

concentration of these services increased over the time period we looked at, 2007 to 2011.

Second, we identified nearly 1,500 ambulance suppliers that began billing Medicare for ambulance transports between 2008 and 2011. On average, 65 percent of the transports provided by these new suppliers were BLS non-emergency. And in contrast, 41 percent of ambulance transports provided by established suppliers and providers were BLS non-emergency.

Ambulance transports to and from dialysis facilities accounted for 15 percent of all transports in 2011 and 13 percent of all Medicare ambulance spending, or $700 million. Ninety-seven percent of these dialysis transports were BLS non-emergency. In addition, from 2007 to 2011, the volume of claims going to and from a dialysis facility increased 20 percent overall, more than twice the rate of all other claims combined.

We also observed a 50 percent increase in the number of claims going between skilled nursing facilities and dialysis facilities. This type of transport accounts for 45 percent of all dialysis transports.

Just as with BLS non-emergency overall, a small

group of suppliers and providers concentrated their business on transports to and from a dialysis facility and accounted for a disproportionate share of these transports.

In 2009, using data from the United States Renal Data Systems, we found dramatic variation in State-level ambulance spending per dialysis beneficiary, that is, spending on all ambulance services, not just transports to and from dialysis facilities. For example, per dialysis beneficiary spending on ambulance services was approximately $9,500, on average, in West Virginia, and approximately $500 in North Dakota. The median State was Louisiana, with $1,900 in ambulance spending per beneficiary. Overall, spending per beneficiary was significantly higher than average in six States, marked in red above. States above the median level of spending are labeled in orange. And States at or below the median are labeled in green. But I would like to note a more dramatic outlier here was Puerto Rico, with spending of over $25,000 per beneficiary in 2009.

Using Medicare claims data instead of the U.S. RDS data from 2011, we observed that the same six high-use States continued to have significantly higher average ambulance spending per dialysis beneficiary than other

States, and we also found that the average spending was higher in 2011 than in 2009. And this was true across most States. More importantly, the wide variation in State-level utilization of ambulance services suggests that more uniform utilization patterns might result in potential savings for the Medicare program. Using those 2011 claims, we estimate that if ambulance spending per dialysis beneficiary in high-use States were brought to the level of the national median, Medicare might save over $460 million per year.

And now, John will discuss our analysis of costs.

MR. RICHARDSON: When trying to assess ambulance providers' and suppliers' costs and Medicare margins, the basic issue we encountered is that CMS does not collect cost data from the suppliers that make up 94 percent of the entities billing Medicare. We examined the cost reports that are available from providers, such as hospital-based ambulance services. We found that costs were not consistently reported nor generalizable to stand-alone ambulance service suppliers.

So the best information available on costs and margins is in two GAO reports that were published in 2003 and 2007. One key finding in both of these reports is that

low-volume providers have higher costs per transport. Looking for a specific definition of low volume, that is the point at which per trip costs increase significantly, it came out to about 700 transports per year. This preliminary estimate sounds reasonable considering that if a supplier kept an ambulance and crew at the ready for 24 hours a day but made only 700 transports per year, the fixed costs alone of each trip will be quite high.

Another key data point from the 2007 GAO report is their estimate that the average Medicare margin in 2010, assuming that all of the temporary add-on policies had expired, for a stand-alone ambulance supplier would be negative six percent. It's important to note, though, that because this estimate was based on a small sample of suppliers, the 95 percent confidence interval around that average range from negative 14 to positive two percent.

Under the same law that directed the Commission to produce its report, the GAO was directed to update its 2007 report on costs and Medicare margins, and this report is due in October and we understand will be based on a new survey of 2010 industry cost data.

Now turning to fraud and abuse involving the

Medicare ambulance benefit, we found that the HHS Inspector General has conducted several activities in this area. In the 1990s, the IG found that many dialysis-related transports did not meet Medicare's coverage requirements and also that many ambulance transports were not medically necessary because alternative forms of transportation were not contra-indicated. In a 2006 report, the IG found that a quarter of transports, mainly non-emergency and dialysis-related, did not meet program medical necessity requirements when the transported beneficiary's medical records were examined. There also have been several specific cases where ambulance suppliers and providers were found guilty of fraud. Some of these cases involved unnecessary use of ambulance transports to and from dialysis centers and some involved inappropriate upcoding of claims from basic life support to advanced life support services. In short, it appears that the ambulance benefit is vulnerable to fraud and abuse with non-emergency and dialysis-related transports a particular area of weakness.

This concludes the background and analysis sections of our presentation. David now will present a series of policy options based on our analysis and then open

it up for your discussion.

MR. GLASS: Thank you, John.

The first policy is the temporary ground ambulance add-on. This policy cost about $134 million in 2011 and adds two percent to urban and three percent to rural ground ambulance payments. Use of the benefit has been increasing and there is no evidence of access problems.

The evidence from the GAO report was that the average margins after removing all the add-ons may be negative, that the confidence interval was wide, as John said, and that cost data are somewhat dated, from 2004. The forthcoming GAO study may provide new evidence on margins and costs. We also note that we have no evidence on margins for the efficient provider. We do see evidence of suppliers coming into the program, private equity entering, and volume increasing.

So there are two policy options here. First, if Congress takes no action, the policy will expire and payments for ground ambulance transports will go down.

The second option would be for the Congress to fold the add-on payments into the base rate. This action would increase Medicare spending relative to current law,

but might make sense if there are legitimate fears for access to the benefit if rates are reduced.

In choosing between these options, the Commission might want to consider the direction of costs and margins in the forthcoming GAO report and that the conversion factor is updated each year by CPIU minus productivity. The 2012 update was 2.4 percent.

The temporary super-rural add-on cost $41 million in 2011 and affected over 500,000 transports. It increases ground ambulance-based payments by 22.6 percent in the designated zip codes. The intent is to raise payments for low-volume providers serving isolated areas because they face circumstances beyond their control that raise their costs. However, we find that the policy does not efficiently target low-volume isolated providers. For example, over two-thirds of super-rural zip codes are not in frontier counties.

There are two policy options. First, let it expire. This requires no Congressional action.

Second, combine it with the permanent rural short mileage add-on policy, which increases the mileage rate by 50 percent for all rural zip codes, and replace both add-ons

with a well-targeted low-volume isolated payment policy. This could have some cost or be designed to be budget neutral.

In the paper, we sketch out how one such policy could be designed. It would determine how many transports the zip code or area surrounding the zip code would generate. If that number of transports were less than the low-volume threshold, payments could be raised. Because some payments today go to zip codes that are not particularly isolated or low volume, a properly designed policy might be budget neutral.

The temporary air ambulance add-on policy cost $17 million and raised payments for only 8,000 air transports in 2011. It provides a 50 percent add-on to urban areas that used to be designated as rural areas. It was justified as a transitional policy following OMB's redesignation of rural and urban counties. It has been in place for four years, arguably long enough for providers to adjust to the new designations.

The two options are let it expire, which requires no Congressional action, or retain, which would add spending.

The issue with non-emergency recurring dialysis-related transports is that their volume is growing rapidly, about twice as fast as everything else that Zach described. In addition, the spending is highly variable by State, with some States over three times the national average and, I think, there is a factor of almost 20 between the highest and lowest State, and that seems very unlikely to be justifiable on differences in health status. Also, there has been rapid entry of for-profit suppliers focused on this benefit. All of this is evidence of overuse in some places and even fraudulent use, as the IG has found.

One option would be for the Congress to direct the Secretary to review unusual patterns of use and implement safeguards. The Secretary now has the authority to restrict new entry and re-enroll providers. The Secretary could also enhance physician certification requirement by closing the loophole for non-recurring transports and then enforce the certification requirements more frequently when a pattern of unusually high use is detected. Another enhancement could be to make the nephrologist or other physician supervising treatment responsible for certifying medical necessity. Prior authorization for transports to dialysis facilities

would be another direction. That may require a statutory authority.

Perhaps the first order question is should Medicare pay for non-emergency transportation to or from dialysis as part of the ambulance fee schedule at all. Maybe it is a rare event and it should be covered in some other way. However, as a first estimate, if spending per dialysis beneficiaries could be brought to the level of spending in the median State, the program could save about $460 million a year.

The issue with the BLS non-emergency transports is that they are growing more rapidly than other services and there are suppliers focused on these transports. One option would be for CMS to identify over-valued services with the expectation that BLS non-emergency services would be shown to be over-valued. Eventually, CMS could gather cost data, then rebase the payment system to drop the RVU weight for BLS non-emergency and recalibrate the other values. However, in the interim, CMS could reduce RVU for BLS non-emergency transports by some set percentage and preserve budget neutrality overall.

We invite your questions on any of the content of

this presentation and the paper, and also, we would appreciate your reactions to the policy options we have introduced.

MR. HACKBARTH: Okay. Thank you very much.

Let me just say an additional word for our audience about our plan, our schedule on this issue. As John indicated at the outset, we've been asked by the Congress to provide recommendations before the end of the calendar year, and to meet that objective, our plan is to have today's discussion. Based on this discussion, we will formulate draft recommendations to be considered at our October meeting and then final recommendations for a vote at our November meeting.

So, Peter, do you want to lead off with clarifying questions?

MR. BUTLER: [Off microphone.] No, I will pass.

MR. HACKBARTH: Okay. Alice.

DR. COOMBS: One question I had is the data that's been portrayed here, were you able to correlate that with alternative means of transportation for the non-BLS and non-ALS transportation? In the regions where the greatest increase in non-emergent transfer, was there any kind of

correlation with the availability of alternative or substitute transportation?

MR. GAUMER: Such as a Medicaid benefit or some other State-run --

DR. COOMBS: Yes.

MR. GAUMER: We weren't able to do that. I do know that there is wide variation in the availability of alternative transportation sources, such as those run through Medicaid.

DR. COOMBS: Right.

MR. GAUMER: But that's something we could look at.

DR. SAMITT: On Slide 16, it's just such a striking representation of variation. Is there any greater indication as to what the drivers are for such a distinct utilization of transportation for dialysis from State to State?

MR. GAUMER: It seems unclear, generally, why there is such variation from State to State. I guess I'll remind you that this is not just transports to and from dialysis facilities. This includes all transports, you know, of a dialysis beneficiary, you know, to the hospital

for something unrelated or related. We're not exactly sure why there's such State variation. If you guys want to --

MR. RICHARDSON: No, just to make the observation these patients all were sick enough to require dialysis, so one question would be is there some kind of systematic variation in their health status that would account for some of the differences. But this is a very small, relatively homogeneous population, so it seems unlikely that there is that kind of factor driving it.

It's also interesting that some of the states on the far right are rural, North Dakota being the lowest, and West Virginia is obviously rural as well. But given the way the fee schedule is structured, rural transports tend to get higher payments, so, again, that seems counterintuitive to what we're seeing here.

MR. HACKBARTH: Let me just pick up on Craig's question. Are there data on distances and time traveled by beneficiaries receiving dialysis? My vague recollection --

MR. GLASS: The claim would have distance -- go ahead.

MR. GAUMER: Yeah, the claim does have distance on it, so we could look at the distance. We haven't done that

for the dialysis-specific ones.

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

MS. UCCELLO: You mention a 2012 GAO report that's coming out. I'm assuming that's not going to be ready for us before we make our recommendations. I mean, it seems like that could have important information.

MR. HACKBARTH: When is it due?

MR. RICHARDSON: It's due October. I don't know if the date in October is specified, whether it's the 1st. We understand that they're diligently working toward that. They were given the assignment about the same time we were, so it's very quick for them, but -- quick for us as well. But as far as we know, they are on schedule to do that in October. The timing is a little bit --

MR. HACKBARTH: And remind me again exactly what their charge was, John.

MR. RICHARDSON: The language specifically said that they were to update the 2007 report, which was based on a survey, a nationally representative survey of suppliers, ambulance suppliers. And so we presume that they will be doing something again like that with a survey.

MR. HACKBARTH: Producing margin information in particular?

MR. RICHARDSON: Industry costs and margins, yes, I believe they're supposed to do that.

DR. MARK MILLER: And if I could just set this up on the out chance that it doesn't happen, you know, in thinking about these add-ons, you know, you think about access and you think about the influx of suppliers as an indirect indication of access. But when it comes Mike's turn, he may have things to say about how much to deal with -- to consider the margin.

MR. HACKBARTH: Why don't you go ahead?

DR. CHERNEW: This is my round two, so I feel especially privileged. I was just going -- I don't believe that margins are a great indicator in general of what we should do, and my personal opinion is if you see a lot of entry, particularly by for-profit organizations, into an industry, the extent to which I would accept margin data, as noisy as it is, as an indicator of profitability would be really low.

MR. HACKBARTH: And, of course, you'll recall, Cori, that in doing our update in general, we usually have

margin information, but it is only one of a number of factors that we consider in our analysis, including entry, access to capital, access to care for beneficiaries, and quality.

Herb, clarifying questions?

MR. KUHN: Yeah, just a couple. Staying on that theme of margins, again, we've got the '07 report which has the negative 6 percent, although there were some -- the confidence intervals you said create some variation. Obviously, we don't have access to any cost report information here. So as Glenn just kind of reiterated, you know, we look at access, private capital, expansion, all that kind of stuff. But the industry -- that is, the ambulance industry -- when they talk about this issue, they say access isn't enough, that there are a lot of state and local mandates that impact their behavior and impact their cost. How do we factor those kind of questions that they're asking into kind of our assessment or analysis?

MR. GAUMER: We've also heard that there's wide variation on the state level in terms of licensing the types of technologies they have to have, response times, and a variety of things that differ from state to state. And

we've heard from the industry that they do affect costs. You know, we haven't been able to factor that into our analysis in particular other than to look at spending and variation from state to state. And I don't think GAO reports in the past have gotten into that issue either.

DR. MARK MILLER: Those mandates would affect their costs, right? And so I guess one thing is what direction does the GAO report sort of show.

MR. KUHN: Right.

DR. MARK MILLER: Again, notwithstanding -- you know, I mean Mike's view is I'm still not sure it's much of an indicator, but what direction does that move in could be a question that GAO's -- which direction the margins move in could be a question that that report informs.

MR. RICHARDSON: And one other comment would be that if you're concerned about the paucity of cost data, one of the things you could consider doing is making there be some routine way of gathering that information.

MR. KUHN: Right, okay.

DR. MARK MILLER: Also to say about, in our conversations with the industry, there's real concern about trying to collect in a uniform -- and I know you guys know

this, but in an uniform way, because they argue very strenuously that they're very different configurations, on the part of the hospital, on the part of the fire department, on the part of for-profit and not-for-profit. You know, their point is that, you know, sort of getting an instrument that really gets at the real cost of each of those types of configurations is extremely difficult. They've impressed this point on us.

MR. KUHN: Yeah, I can imagine each one is -- I just see the variation of our state of the different kinds of locus of ownership and the control, et cetera. Maybe during the public comment period the industry could share with us some thoughts on this, if possible.

A couple of other quick questions. On the dialysis transport, are a lot of the folks that are getting dialysis transport, are they dual eligibles or do we know much about their status?

MR. GAUMER: We don't know specifically in our data whether or not they're dual eligibles. I do know that about 47 percent of ESRD beneficiaries are dually eligible for Medicaid.

MR. KUHN: Right.

MR. GAUMER: And we don't have the ability to break that down so far, but maybe that's something we can look at.

MR. KUHN: Okay. And then, finally, it was a little unclear to me in the -- or I'm a little foggy on this one. So for dialysis transport, is physician certification required or not required? And if it's not required, who then authorizes that transportation?

MR. RICHARDSON: It is required, and it has to be renewed at least every 60 days. One of the things that some of our research suggested looking at the IG reports is the extent to which that has to be produced, that the ambulance supplier is supposed to keep it on record, you know, in their files. But whether that's systematically required by the MACs before they actually pay the claims varies across MACs and is not -- there's no national uniform policy on that.

MR. HACKBARTH: John, did I read that it has to be authorized if it's recurring? Is that right?

MR. RICHARDSON: That's right.

MR. HACKBARTH: And what is the definition of "recurring"? How frequently does it have to --

MR. GAUMER: We didn't look at that. The --

MR. RICHARDSON: I don't have my coverage --

MR. GAUMER: I think generally if the claim is -- if the physician certification is signed as a recurring claim, then it is such. If they do not identify them as recurring, then it is non-recurring.

[Laughter.]

MR. GAUMER: Yes, that's right.

MR. HACKBARTH: So if I understand that correctly, it's impossible not to be authorized for this transport.

DR. MARK MILLER: Yeah, I mean, I think there is probably some more structure than this, but, you know, in talking to people across the country and in different settings, whether you talk to carrier medical directors and that type of thing, I think this has a certain looseness to it.

MR. GLASS: That's why in one of the options we discussed you might want to make -- end the loophole for the non-recurring and also actually get the physician in charge of the dialysis for that beneficiary, in charge of the treatment for end-stage renal disease, responsible --

MR. KUHN: And physicians kind of get this, at

least in the DME space, and the old Certificate of Medical Necessity. Now it's updated with the coverage decision that CMS has. They do this for the DME side. It just seems like there's a lot of portability that this can move over to the ambulance side.

MR. GLASS: And there's also the question of face-to-face encounter, which in this case probably wouldn't be a burden on the beneficiary because they're seeing that physician every 30 days anyway, at least.

MR. HACKBARTH: I'm sorry, Scott, for jumping in here, but it's on this same topic. Is the justification purely a medical one that the physician believes that there's some medical risk if the patient isn't transported by ambulance?

MR. RICHARDSON: Right, that --

MR. HACKBARTH: So that's what the physician is certifying, is that --

MR. RICHARDSON: That the use of any other form of transportation would endanger the beneficiary's health.

MR. HACKBARTH: Okay.

MR. GLASS: And the bedridden or --

MR. RICHARDSON: Well, then there are a series of

rules or decision aids that you could use to determine that, for example, whether they're confined to a bed, and that has very specific requirements within it.

MR. HACKBARTH: Scott, clarifying question?

MR. ARMSTRONG: I feel like declaring that this is a recurring question, but for me, I'm having a little trouble with this. Ambulance services and transportation services generally I think of as an investment where you expect a return on lower overall cost of care. And so this just seems to me such a great example of where this fee-for-service payment structure is really hard to do. So my question is, you know, you think about access, quality, cost, margin, contribution to lower total cost of care as criteria for whether payment policy is actually having an impact on achieving our goals. And my sense from your analysis is that we don't see much evidence that payment policy has much of an impact.

Is that a fair conclusion or not? I mean, because our outcomes are kind of all over the map, regardless of the different policies that we've pushed.

MR. GLASS: Well, I'm not sure how you factor emergency ambulance service from a car crash or heart attack

into that.

MR. ARMSTRONG: I'm just thinking about our payment policy so far has had very little impact on the average cost of transport or on utilization, and maybe it has when you more narrowly define the acute ambulance service versus the recurring trip to dialysis or whatever. It's just a little -- maybe I'm overreading it, but my sense from the analysis is that, wow, we have tried a gazillion different add-on policies and basic policies, and we're just not getting very predictably the outcomes that we're trying to achieve.

MR. GLASS: Well, I mean certainly for the dialysis-related it seems not the out one would want to achieve

MR. ARMSTRONG: Okay. So for some --

MR. GLASS: Something is definitely increasing utilization in some states.

MR. ARMSTRONG: Okay. Well --

DR. MARK MILLER: I mean, again, I think it's where you started, David. I would parse something in my mind between emergency, non-emergency, you know, ALS/BLS. For example, the last thing that David presented was whether

the payment rates between emergency, non-emergency -- I don't have all the terminology right -- were correct, and in a sense, since we're getting such an influx with such a focus on that BLS side of things, maybe that suggests that payment signal is not correct.

But I think David is trying to cautiously say don't sweep right across the emergency transports because I think we're less, you know, clear there in making sort of statements about the effect of payment policy.

Is that fair, David? Was that where you were headed? All right.

DR. DEAN: On Slide 12, is that data -- this is the growth data. Do you have that broken down geographically? Because I guess I've always been troubled by saying that if there's overall increase in utilization, then there's no access problem. I mean, I think especially when we saw the other graph of the huge variability in the cost, I mean, there's clearly overuse in some areas. And that would raise a concern that there's probably some areas where there may well be an access problem that would be obscured by this data.

MR. GAUMER: Yes, we did not look at this on a

state level or below a state level. We did look at this by urban, rural, and then the super-rural designation, which is something specific to ambulance. We saw claims growth in all three of those, but that's really the lowest we went below the national level, must breaking it out by urban, rural, and super-rural.

MR. GLASS: But we did look at ALS emergency in particular because that's where, if there were no access, that would be a bad thing. And there it seemed to be growing more rapidly in rural.

MR. GAUMER: Yeah, I think, in fact, it grew about 14 percent.

DR. DEAN: But, I mean, not just urban/rural, but I would say it needs to be broken down into much smaller areas than that. What is, again, the definition of the super-rural? I understand that that's a -- I tried to understand and I didn't quite get it from the --

MR. GAUMER: So what they do is they take counties, and they find the population density of all the counties in the United States, and they rank order them, and they take the bottom 25 percent by population density, and all of the zip codes within those counties are super-rural.

And there's a different jog I guess for the rural definition. To define a rural zip code, it's basically broken down by MSA versus non-MSA, as we're all kind of used to, but laid on top of that is this Goldsmith modification, to bore you to death, and what that is is specific zip codes that have been identified in urban counties that are rural and isolated. So that's in there, too.

DR. DEAN: Okay.

MR. GAUMER: It's very unique to the Medicare program.

MR. GLASS: The problem is that one level that -- the super-rural designation goes off the county, whereas all payments are at the zip code level. You can get zip codes--

DR. DEAN: I presume the zip codes, they don't follow county boundaries at all, right?

MR. GLASS: Well no, even if they -- but even if they do, they just are -- there can be a very sparsely populated area in a county because some counties are very large.

DR. DEAN: Yeah.

MR. GLASS: Right.

MR. GRADISON: I want to make sure I understand

the distinction between the basic life support transport and the advanced life support. My understanding is that increasingly -- and please correct me if I don't understand this correctly because this is sort of anecdotal. But my understanding is that increasingly ambulances are equipped and staffed to be able to do some significant things that arguably improve the quality of care, for example, do certain scans or tests and transmit that information to the hospital so that they're better able on the arrival of the patient to move quickly into appropriate treatment.

Is that part of the distinction between the BLS and the ALS? What's going on there?

MR. GAUMER: The way I think about the difference between ALS and BLS ambulances is staffing. There's also a lot of tools I think that go into it, different technologies that one ambulance will have over another. But I think of it as staffing, and the ALS emergency ambulances will have -- or the ALS ambulances will have a higher level of labor, I guess you could say, a higher intensity of labor in the cab. And, you know, there are ALS-specific ambulances and BLS-specific ambulances in different ambulance companies. It varies quite widely.

MR. GRADISON: And how about the reimbursement rate depending upon which it is?

MR. GAUMER: The ALS is higher RVU than the BLS generally, and they result in a higher payment. And I'll generalize here. In the appendix of the mailing materials, there's more specific averages. But ALS might reimburse at an average under Medicare of about maybe $500 and BLS might be, you know, $425, somewhere in that range.

MR. GRADISON: That's helpful. Thank you for that clarification.

MR. HACKBARTH: So just to follow up on that, by what mechanism is it decided whether advanced life support was necessary and Medicare should pay the higher rate? Where does that happen in the process?

MR. GAUMER: The decision whether or not a call is going to be ALS or BLS is made by the dispatcher or it's made at the scene. You know, the dispatcher could send out an ALS emergency based upon the call, based upon the information that they're gathering. When the ambulance arrives at the scene, we're told that the ambulance can change the level of service from ALS to BLS if the patient presents in that manner. And there are some guidelines

generally that are state variable about what is ALS generally and what is BLS.

So a lot of this is driven by the individual state, the state's rules on what is ALS and what's BLS. But when the ambulance company bills Medicare, they are the ones determining, you know, whether this is an ALS/BLS, emergency/non-emergency transport

MR. HACKBARTH: And there's no mechanism by which Medicare seeks to verify that the designation was appropriate, it just accepts what --

MR. GAUMER: Yeah, and I think John's right here. It's not systematic. The MACs, the Medicare administrative contractors, are in place to handle all these claims, and I think they do a bit of verification on this. I'm not clear about how much they do, but they are in place to do this. And just to follow on the line of the MACs, the RACs really don't get into ambulances at this point.

MR. HACKBARTH: For the new Commissioners, Zach, you may want to explain the terminology.

MR. GAUMER: Sorry about that. Medicare's recovery audit contractors, the folks that are auditing claims kind of after they've been processed to recover

dollars that they think might have some lack of medical necessity or some other problem.

MR. GLASS: But some of the OIG cases they did, the charge was up-coding, presumably of BLS to ALS when they shouldn't have. So there may be some way -- there must be some way of auditing it to figure out what was correct.

MR. RICHARDSON: Right, that --

MR. HACKBARTH: Remind me, did GAO -- or OIG, rather, conclude that there was a big issue with up-coding?

MR. RICHARDSON: They had found in some individual cases, most of the --

MR. GLASS: In some of the specific cases that we looked at, there was --

MR. RICHARDSON: There was up-coding.

MR. GLASS: There was up-coding.

MR. RICHARDSON: The issue, I was going to say, is that you need to go the beneficiary medical record to do that, and that is not systematically part of what the claims processing contractors are doing.

MR. HACKBARTH: Okay.

DR. REDBERG: Glenn, just to clarify, you said that, if I understood you, the emergency vehicle at the

scene could decide it was BLS when they arrived and they thought it was ALS, do they like lose a staff member because it was a staffing difference? How do they do that? Or it's the same --

MR. GAUMER: No. Then it's dependent upon the status of the patient and the level of care that they're going to have to provide. You know, they can downgrade if they need to. They can also upgrade. If they're called out for a BLS call and they're an ALS ambulance, they can go out and serve that patient, and they might decide at the scene that it's actually more severe than was reported and it's an ALS transport. So there's this on-site decision.

DR. REDBERG: It's the same vehicle and it's just the level of service they're giving according to the situation, theoretically?

MR. GAUMER: Correct.

DR. DEAN: [off microphone].

MR. GAUMER: BLS could not go to an ALS call. That's right.

DR. DEAN: They might get called but they still -- they couldn't provide the service [off microphone]?

MR. GAUMER: That's right, yes.

MR. GEORGE MILLER: On this slide, does this include -- does this encompass everything both emergent and non-emergent in this slide here?

MR. GAUMER: Yes.

MR. GEORGE MILLER: Okay. And then, as you have looked at the data for both rural and urban -- and I would doubt this question has anything to do with urban, but have you been able to determine what communities in the rural areas have only one single provider? And is there a significant difference for those areas that one way or the other just have one provider as far as utilization? I noticed you had West Virginia, which is a rural state. Any significant difference between West Virginia and I think it was North Dakota?

MR. GAUMER: We haven't looked specifically at areas to find out which geographic areas have only one provider or maybe just one or two or less than average. We do know from the claims that, you know, these areas exist. In some of the conversations we've had with the industry, there are certainly isolated providers out there that are serving all of Jackman, Maine, or what have you.

MR. GEORGE MILLER: Or Stockton, Texas.

MR. GAUMER: Or Stockton, Texas.

MR. GEORGE MILLER: Okay. I'll come back in round two.

DR. NAYLOR: So what an unbelievably comprehensive report. Thank you. Slide 16. Oh, no. Maybe it's my 16. Well, let me just ask the question. Fifty percent of the growth in dialysis is from skilled nursing facilities, and we heard earlier today 10 percent growth per year in chronic kidney disease as the number one grower of chronic conditions. I'm wondering, are we seeing a big rise in the use of dialysis by people either in post-acute or long-term care?

MR. GAUMER: I'm not sure that we can speak to that. We can look to the staff for growth in ESRD, but...

DR. NAYLOR: And related to that, how else would someone from a facility such as a skilled nursing facility get to a dialysis unit?

DR. MARK MILLER: Just for a second, I think the slide number you're looking for is 21, just to put up -- you were looking for the 50 percent point? Was that what you were looking for.

DR. NAYLOR: Yes, it says 16 [off microphone].

DR. MARK MILLER: I think if you -- oh, okay. I'm sorry. You're right, the one you were on, 15. Okay, or whichever one it was. I guess the thing on this SNF point is what we know here -- and I'm looking for some help, guys. What we know is that the origin of a trip is from a facility that has been certified to be a SNF. Okay? The person who actually gets into the ambulance at that point may or may not be a SNF patient. They could be a dual eligible who's in nursing care at a facility that's certified to do a SNF.

DR. NAYLOR: So either way, they're either in post-acute or long-term part of the nursing home. And I just wanted --

DR. MARK MILLER: Is that --

MR. GAUMER: That's correct, and the reason for this is this is coming off of claims data, and what we have essentially is a flag that says -- a flag submitted by the ambulance company saying that this case came from a SNF. They could be identifying this facility as a facility that just does SNF care, but it doesn't say specifically about the beneficiary themselves.

DR. NAYLOR: Thank you. And one last question. On the cost to the beneficiary, you in the report say it's

either -- it will be dual eligible or supplemental. But do we know how many beneficiaries are actually paying the 20 percent out-of-pocket?

MR. GAUMER: No, we don't.

DR. HALL: Stay right on that last slide, which shows tremendous state-by-state variability in hemodialysis charges for transportation. I think this data might be mined a little bit more, particularly if we look at the individuals in SNFs. One thing about dialysis is it's not an optional transfer to a hospital facility. This is not like someone has chest pain and it turns out they didn't have any pain at all, which often happens in a lot of emergent transport. So basically I think we can eliminate the fact that people are doing sham dialysis or that there's fraud and abuse in this particular area.

What I think would be interesting would be to see -- so taking that assumption, is this possibly a natural phenomenon of an aging population of dialysis patients? If you ever go into a dialysis unit, what you're impressed with is the frailty of the population, and this has changed dramatically over the last 10 or 15 years. These are people who it's impossible to imagine they could be transported any

other way. And if there's a payment stream for it, I mean, I don't -- so I think the question is if you -- maybe you already looked at age adjustment, but if you haven't done that, I would suggest we do that. It might give us some more insight into this issue.

MR. GLASS: I guess the thing is if you look at -- I mean, are they more frail in, Rhode Island than they are in Maryland?

DR. HALL: No.

MR. GLASS: Then why would there be this tremendous difference?

DR. HALL: Well, I don't know.

MR. GLASS: I guess that's what struck us. They're very reasonable -- and, by the way, apparently the ESRD population is growing at 4 or 5 percent a year.

DR. NAYLOR: Okay.

MR. GLASS: So it's still much faster than that.

DR. HALL: No, I think it's probably some phenomenon of ambulance companies and local custom more than anything else. But I think we do have to know a little bit more about age.

MR. GAUMER: Just to answer that point, we haven't

looked at beneficiary characteristics of these folks, and we can do some of that.

DR. HALL: I would just do a very simple cut, and probably I would put the cut at 80. A lot of dialysis patients now are in excess of 80 years of age, and I bet you that their utilization is much higher -- well, I'm not so sure of that. We'd have to see what it looked like.

MR. HACKBARTH: So your hypothesis is that at least a portion of this dramatic variation could be because some states have a much higher proportion of elderly, and therefore, more frail dialysis beneficiaries? Am I understanding your --

DR. HALL: That's one possibility. The other possibility is that these states might have organized nephrology groups who have set up different standards for dialysis. That's also a possibility.

DR. NAYLOR: And to some extent, it's reinforced by having a 50 percent rise in use of ambulance services by that population.

MR. HACKBARTH: Rita?

DR. REDBERG: So just to follow on the point of different standards for dialysis, I mean, we know that the

criteria for end-stage renal disease, that's changed dramatically in this country in the last ten years and we are now dialyzing people in much earlier stages, much higher GFRs than we used to and without any evidence of improved benefit; in fact, suggestion of poor outcomes.

We also know that we dialyze a lot more people in this country and spend a lot more on dialysis with poorer outcomes than anywhere else in the world. So I would question. It's true that people are very frail and on dialysis, but the question is, are we making them better with dialysis or are we making them worse.

And do you know what percentage of patients go to dialysis by ambulance? Because I was struck by the rapid increase in non-emergency BLS patients going to dialysis.

MR. GAUMER: We can get that number. We didn't put it in the slide deck, but I think we have it.

DR. REDBERG: And then I'm assuming then the certification for ambulance occurs post-FAF [phonetic], not before the ambulance comes? You don't have to be certified before you call for the ambulance and the ambulance arrives to the skilled nursing facility?

MR. GLASS: Are you talking an emergency or --

DR. REDBERG: For these non --

MR. GLASS: -- these non-recurring --

DR. REDBERG: For the ones -- the recurring.

MR. RICHARDSON: Yeah, there actually is a requirement that the ambulance supplier get that within 48 hours of the transport.

DR. REDBERG: 48 hours after the transport?

MR. GAUMER: Yeah, I think that's right, 48 hours after.

DR. REDBERG: And who certifies that that occurs 48 hours after?

MR. GAUMER: I think the ambulance supplier or provider is responsible for certifying this 24 -- 48 hours after the transport has occurred.

DR. REDBERG: They certify it to the carrier?

MR. GAUMER: They're responsible for getting the certification.

MR. GLASS: The physician certification.

MR. GAUMER: The physician certification.

MR. RICHARDSON: But your question, who makes sure that that happens?

DR. REDBERG: Correct.

MR. RICHARDSON: That's a good question.

DR. REDBERG: And then my other question was on the air ambulance. I know there's been a lot of publicity about accidents from air ambulance, and did you look at all -- did that tend to occur more in for-profit or what type of -- or were there any patterns to it?

MR. RICHARDSON: We have talked to a couple of groups, patient advocates and industry groups, about that. We didn't do a systematic analysis of it. We looked at the GAO report that came out in 2010 where they spent a considerable amount of time and resources looking at that. A lot of the same issues came up.

It not only involves ambulance payment policy, there are numerous regulatory issues, transportation -- Department of Transportation policy issues affect it, because when you get into air ambulances, you're involving air transport as well as the medical care involved. So there's the maze of Federal and state regulation on that.

But what the GAO found in their 2010 report is that there didn't seem to be a systematic relationship certainly between Medicare payment policy and what was happening. But there is, arguably, some room there for --

and one of the recommendations of the National Transportation Safety Board when they looked at this was that a Federal agency -- and they suggested the Secretary of HHS do this -- step up and try to systematize all of the regulatory framework that governs air ambulances. To our knowledge, that hasn't happened yet and probably would require some Congressional action as well.

DR. NERENZ: Very quickly, is there any form of Medicare coverage for transportation other than ambulance? Is that the only one?

MR. RICHARDSON: No.

DR. BAICKER: So quick question about this slide. My understanding is that this is all ambulance rides incurred by people who happen to be on dialysis, that it's not dialysis-specific ambulance rides?

MR. GAUMER: That's correct.

DR. BAICKER: And so then, the argument which makes a lot of sense to me is that these people should be relatively similarly sick. By the time you're on dialysis, there shouldn't be a lot of differential risk adjustment, although there might be differences in age profiles. It would be interesting to see how those rates correlate to the

rate of dialysis in the Medicare population in those states just to make sure that it isn't that you're creeping much further into the healthy distribution in some states than others.

But assuming that that's not the case and that this profile is uncorrelated with the rate of dialysis in the different states, then what I'd want to know is how it correlates with things like trips to the hospital. Is this about ambulances or is this about some states are sending people to the hospital a lot more and that the rate at which people are getting to the hospital by ambulance is similar across states, or is this about extra ambulance use conditional on other resource use?

Is this a marker of some places are just churning through a lot more services or is there something about the ambulance payments in particular or the ambulance use in particular? Maybe you already know the answer to that.

MR. GAUMER: No, we don't. We can look into it, though.

DR. CHERNEW: I have a quick question about Slide 23. In the bottom option, you note, CMS can identify over-valued services. I think it's worth saying whether over-

valued means relative to the cost of providing those services, or relative to some aspect of what the alternative transportation method is, or some measure of actual value. We talk about them in a different --

MR. GLASS: Well, this, I think, would be relative to other ambulance services. So BLS non-emergency relative to ALS emergency.

DR. CHERNEW: Or relative to know. A lot of times when we think of RVUs, we think over-valued, I mean, relative to the cost of that particular service.

MR. GLASS: Right.

DR. CHERNEW: And that's not how you mean over-valued.

MR. GLASS: I don't think we'd know that here.

DR. CHERNEW: Right. So you mean over-valued in some different context --

MR. GLASS: In a relative sense to other ambulance services.

DR. CHERNEW: I understand.

MR. GLASS: Because I don't think we have the data to do the other.

DR. CHERNEW: I understand. Just when we say

over-valued in our other language, we use it in a different way than I think --

MR. HACKBARTH: I find myself wondering how Group Health Cooperative or Dean Clinic or Henry Ford might be dealing with the same issues where there are patients that need to get to their dialysis -- this is a critical, clinical issue -- and may have transportation issues that get in the way. But ambulance, whether BLS or ALS, may not be the most efficient way to deal with it, and maybe that's what your question was getting at, David. Is there any way that we can sort of bring that alternative experience into the discussion and shed light on this? Any data or -- I don't know.

MR. ARMSTRONG: We'd be happy to. I can't answer that just off the top of my head, but we'd be happy to describe what we do. I know it's much more of a volume contract with one or two providers and we really see it as a small cost contributing to overall lower expense trends on a total cost of care for the population.

DR. NERENZ: Similarly, I couldn't answer off the top of my head. Happy to go back and do some checking and look into it. I think my question was prompted by this

observation that seems to be not only in the chapter, but also some of the other background readings we were given where what is nominally medically necessary is not, in fact, medically necessary.

MR. HACKBARTH: It's important that the patient get there --

DR. NERENZ: Oh, sure.

MR. HACKBARTH: But it may not be medically necessary to have this type of vehicle.

DR. NERENZ: Yes, yes. Clearly transportation matters, but the question is, does it matter at that level of supported expense. I would just have the same curiosity about how these benefits that are managed in the context of -- well, Medicare Advantage, for example. Is this a Medicare Advantage benefit and if so, is it managed differently in those settings?

MR. HACKBARTH: Well, we have a chronic problem, David, with not having access at this point to the Medicare Advantage plans encounter data. Hopefully we'll have that soon, but that is an ongoing issue for us. And so, we would be forced to rely, you know, on your organizations as opposed to being able to dip into a Medicare database.

DR. SAMITT: Although to your point, Glenn, I mean, it's the same reason why all of us are looking at this wide variation slide and saying, What can we learn from this variation? Are there best practices?

If we look at organizations that are not even Medicare Advantage that take fee-for-service Medicare, but have been in the value or risk business, how do they manage this trend, and is there anything that can be learned from that, even in a fee-for-service Medicare environment that can influence the rest of the market.

MR. HACKBARTH: Another clarifying question. Would you put up Slide 8, please? So this describes the level of the existing adjustments that we're being asked to evaluate. Is there any empirical foundation for any of these adjustments? How were these numbers arrived at, that the appropriate thing was a 50 percent increase in the mileage rate for the rural short mileage that a 26.8 percent was appropriate for super-rural. Could you just say a little bit about where these numbers come from?

MR. GAUMER: Okay. The two permanents, the ones in white, 50 percent on either one, that comes out of the negotiating rule-making process that set up the fee schedule

to begin with. Going back and doing a historical analysis of how that occurred, information is relatively sparse, but that was something that came out of that process.

The 2 and 3 percent -- this is the second add-on, the temporary, rural and urban temporary, a few years ago those were increased from 1 and 2 percent to 2 and 3 percent, as you see there, and it's also somewhat unclear why those specific numbers were chosen, except for data on margins had been out at that point from the GAO information had been published.

So they were looking at like a negative 6 percent margin when they came up with those numbers. The super-rural temporary, 22.6, that one there's a little bit more history on. What they did was they took a study that was done by Project Hope, Penny Moore at Project Hope, and that was the basis of the fee schedule's RVUs. They used the survey data from there that determined costs of ambulance providers and used that to set up the RVUs.

They also used that study to determine this 22.6 percent. And how they did that was they looked at -- here I have to be very general. They looked at the costs of providers that were in rural areas compared to providers

that were in super-rural areas, and they came out with a number that said that costs in the super-rural were basically 22.6 percent higher for the super-rurals.

MR. HACKBARTH: I'm sorry, Zach. I missed the source of the cost data, given that Medicare doesn't collect it. The cost data came from where?

MR. GAUMER: From a survey. It was 1998 survey data collected by Project Hope and it was on a small sample similar to what GAO has done.

MR. HACKBARTH: Okay. Round 2 comments. Peter?

MR. BUTLER: So several. While I'm no longer -- long departed from Henry Ford Health System, but I suspect your question a little bit is that for the dialysis patients, they're probably aren't a lot sitting in Medicare Advantage plans in these three organizations. So that coordination issue probably is one of the reasons why it's small.

DR. NERENZ: Agreed, yes. In fact, as I was thinking of that question, I wondered whether --

MR. BUTLER: Maybe they're opted out or --

DR. NERENZ: They may be out, but there still may be some more general issues of management of ambulance, even

outside for ESRD patients where we might learn something. But that probably -- what you just is true.

MR. BUTLER: So as I think about where this may be headed, we've said as Commissioners maybe this isn't the highest priority, but we're mandated to do it. But I don't think that that means it's a small issue. I just think it's maybe not in our competencies so much given the time frame and the technical issues involved.

But I would draw to Slide 9 and say that if we are going to -- well, I'll use my filter I was talking about before, access and cost and things -- if we are to make a recommendation with respect to these, it seems to me, based on what I've read, the rural and urban temporary one there and the rural permanent one under air, the rural and urban under temporary under ground and the rural under air are the two areas, if we're going to make a recommendation that's going to impact costs and things, that those would be the areas.

The other ones are pretty minor in the big picture. So if we're not ready or we don't feel we have solid opinions on rates, it's not -- we're not making a big contribution unless we're willing to make a statement on

those, too.

Now, the other two themes that I do think we need to comment on, even if it's not technical, is that the overwhelming data on either the undocumented or unneeded, way beyond dialysis, there's just a big bolus of activity that looks like it's not justified. And that whether we say the OIG or somebody should, you know, redouble their efforts as, you know, we've got other anecdotal -- the Houston story and things like that -- just reaffirm that, you know, keep that up maybe as part of our recommendation.

But the other thing that strikes me is this is an area where discretion given to the CMS is a good idea. Now, they have their own staffing issues, but whether it's, Gee, maybe they have the authority to have moratoriums on new ambulances where it looks like there's a problem, or they have authority to adjust some of these rates directly, we ought to reinforce in this exercise maybe that that's the right place to do some of the pricing as opposed to looking to us as a Commission or Congress to get into those level of details.

So those would be my three comments. If we summarize them again, if we do something, let's make sure

that those two line items I suggested up there, let's reinforce how many dollars are in this apparent overuse category, and then third, give the Secretary a fair amount of discretion to kind of address the issues.

MR. HACKBARTH: Just to pick up on that, I think that's an important observation, that the real money is in the two lines, one temporary and one permanent. Remind me again that the charge was to make recommendations just on the temporary items or on --

MR. RICHARDSON: It was to specifically look at the temporary ones, but then there was a broader piece of the mandate whether the whole fee schedule needed to be reformed or should be reformed. So it was definitely to address the temporary ones that are going to expire at the end of the year, but if you wanted to address some broader issues, that's open, too.

MR. HACKBARTH: Well, so I agree with your observation about, you know, talking about the small adjustments is really not a productive use of time. That's truly rounding air for the Medicare program. I think both rural and urban temporary and the rural permanent raise potentially a theme that has been a common one for us,

namely, targeting.

You know, if the data suggests that the real issue is volume and that there are significantly higher costs for low volume ambulance providers and there are areas of the country that only have one and it's, by virtue of the nature of the area, a low-volume one, I think that's the framework for a pretty compelling adjustment -- argument for an adjustment and to pay more to assure access to ambulance services in areas that would otherwise not have one.

But just to have add-ons when, in fact, there may be many alternatives, many competitors, and in fact, capital flowing into the industry, the arguments are way less compelling. So as I look at those two big items, that would be a question that I would be focused on. To what extent is this money well-targeted to assure access to needed ambulance services in areas that otherwise would not have them.

DR. MARK MILLER: And if I could just at least reinforce one of the ideas, so not focusing on the air rural for a moment, but the top two, the rural short mileage and then the urban and rural temporary add-on. Without talking about the absolute level of dollars, whether that stays the

same or goes down, one of our ideas is, is that those two become a different way of support. You use that pool of dollars to have a different way of supporting ambulance providers and you do it on the basis of low volume and serving very low density areas as the proxy for isolation.

So if there needs to be something that goes on there, it doesn't work like this. It works differently and tracks to the fact that they have low volume and they're actually out some place where there aren't other alternatives.

And, George, that's trying to catch the comment that you were making earlier about, Well, what if there's just one out there? That would be kind of the target.

MR. RICHARDSON: Just one clarification on it. That would be the option of the rural short mileage, the first one, and the third one, the super-rural.

DR. MARK MILLER: You're right. I'm sorry.

MR. RICHARDSON: But definitely picking up on this theme of targeting the payment adjustment more specifically on low volume and isolated providers.

DR. COOMBS: So Mark, I really liked the suggestion you just made. And as I was sitting here

reflecting on what's happening in the rural, because of Slide 13 and showing an increase in the number of ACLS in terms of the budget, a couple things came to mind in that there's some critical illnesses that are time sensitive. Treatment modalities need to be implemented right away, so just acute stroke and TPA, acute MI.

So with that being said, the advent of telemedicine has greatly changed the landscape of medicine in the rural communities such that now you have access to these time sensitive therapies that actually can result in major resolution in terms of permanent complications such as a paretic extremity.

And it would be more important to make sure that those people had access to transportation, because the long-term morbidity from what would happen if they didn't have it is far more serious. And so, things such as stroke, acute MI, also rhomb occlusive disease with peripheral vascular disease, so medicine, the house of medicine is changing along with some of these things that are happening in the rural medicine, bringing urban medicine or, would you say, more academic medicine to the rural community through telemedicine.

DR. SAMITT: Just three things quickly. In terms of the rural and urban, you know, I concur completely that any time we see private equity coming into a market, despite the rationale for why that happened, I'd much -- I think there is a lot of merit in that versus the margins. And so, I'd be comfortable, essentially, letting that lapse given the information we've heard.

The second thing is, I also very much like Mark's idea, and what's, I think, on Page 20, regarding the rural and super-rural in terms of finding another alternative specifically focused on low volume. I think that's an innovative approach.

And the third thing, which may segue a bit into our next topic is really on Slide 22 about the dialysis transports. I wonder whether we should even be thinking more broadly and innovatively, which is, have we ever thought about the applicability of bundled payments in this realm?

So if we bundle dialysis providers, that transportation is essentially a component of the bundle. Then they'll seek to work with patients to find alternative ways of transport, or whomever we bundle. But maybe we can

make another suggestion for addressing this through, again, moving more toward the world of value from the world of fee-for-service to apply it to this as well.

MR. HACKBARTH: Craig, as I think you know, recently, within the last couple years, Medicare has, in fact, moved to bundle payment for dialysis services. This is not currently an element of the bundle, but conceivably could be added to that. Cori?

MS. UCCELLO: I think that makes a lot of sense thinking more about the bundling including the transportation. We didn't talk about this, I don't think, but the principles that you laid out in the chapter, I don't know if we already talked about this last time or not, but those make a lot of sense. So I just want to confirm that.

And part of that is targeting better for volume as opposed to location, so the options that you laid out for that make a lot of sense. But I think there's still an issue of making these payments accurate seems to me they only bring us so far when there seems to be something more going on here in terms of this overuse/fraud kind of area.

So strengthening the ability of CMS or whoever to investigate and take actions on that side of things, I

think, is also an important component of this.

MR. KUHN: Yes. On Page 24, you lay out kind of the reaction to the policy options. So for the first three, the temporary ground ambulance, the temporary super-rural, and the temporary air ambulance, whether it's expire, whether it's fold into the base, whether it's retained, or the other options that have been talked about, I think all those options would be interesting for us to look at as we kind of wrap up this report here and in the next months that are coming forward.

In terms of the dialysis transport, I think Craig is right. I think thinking bundle. But another thing that obviously has come up here in the conversation is the whole notion of fraud and abuse. And so, on this notion, one of the things I've been watching with real interest some news reports over the last month, is the opening by CMS of this new command center they have in Baltimore. It's been opened by the Center for Program Integrity.

And what I understand is that CMS, this new center, they spent about $80 million on it, according to the news reports, and it has a predictive analytics program that permits them to scan fee-for-service claims, that they have

a capability of anywhere from 4 to 5 million fee-for-service claims per day that they can scan where they can look for suspicious billing and coding patterns.

What I understand, this is kind of analogous to what credit card companies do now, where they look for their financial network looking for fraudulent charges out there. So CMS looks like they have built the capability, and then if they detect these items then they have the capacity to then give them to the RACs or whoever they want to of their contractors to go out and look at these issues much more quickly, hopefully, than waiting 18 months or 24 months, what they have in the past, and play the old pay and chase game.

So I guess one would be interesting to learn a little bit more about that effort, and if that is something that -- maybe CMS doesn't want to say who they're targeting -- but is this an area where they are looking at claims, and if not, this might be an interesting area for them to look at claims.

And then also, I would repeat the same thing tomorrow when we talk about outpatient therapy, that this might be an area for this new data mining system that CMS

has to look at as well. So another thing we might want to learn more about and see if that's a tool that we can help direct some of that activity on.

MR. GLASS: If people are getting transported three times a week, round trip, that should be easy to pick up pretty quickly.

DR. MARK MILLER: And we have gone over and talked to the CMS program integrity folks. As you would predict and as you would understand, they didn't want to tell us what they were focused on. We did talk to them about OT and ambulance, which OT we'll talk about tomorrow. But we can still look into what exactly is going on here and how it might help.

In the end, though, it will still be a pay-and-chase proposition. Even though it may be faster pay-and-chase, it's still that. The Secretary -- I want to say this because several of you brought it up. The Secretary does have a lot of new authorities to do things, you know, to say there's no more providers needed in this area anymore, I have plenty of utilization, I don't need any more to get providers to re-up, you know, to sort of try and cull through what might be fraudulent providers. The big problem

always is resources, and if the clarity on what basis you're going after someone is not -- if the standards and guidelines are not clear, it also gets hard to make the cases.

And so, you know, it's always difficult to -- and we should say this -- redirect and even say that the -- you might want to say that the Congress should put resources into it if they want to get control of this problem, but there's even deficits there once you go that direction.

MR. KUHN: You know, part of the issue, too, is they look at this that obviously they have now, what, 15 MACs, I think, you know, from the old days when they had 40 or 50 carriers and intermediaries. But certain ones have edits, certain ones don't, and so there's no consistency across the edits out there, so that, too, could be part of the recommendation process, too.

MR. ARMSTRONG: I won't repeat but I just would concur with the kind of direction that you've been hearing from these guys about both the principles for evaluating the policy options and then the approach that we would take to looking at these.

Just one other point would be that there's post-

acute bundling, there's dialysis bundling, and, you know, after awhile, chunks of these costs may end up getting folded into some of these bundling ideas, and it just might be interesting to kind of pay attention to where are the -- how much of this overall cost for ambulance services could be candidates for getting folded into some other payment structures.

DR. DEAN: I would just echo what Craig said. You know, it occurred to me too that if we're bundling dialysis services and the effectiveness of the service is clearly going to be affected by whether the patient is there or not, it fits well. They're the ones that both would have the incentive to do it in an economical way and the incentive to see that it happens, and it seems to me that it would just fit.

Secondly, I guess the whole issue of physician certification, this is the thing that drives especially primary care docs just nuts, and I would say that we -- it's probably the bane of our existence because we're asked to certify things that very often we don't have any of the information about and do they need this particular piece of durable medical equipment or, you know, are they truly

homebound or stuff like that. It's kind of been an automatic knee-jerk response that if we have to have some kind of verification, we'll get the doc to certify it. And I would argue that, first of all, it's a very ineffective mechanism, and also it's a thing that is very disillusioning, as one of the things that I think you will hear negative responses almost uniformly from primary care docs, and it has gotten much worse over the last five to ten years.

So I would say that's a very undesirable mechanism, plus it's ineffective and it disillusions people.

MR. GLASS: That's what we were wondering what about if the nephrologist, or whoever was overseeing the ESRD, because there's supposed to be a physician for any ESRD patient who's overseeing --

DR. DEAN: Perhaps, but they're not going to be in any better position -- I mean, first of all, what are we certifying? Are we certifying that they need the service or that they need -- I mean, that they need the dialysis or are we certifying that they need the ambulance?

MR. GLASS: That they cannot get there -- that they can't sit up in a wheelchair.

DR. DEAN: And --

MR. GLASS: Which I think they would know.

DR. DEAN: How would the nephrologist know that? I mean, I --

MR. GLASS: Well, they're supposed to be seeing the patient every 30 days.

DR. DEAN: Yeah, well --

DR. REDBERG: Tom, who would you suggest should do that?

DR. DEAN: I'm sorry. What?

DR. REDBERG: Who would you suggest should be the person to certify that?

DR. DEAN: Well, it needs to be somebody that has access to the information and to know -- I mean, I would say it needs to be social service, it needs to be somebody that actually knows what the living conditions of that person actually are.

MR. HACKBARTH: Tom, go back to David's point, though. Dialysis is in some ways, I won't say unique but different in that as part of getting the payment, there is a specific requirement that the physician see the patient at certain intervals, and, for example, the ability to sit up

in a chair is something that could be readily observed during those required visits, those required face-to-face contacts. And I say that understanding and agreeing with your basic point that, you know, a primary care physician who may not have a relationship where they're regularly interacting being asked to certify things beyond his or her personal knowledge is a problem. It's a waste of resources and the like. But this may be different because of the nature of the interaction.

DR. CHERNEW: But if you get the incentives right, no one may have to certify.

DR. DEAN: Yeah, I --

DR. CHERNEW: You might be able to get around any certification.

DR. DEAN: I think that makes the most sense. I mean, let's get the incentives right about what does it take to get the person there rather than, you know -- because I think, you know, even the nephrologists, who are probably seeing, you know, a large number of patients -- I don't know. I'm not so sure that they would have as much familiarity as we're assuming. But I could be wrong.

DR. REDBERG: I agree to get the incentives right,

but it seems like someone has made a decision that the person needs an ambulance; otherwise, why are we calling an ambulance? So there should be a certification.

MR. GRADISON: I just want to say a little bit in addition to the excellent comment by some of the others about dialysis. It would seem to me that what we ought to do is to address the specific questions that have been addressed to us by the Congress, and with regard to dialysis, indicate there are issues, maybe even outline some of the things that we think ought to be looked into, but I truly believe there is gold in them thar hills and that we're not going to be in a position to identify a plan of action in a timely manner on dialysis.

With regard to bundling, there are some complications in that. I'm not speaking against it, but I've sensed that in some respects the discussion suggests, well, that may be the answer, and maybe it is. But one of them is that the nephrologists are often the medical directors of the dialysis centers and may have a financial interest in the P&L of the center. I don't think that's uncommon at all. And their role is certifying and also -- there could be some conflicts of interest that at least need

to be thought through. Let me say it as nicely as possible.

Another thing is that if this is bundled, you get some situations where people -- nobody's reimbursing them, their spouse drives them or a neighbor drives them or somebody from their church drives them back and forth three days a week. That's not uncommon. But once the center is in the act, they may have a financial interest in having something set up for which money passes and which they get to keep a piece of it. I just want to point out that another thing about dialysis centers in urban areas, the reason they're as small as they are -- 30 chairs is fairly typical -- is the geography. They don't want people to have to travel too far three times a week. I think that's the fundamental reason for that geographical dispersion in large urban areas. This may have a bearing on it, too, in terms of the length of the trips.

In any event, I think you've done an outstanding job, and I just think we ought to separate the more immediate issue, as important as it is, and respond to it, but also think about other things for another day.

MR. GEORGE MILLER: Yes, I would just like to add to the argument for bundled payments, particularly on the

end-stage renal dialysis from the standpoint -- and I think the legislation could be -- excuse me, the rules and regulations could be structured so that it's just a payment that is paid to the facility and not a co-pay, to Bill's point.

I am troubled in the chapter by the increase in the utilization, both there, the entry of for-profit entities in that arena, and the increase in utilization that there's a reason for that, and I think Cori may have alluded to part of those reasons, and we need to get a handle on it or raise that as an important issue.

As it deals with these issues, as long as we identify and understand the rural issues where there may be a single provider and appropriately compensate for the low utilization, then I'm in favor of eliminating all the temporary add-ons and then rebalancing the RVUs appropriately.

DR. NAYLOR: Again, kudos for a fantastic piece. I totally support the principles that you've outlined. The recommendations related to add-ons, I am very much leaning toward eliminating the add-ons and targeting the resources to better address issues of access.

On the issue of dialysis, I would reinforce the early recommendation that this is really worthy of study. Looking at the variation by state by dialysis beneficiaries for all services really suggests an opportunity not just to look at ambulance but use of all services, and this I think could be a great case to, on the one hand, make sure that people who really need these services and are frail and meet all the criteria have access to the highest-value services, and maybe in some cases to make sure people who don't have access get it, but certainly to understand how people -- we're seeing this variation in ambulance use, but it is emblematic of use of many, many services and it represents a great opportunity for study. So encouraging the Secretary to study this based on the data that you've uncovered I think is a great opportunity.

DR. HALL: I'm still on Figure 4, I guess, which we've all talked about. A simple analysis, maybe simple for me to say, maybe not so easy, would be to just take a couple of the contiguous states, like New Jersey-New York, New Jersey-Pennsylvania, North Carolina versus South Carolina, a 250-percent increase in charges and just take a look at it and look at the frequency of dialysis in those two

comparable states that share the same geographic region, same climate, and presumably the same kinds of people. And if you see that this is related to increased frequency of dialysis, that opens up a whole different scenario in terms of who's ordering all this dialysis and what is the clinical justification and outcomes.

DR. REDBERG: And also, maybe you've already done it, but what's going on in Puerto Rico? It's so off the charts.

DR. NAYLOR: [off microphone] Miami.

MR. GLASS: It seems to have dropped off in 2011, so we think there may have been some enforcement activity.

DR. REDBERG: I see.

MR. GAUMER: In '11 it came down to about $9,000 which is --

DR. REDBERG: Still at the upper end.

MR. GAUMER: -- still in the red, but -- yeah.

DR. REDBERG: And then, you know, I think the idea of considering bundling for the ambulance for dialysis makes a lot of sense, and eliminating the temporary add-ons. That's all.

DR. BAICKER: Just agreeing with Mary that I think

the bundling with dialysis makes a lot of sense, but I'm also interested in how much this is indicative of a broader phenomenon of just higher intensity use across the board in ambulance use and then across the board in other services in some areas versus others where we'll focus on dialysis because the example is so salient, but is this an ambulance-specific problem or is this just an extra resources being used in home health and all sorts of other things in the same time?

DR. CHERNEW: I want to return to my theme before about status quo confusion. The status quo now is that current law gets rid of the add-ons. So I think the question on the table is: Do we have compelling evidence to put them back? And from what I hear around the table and from sort of my program evaluation kind of view, would it be bad if we didn't or good if we did or something like that, I don't see the compelling evidence why we would put them back. But the question on the table is should we eliminate them. That's the status quo. The question is should we put them back, and I don't see a particular compelling evidence. So I think that's the first order of business.

The second order of business is whether or not we

should do something else, like bundle or do other empirical investigations. That might work on a slightly different time frame. I'm not sure. But I tend to think that, yes, even if you were to revert back to the status quo, I do think we might be able to both learn more and think of other ways to deal with this issue in the context of broadly moving the system forward. So I would be supportive of doing that activity as well.

MR. HACKBARTH: Okay. Thank you very much, and we'll look forward to our next discussion next month.

So our next item is approaches to bundling for post-acute care services.

MR. CHRISTMAN: Good afternoon. Today Carol and I will discuss bundling of post-acute care. This resumes discussion of a topic we explored last spring.

The Commission is interested in bundling of post-acute care because it has a potential to address many of the current problems caused by having separate fee-for-service payments for each provider in an episode of care.

First, bundling payments for PAC services could create greater incentives for the coordination of care longitudinally across an episode, which could be

particularly important for PAC patients as they make a number of care transitions among different sites of care.

Secondly, bundling payments could provide an incentive for the efficient use of PAC. Currently no entity is responsible for ensuring that beneficiaries are referred to PAC only when necessary or that beneficiaries are referred to the site of care that is appropriate and least costly.

Third, PAC spending varies widely among regions, suggesting overuse or inefficient use. A bundled payment could be set that would narrow the differences between high-spending areas and the rest of the country.

Fourth we are also examining methods for the risk adjustment of payment bundles that include PAC.

And, finally, PAC spending is also important because of the size of the opportunity. Medicare paid over $50 billion to SNFs, IRFs, LTCHs, and home health for post-acute care in 2012.

Bundling is a promising strategy because it is complementary with other payment reforms underway. Bundling could permit Medicare to address the separate PAC silos without the complications of designing reforms that include

other Medicare services. The Commission has long been concerned about the different PAC silos, and bundling would be a way to create a more uniform approach to paying for PAC.

Bundled payments could be a stepping stone to more comprehensive models of care, letting providers gain experience before they proceed to more sweeping models like accountable care organizations. Successful ACOs will likely have to establish bundle-line models of care to achieve the desired efficiencies, and prior experience with bundling could help smooth the transition from fee-for-service to an ACO.

Another reason for MedPAC to examine bundling is that it may be some time before other work in this area leads to sweeping policy changes. Currently CMS is exploring bundling in the bundled payment for care improvement initiative, or the BPCI. However, it may be difficult to draw conclusions for broader bundling policies from this initiative because providers have been given considerable latitude in designing the bundles. So the results may not be unique to each provider organization and not necessarily applicable to the broader program. Also,

this demonstration is voluntary, so only a limited number of providers will be participating. By examining patterns in PAC and acute-care use, the Commission may be able to identify a national approach for implementing bundling on a faster track then current efforts.

There are a number of ways to configure bundles. Today we are asking for your input on three specific issues:

First, how should a PAC bundle be structured?

Second, should the bundle include readmissions?

And, third, what length of time should the PAC portion of the bundle cover?

There are other design issues for PAC bundling. We plan to return in the future to address at least one other question, how to set the payments for the bundle. Commissioners will also have to consider how to structure the payment. More flexible approaches might be appropriate for entities that are not ready for a highly integrated model of care. For example, under a virtual bundling approach, providers would continue to be paid under fee-for-service up to a target amount. Given the numerous bundling approaches possible, we wanted to get Commissioner input on the three areas indicated on the slide before considering

different approaches to payment.

To provide some context for our discussions, we worked with a contractor to construct a set of illustrative bundles using Medicare data from 2008. 3M developed risk adjustment models that used MS-DRGS and clinical risk groups, or CRGs, to predict resource use under the different bundling approaches. Resource use was measured using Medicare payments for the services in a given bundle. Carol will now take you through the three questions I mentioned previously in more detail.

DR. CARTER: The first design decision is whether the bundle should include both the hospital stay and PAC services or be a PAC-only bundle. This slide illustrates the two options: One would establish a payment to span all PAC services within a specific time frame, and those are the PAC services in red. Another would add to these to the inpatient stay, which is in blue, for a combined bundle that's in purple down below. For this work, we included physician services furnished while the beneficiary received post-acute care and during the inpatient stay. Readmissions, which are in green, could be included in either design, and we'll talk about those in a minute.

This slide compares the broad features of the two options. The combined hospital-PAC bundles would create greater incentives for care coordination. By including more services in the bundle, this design would bring providers one step closer to the broader payment reforms. However, a combined bundle might influence whether providers refer patients on to PAC as a way to lower their costs.

PAC-only bundles may not achieve the same level of care coordination between the hospital and PAC because there are fewer incentives to do so. In this bundle, the decision to refer patients to PAC would be separate from payments, just like in the current FFS, so that patients who require PAC are more likely to receive them.

Under either design, providers would have an incentive to furnish fewer PAC services as a way to lower their costs. Because current patterns reflect payment incentives and do not necessarily reflect care needs, some reductions in service may not erode quality of care. Putting providers at risk for quality measures would counter incentives to lower reductions that harm patient care, and these could be measures such as the use of the ER, potentially preventable readmissions, and changes in

functional status.

A consideration in evaluating the designs is whether one design does a better job of explaining spending differences across episodes. Across all conditions, we could explain 72 percent of the variation in spending for the combined hospital-PAC bundles, including readmissions. And for PAC-only bundles, we could explain 26 percent of the variation in spending.

One thing these results underline is just how hard it is to predict PAC spending. There are large differences in who uses PAC, which setting gets used, and how much service is furnished. MedPAC's previous work on the variation in Medicare service use found that post-acute was the most variable of all services. In addition, risk adjustment methods have traditionally not focused on trying to explain differences in PAC spending. We have work underway to examine whether including functional status into the risk adjustment will improve our ability to explain differences across episodes that include post-acute care.

Selection of the services to include in the bundle could hinge on factors other than explanatory power. The combined inpatient hospital-PAC would require entities to

assume more financial risk than PAC-only bundles, which might disadvantage small entities. An outlier policy would help defray the impact of exceptionally high-cost bundles. Yet combined bundles would encourage greater care coordination and thus represent a larger step towards broader payment reforms.

The second design decision is whether readmissions are to be included or excluded from the bundle. Including readmissions in the bundle would give providers a strong incentive to coordinate care across all settings. However, they are complex to design and to administer. For example, we would need rules about attribution and financial accountability for readmissions. If Medicare made a single payment for a bundle, providers might have to pay other providers for the readmission. Paying providers fee-for-service up to a target amount, as proposed by CMS in its bundling initiative, would sidestep some of these complexities.

Alternatively, readmissions could be excluded from the bundle. Hospitals would be paid for readmissions, and the hospital readmission policy could be extended to PAC providers. This past year, the Commission recommended that

SNFs be held accountable for readmissions that occur during SNF stays. In either option, we will need to specify which readmissions to consider. An all-cause measure holds providers accountable for readmissions for any reason, whereas a targeted measure, such as potentially preventable readmissions, focuses on readmissions that could have been avoided. In these slides, we're reporting potentially preventable readmissions.

Readmissions are both infrequent and costly, and that makes them hard to predict. Bundles that exclude them are better able to predict episode spending than bundles that include them. For example, our ability to predict spending for the combined inpatient PAC bundle for 30 days increases from 67 percent to 72 percent once readmissions are excluded from the bundle and from 22 percent to 26 percent with the PAC-only bundles.

The third design decision is the length of the bundle. The length establishes the number of days during which service utilization would be included, such as 30 or 90 days after discharge from the hospital. And there are advantages and disadvantages to each.

For short bundles, such as 30 days, these are more

likely to include services that are related to the initial hospital stay. Short time frames may be fairer than long bundles across providers of all sizes because small entities may not be able to manage (or finance) the risk associated with care furnished over longer periods of time. However, a sizable share of PAC is furnished over more than 30 days. For example, one-third of SNF stays are more than 30 days long. On the other hand, short bundles may result in higher overall utilization because providers would be paid separately for services that are furnished after the bundle is over. This may ensure access to services, but it could also result in the provision of unnecessary services. And, finally, short bundles will result in less care being coordinated.

Here we're comparing the features of long bundles. These are more likely to include almost all of post-acute care, but they are also likely to include services that are unrelated to the original hospital stay. Some providers may resist being at risk for services that are either unrelated to the care they furnished or the condition that they originally treated. While long bundles would give providers flexibility to consider the mix and timing of services they

furnish, they would put providers at greater risk because costs and readmissions are more variable over longer periods of time. Furthermore, providers may underfurnish care because their risk is extended over a longer time period. However, long bundles would be a natural stepping stone for broader payment reforms.

One way to consider whether bundles should be short or long is to look at whether short bundles capture a large portion of the spending and readmissions that occur in the longer bundles, and we found that the majority of spending and readmissions included in 90-day bundles occurred within the first 30 days and were, therefore, captured by them.

Another factor to consider is whether our ability to predict spending for the two bundle lengths is comparable. Across all conditions, our ability to explain variation in spending across stays is lower for 90-day bundles than it is for 30-day bundles. We were able to predict 72 percent of variation across 30-day combined bundles compared to 58 percent of the variation across 90-day bundles. And we see similar differences for PAC-only bundles for short and long bundles. Here we show the

bundles without readmissions, but the patterns were identical for bundles that included them.

Our results illustrate the tension between greater payment accuracy and stronger incentives for care coordination. Shorter bundles are more likely to result in more accurate payments, but longer bundles will create more incentives to coordinate care over a greater span of services.

In terms of next steps, we'd like to narrow down the bundle options that we continue to explore, selecting a bundle type and length, and how we handle readmissions. We will also continue to work with the contractor on a risk adjustment method. At a later session, we plan to present alternative ways to establish payments for the bundle. For example, we will consider options based on the variation in current PAC use. We will also look at private plan experience and the practice patterns of efficient providers. These analyses will not yield a "right" price but rather will provide us with useful comparisons and benchmarks to inform our discussions.

Given the array of payment comparisons, it would be very helpful to narrow down the alternative designs to

those that reflect the direction the Commission would like to take in the bundling policies. To recap, the basic design decisions center on: the type of bundle: that is, should it be a combined hospital-PAC or a PAC-only bundle; whether to include or exclude readmissions; and whether to focus on short or long bundles.

Identifying options that the Commissioners would prefer will help us in our modeling of payments. And now we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you.

Kate, do you want to lead off with clarifying questions?

DR. BAICKER: Yeah, I was really interested in the analysis of what share of the variation you can explain under different bundles and under different windows, and I can imagine a couple of different stories that would produce that. So as a first pass of questions, I wonder, which risk adjuster are you using? Is it sort of the standard HCCs? What are you trying to explain the variation with? And how much of a difference do those make in explaining the variation? In other words, is the variation just completely idiosyncratic so we don't need to be worried so much about

selection going forward? Or are your limited set of risk adjusters really moving things a lot, and so if you had even better risk adjusters, you would expect them to move things more and you would expect providers to be able to observe that kind of nuance and, thus, capitalize on it?

DR. CARTER: Well, our risk adjustment method right now has two pieces, as Evan mentioned. The first is we use MS-DRGs and the severity levels that are included in that. And then to look at the co-morbidities and sort of the chronicity of the patient that they bring before the hospital stay occurs, we're using 3M's risk adjustment that looks at the clinical risk groups. And so that's helping to -- because that looks at two years of claims experience before the hospital stay. So it's looking at the chronic conditions that a patient has.

And as I think I mentioned, or maybe Evan did also, we're looking at folding in functional status for the PAC users where we have assessment data. We are looking to see if including that on top of those two helps.

DR. NERENZ: Three questions. I'll try to do them quickly. First of all, if you could just clarify the goal of these questions for us. I could see that they are either

to inform you about what you would focus on for additional analysis or they could be recommendations to CMS about what actually to pursue in terms of their bundling. Is it A or B or both?

DR. CARTER: It might be both. But certainly at least in terms of our modeling, to have this many permutations in play is just -- I think we'll drown in data and not have much information. So it would be really helpful to narrow down sort of the focus or the things that you feel are most promising. If the Commission was inclined to make recommendations about a bundle type or length or, you know, readmissions in or out, I sort of leave that up to you.

DR. MARK MILLER: And probably further down the road. I think this was about what would you like us to focus on.

DR. CARTER: For today, certainly, just helping us pare down what we're moving forward with.

DR. NERENZ: Good. Okay. Also, quickly, if you can go to Slide 8, please? This is one the variance explanation. The first question here is about the 72 percent. If I understand correctly, what you're doing is

looking at -- what was your phrase? -- across all conditions, and then you're using MS-DRG. The question is: Why should we care about that? Because, for example, in the BPCI, people proposing bundled prices select specific MS-DRGs or close groupings. And the question, therefore, might be: What happens with the ability to predict costs within one of those on the basis of then some other factors?

So what should we be thinking about in terms of the 72 percent? I'm not sure why that matters, why it's important.

DR. CARTER: Well, I think it matters in the sense that you would like to know how well your risk adjustment is doing across all conditions, not condition by condition. I'm not sure you would want a different risk adjustment method, depending on the condition. So this is sort of looking across everything, how well can you do.

DR. NERENZ: Okay. I guess we'll hold that then for round two.

DR. CARTER: Okay.

DR. NERENZ: Then finally the last one, just drop down a bullet to the 26 percent. I presume it's here because it's to catch our attention as a low number. Now

we're nearly, what, 30 years after the DRG system. It seems to me the DRGs explain less variance than this. So is this a remarkably low number, do you think? And if so, again, how should we be thinking about that?

DR. MARK MILLER: I don't think it was intended to sort of -- you know, you tell me. I don't think it was intended to steer you away from that. I think probably part of the reason you get such a big jump in the explained variance is because you have -- or explained variation is that you have the hospital in there, and the MS-DRGs, and so you've got a big block of dollars where the risk adjuster is working pretty well. And so I think that -- but I do think we were just trying to point out that you have some differences and some greater difficulty if you're focused only on the post-acute care services, and part of that reflects this state of risk adjustment, which you probably are pretty --

DR. BAICKER: And the DRG is doing well not because necessarily it captures true patient costs, but because payment is based on the DRGs, so there is --

DR. CARTER: There is a little bit of -- although we've looked at the --

DR. MARK MILLER: There is some of that going on as well.

DR. CARTER: -- R squareds using charges as a measure of resource use, and you still see the large difference. And, again, it is because the MS-DRGs are designed to explain differences in inpatient resource use.

I actually look at the 26 percent and am pretty impressed by it, so I don't put it up there as a low number. I think it's a good number.

DR. NERENZ: But that's exactly -- I just want to make sure we're drawing the conclusions that you want us to draw, and then we go from there. Okay.

MR. HACKBARTH: So I'm going to pick up on David's question and ask a really stupid one as a lawyer who doesn't really understand statistics very well. When I see these numbers, I never quite know what to think. On the one hand, I can see that if you've got a method that explains a lot of variation, that might be a good thing and that you've got, you know, a robust tool for describing, characterizing the variation in patients. And so you've got a relatively -- you've got a tool that allows you to have relatively homogeneous payment categories, and that might be a good

thing.

On the other hand, if there's no variation, it also seems like there's no opportunity here -- no opportunity for improvement. If everybody's doing the same thing, you know, having a payment method based on this new payment mechanism isn't going to improve things much because there's already sort of a standard approach. Everybody's incurring the same cost for treating the same patients.

DR. CARTER: Right, and actually I wanted to mention that the variation in PAC is one of the reasons why that R squared is lower. You have that same variation in the combined bundles, but it almost gets swamped by the inpatient stay dollars. But you're absolutely right, I mean, there's a lot --

MR. HACKBARTH: Is the high number good or --

DR. BAICKER: We also want to distinguish between the amount of variation that there is and the share of the variation that you're explaining. So these are not telling us -- it happens to be the case that PAC is more variable, but the fact that we're explaining a different share of the variation doesn't tell you that it's more variable. This is telling us how predictable the variation is, not how much

variation there is overall. And it seems important in understanding the source of the variation, understanding is that something we want to build in. Do we want to correct for that, or do we want to dampen it out?

MR. HACKBARTH: Right.

DR. BAICKER: Understanding that is going to affect the policy, but those are two different things.

DR. CHERNEW: Plus you could have no variance beforehand, change the marginal incentives, have no variance afterwards, but it made a big change. Everyone was doing the exact same wasteful stuff, change --

DR. COOMBS: That's the point I wanted to make about cataract surgery and the cost of cataract surgery 10 years ago, 20 years ago, and that everyone would have been in the same bar, no variations, but guess what? You're right here now.

MR. HACKBARTH: Yeah. Okay. Well, I'm going to have to work on this one some more, but we won't do it now.

DR. REDBERG: I'm just wondering, because there are four different PAC settings, and did you see a lot of differences between -- in the costs or the explanation of variation between those four settings?

DR. CARTER: There are huge differences in the PAC spending, and there's the table in the mailing that shows that. But we did not look at the different R squared based on sort of first site used, and I think that's one of the reasons for the 26 percent, is depending on if somebody goes to a NRF or a SNF or home health post hip surgery makes a big difference on the spending, and yet we can't explain those differences because the patient characteristics aren't different enough.

MR. CHRISTMAN: As I recall, we didn't look at the four silos, but we did compare institutional versus home health, and the institutional was always -- the R squared -- the fit for that was always a little bit better than the home health. Home health tends to be the hardest setting to predict.

DR. MARK MILLER: And as you recall, that's one of the most variable ones across the country.

DR. HALL: I just want to reinforce a comment I think I made at our previous go-around here, that we shouldn't think of SNF, home health, et cetera, as being equal options in all these patients. And one of the things we might want to look at would be to pick one of these, and

certainly SNF would be one where there would be higher expenses involved and much more frequent use than the other entities. This is a very, very complex area that we're looking with an extraordinary number of confounding variables in terms of clinical course. So I would think very seriously about paring this down quite a bit from the ten entities and four different options to maybe three or four entities to really understand some of the characteristics, I guess. I haven't --

DR. CARTER: When you say entities, do you mean conditions?

DR. HALL: No, I meant the first PAC site used.

DR. NAYLOR: We've decided that we're reinforcing each other, but I think that's a really huge opportunity in the modeling to think about PAC as we describe it now but also to think about how variation in spending under a bundled payment model that would include acute and post-acute might be different depending on whether first site is home health or post-acute skilled facility. So I think that's terrific.

I also wonder whether or not there's an opportunity here with all the focus on readmissions, which

is where some of us have spent our life, is there an opportunity to think about modeling that's a little bit more robust in terms of acute service use that might include emergency department, acute-care visits to physicians, and readmissions rather than just readmissions? To me it's the collection of acute-care resource and the path that I think is really important going forward. And so to take it beyond just hospital readmissions as -- I don't mean that you can't look at that, but then to look more broadly at other acute-care service use either in a 30-day period or 90-day period. So it's just a thought. Or have you thought about that?

DR. CARTER: I'm actually a little confused by what you're saying. Can you try that again?

DR. NAYLOR: On round two.

MR. GEORGE MILLER: Let me see if I can add to your confusion. I guess I look at this and am a little bit -- certainly impressed by the data and the information, but I'm a little concerned from a rural hospital perspective with the four different choices. I remember the presentation that was made on the differences in the four post-acute care sites and where they are scattered across the United States. So as we try to figure this out and make

policies, there's some parts of the country that only have one option and some part of the country only have two options. But it seems to me we're trying to define -- or you're asking us to give recommendations based on the entire country, but the country is different, particularly in the rural areas. That's one statement, not a question.

But I guess my question comes down to what is the impact of the differences when one of the four -- only one or only two of the post-acute care sites are available and how will that impact that bundled payment?

And then the second part of my question, a little bit different, dealing with the readmission, what happens if that readmission, in fact, that can be documented the results of -- I don't want to use the word "fault," but results of the post-acute care stay and is being readmitted back to the hospital? Then what happens? Who pays for that? How is that going to be impacted? I'm not sure I read that definitively in the chapter or understand it. Maybe I don't understand it. That would be a factor also at least in my mind. If you could help me understand those two issues, that would be helpful for me.

end track 5a

DR. CARTER: Well, the paper talks about two different ways and under -- if you thought about paying providers what we've typically called virtuals, so you sort of pay as you go up to a cap, up to a targeted amount, then if a hospital incurred a readmission, then the hospital would be paid for that readmission. But, of course, then all of the entities that are related to that care still have a bundled price that goes with all of the care.

So that would be in the version where readmissions were included in the bundled price and the hospital would get the payment, not get the payment from some place else. But you could also imagine paying -- having readmissions separate from a bundled payment and have readmissions be paid the way they currently are, but extend the readmission policies to PAC providers so they, just as well as hospitals, have an incentive to minimize the readmissions.

MR. HACKBARTH: Let's stick with George's focus on areas that may not have all of the different types of PAC providers. The two most common are skilled nursing facility and home health agency. The distribution of IRFs and LTCHs are a little bit more uneven, especially the LTCHs. So one empirical question that I would have, I'm thinking along

George's lines, is, what do we know about readmission rates and how they vary depending on the type of PAC providers available?

Are there higher or lower readmission rates in those areas that have only home health agencies and SNFs for post-acute care? One might hypothesize that the rates could be higher because IRFs, and especially LTCHs, have more robust hospital-like capabilities and that may, all other things being equal, reduce the tendency to readmission. So that would be a question that I think is amenable to analysis and might be worth looking at, if you haven't already. Perhaps you have.

DR. CARTER: We haven't looked at that. You'll probably remember in the SNF readmission work that I did last spring, we looked at the readmission -- the variation in SNF readmission rates and it's considerable. But you're asking a different question, which is for hospital readmission rates, how much do those vary by the PAC providers that are in their market.

MR. HACKBARTH: Yeah, the configuration.

DR. CARTER: And I assume we can do that. I don't know if we can do it in what kind of time frame, but the

data are certainly all available.

DR. MARK MILLER: Could I also take a pass at a couple of things he said? Just to make sure that the audience understands, we're not up to recommendations yet. I mean, eventually down the road, that might be the point, but we're really talking about how to think about the analysis and the structure. So I just wanted to make sure that people didn't leave the room thinking that we were anywhere near recommendations.

And on that point, George, the notion of how to treat rural hospitals or, say, small or very low volume or, you know, the location issues, that would be something that would develop through our conversations.

And then just to reinforce the exchange you had here, you were sort of asking, Well, how would it work? Assuming that there was one payment that went to a hospital and the hospital was responsible for the bundle, then that hospital would be responsible for making arrangements with providers, either in their area or out of their area, which may implicate your rural problem, and then have to pay, in a sense, some entity would receive the payment, let's just say the hospital at this point, and then disburse it out to the

other providers.

The other alternative that Carol was speaking to is virtual where you say, everybody continues to get their fee-for-service. There's a set target. If a readmission occurs, then everybody's bill is affected by that, you know, downward by that readmission. So you take -- I'm making this up -- 5 percent off of everybody's bill because they were all involved, and they could either organize and try and stop this problem or just continue to take the hit whenever the readmission occurs.

I think that's the two models that she's saying. And you were asking, well, what specifically would happen, and that's the idea.

MR. GEORGE MILLER: Okay, thank you. That raises more questions, I guess. But I'll wait until Round 2. Particularly you now have EMS. If you're saying that I get to pick up a provider, a post-acute care provider, and that provider is a ways away, and they say, Yeah, I'll take them, but you've got to pay for it, then I'm involved in the EMS, the transport. And is that included in the bundled payment?

DR. MARK MILLER: That may be why you, as a Commission, want to think about more virtual situations

where you let the fee-for-service run, but you cap out what the bundle is going to pay and just put people at greater risk. But that's a question.

MR. GRADISON: I have a number of Part 2s, but one factual question with regard to the numbers. I'm trying to understand -- let me just express this sort of as a mathematical thing. I'm trying to understand the total current cost, approximate total current cost for post-acute care as a percentage of the hospital bill for those particular patients who, after the hospital stay, require post-acute care. I think that's probably something you can get, I don't mean this minute, but --

DR. CARTER: We definitely have that.

MR. GRADISON: Okay. I'll speak more broadly later. Thank you.

DR. DEAN: On the readmission issue, my assess is that certainly there should be some responsibility for that, some incentive to avoid those on the part of the post-acute care facility. On the other hand, this will be a relatively high-risk population and you certainly don't want to affect the access because nobody wants to take these people if they're going to be subject to penalties.

And I guess the question is, how well worked out is the whole distinction between avoidable readmissions and unavoidable readmissions? I mean, some of these people are going to get sick and require readmission. I think that's just a given. And I just wondered, do we have good information on how to make that distinction? I mean, it's going to be a judgment call in some cases, and I guess I'm just not sure.

I mean, if somebody gets an infected pressure ulcer, that's probably avoidable. If somebody gets pneumonia, maybe, maybe not. And if somebody has an MI, probably not avoidable. But, you know, I just wonder, how clear are those distinctions worked out?

DR. CARTER: Well, in the methodology that we used, and we ran all of our numbers using all cause readmissions and potentially preventable readmissions, which is a methodology that 3M has developed, and having looked through that, it is a very transparent, explicit methodology which they used a panel of clinicians to develop. And I can share that with you to see what your reactions are to it.

MR. HACKBARTH: And, Tom, readmissions is also on the agenda for tomorrow's meeting and I'm sure that there

will be some more talk about all cause versus avoidable. Scott?

MR. ARMSTRONG: So I'm going to avoid the accuracy analysis stuff and not get swallowed by that, but just step back just a half a step and ask, just to clarify, so in the 2007 to 2008 work cycle for MedPAC, we made a series of recommendations to CMS to advance bundling of post-acute care service pilots. And so, did we do a similar analysis to this back at that point in time or not?

DR. CARTER: So, Craig, yes, we did. We developed, I think, 30-day bundles using a similar methodology. I'm not sure that they used CRGs to do the risk adjustment. It was just APRDRGs. And I think they looked at 30-day bundles and it included post-acute care, but I'm not sure, and physician services, but I don't think sort of the post-discharge, you know, outpatient services or after PAC. How am I doing?

MR. LISK: Pretty good.

MR. ARMSTRONG: Maybe the question a little more specifically then would be, perhaps -- would there be merit in understanding or bringing forward -- or maybe you've done this already, some of the things we learned from the

analysis that we did back then into this analysis. And in particular, my interest is in, so what was it about the analysis that laid out a presentation and recommendations in 2008 that still has not resulted in anything actually being implemented. And how can our recommendations now be built in a way that much more likely results in actually piloting happening and something being implemented.

It seems like a really significant criteria we used to consider the different bundles and the way we bundle this is the accuracy of our ability to predict costs. Actually I guess it's a Round 2 point, but it just seems like there's some other criteria that we would use to evaluate, one of which would be, well, how can we package this analysis so it's more likely to actually be implemented in the next couple of years.

MR. HACKBARTH: So let me just say a word about that and Mark and Carol and Evan and others can help me out. So when we looked at this issue in 2007 and 2008, we stopped short of making a bold-faced recommendation that Medicare ought to move to bundling of all these services around a hospital admission.

We thought, based on our analysis at that point,

that a reasonably compelling argument could be made that there was a potential here for improving both the efficiency and quality of care delivered for Medicare beneficiaries, but there were a number of issues that needed to be addressed to have a full-blown recommendation. What we did recommend is that CMS do some pilots in this area. Congress adopted that and it was included in, I guess it was, PPACA. So now those demonstrations or pilots are being organized.

One of the issues that I have in this area is the pace at which all of this stuff is happening. It was 2007-2008 and we're just now in the process of beginning to organize pilots, which by their nature, will take some years to run and time to be evaluated. And the schedule is really elongated.

Frankly, part of my personal interest in this area was, is this something that we can do more quickly than moving towards ACOs and organizational arrangements that assume overall responsibility for all care for a defined population. And we're sort of stuck. So one of the reasons that we're taking this up again is, consistent with your comments, are there ways that we can get this unstuck? Do we want to get it unstuck and try to put this on a faster

path? So that's a little bit of historical context and it's quite consistent with the issues you were raising. Mark, anything you want to add to that?

DR. MARK MILLER: No. I mean, the pace was really on point and that's what I would have said, and I think you also hit it there at the end. I mean, you could, as a Commission, say, no, just wait. Or you could say, no, we should try and move the pace along. And what would fall out of this research, at a minimum, are ideas about ways to do bundles, improvements in risk adjustment, because, you know, there's not -- we're one of the people who are trying to move this process along.

And it could be, if we got far enough down the road, to say, we think this is the most promising direction, and then you could say to the Congress or to CMS, move that other stuff aside and this is the way to go. Or, for these sets of conditions, let's go with these now because this seems to be ready. That would be the outcome.

But there is this basic question of, you know, do you pursue this or not, or do you just let that run, and so, there's some basic science that comes out of it, risk adjustment, a bundle that looks like this, and possibly some

directions that come out of it.

MR. ARMSTRONG: And I'll express my opinion about how far and how fast I think we should go in a minute, but the question really was, our staff and our analysts and team here are brilliant and we're doing this incredible work, but is that really what's going to get this thing moving, was kind of the question. You know, if there are some other considerations for how we would do this analysis that might actually accelerate our ability to actually get something done. That's why I was asking that.

MR. KUHN: Two or three quick questions. One, you talked about the predictive capability on home health and that's pretty consistent with what we saw with the Care tool as well. That tool also validated. That's very hard to predict kind of resource utilization there as well. Is that correct? Did I remember that right?

DR. CARTER: Yes.

MR. KUHN: Okay, thanks. And the second question is the whole issue of readmissions, and I appreciate George's question and Mark and others' follow-up because that helped me think that one through a little bit more because I was kind of quite confused on that. But let me

maybe go to a finer point here, and I might be off-base here.

We're talking about readmissions, but in effect we're talking about rehospitalizations. But what would happen if, for example, you had someone that had an acute care stay, they went to home health, they stayed home, and then a couple weeks later they said, well, we might need some more home health, we're coming back. So is that kind of a readmission versus a rehospitalization? Am I think that through incorrectly or what would happen in a situation like that in a bundle?

DR. MARK MILLER: If I understand the scenario he's saying, you're saying that they go to either post-acute care setting or they go to home health?

MR. KUHN: Right.

DR. MARK MILLER: Then they go home.

MR. KUHN: And then they come back to post-acute care.

DR. MARK MILLER: Then they come back to post-acute care.

MR. KUHN: Not rehospitalized.

DR. MARK MILLER: Got it.

MR. KUHN: But they're readmitted to a PAC provider.

DR. MARK MILLER: So what I think is, is if the bundle is this time period and that event occurs within that time period, then they're responsible for it. If the person comes back in past the end of the bundle -- notice my scientific graph here, end of the bundle -- then that would be outside the payment. But if that little event that you talked about, I'm in post-acute, I go home, then I come back to post-acute all occurs between here, then whoever is responsible for this bundle is responsible for that care.

MR. KUHN: Okay.

DR. MARK MILLER: You guys okay with that answer?

DR. CARTER: Yep, that's fine.

MR. KUHN: That's helpful, thanks. And one final thing on the bundles. If we put together both inpatient and post-acute care together and say a person presents themselves for care and the care team says, Boy, this could be an inpatient admission with maybe some PAC services, but given kind of the care delivery of certain SNFs in the area, we can bypass the acute care, go right to the SNF, and get the care level that we need, but right now they're bound by

the three-day prior hospitalization.

Do you see PACs being able to kind of waive those kind of systems so that you could get folks into the right setting and get the most efficient care possible and get some of those fee-for-service barriers out of the way that exist now?

DR. CARTER: All of our work has centered around an initial hospital stay, and so we haven't looked at bundles developed around either observation days or not a hospital stay at all. And I think that would be kind of a different project, and I know it's something Evan is particularly interested in because, you know, something like a third of home health doesn't start with a hospital stay. But our work so far hasn't focused on that.

DR. SAMITT: Just two clarifying questions. On Slide 9, I wasn't sure whether this was an either/or, and what I mean by that is, could we envision a scenario where the readmission is included in the bundle and there are policies that apply to the PAC regarding readmissions from a PAC as well, or whether the vision is that it would be separate and distinct.

DR. CARTER: We haven't really thought about kind

of the overlay. I think we were thinking more readmissions in or out and if they're out we would certainly want something in place. I guess I wouldn't rule out an overlay, but we honestly haven't thought about that much.

DR. SAMITT: And my second question is on Slide 11, and this was also -- this was about the bundling and it was also referenced in the meeting brief. It talked about the concern of a shorter bundle resulting in providers delaying services until the bundle expired. And I had a hard time envisioning what that would look like. So what does that mean, if a provider delays services before a new bundle? I didn't quite understand whether there were specific examples of what that could be, because I had a hard time imagining that.

MR. CHRISTMAN: I guess maybe I'd grab Herb's point about the patient that maybe is in home health and needs to bounce back to a higher level of care. You know, the bundled entity in that 30-day window, they're holding them in home health. If they could push that start of that SNF day outside of the 30-day window, the cost of that SNF care would be paid under the regular fee-for-service. It would not be the responsibility of the bundle because it

happened outside of the 30-day window.

So that's kind of one way. When the period is relatively short, the amount of sort of time that you have to serve a stint is shorter and perhaps easier to game. I think that was the concern.

DR. SAMITT: But they're also risking additional expense within the bundle by delaying nursing services for that full duration of time.

MR. CHRISTMAN: It depends on whether they -- yeah, it does.

DR. COOMBS: Craig, just one issue with that. In a lot of the SNFs, they may have patients with wounds and they may treat them conservatively and they might want to apply a VAC or they even may want to do a re-vascularization. And it's one of those things that they can treat conservatively until that window expires.

A question I had, had to do with how you resolve diagnoses that are remotely connected to the primary diagnosis for which they were hospitalized. A complication ensues that is unrelated to the primary diagnosis just by the mere fact of the co-morbid conditions. So that's one issue. How do you resolve that piece?

And then leakage. A lot of hospitals or SNFs are located within a small geographic area in terms of bounce-backs, what they bounce back to. I would love to see this and I don't know if you guys did this. If an on-site LTCH, SNF within the confines of a hospital delivery system, does it make a difference in terms of cost variations?

DR. CARTER: Okay. So the first question had to do with risk adjustment, I think, right? And sort of how do co-morbidities affect the assignment of the patient to an MS-DRG? So the diagnoses that are related to the hospital stay would affect the coding in the MS-DRG, and then we've overlaid on top of that the co-morbidities that a patient has had kind of prior to the hospital stay.

So you could think of it as for any MS-DRG, it gets blown out into many different tiers, not just the severity levels that MS-DRGs --

MR. HACKBARTH: So, Alice, I thought I heard you ask a little bit different question --

DR. CARTER: Okay.

MR. HACKBARTH: -- not one about co-morbid conditions and MS-DRG assignment, but responsibility, clinical and financial, when a patient that's within the

bundle --

DR. COOMBS: That was part of it.

MR. HACKBARTH: -- has a separate condition, that it wasn't the principal reason for the initial admission. Are they responsible for the costs incurred?

DR. CARTER: Yes, they would be, yes. So they would have a financial responsibility for the care within the bundle that's triggered by a hospital stay. So that was your first question.

DR. MARK MILLER: Wait just a second. Before we leave that first question, but I thought your specific point was, what if it's truly -- and I don't have a good clinical example, but say unrelated. Okay? Right? That's what you were asking? So let's just go back to this because I want to connect this dot back over to Tom.

What the Commission has done on this issue up to this point has taken a position that is potentially preventable admissions, which is different than all cause, as you guys know, and that's a question and you can revisit it. And the attempt in these methodologies and in the methodology we're using here is that there is a clinical panel that says, These admissions shouldn't be counted in

this measure. So that's the concept.

Now, you could potentially take issue when she shows you that list or shows you that list, whoever wants to see it, you could say, Well, I don't agree with this. But the point is, is the methodology tries to incorporate a clinical judgment that -- when you get a car accident after, you know, this, it's unrelated and that shouldn't be counted in the readmission. And I think your first question was about an unrelated readmission. Right?

DR. COOMBS: Right.

DR. CARTER: Oh, it was? Okay. I didn't hear the readmission part. Yes. You could use potentially the way the bundle would separate those out. And then your second question --

DR. COOMBS: The second question was about leakage. In some of the metropolitan areas, Boston, New York, there are lots of hospitals with SNFs within each other. There's a small geographic distance. How do you accommodate that in the statistics? So that a patient might go to one hospital SNF and then out and then back to another facility.

DR. CARTER: Well, right now our bundle spending

includes the spending regardless of where it occurred. So if there's leakage outside some market that just doesn't matter. The spending is scooped up kind of in our bundles.

MR. BUTLER: So when you're at the end of Round 1, I think you should be the first in Round 2 because I have no questions, but I do have all the answers, but I don't know if we'll get to them. I do have suggestions about how to speed all of this up, but if we can get a round again, maybe I'll get them on the table.

MR. HACKBARTH: And we're not going to wait. You've got all the answers?

MR. BUTLER: He's going to take me up on it. Okay.

DR. DEAN: Calling your bluff.

MR. BUTLER: Calling my bluff. The medical spending per beneficiary we all have now, which shows exactly our profiles for a 30-day bundle, three days prior, 30 days past. It is poised for value-based purchasing in 2015 or something like that.

It could be treated much like an ACO model, in a sense, and you could tweak either -- well, say you could pay out claims as we are now without paying out a fixed bundled

payment and you could tweak the hospital payment up or down, or, you know, provide just improvement over your base using the data we have now and you wouldn't have to change and fix an exact price per-bundle. You could do it in the aggregate, and I think fairly effectively and have a big impact. So that's the way I would go.

We already have in our hands and is publicly available how we're performing in the PAC world and it is displayed by a major diagnostic category, not by MS-DRG. A lot of the data is right there in the hospital's hands as we speak. So it's kind of like a mini ACO within the broader picture.

Now, this is an idea I haven't run by anybody other than myself, so I can take all the credit and all the blame for it being stupid or brilliant, but I think it is a real possibility.

DR. MARK MILLER: So just to make sure I'm following, you would say, I'm going to draw a circle around all of the hospital and post-acute care that follows that hospitalization, compute a per-beneficiary amount, and in a sense have a global dollar amount that you're sort of managing, too?

MR. BUTLER: Well, you could do it in a global amount --

DR. MARK MILLER: I'm not making a payment. I'm just letting fee-for-service run.

MR. BUTLER: Exactly.

DR. MARK MILLER: But what happens in your mind when, okay, so your hospital, really good, it stays within that global. My hospital, really bad, runs over that. What would you do?

MR. BUTLER: We have a ratio around that right now and you could apply that ratio to your inpatient payments, in effect, up or down based on how you're performing globally, or you could take -- because we have it now -- you could say, You know what? I'm going to do it only for half of the cases. Some of these things are not really things you want to have apply to a bundle, so maybe it wouldn't be the global amount.

But you'd pick out the ones that you think are, you know, this 30 percent of the business would be focused on it. But you wouldn't have to disrupt the current play. You wouldn't have to hand out dollars by bundle. You would be putting the financial penalty and benefits on the

hospital directly, I realize that, which is not the only model to do.

MR. HACKBARTH: So in this model, Peter, there would be no effect on payment to the skilled nursing facility and home health agency?

MR. BUTLER: No, none would be required. You would be managing the coordinated bundle, but you wouldn't have to address any of the downstream unit payments. Just like in ACOs. You're paying the claims out and you're looking at, you know, how that's being managed, but --

MR. HACKBARTH: Okay. We've got that on the table and people can react to it as we go around Round 2, ask further questions about it. Mike, you have a Round 1?

DR. CHERNEW: I just wanted to go to the slide that had the risk adjustment on it. It was Slide 8. And I wanted to ask a question about the 72 and the 26. What matters to me -- the quick question is, this is a percent of the individual level variance. If you run an individual level model, this is the percentage of the variance at the individual level that's being explained. Is that how to interpret these numbers?

DR. CARTER: Right.

DR. CHERNEW: And so the real question is, when you group this up into larger organizations that might be bundled, how much of the variation across those organizations you were explaining as opposed -- because I don't care if you get way off for a bunch of things. I care about how much between organizations you're doing, and that's going to depend on sample sizes and case mix differences and a bunch of things like that.

DR. CARTER: Yes. I understand what you would like. We haven't done that, but I understand what you're interested in.

DR. MARK MILLER: Doesn't the R-squared have to go up? If it's done at the episode level and then you aggregate up to the entity, the facility or the hospital?

DR. CHERNEW: Yes. I would suspect that you're going to do a lot better --

DR. MARK MILLER: That's what I --

DR. CHERNEW: -- because you care about the systematic variation, not the random variation. And so you just have a --

DR. MARK MILLER: All right. We'll figure it out.

DR. BAICKER: [Off microphone.]

DR. CHERNEW: Yes. But, in general, I think your intuition is right, that you're going to do a lot better.

So I guess the only comment I would have is a broad comment beyond this. The common evaluation of risk adjustment tools is often -- has the same paradigm, which is we're going to run a bunch of individual analyses and look how bad the R-squared is, and it's never good because it kind of hinges on variation. But that's not the test that a predictive risk adjustment tool should have to meet. It's how much systematic remaining residual variation is there, and then, even more than that, how it relates to the sort of incentive effects of what the thing is. Even if you explained it good or poorly, you care about how the incentives are going. And so you could tell a story where there's a huge amount of variation that's not explained, but it's all because some of the people are doing way hugely wasteful stuff. I wouldn't feel so bad if I'm not predicting all of that one way or another.

MR. HACKBARTH: Okay. So we're going to start round two, and as always, any comment that you think is important is invited, and we can talk more about the technical aspects of this. Or I would invite, also, your

reactions to where this fits in sort of the grand scheme of things and priorities for not just MedPAC, but for Medicare improvement, and in particular are there ways that we can improve the incentives around managing post-acute care, which right now are quite problematic, in ways that are relatively quick and easy to implement. And Peter has offered one way to think about that and I invite reactions to Peter's idea or any others that you might have.

DR. BAICKER: So I think the idea of the bigger bundles across admissions, PAC, readmissions, and over a longer time is great in that we think that a lot of those handoffs are the opportunity for coordination to fail and care to have lower quality and higher cost. So the fact that you move the bundles across those transitions seems like a great opportunity to improve the quality of care by incentivizing the people at the beginning to follow the whole stream.

I think the reason I'm focused on the risk adjustors and I think Mike's interest is similar is that the danger there is that you don't want to punish providers that end up having particularly sick patients. You don't want to disincentivize taking care of patients who are likely to

have worse downstream health episodes. But at the same time, you don't need to explain 100 percent of the variation. You need to explain enough that there's not that residual selection left. And also, you don't want to explain the variation that's driven by the choice of which kind of PAC facility. And I think that's one of the reasons not to -- to make the bundle independent of which PAC facility because if there are ones that are more efficient, we want people to be going to those if they're lower cost. So that's a reason to incorporate that whole array in the same bundle.

To the extent that we're able to adjust for patient risk enough that there isn't -- first, the providers aren't facing an undue amount of risk, and that's why I was saying at the provider level when you aggregate out how much of the risk can you explain, because, of course, you're going to pay too much for some, too little for others, and all of that evens out. That's okay as long as it evens out over a reasonably small number of people, except you still care about the individual level for the selection reason. So you care about the provider level, explanatory power for the risk smoothing for the provider. You care about the

individual level risk selection -- the individual level adjusted predictability because you don't want them selecting away from expensive individuals.

DR. CHERNEW: [Off microphone.] If they can predict it better.

DR. BAICKER: If they can predict better. Right. So you don't care about the absolute prediction. You care about the power of our prediction relative to the power of their prediction. So does that make sense to everyone? We're all agreed on that.

DR. CHERNEW: Kate and I agree.

[Laughter.]

DR. BAICKER: That's right. So then you care about that, and also one thing which has come up in our past discussions that I know everyone is aware of but we haven't mentioned here is that, of course, you care about the patient outcomes, too. All of this is conditional on patients getting sorted to the appropriate post-acute care facility. You don't want to do disincentivize the expensive one when it's the right one. You're trying to incentivize the best care at the lowest price that you can get for that care, and so that suggests that some people are probably

going to higher-cost facilities than they need to. But if we're not adequately measuring either the patient risk going in or the outcomes on the back end, you risk selection on the front end or stinting on the back end. So, of course, all of this is conditional on adequate quality measures.

DR. MARK MILLER: [Off microphone.] One really minor point. Another way to kind of deal with the selection issue is you could build an outlier policy into the --

DR. NERENZ: Okay. Three closely related things I'll try to do quickly. First of all, in the written chapter, there are several points where this whole approach is described as a transitional step or a stepping stone to capitation, and I would prefer actually that we just not include that concept. It seems to me that this payment model is a perfectly valid and good end state payment model for many circumstances and we just -- we have effectively the same discussion without making the inference that this is going to move on to something else in the future. So that's a quick thing.

Now, with that in mind, if we do think about it as sort of an end state payment model, I go back here to my 72 percent and now make the observation, I'm still not

particularly interested in that sort of all conditions analysis. The reason why is I think, as I imagine this going forward, it will look like the BPCI demo, and that is that the hospitals or other entities wishing to do this will want to select specific sort of clinically tight episodes, so heart surgery, joint replacement, and they will not be particularly interested in kind of a big global bundle for which then the DRGs become adjustment factors. We can talk about that. We can challenge that. But I just -- I don't see it.

With that in mind, then, I think the focus would be on to select some likely tight, clinically tight bundles and then focus the question on the issue of predicting costs within those bundles on the basis of clinical and other factors that would generally be outside the hospital or other entity's control -- now, this is kind of this territory again -- in order to come up with really good risk adjustment models that would do the right things that we want risk adjustment models to do. So I would focus the analysis within selected clinically tight bundles like joint replacement, like heart surgery, not across all.

And then, finally, the last thing is that -- back

to our point about social risk factors -- bundled things right now, I think, don't do this. I know the folks working on them with the Prometheus System have at least expressed some interest in this. But this may be a time to get some of these issues on the table to determine whether, example, poverty, illiteracy, lack of social support, other things actually have a place as risk variables in a bundled payment model. I don't know that they do. I don't know that they don't. But this might be the time to look. Because if they matter, this then becomes a gaming problem because if they're not included in models, organizations may then have incentives to avoid cases that are difficult or expensive on that basis and I don't think we want that to occur.

DR. MARK MILLER: This stepping stone thing, I'm sure Mike will say something when it comes around to his turn. But the thing I want to just draw your attention to is you're saying that nobody will -- you're thinking about this as a demonstration, that if you went through and -- okay, then let me put it this way. Let's say that the Commission went through all of this work and came up with a bundled model that was risk adjusted in such a way that people felt comfortable it was to go forward. One way this

could all turn out is that becomes the way it's paid. It's not a choice to the provider that they can say, well, I only want to do this DRG or that DRG. It's this is how we pay when you hit a DRG.

That's what I didn't follow in your comments. And I was thinking you were thinking, well, this is all a demo and people are volunteering, which is one way. It could inform the demos. But the other way is if it became the way it paid, this is how people would get paid.

DR. NERENZ: No, I understand that, and I did make a different assumption, but I didn't assume that my different assumption made it a demo, that there actually may be the ability to select payment --

DR. MARK MILLER: Oh, I see --

DR. NERENZ: -- to be paid this way in real life outside a demo.

DR. MARK MILLER: [Off microphone.] That's against the selection --

DR. NERENZ: Well, maybe yes, maybe no. I think that we could debate this at some length and we'll have to see how we do this.

Just a point, though, that others may correct on.

It seems to me in the current BPCI demo that this "must do all this" charge is as characteristic of the model one as it was called in that demo, and if I'm correct, I think there were very few takers on that.

DR. MARK MILLER: [Off microphone.] That's right.

DR. NERENZ: In models two and four, where you could pick, I think there were a lot of takers on that.

DR. MARK MILLER: [Off microphone.] That's right.

DR. NERENZ: So, I mean, CMS may -- we may recommend and CMS may come out and say, you, hospital, must do this for all your DRGs. But I think there may be a lot of push-back on that.

DR. MARK MILLER: [Off microphone.] I suspect there would. I'm sorry. If these are all of the conditions, it could be that we recommend you go with this set of conditions, but that's how you get paid when you have those conditions. But the provider isn't picking. And it was kind of unspoken, but one of our concerns about the demonstration is, is if it is completely within the control of the provider to pick where they are, you could be getting some demonstrations that are demonstrating places where there's very little variance and sort of agreement on how

you approach it and the opportunity may lie, and I think this was Glenn's point earlier, in conditions where there's much more variance in how it's being treated.

DR. NERENZ: Right. Well, I guess maybe just for me the last comment. I guess we just have to think, big picture, do you want to essentially force hospitals to do things that they cannot do or don't want to do or don't have the tools to do, or are we better off if we invite hospitals or ask hospitals to do things that they can do and are good at and can produce savings. And I think that may differentiate, do you have one big thing by which you pay all discharges or do you select areas or offer hospitals the opportunity to take up this model in areas where they think they can do it effectively.

MR. HACKBARTH: So, Dave, in the approach that Peter described, the financial responsibility and, I guess, ultimately, the clinical responsibility for managing the admission and associated post-acute care within a defined category was borne by the hospital as opposed to allocated across the hospital and the home health agency and the SNF. Any reaction on that?

DR. NERENZ: Well, just that if you build a bundle

or an episode around a discharge and you include that cost, you put the hospital in a central position almost automatically. Now, you may find somewhere that there's some different entity that actually could do that, but it forces you, at least, to think primarily about hospital.

If we talk about post-acute care episodes only, then I think it's a whole another story. It's not necessarily the hospital now that would do that. Someone else may do that. All sorts of different entities may do that.

DR. REDBERG: I think the idea of bundling in the bigger picture is good because it promotes the things we want to -- I think we can use it to promote what we want to promote, care coordination, you know, especially the hospital PAC with including readmissions and a longer-term window, because then I think we have more incentives to have higher-quality care for the patient and have everyone working together to achieve that goal. And so I think there's the most potential for doing more with bundling in a bigger picture.

DR. HALL: You know, there's a substantial experience with bundling of some key medical and surgical

procedures in medical tourism, where people go to India or South America or Mexico for major things like heart surgery, elective orthopedic surgery. It's not just all plastics. It's very major things. Well, they're bundled. Not only do they do the acute surgery, provide post-surgery care, but they even allow the families to come forward or come over, as well. And I'm not suggesting that's what we should be doing, but the idea that -- but what it points out is that there are certain things that tend to lend themselves to bundling much more than others, as I think many people have said around here, and David just talked about so eloquently.

So I'm kind of wondering if in the bigger picture of things we should kind of make life a little bit easier for us to sort of say, are there certain bundles that we could look at that would allow us to make some observations, not only about what people might be doing wrong, but might be doing right. And I would immediately focus on the orthopedic procedures.

For instance, in Table 1 that's in our written materials -- I'm not sure, is that in the slides or not? It has the ten conditions. Three of the middle conditions are all orthopedic -- major joint replacement, hip and femur

procedures, fractures. As near as makes no difference, every one of those patients has some form of PAC. The majority are SNF, but a substantial minority are home health agencies.

I think concentrating on those areas and then look at what kind of variance explains whether there's much readmission, inappropriate first pass, putting people in the wrong PAC environment, I think it's perhaps a quick and dirty way but I think at least it gets us started. The idea that we're going to bundle all of medical care, particularly for unpredictable illness, just strikes me as almost audacious that we would say that we could do that at this point without understanding the mechanics a little bit better.

DR. REDBERG: -- Geisinger are doing it now for bypass surgery, kind of a bundle --

DR. HALL: It could.

DR. NAYLOR: So I think we should be audacious. I think that the greatest opportunity we have right now to improve care and reduce costs, get to affordable care for Medicare beneficiaries, is to really figure out how to better align the care with their needs. And this is an

area, in addition to having experience with bundled payments, as Bill has suggested, we also have a tremendous evidence base about how to do this. And I think it -- so I like the frame that you've described. I think focusing on hospital plus post-acute for all the reasons that Kate talked about, we have a great evidence base on all the things that go wrong in the connections between one and the other. We have 50 percent of our people who are hospitalized don't even get referrals for post-acute and they are at risk for poor outcomes. So there is really good reason to think about that.

I think including readmissions in the bundle is something that we should seriously consider. My question was whether or not we could not also include ED visits, and I don't know if we can or can't, but it's -- and observational visits -- because I think that they are increasing and we need to think about ways that they are part of what we look at. Acute care visits to physicians are already there.

I really -- obviously, we need to have really good metrics post-bundle that look at acute care resource for a period of time, but the whole goal here is to create

alignments in these policies. We call them hospital and post-acute. People call them what's happening to me here and here. And so how you create alignment in the policies that really are much more addressing and responsive to people's needs.

And I do think all cause readmission is where we need to be focused, both in looking -- including in the bundle and looking at measuring its impact.

MR. GEORGE MILLER: One of the things I mentioned earlier about disparities, I'm just wondering how we can risk adjust for the current state of disparities in health care, and adding a bundled payment, does that improve that process? Does it not address it? Or does it make it worse? I'd certainly like at least some research on that issue, and particularly in people where service disparity is still prevalent and has not improved, according to some of the data we read in our package.

Just commenting on Mary's comment, looking at ED visits, there's a growing body of, especially the uninsured, that still use the ED for primary care and I'm not sure how that would impact, being put in the bundle and if that's appropriate. But I certainly would like to see that

information, but we're having, at least anecdotally, our facility is seeing more and more patients using the ED for primary care, and I suspect that is happening in other places, as well. So I just would be curious to se how that would impact a bundled payment.

MR. GRADISON: I haven't heard a word so far in this discussion about the role of the patient, their family, or their physician, and I think it's important to talk a little bit about that before I talk about hospitals and their ability to take this risk.

My understanding of this is that the hospital would make the determination of where -- of which post-acute care setting was appropriate and which particular facility. If the patient has a preference, if the family wants the one a mile from home instead of the one the hospital chooses ten miles from home, they would not have this choice if I understand the way this model is intended to operate. If the physician has a nursing home, a SNF, where they regularly make calls and have confidence themselves in the quality of the care, that decision or recommendation of the physician, I would suppose, would have to be overridden by the hospital in order to make this plan work.

In other words, we're talking about managed care, folks, in the sense that the options for the beneficiary are reduced from what they are under traditional fee-for-service medicine. Now, that may be a good idea or a bad idea, but I think it's important to recognize it straight up.

Let me use this analogy of the ACOs. One of the ironies about the ACO is the patient doesn't even know at the outset what group they're assigned to. And furthermore, once they find out or any time later, they can move to some -- they can drop right out of the group. They have total flexibility under that particular model, which makes me wonder whether the folks who wrote that provision in would even conceive of taking away that degree of flexibility when it comes to the range of post-acute care services which we're talking about right now.

But let me talk a little bit about this from the hospital's point of view. I'm not sure the hospitals -- there are exceptions, I'm sure -- but I'm not sure hospitals in general are in a position to take the financial, or potential financial risks that may be involved here, nor am I convinced that in many instances they have the experiential basis for making the management decision with

regard to which post-acute care facility the patient should go to.

With regard to financial risk, keep in mind what we're doing, to a small extent, I acknowledge, is making the hospitals into insurers because they, in effect, are at risk for some portion of the expenses that are incurred for the whole package, not just the part which is under their direct control.

Now, that opens up a whole other way of thinking about this, which I think we should put on the table at some appropriate time, and that is whether to limit this to hospitals. If a hospital wants to take the risk, I wouldn't stand in their way. But there are other entities, such as health plans, which are accustomed to making these determinations and have a whole lot more experience, especially the larger ones, in knowing about the clinical capabilities and the costs of the post-acute care settings than most hospitals that I know about with the current state of knowledge.

So I do want to raise the -- I know we've talked just, in effect, let's do it through the hospitals. I'm not at all convinced that it should only be through hospitals

that this type of bundling should take place. Strong letter to follow.

MR. HACKBARTH: So, Bill, those are really important points. I would emphasize that there is no proposal on the table about who has control over where the patient goes, but those are issues that certainly need to be thought through. And there is this tension that exists that within the confines of traditional Medicare, we've got all these ideas for trying to change the fee-for-service incentives and give not just clinical, but also some financial responsibility and risk to various types of care delivery organizations, a role that is unfamiliar for many of them. And there is this corollary question of, well, what does that mean for the patient and do they have constrained options as a result.

Now, I've felt -- in fact, the Commission as a whole felt in our comments on the ACO rules that they struck a balance that probably doesn't make a lot of sense. You know, they're trying to create organizations with financial and clinical accountability, but the patients are not buying into the choice. They're not making any election. They're retaining their free choice. And I, for one, wonder

whether, in fact, that's a sustainable combination of arrangements.

Now, let me just push you. You know, one approach would be to say, look, trying to do -- change these financial responsibilities in the traditional Medicare program is problematic for all these reasons, the unfamiliarity of providers in bearing risk and the implications for beneficiary choice. The alternative way to accomplish these things is through Medicare Advantage. Patients have the option of electing a private plan that, on its face, may limit their freedom of choice and they get to say, that's what I'm willing to do in exchange for a lower premium or enhanced benefits. Are you suggesting that we really ought to leave these new payment arrangements to Medicare Advantage and not try to introduce them into fee-for-service? Talk about that for a second. I'm not sure where your comments lead.

MR. GRADISON: I'm fine. If the hospitals want to take this risk, I'm -- more power to them. I think that the more competitors we have, the better. But I would not say that a health plan could not participate and take this risk. With regard to the existing Medicare Advantage plans, they

might find this attractive, too, but I could envision a health plan that would not necessarily be in Medicare Advantage but might wish to examine this particular type of risk to see if they have enough know how to feel that they could manage it.

I can't overstate that -- but I'm going to repeat myself to make sure you understand -- we're talking about making hospitals, to a degree, into an insurer, and that's not what they're -- that's not what their competitive advantage, their knowledge basis is in most cases. Now, if they want to take that chance, I'm not against it, but I look at what's going on in the hospital field, the risks that they're going to bear under current law with regard to readmissions, and I ask myself, are they going to get dinged for things that are totally beyond their control? I don't know the answer to that, but I think there's a fair risk that they will.

I look at the ACOs. My sense is that for an ACO to be successful, at least initially, the low-hanging fruit is going to be to take money, that is admissions, away from hospitals or reduce the length of stay or do something in the hospital area, which I think may not be such a far-

fetched comment. It may help to explain why there aren't more hospitals, at least in the initial rounds, that are -- I don't say there aren't any, but why there aren't more that are participating, because they're being asked in some cases to come up with the management for the ACO and the money for the capital, and if it's successful, it more than likely comes out of their pocket. I don't quite see that business model working very well.

So that's all. I'm not trying to say it's one or the other at all.

MR. ARMSTRONG: So I'll just be fairly brief. First, I think we've studied this long enough. It's time to push hard. In terms of the design options, I think we should combine hospital and PAC, include readmissions and include the longer period of time for many of the reasons expressed already.

I also just want to say that I think that this is an important policy issue for MedPAC, not just because it solves issues we've been trying to deal with for a long time, but because it does accelerate in our industry the kind of changes that we are trying to accelerate. And to a lot of the points that you all have been making about, well,

how hard this is going to be for the hospitals or for skilled nursing facilities or whoever, yes, that's exactly the point, because the way they're working together is the way that won't work in the future and that this is our vehicle, through payment policy, to force these organizations to work differently.

I don't necessarily believe hospitals are the only organizations capable of owning responsibility for creating the kind of integration and alignment and coordination. I think there are a lot of well organized medical groups and I think there are all sorts of other organizations, not just health plans, that are very capable of stepping up and have been demonstrating their ability to step up to this kind of a role.

I also -- Bill, I think your point was an excellent one. Let's not forget that this is actually less about getting the payment right and more about using payment to start forcing change in care delivery, that will deliver on different outcomes. And it's not actually just about care delivery. It's forcing changes in care delivery so they can engage patients and their families in a different relationship, as well. Patients and their families play an

incredibly vital role, particularly in this post-acute period of care, in advancing better, distinctively better, outcomes. But care delivery systems are woefully ill prepared to engage them productively and I think that's another example of the kind of change that we're trying to force.

And I think the last point I would make would be that -- someone said this already -- this really begs not only an attentiveness to what kind of care system changes are being forced, but quality reporting and other complementary kinds of information. And I realize we need to feel like we're nailing the payment policy and the analysis behind that and so forth, but I think our report really needs to speak to a lot of these other issues, as well. And I'll stop there.

MR. KUHN: A couple of quick thoughts.

First is, on Peter’s proposal, I don’t know if I completely understand it all together, but I’d like to hear more about it as maybe he develops it or develops it more with, Mark, you and your team.

But if I think about how this would impact the post-acute care providers, I can see a real distinction of

how folks would operate. I think, under his proposal, if the locus of control is at the hospital level then I would see the PAC providers actually really marketing themselves to the hospital and saying we can be the partner of choice because here's what we can do in terms of reducing readmissions or all the things that we can do as part of the process versus an alternative, if they're part of the PAC bundle, more of a partnership where you're kind of working together to spread the risk overall and payment.

So really two different looks at that. And I don't know which one is preferable, quite frankly. But I am intrigued, the fact that you would be in a position where they would actually be bidding or marketing themselves as hard as they can, that we're the folks that can deliver this service and give you these guarantees, et cetera.

Just that I think it creates two different kinds of incentives that would be interesting to kind of look at and explore a little bit more as we go forward.

In terms of the issues as we go forward, and kind of the three questions you put forward, I still would be interested in looking both at hospital-PAC as well as PAC-only. I'm intrigued by both of those, so I think further

exploration on both of those.

In terms of readmissions, I'm kind of in the mindset right now of probably excluding the readmissions. My main notion for that is the fact that last year we put forward a proposal for SNF readmission policy. Hopefully this year we're going to be thinking about a home health specific readmission policy.

So I just don't want the readmissions to be just in the bundle section only. I really want it to be broader thinking of organizations overall. So if hospitals have one that begin on October 1, who knows what Congress will do with SNF. But if they think future about SNF and home health, it's part of the overall culture of the organizations. It's just not for these particular payment streams. And so that's why I'm thinking about exclusion.

And then on length of 30 versus 90 days, probably the short one, a little bit what Bill and others were saying. A lot of unknown here, a lot of risk. I think if you put it in a more manageable time frame it gets at the question that we had of how we make it simple, but also it makes probably easier to integrate into the overall system. So just a couple of thoughts.

MS. UCCELLO: Unlike Herb, I know I didn't quite understand what Peter was saying, so I'll defer comments on that until I understand that better.

In terms of the questions laid out, I prefer to err on the side of more encouragement of coordination of care. So longer and more inclusive bundles makes sense to me.

And to the extent that the risk adjustment has some shortcomings or smaller providers or others may not be in the greatest position to handle that risk, if we can handle those issues throughout outliers or some other kinds of risk-sharing mechanisms, I think those should be examined more.

DR. SAMITT: A couple of quick points. I live in the word of bundled payments so you won't be surprised that I would be in favor of a more inclusive bundle. In our experience, bundled payments unveil poor quality and inefficiency and drive system integration. And so I certainly would go that way.

As I thought about the questions, I couldn't help myself but to think of at least the first two in a two-by-two matrix. I think we have to be careful to not think of

those two questions, the hospital-PAC and PAC alone as well as readmissions in isolation. Because I think there are unintended consequences if we combine the two wrong things together.

So for example, if we go with a hospital-PAC bundle and readmissions are not included, well as a hospital I probably would want to send as many people home as possible which is probably not a good outcome. Whereas if readmissions are included, I would think very carefully about -- I'd want to send the patient to the exact right destination.

Likewise, if we think about it today, there already is an impending readmission implication. If we think of that, in the absence of a hospital-PAC bundle -- if there were only a PAC bundle alone, for example -- well, as a hospital, I would probably want to refer all my patients to IRFs or LTCHs because there is a risk of readmission. I don't want them to be readmitted. But I'm not responsible for the bundle about where I send patients to PAC. So I'm going to want to go to the highest cost setting in terms of my referral pattern.

So I think as we think about these we have to

think about them together in terms of evaluating next steps.

DR. COOMBS: I agree with Craig in terms of the comprehensive global budget for post-acute care admissions in the sense that if the hospital has some investment into the post-acute setting then they have some control over the quality of that institution. But where there is no agency for those post-acute care settings, then you have less control.

And the things that really plague Medicare patients, such as c. difficile, VRE, if they're on the ventilator then ventilator-associated pneumonia. You lost your cost savings from the acute hospital in the post-acute care setting. You've lost it. In a week's time whatever you save on the hospital end, you can lose in the rehab hospital or the LTCHs.

So I think that without that you lose the control over quality and cost.

MR. BUTLER: So quickly, I would do the hospital plus the post-acute. I would include readmissions. And I would do 30-day, not 90-day. I think the analytics and the adjustments and exclusions you need to make for 90 day get a little tricky.

And then I wouldn't lose the risk adjustment and the attentiveness to the socioeconomic issues that David had just as a -- think about that.

DR. MARK MILLER: [off microphone] Did you say no PAC?

MR. BUTLER: You want the hospital and the PAC together. That would be my vote.

MR. HACKBARTH: Peter, under your proposal, do you envision a virtual capitation, sort of payments fee-for-service against the target?

MR. BUTLER: Yes.

MR. HACKBARTH: Mike?

DR. CHERNEW: So first, I think one of the big motivators here is speed. And so I think whereas philosophically I might be in the do more thought, in the purpose of speed that pushes me into the do more targeted places where you really know it can work camp. And that's where I am regarding this.

But more importantly, I don't actually see this as a good end-state because of all of these complications. And I see the end state as being a much broader, more global budget for caring for the person and making all of these

things sort of work. I don't think it would -- I think we would end up with a lot of complexities if our end-state was a series of complicated post-acute bundles with things ending at a particular point in time and then new things happening right after that time. So I view that as more complicated.

So I think we do have to begin to push the system to organize better, like Scott said. But here I think we should grab as much low-hanging fruit as we can and move as quickly as we can and begin to push forward to the broader set of changes. And I see these types of episode-based bundling things as not where we would end up way down the road.

DR. NERENZ: If I could just quickly respond, I think we just have to clarify end-state for whom? Because my statement was presumed on the idea that there may be organizations or sets of organizations that are really good at doing bundled episodes. They are not going, for example, at doing ACO-type full capitation.

And maybe an end-state is some combination in which CMS would pay ACOs on a capitation basis, the ACOs would turn around and subcontract for bundles. And so you

have an end-state that includes both components.

I was just saying that what I was reading in the text was the idea that this bundle would be around for a while and then it would go away. I don't know if it will ever go away.

DR. CHERNEW: I understand, although I guess what I would say in that case -- and I agree with you, I see that exactly happening. And I guess my view would be but then all these complicated things that we struggle with would have to be dealt with by those two organizations as opposed to us sorting through all of the nuances of telling them how they need to risk adjust, how they need to set their dates, when they can do it.

I could not agree more with Bill's comment about how to engage the beneficiaries and think about how to maintain that in the context of the overall Medicare program is really hard and very hard to do in this context.

MR. HACKBARTH: Okay. There's lots of food for thought here. I hear some important areas of agreement, some areas of disagreement, and some just frank questions that need to be thought through in more detail. So we'll process this conversation and then come back, hopefully,

with a proposed direction to get your reactions to.

Thank you, Carol and Evan. I appreciate your work on this.

So our final session today is on competitively determined plan contributions. In the audience, could I get you to move in and out quickly and quietly, please?

Unfortunately, we have run over. I didn't want to cut short the preceding conversation because we just need to figure out a path. We need to make some progress on this one way or the other, so we have run over. And as a result, we have only 45 minutes for this last conversation. And since it's our very first one on this topic, I think that's fine. And what we will do is limit the discussion to just one round of clarifying questions.

Before I turn over the presentation to Julie and Scott, I just want to say a little bit about the context for this, including why this name, competitively determined plan contributions. And I think the best way for me to approach that is by talking a little bit about recent MedPAC history on the Medicare Advantage program, which at various points in time we've invested a lot of time and effort in.

This history that I'll very quickly summarize

really goes back over the full 12 years that I have served on MedPAC and several different periods of intense examination of the Medicare Advantage program.

Over the course of that 12 years, there have been a couple themes that have been consistent and constant, even while the membership of the Commission has turned over several times. One of those themes is that it is a good thing for Medicare beneficiaries to have the option -- and I emphasize, the option -- of enrolling in a private health plan as an alternative to staying in the traditional Medicare program. It may not be good for all beneficiaries. It may not be what every beneficiary wants for herself or himself. But it's an option that could suit the needs and preferences of individual patients. Some private plans, in fact, are proven performers at doing some things that traditional Medicare has found difficult to do, including effective care coordination. So consistent theme one is having choices for Medicare beneficiaries is a good thing to do.

The second theme that has been consistent is that how we structure that choice is very, very important, and an important part of structuring it properly is to give

Medicare beneficiaries a financially neutral choice between staying in traditional Medicare or enrolling in private health plans.

To put that a little bit differently, the government ought to pay the same amount on a risk-adjusted basis whether the beneficiary elects to enroll in a private health plan or stay in traditional Medicare. So the importance of options and financial neutrality have been very, very consistent themes.

Because of these views, what we've found is that while the Commission has been very supportive of Medicare Advantage because it does offer that choice, we have expressed concerns over the years about the payment mechanisms used in Medicare Advantage, and particularly the system of benchmarks that were often set well above the Medicare expenditure levels in the same area, and as a result of that, resulted in Medicare expenditures being higher on behalf of beneficiaries who exercise the option to enroll in a private plan as compared to those that stayed in traditional Medicare. And that had been a point that we repeatedly in recommendations urged Congress to eliminate that gap and restore financial neutrality. As you know,

PPACA took significant steps in that direction of moving towards neutrality, although not all the way there.

As we have worked through these issues over the course of years now -- and I testified before Congress a number of times on the issue -- I've tried to make the point that financial neutrality is a key principle, but there are various ways that you could get to financial neutrality. The way that historically we have emphasized is using a system of administered prices, namely, use the projected Medicare expenditure per beneficiary as the peg and say that's the amount we're willing to contribute, either on behalf of the beneficiary if they stay in traditional Medicare or the same amount if they elect to enroll in a private health plan -- of course, with risk adjustment.

An alternative approach to financial neutrality, however, would be to say let's not peg the contribution to traditional Medicare expenditures, but let's peg it to competitively determined rates, so have a competition with traditional Medicare as one of the options but also private plans, have them submit bids, and then link the contribution to that competitively determined approach, and obviously different formulas that you could use, the low bid, the

second low bid, the average bid. In fact, there are programs that exist around the country, including the Federal Employees Health Benefits Program, that operate much in this way.

So the topic for this discussion is to begin just trying to understand what the implications might be of moving to competitively determined contributions as a way of establishing financial neutrality between traditional Medicare and private health plans being offered to Medicare beneficiaries.

Now, I imagine that there are people in the audience who are saying, well, this sounds a lot like premium support, vouchers, defined contribution. There are a lot of different names out there being applied to some of the same ideas. Why aren't they using those terms? And the reason for that is that what I want the Commission to engage in is a discussion of this principle of how we set financial neutrality, which raises a host of other issues beyond just the financial calculation, to be sure. And I want to do that in a way that starts with a blank sheet of paper so that we can structure the conversation in a way that we think makes sense to us. All of the different proposals out

there, whether they're called premium support or something else, they are already ideas that have content attached to them. There are various proposals that have answered questions in different ways, and what I want to do is free us from those already existing ideas to talk about this as a matter of principle and how we would approach it, what issues we would think are important to resolve, whether we even think they're resolvable at all, without trying to evaluate one or another competing proposal that already exists in the environment.

So that's the reason for what some may say is a very awkward title of competitively determined contributions. I am not trying to cast a new label that the world is going to latch onto. Actually, I'm trying to do the opposite. I'm trying to distance our conversation from all of the existing ideas out there, proposals out there, so that we can focus on some first principles, again, starting with a clean sheet of paper as it were.

Where will this take us? Frankly, I don't know at this point. It could be just an examination of the issues, identification of the issues that should be addressed. We may find that there's a sufficiently broad consensus within

the Commission that on some of those issues we have a real clear point of view about how they should be addressed, or we may find that we have very different answers to the critical questions and it leads to no particular set of recommendations or conclusions. We'll have to see where the path leads us.

So that's my preface to this conversation, and let me ask, Mike or Mark, anything you want to add to that?

[No response.]

MR. HACKBARTH: So with that, Julie, are you leading the way?

DR. LEE: Good afternoon. The Commission has been considering reforming the traditional Medicare benefit to complement our ongoing work on improving the payment system.

In the last June report, the Commission recommended a redesign of the fee-for-service benefit package as shorter-term improvements to the Medicare benefit. Continuing our discussion of the benefit redesign, we present an overview of the concept we call "competitively determined plan contributions" and discuss some of the key policy issues that the Commission would need to consider.

Today's presentation is in four parts. First,

we'll begin by defining the term "competitively determined plan contributions." Then we'll look at Part D as an example of the concept in current Medicare. Next, we'll go over some key design issues. And we'll conclude with additional policy issues that have significant implications for Medicare beneficiaries and the program.

"Competitively determined plan contribution," or CPC, refers to a federal contribution toward the coverage of the Medicare benefit based on the cost of competing options for the coverage.

Specifically, CPC has two defining principles: First, beneficiaries receive a federal contribution to buy Medicare coverage, and the contribution amount would be competitively determined. And, second, their individual premiums would vary depending on their choice of coverage and the level of the federal contribution.

CPC is not a totally new concept. In fact, we have an example of CPC in the current Medicare drug benefit, or Part D. Under Part D, plans submit bids to provide a standard drug benefit. Then CMS calculates the national average bid based on plan bids, weighted by enrollment. Then the national average bid is divided into two parts:

base premium and direct subsidy. The base premium is what an enrollee pays, on average, to the plan, and the direct subsidy is what Medicare pays to plans for each of the plan's enrollees.

This slide illustrates the process just described. We have three plans who each submit a bid. In this slide, Plan 1 has the lowest bid and Plan 3 has the highest. Their bids feed into the calculation of the weighted national average bid, which gets divided into the base premium and direct subsidy.

Now let's look at how enrollee premiums get calculated under Part D. What each enrollee pays individually for his or her drug benefit depends on how the plan bid compares with the national average bid.

Picking up where we left off in the previous slide, and moving left to right on this slide, let's start with the national average bid, consisting of the base premium and direct subsidy.

Plan 1 had a bid less than the average bid, and in this case, the subsidy amount is sufficient to pay for Plan 1's benefit, and the enrollee pays no monthly premium.

In the case of Plan 2, whose bid is equal to the

national average bid, an enrollee pays the base premium.

In contrast, Plan 3's bid is higher than the national average bid, and if the enrollee chooses Plan 3, then he or she pays the base premium plus the entire additional cost of the bid.

To sum up, this slide illustrates how enrollee premiums under Part D can vary depending on which plan they choose.

As noted previously, Part D represents one version of CPC and provides a useful reference point for how CPC could work in Medicare. But in some important ways, the Part D example might not translate so easily to Part A and Part B.

For example, there's more variance in the cost of providing medical benefits compared with drug benefits. And the cost of providing medical benefits might be more local than national. These differences have important implications for the design of CPC models for Part A and Part B services.

As the Part D example suggests, there are different ways to apply the principles of CPC. On this slide, we focus on two key design questions: One, should

the benefit package be standardized? And, two, how should the federal contribution be determined? We'll examine this question in three dimensions, which we'll come back to after the standardization question.

The CPC model would require some form of a standardized benefit package. The idea is to encourage plans to compete on the same or similar enough package of benefits. But standardization can be interpreted in different ways, with a varying degree of restrictions on what plans can do with the benefit design. In this slide, we illustrate three such examples.

The first version is most restrictive in that plans are required to cover the same services at the same level of cost sharing. For instance, Medigap plans are regulated in such a manner. There are 10 standard Medigap plans, and each specifies how it can fill in Medicare's cost sharing. Such strict standardization means that plans are easy to compare and more likely to result in price competition. And because there's not much room to differentiate plans, there's very low potential for risk selection. However, there's no flexibility in plan design, and beneficiaries who want something other than what's

offered would not be able to buy it.

Under the second version, plans cover the same services, but can vary cost sharing. This is the approach used in Medicare Advantage. MA plans have to cover the same services covered under the Medicare fee-for-service benefit, but they can change cost sharing, such as having different levels of out-of-pocket maximums or a set of co-payments, as long as the value of the benefit package as a whole meets the benchmark value. This approach allows for some but limited flexibility in benefit design, catering to different beneficiary preferences.

In contrast, Part D requires an actuarially equivalent package of services and cost sharing, which allows for much flexibility in the design of benefits. But in practice, there are more restrictions on Part D plans because they're required to do certain things. For instance, they must cover all drugs in certain classes, and at least one drug in all classes.

In general, as we move left to right in this table, from more to less restrictive standardization, we get increasing flexibility in plan design, increasing beneficiary choice, and increasing potential for risk

selection.

Under the CPC approach, how the federal contribution is calculated has significant consequences for beneficiaries and the Medicare program. We want to examine three dimensions of this question.

First, should the federal contribution be based on plan bids or set to a predetermined amount independent of plan bids? For example, we can set the federal contribution equal to a predetermined level -- let's say $8,000 in the base year -- and simply index it to grow at the rate of GDP, inflation, or anything else. Under this approach, Medicare program spending is predictable, whereas beneficiary premiums are at risk for Medicare costs increasing at a faster rate than the growth factor.

In contrast, a formula based on plan bids can result in contribution amounts that vary over time and across markets and are less predictable for both the program and beneficiaries.

Next, should the contribution amount be set nationally versus locally? To illustrate this question, we provide two examples. In both examples, we have three areas with different average cost for Part A and Part B benefit,

as shown in the first column of the tables. The national average cost of the benefit is $800 per month, and the federal contribution rate is 87.5 percent.

So let's start with the first table on the top, corresponding to a nationally set federal contribution. The national contribution amount is $700, which is 87.5 percent of $800, or the national average cost.

As shown in the second column of the table, all three areas receive the same $700. That means beneficiary premiums in each area equal the area-level average cost minus $700. Or Column 3 equals Column 1 minus Column 2.

In Area 1 -- that corresponds to the first row of the table -- the average cost is below the national average at $680, and even lower than the federal contribution amount of $700, and, therefore, the difference is minus $20. The simplest way to think about the minus $20 is that beneficiaries get $20 in rebates. Alternatively, beneficiaries could get $20 in additional benefits or simply pay no premiums.

In Area 2, the average cost is the national average, so its beneficiaries pay $100 in premiums and receive $700 in the federal contribution.

In contrast, in Area 3, beneficiaries pay $220 in premiums.

Now, let's look at the second table at the bottom corresponding to a locally set federal contribution. In contrast to the first example, the federal contribution is 87.5 percent of the local average cost of Medicare benefit. Therefore, the contribution amount now varies across areas.

Looking at the second column, it is lower in Area 1 at $595 and higher in Area 3 at $805. As a result, beneficiary premiums are now $85 in Area 1 versus $115 in Area 3.

Contrasting the national versus local, you can see that beneficiary premiums in Area 1 go up from minus $20 to $85, and those in Area 3 go down from $220 to $115.

As this simplified example points out, what the federal government pays and what beneficiaries pay in their premiums very much depend on the exact formula of the federal contribution.

The third and final question related to the federal contribution is: Should fee-for-service Medicare be included as a bid or not? For example, let's consider two areas, one with low Medicare service use and one with high

Medicare service use. Each area has two plans bids, and the average plan bid is illustrated by the red line.

I want to point out that these are for illustration only and are not drawn to scale.

In our example, including fee-for-service Medicare would lower the average bid in the low Medicare service use area on the left, while raising the average bid in the high Medicare service use area on the right, as illustrated by the yellow dotted lines.

In other words, when fee-for-service Medicare coexists with private plans, beneficiary premiums for fee-for-service will now depend on how it compares to private plans. In low Medicare service use areas, plan bids are likely to be higher than fee-for-service. Because fee-for-service is lower than plan bids, beneficiaries are going to pay more to be in private plans.

The opposite is true in high service use areas. Because plan bids are likely to be lower than fee-for-service, beneficiaries would pay more to be in fee-for-service Medicare.

These design issues have implications for beneficiaries and plans. Under the CPC approach,

beneficiaries would pay different amounts for fee-for-service Medicare across areas, depending on how the cost of fee-for-service Medicare compares with the cost of available private plans.

Moreover, how many plans would participate in a CPC model and which plans would be available to beneficiaries would also vary across areas.

Shifting gears a bit, we now turn to a couple of additional questions that are broader in nature. The design questions we've discussed so far are focused on creating the mechanism of a CPC model. They're complicated, but at least conceptually straightforward. You can see how those questions can turn into design parameters or specs.

The two questions on this slide are broader: What is the role of fee-for-service Medicare in a CPC model? And what provisions should be made with respect to low-income beneficiaries?

So let's first consider the role of fee-for-service Medicare. Should traditional fee-for-service Medicare still exist in a CPC model?

There are at least three possible roles it can play. One, beneficiaries can have fee-for-service as an

option everywhere. This would be especially relevant if there are areas where private plans do not bid. Two, as we discussed previously in the presentation, fee-for-service can be included as a bid in calculating the federal contribution amount. And, three, independent of how fee-for-service affects the contribution calculation, it might be important to have Medicare payment rates available because they can exert downward pressure on plan bids.

There's evidence from the literature that private sector payment rates are higher than Medicare payment rates in certain areas, and those differences in part reflect the market dynamics in the area, such as provider or insurer concentration. Therefore, lower Medicare payment rates may constrain how much higher private sector payment rates can go.

The CPC approach presents an additional set of challenging policy issues with respect to low-income beneficiaries who will need extra help paying for the beneficiary share of the cost of Medicare coverage.

On this slide, we want to briefly mention some of the questions any policies related to low-income beneficiaries will need to address, such as: who will get

the additional subsidy, and how much; how will they choose among available plans; how will benefits be coordinated between Medicare and Medicaid services; and finally, who's going to pay the additional subsidy and how will the federal and state governments divide up the financing.

Depending on the answers to these questions, some states could pay more compared to current law, and some states pay less.

As we continue our work on this topic in the next several months, here are some possible next steps: Exploring the effects of Fee-for-Service in Medicare on private plan bids, the importance and adequacy of risk adjustment in a CPC model, empirical analysis of design elements from today's presentation and the issues related to low income beneficiaries.

We welcome your input and guidance on these items.

That concludes our presentation, and we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Julie.

So, we have only about 15 or 20 minutes left.

As I said at the outset, what I'd like to do is focus on questions that commissioners have about the concept

and just try to clarify the concept, plus any analytic issues you think would be good for the staff to begin working on. So, those are my limited objectives for this brief discussion, and Mike, I'll start with you.

DR. CHERNEW: Yeah, I'll be very quick. First, on slide 3, I just want to make sure that I'm clear. The first bullet point says the contribution is competitively determined, but then later you have a big discussion about predetermined contribution.

So, the question is you wouldn't -- would you include in the CPC umbrella, models that have federal contributions that are neutral, the way Glenn described it in the beginning, but not necessarily the outcome of a bidding process? It seems in the end that you would.

MR. HACKBARTH: So, let me address that, Julie.

I think that we can look at it either way, and each approach has merits and demerits, but I don't --

DR. CHERNEW: I just wanted to be clear as to what was in there.

MR. HACKBARTH: Did you have another one?

DR. CHERNEW: Yeah, just very quickly.

So, the second issue is there's a lot of analogy

in here to existing programs, like Medicare Advantage and Part D, which I think is fine. In those programs, there's an issue about what the plan can do with the money between the bid and whatever the federal contribution is, and I might add that to my list of things to think about analytically as to what restriction.

What happens when plans, for whatever reason when you set it up, when they're under whatever the contribution is, thinking about what the rules are about -- that might be another analytic thing that I would put on my list of differences.

DR. BAICKER: Yeah, that was actually one of my questions just to further clarify is there potential for rebates to enrollees if they choose a plan that's below whatever the benchmark or bid is, even below what any premium contribution would be, but you know, in-pocket money is one question.

And then, a second question -- I thought it was very helpful to lay out how Medicare Part D and Medicare Part C, or Medicare Advantage, array on these dimensions. We have an interesting example of free-standing Medicare Advantage and Medicare Advantage Part D plans, but combine

these things, and it would be interesting to see what the evidence from the bids that those plans have made and what beneficiaries elect and then the cost of care that they receive to the extent that we have that data, how that maps in those three different types of plans to give us some sense of what outcomes you might expect on those different dimensions.

DR. NERENZ: Yeah, quickly, slide 10, please.

Could you just remind me, or remind us, why we think the plan bids are higher than Fee-for-Service on the left and lower than Fee-for-Service on the right. What's going on there?

DR. LEE: Just generally speaking, I think were the plans to have an opportunity to manage utilization and to do the things that the plans are supposed to do, there's more opportunity for them to alter the utilization or do more management in high use areas. So, I think those -- in very broad brush strokes, that was kind of the thing that we were trying to indicate.

DR. NERENZ: It doesn't explain the left though.

DR. LEE: Oh.

MR. HACKBARTH: Well, I'm not sure I'm going to

explain the left. Just to build on what Julie said, so as you well know, there are very large variations in service use across the country, and in areas where Medicare Fee-for-Service/traditional Medicare service use is quite low it is more difficult for plans to underbid traditional Medicare because the way they usually do that is by cutting service use, hospitalizations, et cetera.

A related issue is pricing in different markets and different market dynamics. In some parts of the country -- urban areas, typically -- there are lots of providers competing, and because there's a generous supply of providers there's greater opportunity for plans to get lower rates because they're actively bidding against one another. And so, in those areas, the gap between the Medicare Fee-for-Service payment rates and plan rates may be relatively small.

In areas, though, where there are fewer providers and plans have much more market power, it's difficult for private plans to negotiate and get effective rates. And so, Medicare payment rates may be significantly lower.

And so, it's a combination of those factors.

DR. MARK MILLER: And, the only other thing I

would say is it's not just -- this is just an illustration, but if you look at current bids in MA, this is what happens.

And then, the $64,000 question is: Does that change under a different paradigm?

DR. REDBERG: Just curious; what's the take-up in Part D now? Do you know?

DR. LEE: For the overall?

MR. HACKBARTH: [Off microphone.] So, your question is what percentage of beneficiaries -- [inaudible]?

DR. REDBERG: Take Part D, which obviously is different because it was nothing versus Part D and now it's Fee-for-Service, but I'm just -- because to me the challenge is for people to be able to compare different plans and how it gets fairly complicated.

DR. CHERNEW: Sixty percent of folks are in Part D, but remember, most people have broad coverage through some other ways. So, there's only 10 percent who have no drug coverage, or less. I think that's right.

So, it's -- MAPD, for example, does that take up a Part D?

If you have employer-provided drug coverage, does that take up a Part D?

So, I think the right answer to your question is 90-some percent of people, I think --

DR. REDBERG: Have some.

DR. CHERNEW: -- have some drug coverage, one way or another.

DR. REDBERG: And then, would you foresee that people could go in and out of these different plans, like go from Fee-for-Service to a CPC and then back to Fee-for-Service?

DR. LEE: Presumably, there will be -- like as in Part D, there's an enrollment because you are relying on beneficiaries to make choices, and as the relative bids change you want them to have things to make choices that are better for them.

MR. HACKBARTH: But, that is a design issue. So, over the course of Medicare Advantage and its predecessors -- Medicare Plus Choice and various other names -- that has evolved.

So, originally, it was month-to-month enrollment. Every month, a Medicare beneficiary had the opportunity to either go back to traditional Medicare or change plans. Now, the format is different, and beneficiaries make

elections for a year-long period.

So, that is a design question.

DR. HALL: I'll pass.

Thanks so much.

DR. NAYLOR: I'm trying to envision the standardized package. Can you talk about what might be some of the opportunities to create a standardized package under CPC, what it might look like?

I think it's one of the design elements.

MR. HACKBARTH: Are you referring to that early table?

DR. NAYLOR: Standardized.

MR. HACKBARTH: Yes.

DR. NAYLOR: I'm sorry. Standardized benefit. Sorry. Yes.

MR. HACKBARTH: So, if the -- question is: If a plan was to do more than Medigap a model --

DR. NAYLOR: Yes.

MR. HACKBARTH: -- and have more stylized choices, how might that look?

DR. NAYLOR: Exactly. I'm just -- I'm trying to figure out what opportunities exist to really take advantage

of a standardized benefit here.

DR. MARK MILLER: Since we're getting a cold start here --

DR. NAYLOR: It's probably -- I'm sure it's the question.

DR. MARK MILLER: No. I'm not exactly sure, but I mean, one way to start thinking about it is in MA -- and if I mischaracterize this, guys.

In MA, sort of the way it works is there's an expectation that the managed care plan provides certain benefits -- hospitals, physicians, whatever the case may be. And, the plan is given latitude on the cost-sharing. It has to be an actuarial equivalent, but it can modify the cost-sharing.

There are some ground rules within that, but it can modify the cost-sharing. And then, the beneficiary is getting a set of benefits and also may be able to go to a different plan and get a different cost-sharing arrangement.

So, starting from that point, do you go more in the direction of putting more of the benefit in an actuarial equivalent box and saying let people define things?

Or, do you go stay at that midpoint or go further

in the sense of saying, well, no, I want to specify the benefit and then say specify the cost-sharing, or that type of thing?

I think that's sort of what the toggle is.

I don't know exactly how to answer your question beyond that. It would be --

DR. NAYLOR: Actually, what you're describing, though, is a range of choices in the design that we have.

DR. MARK MILLER: Right.

DR. NAYLOR: And, I wasn't -- I actually was looking at the column across and not down.

MR. HACKBARTH: Keep -- I'm sorry, Julie. Go ahead.

DR. LEE: I think the way to think about the three different columns is that the value of the benefit package is fixed. Now, to what degree or which levers do you have in the benefit package that you can change to meet the value of the package -- I think that's, as you go from left to right, that flexibility. You have more levers that you can go. I think that's the way to kind of think about it as a continuum.

MR. HACKBARTH: Yeah. And, as Julie indicated in

her initial presentation, there are trade-offs.

On the one hand, allowing more flexibility allows plans more opportunity to develop benefit packages that are, you know, customized to meet the needs of particular groups of patients; there's more choice for beneficiaries. On the other hand, there's the concern that as you move towards the right on that continuum the potential for those benefit structures to be used to select better risk and avoid high risk increases. And so, there are trade-offs in that decision.

MR. GEORGE MILLER: My question has to do with quality evidence-based medicine. Would we be able to use this as a lever to drive quality for things we think, or the evidence says, has benefit versus something that someone wants to select.

And, then would we have the flexibility to say: You can have it, but you pay more. This is going to be in the package. This is evidence-based medicine. We think that the majority of the Medicare beneficiaries would have better outcomes if they choose this methodology.

Then so you could have a price tier and then another lever if they want to go off on their own or try

some other things. Would we have the flexibility to do those types of things?

Especially, what I've read and learned from this Commission -- we can really drive quality and this may be a lever to drive quality based on, as Mary said earlier, all the body of evidence, that it's evidence-based medicine.

MR. HACKBARTH: The way I think of it, George, is that this format allows us to pursue different potential approaches to increasing the use of evidence-based medicine, improving value for Medicare beneficiaries. You can try to continue to do that through the traditional Medicare program.

None of this would preclude all of the payment reforms that we spend so much time talking about, where we try to restructure the program to create both stronger incentives and greater opportunities for providers to identify what's high-value care and get it to Medicare beneficiaries.

All of that work will continue, but it also creates the avenue of private plans using a somewhat different tool set to also drive towards that goal of high-value, evidence-based medicine.

So, traditional Medicare offers a free choice of a provider. Private plans often use selected networks. And, each of those approaches has pluses and minuses in terms of advancing the cause of high value.

This would basically make both approaches available to beneficiaries and give them choices. In that sense, it's really no different from Medicare Advantage, and that's what Medicare Advantage does as well.

MR. GEORGE MILLER: Just one quick -- my second question is how often would we adjust these bids or rates. Would this be done annually? A fiscal year? A longer period of time?

Do we have thinking on that yet?

MR. HACKBARTH: Well, typically, we think about doing this on an annual basis --

MR. GEORGE MILLER: Annual basis, right.

MR. HACKBARTH: -- much as is done with Part D or the bidding process under Medicare Advantage.

MR. GEORGE MILLER: Annual.

MR. GRADISON: Looking into your next round, just two questions.

First, I'd like you to give some thought to how

this premium structure would work if the premiums were income-related. Granted, the lowest income is zero. I understand that. So, the premiums would rise in some manner related to the income of the beneficiary.

I would just like to see how that would work or whether in some way it could be integrated into this plan or not.

And, the second thing, which is not unrelated, is how this concept of premium payments would relate to the options that are expected to develop through the exchanges, where you've got -- I understand with the exchanges there's bronze and gold and platinum, or whatever, but I think they have a lot to do not with the benefits so much as they have to do with the size of the deductibles. But, I'm not an expert on that, but I think it's generally what I just said.

And so, I'd just like to see how those two concepts -- income relations and how it would relate to some -- to the premium structure conceptually under the exchanges as they develop. Next round, you know another time, but I'd like you to give some thought to that, please.

DR. DEAN: I know that introducing these kinds of options certainly gives the opportunity to look at different

ways to deliver the care and hopefully come up with things that are more efficient and more effective.

I guess my question is, do we know from the experience, both with MA plans and especially Part D, what happens -- what the beneficiaries' approach that is?

I mean, it seems to me that the value of choice and shopping around and so forth is much more appealing to a younger population whereas the older population -- and I can identify with that now -- are more interested in security and stability and are less interested in shopping around. And, I know when Part D first came around we went through a lot of turmoil, trying to help people figure out, you know, what would fit.

And, I think there are some data about how often do people actually change Part D plans as they're -- and my understanding was it's pretty small even though if they were shopping -- it isn't really -- it doesn't really directly relate to this, but I think it might be relevant to, you know, how the uptake of these ideas by a beneficiary population.

MR. ARMSTRONG: Not really a technical question so much as I would just ask -- the format for the analysis is,

I think, brilliant. I think it's great.

But, I would just ask; I'm thinking about our last conversation that we get into a lot of analysis of alternatives and so forth and that we should -- I would ask that we make sure also as we look at the different choices we've framed that we consider, well, what would you have to believe about the changes in the care delivery system in order for some of those assumptions to really be realized?

So, my request would be that as we go forward with this analysis, it's really giving us the opportunity to talk about what are the kind of changes or capabilities in the care system and the industry that we're really trying to drive through some of these policy alternatives.

MS. UCCELLO: I'm interested in understanding better the national versus local issues. And, Glenn brought up -- mentioned that the Commission has looked at local market dynamics in terms of price and also regional variations in utilization.

And so, what are the implications of national versus local on variations in utilization and/or kind of the price, local market dynamics?

DR. SAMITT: You've talked about MA and Part D as

sort of a comparative example of how this could work.

My question is whether there are any lessons to be learned from the commercial marketplace or employers who may already in many respects have experience and live within the world of competitively determined plan contributions, and whether there's anything that we can look at from a benchmark perspective and an employee perspective in that world that would signal a response to this world.

MR. HACKBARTH: So, even within the federal government, the Federal Employees Health Benefits Plan uses a structure at least somewhat like this. Some of the states do. California's employee system does. And, I think there actually is some literature on how those systems have worked and what the rate of increase has been in their costs as compared to other places. So, we can mine that a bit.

Peter?

MR. BUTLER: Slide 10. Just a little worried if this has a life of its own, just to be absolutely clear. We're neutral at this point in whether Medicare Fee-for-Service as we know it is an option, or not, to pick. This just is about whether or not it should be included in a calculation of a federal contribution.

So, you might -- but, if you just read the slide by itself, it might say should you include Medicare or not.

And, maybe it should say include Fee-for-Service Medicare spending as a bid versus not, or something, because as I read this by itself somebody may suggest that Medicare is going to actually bid, and that's not the intent of this. I think it's to include Medicare Fee-for-Service spending as a part of the calculation.

MR. HACKBARTH: Okay. Let me just to be clear.

MR. BUTLER: And, maybe I'm not sure.

MR. HACKBARTH: Well, at my request, the way this was arranged, it does assume that Medicare Fee-for-Service is an option as I described at the outset.

And then, there would be the question of, well, how do you factor that into the calculation of the competitively determined plan contribution?

And, one way to do that is take the projected Fee-for-Service expenditure and treat that as a bid, and then, you know, do the calculation with the relevant plan bids.

MR. BUTLER: Okay, but later we do raise the policy issue, and you articulated should Medicare Fee-for-Service be an option or not.

MR. HACKBARTH: Yeah.

MR. BUTLER: But, again, this is just including their expenses. It's not that they are going to, per see, bid, and that's the way it might read: Include Fee-for-Service Medicare as a bid.

It's just semantics on words.

MR. HACKBARTH: Yeah. So, you know, as I said at the outset, my goal at this point is really not to preclude any policy options. In fact, the whole purpose here is to, as I said, start with a plain sheet of paper and consider whatever issues you folks think are important.

But, I was just trying to explain why the presentation was arrayed this way. I did ask for it to be a system that included traditional Medicare.

And, maybe the term, bid, is what's hanging you up. Really, it's just a calculation of the projected Medicare per capita cost.

MR. BUTLER: It's not hanging me up. I understand.

MR. HACKBARTH: Yeah.

MR. BUTLER: Somebody else may just read something else into that.

DR. MARK MILLER: Right. Just to make sure I understand, you're saying it's whether it's passive. You know, it's just a calculation of the Fee-for-Service spending in that area, or whether Medicare is actively bidding. That's your point.

Just one thing; we'll have to ask everybody to hand in their handouts. We'll catch it in the future, but this batch is out.

MR. HACKBARTH: Any other final questions?

We are actually 10 minutes over at this point.

Hearing none, thank you, Julie and Scott, and more on this later.

We'll now have our public comment period. And since I see somebody rising to the microphone, let me just briefly say what the ground rules are for this.

Please begin by identifying yourself and your organization and I ask that you limit yourself to no more than two minutes. When this red light comes back on, that will signify the end of the two minutes.

MS. MIHALICH-LEVIN: Great. Thank you, I'll be very brief.

My name is Lori Mihalich-Levin and I'm with the

Association of Medical Colleges.

As you consider your next steps with the competitively determined contributions, the AAMC would encourage you to consider, if this model becomes an option, what would happen to the traditional policy payments that are made to providers like direct graduate medical education, indirect graduate medical education, and disproportionate share hospital payments.

If these payments no longer exist in their traditional form, at least with respect to the beneficiaries who choose this option, we would urge you to consider how teaching hospitals will continue to serve their traditional missions of teaching residents or training residents and caring for their vulnerable populations that they currently care for.

One option that we would urge you to consider is the current model under the Medicare Advantage plan as it exists right now, where GME payments are made directly to hospitals for the patients who select the Medicare Advantage plans.

With that, I'd say that we are very open to the opportunity to discuss this further with the Commission and

the MedPAC staff.

Thank you.

MR. WILLIAMSON: Good afternoon.

My name is Stephen Williamson. I'm president of the American Ambulance Association.

I'd like to take this time also to thank staff for listening to our concerns and recommendations.

We noted in the discussion today that it is possibly impossible to get costing information. We would suggest that we have shared ways with the staff, and would be happy to share it with the full Commission, a model for collecting the data. We think these will address the concerns with the historic surveys.

Also, we encourage you to keep an open mind about the two companies that have had two equity firms purchase them. That's a very small portion of the industry and doesn't reflect the issue as it pertained to the discussion today.

We also would ask that you consider the GAO report which will be out October 1st, and its reflection on local subsidies and local and state regulations on the EMS industry.

And finally, we understand that this area of dialysis needs further review and we are very much open to help in clearing up the misconceptions and conceptions of what is going on in that particular dynamic.

Thank you.

MR. HACKBARTH: Okay, I'm seeing no others going to the microphone.

We are adjourned for today and we reconvene at 8:30 tomorrow morning.

[Whereupon, at 5:42 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, September 7.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 7, 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
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [8:31 a.m.]

MR. HACKBARTH: Okay. Good morning. Our first session this morning is on another congressionally requested report, this one on improving Medicare's payment system for outpatient therapy services.

Who has the lead? Adaeze?

DR. AKAMIGBO: Good morning. The Middle Class Tax Relief and Job Creation Act of 2012 requires MedPAC to study the payment system for outpatient therapy services and to address how it can be reformed to better reflect the therapy needs of the patient. I want to acknowledge Ariel Winter, who is sitting next to me, Kevin Hayes, Carol Carter, and Lauren Metayer.

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

Today I will begin with an overview of outpatient therapy services in Medicare. I will briefly describe the Medicare benefit, including therapy types and providers;

present findings on spending across the different therapy types and the growth in spending over time; discuss therapy caps; exceptions to those caps, which will expire at the end of this year unless Congress acts to renew them.

I will also present some policy options the Commission may consider to address our mandate which can be grouped into three categories: options to improve Medicare's ability to manage the benefit in the short term, and in the long term the collection functional status data and ways to reform the payment system for outpatient therapy services.

MedPAC staff took a broad approach to gather data and information on outpatient therapy services to address our mandate. In addition to claims analysis and literature review, we held numerous meetings with rehabilitation professional societies that represent all therapy types and providers, and several conference calls with CMS staff. We also hosted a panel rehab researchers and practitioners to discuss how the payment system could be reformed and conducted an extensive set of interviews with different health plans and private benefit managers to learn how therapy services are managed in the private sector.

As a quick overview, outpatient therapy services as defined by Medicare include three types of services:

Physical therapy focuses on treatments to restore or improve function;

Occupational therapy focuses on independence in performing activities of daily living;

And speech language pathology focuses on assisting patients with communication and swallowing.

Under the Medicare benefit, conditions for services to be provided must include:

A verifiable need for outpatient therapy services;

A treatment plan which must include at a minimum diagnosis; long-term treatment goals; the type, amount, duration, and frequency of therapy services;

The beneficiary must also be under the care of a physician or a non-physician practitioner who certifies the plan of care;

Outpatient therapy services are identified by designated HCPC codes and paid the same physician fee schedule rate across all sites of care.

You may recall that this is unlike other ambulatory services where payment rates often differ by site

of care such as E&M visits, and we will present more on that topic next month.

Therapy services may be furnished by the providers listed on this slide. There are two main settings where therapy services are delivered, and they are listed on this slide -- generally in private practices and in outpatient facilities.

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

There are two cap limits: one for physical therapy and speech pathology combined, and another for occupational therapy.

Therapy caps are adjusted annually for inflation, and for the 2012 spending year, the cap is $1,880.

Until later this year, therapy caps have not applied to services received in hospital outpatient

departments. So beneficiaries who incur services up to the limit in other settings could simply obtain more services in HOPDs if they chose to do so. HOPDs will be included under the cap under current law from October to December of this year.

Now, a different threshold, unrelated to the caps I just described, will trigger manual medical reviews of therapy services. So starting in October this year, combined spending on PT and speech that reaches $3700 and spending on occupational therapy that reaches $3,700 -- separate -- will trigger manual medical reviews.

As I just mentioned, given the concern that caps could impede access to therapy services, an exceptions process was adopted to allow Medicare beneficiaries to receive services above those limits. A KX modifier is included on the claim to indicate that services incurred above the limits are necessary and are documented in the medical record. The list of conditions beneficiaries could have to qualify for an exception is broad, and the exceptions process has made therapy caps an ineffective tool to control costs. As I mentioned earlier, the exceptions process expires every year and requires legislative action

to be extended every year. The exceptions to the caps will expire December 31, 2012.

Now, Medicare spent a total of $5.7 billion on outpatient therapy in 2011; 71 percent of total spending was on physical therapy, while 19 percent and 10 percent were for occupational and speech language pathology respectively. Almost 4.9 million beneficiaries used outpatient therapy services. Overall, per user spending was $1,173. Since beneficiaries used more than one therapy type, the average therapy visits was about 16 per user.

This chart shows the breakout of spending from the larger billing sites in 2011. Nursing facilities accounted for about 37 percent of total spending; physical therapists in private practice accounted for 30 percent. Hospital outpatient departments and outpatient rehab facilities accounted for 16 percent and 11 percent respectively.

Medicare has experienced significant growth in outpatient therapy services. Across all settings, total spending has grown by 33 percent, or by an average annual rate of 4 percent over seven years, as you see in the last cell at the bottom of this table.

While the overall average annual growth rates

appear modest, growth in some settings are more stark. For example, from 2004 to 2009 -- that's the second to the last column -- spending in nursing facilities grew by an average annual rate of 8 percent and by 7 percent in the last two years. And as we discussed in March of this year, the one-year growth rate from 2008 to 2009 in nursing facilities was 21 percent.

Similarly, spending on physical therapists in private practice has grown by 10 percent annually from 2004 to 2009.

Physical therapists were able to bill Medicare independently starting in 2003, and that policy change might explain some of the growth we see in that sector. But without good data on the functional status of therapy patients, it remains difficult to determine what explains the growth in therapy spending in settings such as nursing facilities.

Per user spending has been growing rapidly since 1999 despite policy changes to the caps, which are indicated at the top of the chart, and the exceptions process indicated at the bottom of the chart. Caps first took effect in 1999, and as we see, per user spending dropped

that year. But from 2000 through 2005 when there were no caps except for a three-month period in 2003, per user spending increased dramatically -- according to the years for which we have data. Caps were reintroduced in 2006, and the exceptions process was introduced that year, although it was a manual process at first. Per user spending dropped that year relative to 2004, but after the exceptions process became automatic with the KX modifier, per user spending has increased every year since.

This chart shows a similar trend in total spending. Caps without an exceptions process leads to lower spending as we see 1999, and with a manual process, another drop in 2006. But the absence of caps or the implementation of caps with an automatic exceptions process has resulted in increases in total spending on outpatient therapy.

The growth in total and per user spending leads to questions about potential overuse, which is heightened by our findings on geographic variation, which I'll discuss next.

This slide shows spending per beneficiary among high and low spending counties.

Adjusting for health status, mean per user

spending among the top ten counties is over $2,800, while it is $477 among the ten lowest spending counties. Counties in the southeast region, like Louisiana, Texas, Mississippi, are among the highest spending areas in the country.

But Kings and Queens counties in New York are also among the highest spending counties and with very large numbers of beneficiaries using therapy services. Queens is ranked 19th highest spending county, so it's not on this list here.

You may recall that in our March presentation, Miami-Dade County was the highest spending county in the country with per user spending of $4,500 in 2009. But in 2011, per user spending dropped to about $1,900 in Miami-Dade County after additional reviews and claims edits were implemented to address overuse and fraud.

The lowest spending counties are concentrated in Midwestern states of Iowa, Minnesota, and North Dakota.

As I mentioned earlier, there are spending caps on therapy services, but there is an exceptions process. In 2011 about one-fifth of therapy users exceeded the caps through the exceptions process, and this has grown over time. The mean spending for users who exceeded the caps was

slightly over $3,000, about three times higher than the national average of $1,173, and much higher than spending among beneficiaries who did not exceed the caps.

I will now switch to some of the concerns about diagnosis and functional status data in the outpatient therapy payment system.

Medicare spends about $6 billion a year on outpatient therapy, and there are no clear diagnosis codes that yield meaningful information about the condition or the acuity of the beneficiaries. Most of the diagnosis codes used in therapy are non-specific such as lumbago, which is low-back pain. The most commonly used code is a V code, V57.1 for "other non-specific physical therapy," which is a description of the service rather than a diagnosis.

There are no commonly used patient assessments among therapists, as we'll get to in a moment. Poor diagnosis codes make it difficult to determine the conditions and the acuity of the beneficiaries and poses challenges for Medicare's ability to clearly define the benefit.

In addition to poor diagnosis codes, there are no functional status measures for outpatient therapy

beneficiaries at baseline, at discharge, or at any time during the course of therapy. There are some instruments available as we described in your mailing materials, but they are not widely used. Providers have not been required to report standardized data on functional status to be reimbursed. This makes it difficult to determine the progress patients make, that is, their outcomes once therapy is initiated.

In sum, we have presented a lot of data that show that the outpatient therapy payment system is fraught with spending growth and wide geographic variation in spending, with therapy caps that are ineffective in restraining spending due to a wide-open exceptions process and little information on the patient's condition or outcomes. As I mentioned earlier, the Commission is required to make a recommendation on how to improve this benefit under Medicare.

Some policy options the Commission could consider would include: improved ability to manage the benefit in the short term; and in the long term, the collection of functional status data; and reforming the payment system to pay appropriately for services provided.

I will now walk through each option briefly.

To improve management of the benefit, the Commission could consider requiring services from HOPDs to be included under the cap. Until this year, HOPDs have not been included under the cap due to concerns about access. But the broad exceptions process makes this unnecessary. Services in HOPDs will be included under the caps starting in October through December this year. The Commission could discuss making this permanent.

The Commission could also discuss an option to introduce focused reviews of therapy claims with specific focus on high-use geographic areas such as Kings County or Brooklyn, New York, and counties in Louisiana, as well as reviews of providers who deliver substantially more services than the average provider. This option could involve medical record reviews, payment edits, and site visits to verify addresses and actual physical location of therapy providers.

PPACA granted the Secretary new authority to address fraud and abuse in geographic areas and among providers who exhibit aberrant patterns that suggest fraudulent billing. Under this new authority, the Secretary

could place a temporary moratorium on enrollment of new providers, require providers to re-enroll, implement payment edits, or suspend payments for services that show a high risk of fraud. The Commission could urge the Secretary to exercise this authority for outpatient therapy services.

The Commission could also discuss the option to reduce the certification period from 90 days to 45 days. Our analysis has shown that the average episode lasts for about 32 days. A therapy plan of care for 45 days would accommodate the majority of outpatient therapy users and would increase physician engagement and oversight of the plan of care. But while this option may increase oversight, requiring recertification after 45 days could lead to more physician visits associated with a therapy episode of care.

The Commission could also discuss potentially requiring that all submitted claims have clear and specific diagnosis codes and prohibit the use of V codes as a primary diagnosis in order to be reimbursed. Finally on this slide, the Congress could give the Secretary the authority to adjust beneficiary cost sharing. This is consistent with the Commission's June 2012 recommendation on cost sharing. Making beneficiaries more sensitive to the cost of therapy

services could encourage them to carefully assess the value of those services.

To collect information on functional status, the Commission could discuss the development of a standard tool to capture key information on functional status and therapy needs. The goal for such a tool is that it would facilitate categorizing the majority of therapy users by severity and functional status during an episode. As outlined in your mailing materials, there are currently many tools that exist to develop clinical plans of care, and they are specific to therapy types such as PT and speech pathology.

But a new tool that would capture demographic information, therapy specific diagnosis, such as osteoarthritis, affected body structures, such as the shoulder, and affected activities or limitations in activities, such as walking or communication, would provide the basic information necessary to group patients into defined levels of acuity and enable CMS to prospectively determine how much therapy a given patient may need. This new tool would not prevent the use of other assessment instruments currently used for care planning, but it would collect information necessary for payment purposes.

There is a prototype for such a tool that was part of a CMS study, and as we discussed with researchers and practitioners, additional data elements to that prototype is a good start towards developing an instrument for payment purposes.

And finally, the Commission could discuss long-term options to redesign the payment system. It could take two forms.

First, a payment system that pays per episode. This would be based on extensive data that has been collected using the instrument I just described. This option would take some time because of the data collection that would need to occur in order to construct severity groups and payment categories, as well as expected episodes. This option could reward providers who achieve better outcomes in the expected amount of time.

For some patients however, the predicted amount may not be enough. On the high end, an unrelated injury or illness could delay progress from therapy services, and in those cases there would be outlier payments to pay providers for their costs above a certain threshold. Similarly, an episode could be truncated for several reasons. Therapy

patients often do not complete a prescribed number of therapy sessions. In those cases, Medicare could pay for the completed visits rather than an entire episode.

Another option could be to implement a similar method to the private sector's approach to managing the outpatient therapy benefit. From the series of interviews we conducted with private plans along with our contractor, we learned they often impose a per beneficiary visit limit and require pre-authorization for any additional visits above that threshold. Under this approach, we may not need information collected using the standardized tool described earlier.

To wrap up, we would like your reactions and guidance on these policy options. Some of the policies we've discussed expire at the end of the year. Congress has required MedPAC to make recommendations in this report. For those recommendations to be useful to the Congress, they need to be produced before the provisions expire.

And with that, I will turn it back over to Glenn.

MR. HACKBARTH: Okay. Thank you, Adaeze. Well done.

Could I kick off the round one clarifying

questions? Over the years, we have spent a lot of time talking about therapy and home health agencies and skilled nursing facilities. And I think it would be useful to make sure that everybody understands how this outpatient therapy service benefit relates to that. Let's focus in particular on home health agencies for a second.

You have a Medicare beneficiary who is receiving home health services. Medicare is paying for a home health episode, and one of the services the beneficiary is receiving is therapy services. How is Medicare paying for those therapy services? Is it all under the home health payment system, or is there also a payment under the outpatient therapy benefit? Would you just clarify that and make sure everybody understands how that works?

DR. AKAMIGBO: Yeah. So it's a similar situation with nursing facilities, SNF. So you can get therapy as part of the SNF bundle or part of the home health bundle payment. In skilled nursing facilities or home health, for the patients -- the beneficiaries who reside there, say skilled nursing, who are not getting therapy under Part A or the SNF bundle, they can get therapy services covered under Part B.

MR. HACKBARTH: Right.

DR. AKAMIGBO: So they're not skilled patients necessarily. They're nursing home residents getting Part B therapy.

In home health, it's less clear there, but basically if they're homebound, getting other services -- not getting therapy services under the home health benefit, Part B -- therapy services can still be billed to Part B to cover physical, speech, and occupational therapy. I don't know if that's clear.

DR. MARK MILLER: Just let me go through this for a second. If somebody is homebound and they're getting a skilled service during the home health episode, that would be covered there.

MR. HACKBARTH: Under the home health payments.

DR. MARK MILLER: Under home health. I'm sorry. I'm not being clear. In theory, that person is homebound and then wouldn't be able to travel for outpatient therapy. They would be getting their therapy there. So I'm not saying there is no billing that occurs. I'm always surprised by what happens.

MR. HACKBARTH: And so --

DR. MARK MILLER: But in theory, that should be two different events.

MR. HACKBARTH: So let me just play it back. If the patient is homebound receiving care under the home health benefit and payment system, then the dollars for the therapy flow only under the home health payment system.

If, however, the patient is not homebound, therefore ineligible for home health payment, and is traveling to a different location for therapy services, then it's paid under this outpatient therapy benefit.

DR. CHERNEW: When they get the therapy in the home care setting, is it a higher case mix adjuster? In other words, I thought home care had different levels of payment for home --

MR. HACKBARTH: Oh, yeah --

DR. CHERNEW: I want to know if the receipt of outpatient therapy changes the severity and payment level in the home care payment system.

DR. MARK MILLER: Within home health, there are different -- like hospital DRGs and that type of thing --

DR. CHERNEW: Yeah, like a RUG.

DR. MARK MILLER: -- there are different

categories.

MR. HACKBARTH: It is a RUG, in fact.

DR. MARK MILLER: No. That's SNF. That's SNF.

MR. HACKBARTH: Oh, that's right.

DR. CHERNEW: So we're close.

DR. MARK MILLER: But it's the same idea, and so you can have high-intensity patients and low-intensity patients.

DR. CHERNEW: And so my question is: The receipt of physical therapy or any of these therapies, is that a cause for moving from one of the home health categories to a higher one? And I say that mostly so we can see what the payment rate is in the --

DR. MARK MILLER: Yeah, so, for example, if you had more complex needs and needed, you know, more skilled therapy services, that would move you up in the home health payment system.

MR. HACKBARTH: Yeah, and then just to complete it, on the SNF side, if the patient is in a skilled nursing facility receiving services, that's a clear-cut case. The payment is through the skilled nursing facility payment system.

If the patient is not actually residing in the SNF, they can receive services at a SNF on an outpatient basis under this outpatient therapy benefit system. So when we see statistics here on the rate of growth in SNF-based payment, these are patients who are not living in the SNF that are going to a SNF on an outpatient basis?

DR. AKAMIGBO: Let me -- yeah. So most of these are patients who live in the nursing facility.

MR. HACKBARTH: Yeah.

DR. AKAMIGBO: They're not the SNF Part A.

MR. HACKBARTH: Yeah. They're not SNF patients.

DR. AKAMIGBO: They're not SNFs. That's why I'm trying to be consistent in saying nursing facility as opposed to skilled nursing facility.

MR. HACKBARTH: Right.

DR. MARK MILLER: Right, so think of the scenario of a dual eligible who is living in a nursing home, so they're getting their nursing home services from Medicaid, but they may be, you know, going to the clinic that's part of the nursing home and getting Part B outpatient therapy.

DR. AKAMIGBO: Therapy, yeah.

DR. MARK MILLER: Again, in theory, or, you know,

the way it's supposed to work, if they're actually in the skilled stay, the SNF stay, then they shouldn't be getting it.

DR. AKAMIGBO: They could get it, but it would be billed under --

DR. MARK MILLER: They should not be getting the Part B outpatient therapy

DR. AKAMIGBO: Yeah.

DR. MARK MILLER: You okay?

MR. HACKBARTH: Okay. Let's see. Whose turn is it to start? It's George. George looks like he's ready to go here.

[Laughter.]

MR. GEORGE MILLER: Well, let me see if I can add to your confusion. What about a patient in a swing-bed, in a hospital swing-bed who may need therapy? Which -- how is that billed?

You think I would know, but --

MS. KELLEY: [Inaudible.]

MR. GEORGE MILLER: Still Part A?

DR. MARK MILLER: So -- yeah.

MR. GEORGE MILLER: Okay.

DR. MARK MILLER: So that the transcriptionist gets it, SNF Part A benefit. Okay?

MR. GEORGE MILLER: Okay. I've got other questions, but I'll wait until round two.

MR. HACKBARTH: Clarifying question?

DR. NAYLOR: Just, if a patient's plan of care is for -- I'm trying to figure it out in terms of the alternative payment opportunities, episode versus private.

If a patient's plan of care is elongated, meaning over time, how would either one of these -- is it the private sector approach that would allow for that flexibility, meaning I want to prevent functional decline in someone and it's not someone who is going to benefit necessary by lots of therapy visits right up front but rather over time?

How would either of these alternatives -- which of these might be the better to address that kind of person's need?

DR. MARK MILLER: I'll give you a couple thoughts, and if you guys -- so, if you start with the episode option, so the idea here is you should have much more detail on the needs of the patient, including functional limitations,

which is really -- there are other important factors that we can cull from our conversations but functional limitation being really important.

So, you know what limitations they come in. You can see if those improve, which is the idea anyway. And then, you would build episodes on the base of those characteristics and have blocks of spending. Say, for these types of characteristics, here's the block of spending. Then, you have two safety valves.

One is the patient stops coming, and maybe the program says, well, I'm not going to pay you the whole episode; I'll pay you for a few visits because the patient opted out.

On the other hand, it would be like an outlier payment which you often see in our other payment systems. Somebody exceeds the episode for some period of time, and then the program comes back in behind that and sort of begins to pick that up. And, what that threshold is and how much they pick that up would be a matter of design.

Now, one thing I want to say is that it still doesn't necessarily put a cap on total episodes. So, people could just generate episodes, and we may still have, you

know, the issue we have now.

In the private sector, the way a lot of private sector plans work, not exclusively, but they say: Our benefit is 14 visits. If you want more, your physical therapist calls our physical therapist and discusses whether there is, you know, a need to go beyond that.

And, the guidelines there -- fairly hazy.

DR. HALL: So, on the V codes, there's -- just to make sure I understand this. There's virtually no way to backtrack how V codes correspond to clinical diagnosis. Is that correct?

DR. AKAMIGBO: That is the diagnosis code.

DR. HALL: Yes, that's the diagnosis code, but I mean, abnormality of gait could be something as simple as a bunion or it could be a stroke --

DR. AKAMIGBO: Yeah.

DR. HALL: -- or it could be horrible frailty. And, there's no way at this point to put that kind of a discriminator, at least.

DR. AKAMIGBO: For the V code, no. It's -- yeah, when it says other physical therapy, that's all we've got

DR. HALL: Okay. Thank you.

And then, just one other question. The geographic disparities and notably the Miami case, which got a lot of publicity you mentioned in the write-up, has anything like that been done in other areas of the country that are very high, seem to have high utilization?

Some of the southern -- other southern economies -- Louisiana.

DR. AKAMIGBO: We haven't heard of any in the outpatient therapy space. Yeah, maybe others --

MR. WINTER: In the -- we did talk to carrier medical director from a southern state that shows a high level of utilization, and they -- he had said in the past they had implemented various things which had an effect, but they just don't -- they had to discontinue then because they just don't have the resources to pursue all the services that are risk.

DR. HALL: Right, right. So, I mean the Miami experience was kind of a no-brainer, right?

A general physician billed no services and then a year later billed a million, maybe two million dollars. I mean, it doesn't take a rocket scientist to figure out what's going on there.

Okay, that's all for round one for me.

DR. AKAMIGBO: Okay.

MR. HACKBARTH: So, on the Miami example, was that an illustration of the effect of intense investigation of fraud and abuse or application of utilization management tools by a carrier?

DR. AKAMIGBO: Yeah, it was more the latter -- application of, you know, payment edits, things that are implausible. An 80-year-old getting an average of 2 hours of therapy a day, unlikely. And, that cut it down significantly.

MR. HACKBARTH: Okay. Good.

Rita, clarifying questions?

DR. REDBERG: Do carriers routinely look at changes in patterns, like ones not quite as flagrant as going from zero to a million but just changes in patterns of usage of providers and beneficiaries in their areas?

DR. AKAMIGBO: Depending on where they are.

DR. REDBERG: Like my credit card company would call me, you know --

DR. AKAMIGBO: Yeah.

DR. REDBERG: -- if all of a sudden they saw

spending in a different area that I don't usually spend.

Does the carrier –

DR. AKAMIGBO: I think it depends on where they are. We talked to a number of the groups that basically cover, I would say, Florida, Texas would review, pay, you know, edit. They would review claims a little bit more often than carriers in others, say Iowa, that cover Iowa or Minnesota. Just, it's not as prevalent a problem in some other areas of the country.

On the private side, I think it also reflects a similar pattern where depending on where they are, if they've seen prior evidence of overuse or fraud, they're more likely to review claims. But, if they're in some other region of the country -- Oregon -- it's not something that they have the resources to routinely do.

DR. MARK MILLER: If I could pick up for a second, and Herb, you may need to help me out here.

So, my sense is that what -- the carriers have a set of -- they have a contract with CMS. They have a set of responsibilities that they're to execute. You know, responding. You know, educating providers, processing claims, doing a number of different activities.

And, this is often a function of the contract, but as resources become limited, what happens in CMS is they sort of prioritize what they're going to do with their resources. Their top priority is making sure that claims are paid, and there are legal requirements to pay claims within certain time limits.

So, the difficulty here is that even those who -- and I think there is some variation, and I think that's what you're saying, on how much attention gets paid to this type of thing. But -- and, I think this goes to some of the exchange here -- how sustained that can be and how systematic it is, I think is something of a question.

You also raised yesterday, Herb, this new effort where there's trying to be much more micro-examination of the data, the kind of thing that credit card companies do, like what's going on here, and have more of a real-time response although we're not real deep on sort of how that's going and where it's going to go.

MR. KUHN: That's right, Mark.

You know, the new predictive analytics program that CMS has launched through their new fraud center helps to deal with that. So, basically, what they've done a lot,

with a lot of the Medicare administrative contractors, is they've got now other contractors -- known as ZPCs, RACs, those other entities -- that when they start to spot these activities they're going more to them.

Where a lot of the carrier medical directors are spending more of their time lately, it seems to me, is looking at their local coverage determinations and trying to drive policy through those.

And, to give you an example of one, to kind of show you a bit of the frustration I think some of these CMDs, these carrier medical directors, are experience -- there's one MAC in the south right now that I understand has an LCD that would prohibit entirely joint replacement patients from going to an IRF for care. It would completely draw a bright-line. And, that comment period on that one closes next week, if I understand right. So, that's kind of the extent where I think they're spending a lot of their time right now.

DR. REDBERG: Just, maybe we can get more into in round two. It seems to me the kind of things we would do -- one would do -- to prevent fraud is different clarifying. It makes sense to clarify V codes because to have a V code

that doesn't tell you what you're doing, but that's more on a clinical side.

And, I think, you know, because there is certainly a suggestion that there's fraud and that currently the carriers don't seem incented to really look for it and because of this pervasive problem, that seems like a different approach and problem and would have a different solution than the kind of more clinical sides and refining the codes, you know, and getting the episodes right and looking at functional status because none of that is going to get at fraud. And, fraud, you know, is serious enough that I think we need to consider that separately.

DR. MARK MILLER: And, just to put this thought in for you guys to discuss in your second round, there is a different kind of auditor. The recovery audit contractors, I think. Did I get that, right, Herb?

The RACs? Okay. And, there, they do have an incentive to find it because part of their fee turns off of what they recover.

And so, a question that you might consider in the second round is: Is this some place for a focus for them?

I'm not sure what their focus is on this now. I

don't know if that's come up in any of our conversations. So, I may be speaking out of turn, but it's something that we can explore.

DR. NERENZ: I'm just curious if you -- if we know anything about how the -- either the geographic variations or the temporal changes relate to similar variations in other payment streams.

For example, one might imagine that a lot of physical therapy for back pain might be associated with lower surgery expenses if the one reduces the need for the other. So, you'd see an offset effect.

On the other hand, if you're in a region where there's a lot of back surgery and the physical therapy follows surgery, you'd actually see them positively correlated because the one follows the other.

Is there a body of knowledge on this, and is -- should we know about this, or is there something to be known?

DR. MARK MILLER: At least -- and not very specifically on back surgery, out-patient therapy, that type of thing, but there's been work done by others and by this group that has looked at geographic variation and broke that

variation down into different categories of service and then asked the question, well, if you see one go up, do you see other stuff go down?

And, my general take from that -- I'm looking for Dan -- is that you basically find positive correlations. If you're higher, you're higher on everything. You don't see a lot of substitution effect.

I don't know if other people have views on that.

Specifically, to your back surgery, OT - I don't know if I could answer.

DR. NERENZ: And, that was just one example to clarify the question. I assume you'd seen it in things like occupational therapies and falls where the question is, does one prevent, or does actually the occupational therapy follow a fall that occurred with high prevalence for some other reason?

I'm just curious how we should be thinking about these things.

DR. BAICKER: I wasn't sure that I understood the option within the episode-based payments to stop payment or to pay less if patients prematurely end their therapy sessions.

My understanding of the episode-based payments is that you try ahead of time to figure out what the typical number of visits would be. That bundle is based on patient characteristics and all of that. And, some patients are going to be higher, and some patients are going to be lower, except if it's lower you're going to pay less and if they're outliers you're going to pay more. And then, it stopped sounding like an episode.

And, I wonder if I'm missing a subtle distinction between the number of prescribed visits versus the visits they actually consume, or if you're really saying we're chopping off the top end for outliers and we're chopping off the bottom end for low users.

MR. HACKBARTH: In the home health payment system, in fact, you have -- what is it? The LUPA, the low use payment adjustment. So, if there are only -- I forget what the exact threshold is, but if there are only a few visits the provider does not get paid on an episode basis but on a per visit basis.

So, it would be analogous to that, and then at the high end, there's additional payment.

DR. MARK MILLER: So, yeah, just to spell out the

high end, let's say, you know, this episode sort of assumes a dollar amount and has an implicit number of visits. You hit that visit. You run two, three, four, five, whatever it is. And then, the outlier payment starts to kick in behind it.

MR. BUTLER: On slide 13, one comment first on these nursing facilities. I've seen a lot of this in multiple settings.

I think just to further clarify; I think there are a whole lot of patients that are sitting in SNF beds, are not receiving Medicare Part A because there was no prior hospitalization but are receiving physical, occupational, other therapies, like we said, in a Part B. And then, it's somebody that could be on a downward path and just needs more activity of one kind or another, and it's just more heavily utilized than ever before. And so, that, I think is a decent part of what you're seeing in the nursing facilities.

But, my question relates to the -- it's getting a little bit at the fraud and abuse. The private practices are primarily the majority of the use on the private practice side.

So, I know that -- let's take a joint replacement where the orthopedic practice may own the physical therapy service themselves and can refer patients to their -- for the use for their own patients. That's one kind of scenario.

And, they do the joint replacement and then come get your treatment. I understand that.

What I don't understand is like the family medicine physician in Dade County who billed $1.2 million. Those can't be just their own patients, I wouldn't think.

So, this doesn't talk anything about these are private practices of physical therapy practices. So, I don't quite understand the billings of physicians versus these separate private practices.

DR. AKAMIGBO: Yeah, well --

MR. BUTLER: Honestly, the physicians are just billing outright fraud and --

DR. AKAMIGBO: Oh, no.

DR. MARK MILLER: [Inaudible.]

DR. AKAMIGBO: Yeah. So, I think -- let me try to answer your question as I understand it.

Physicians can bill for therapy services.

So, we'll take physical therapy. Physicians can bill for delivering physical therapy services. Private practice physical therapists can also bill.

So, if a PT, or a physical therapist, is operating in a physician's office and claims are submitted through the physician, using the physician's number, that is -- that will come up under the physician claim. You know, that will come up under the physician stream.

A PT that owns his or her own practice and is billing using their independent number, that will come up under the physical therapists in private practice.

So, they would be separate, and this line here is showing just physical therapists in private practice.

MR. BUTLER: So, would the majority of the 400 -- you know.

You've got total private practice as 1.4, and the physical therapy practices are 1.0. Is the 0.4 a difference, mostly physicians probably billing for physical therapy services in their practice?

DR. AKAMIGBO: Yes.

MR. BUTLER: Supposedly, for just their patients?

DR. AKAMIGBO: Yeah.

MR. BUTLER: That's what they're permitted to do, right?

DR. AKAMIGBO: Yeah.

MR. WINTER: It could also be occupational therapy.

DR. AKAMIGBO: Yeah, so that subheading there is private practices. The majority would be physician, but you would also have occupational therapists in private practice, speech pathologists starting in 2009 who have their own private practices and then PT, and also nurse practitioners or non-physician practitioners could also have their own private practice, billing -- all billing outpatient therapy, Part B services.

MR. BUTLER: But, the supposed fraud and abuse would be occurring in that 0.4 sector primarily. It could occur -- physical therapists then on their own could be doing things, and there could be all kinds of other payments, but that's where the overutilization from physician practices will likely show up in these numbers. Is that fair?

MR. WINTER: I don't think we know.

DR. MARK MILLER: Also, notice that the more

current numbers. The differential of 1.7 and 2.1 is getting a little bigger. It's the same point. You're focused on 2004. That's the 2011 breakdown.

MR. BUTLER: Actually, the difference is exactly the same between the two, but it has grown in both cases -- 0.4.

DR. MARK MILLER: The -- if it's outright fraud, I'm not sure that it's peculiar to one line or the other. If you're talking outright fraud.

MR. BUTLER: Just crooked billing, under the table pay -- all kinds of things that could -

MR. HACKBARTH: Billing for patients that they don't see.

MR. BUTLER: Right, right.

DR. MARK MILLER: Then, you were sort of setting up, I thought -- but maybe not. You were setting up the potential for a self-referral type of situation where, you know, the physician kind of has got a pool of physical therapists and saying: Okay, now you need to go see the physical therapist. I'm going to bill on that behalf, and then I have a separate financial relationship with what I pay the physical therapist.

And, I don't know that that's fraud, but that is a self-referral type of [inaudible].

MR. HACKBARTH: And also, the inference I draw from Adaeze's response is that that's actually a pretty small amount of activity -- the physician self-referring to his or her own physical therapist. In the private practices group, it's just a fraction of the all-practices, the subtotal line.

MR. BUTLER: That was my point.

MR. HACKBARTH: Yeah.

MR. BUTLER: That's what it looks like.

MR. HACKBARTH: So, there's the occupational therapists and all of the others that are included in that row. The physicians are just a piece of that.

DR. AKAMIGBO: I just want -- sorry.

I just want to be clear. We can't quite -- we can't quantify how much -- and I'll let Ariel speak more to this.

But, we can't quantify how much self-referral is happening in physical therapy with physicians self-referring to physical therapists or any therapist they employ. We suspect some of that is going on, but it's very difficult,

given the data we have, to actually quantify that.

MR. HACKBARTH: But, the inference I'm drawing is so if the all-practice number is 1.4 billion in 2004 and 1 billion of that is coming through the physical therapist private practice. So, the physician is in the residual of the 0.4 billion in 2004, but in that same item there's all the occupational therapy and all of the other speech pathology, all of the other items. And so, the physicians are only a fraction of the 0.4, right?

MR. WINTER: It's a little bit more confusing than that because physical therapists in private practice can bill as a therapist in private practice, but that -- they can be employed --

DR. MARK MILLER: They can still be --

MR. WINTER: -- where the practice can be owned by a physician practice. I want to clarify that.

DR. MARK MILLER: That's right.

MR. WINTER: I think Peter was trying to get at that.

So, many of -- we don't know. We can't tell what share of those are truly independent private practices --

MR. HACKBARTH: I see.

MR. WINTER: -- versus private practices that have some kind of financial affiliation --

MR. HACKBARTH: Got it.

MR. WINTER: -- or ownership relationship with a physician practice. The claims data don't tell us that. And, we've tried to use other data sources to get at that and not been successful. So, that's why we can't quantify the extent or what proportion of physical therapy is related to physicians owning a therapy practice or employing a therapist.

We've heard anecdotally this is an issue and a growing issue, but we can't quantify it.

And, the last thing I'll say is GAO has been tasked by Congress to investigate this specific question, and we don't know -- we know that report is -- they're working on the report. We don't know when it's going to come out, but GAO is looking at this specific question.

MR. BUTLER: Can I ask one more then? Am I right to say, though, that the bad behaviors are more likely to occur in the private practice below the line than in the nursing facilities?

There may be overutilization or utilization that

isn't particularly helpful in the nursing facilities, but that's not as likely a place to go to look for the -- you know, kind of the arrangements that just don't smell right at all.

DR. AKAMIGBO: I don't think we know, but I would be very hesitant to draw that conclusion.

I think anecdotally we've heard of overuse, overbilling practices across all settings, and nursing facilities have not been excluded from that. But, again, without being able to quantify that, I would hedge a little bit and not draw that conclusion.

DR. MARK MILLER: I would too, and I think it's more a question of whether you're talking about outright fraud or whether you're talking about I am -- you know. I have a nursing home patient. They're failing. I'm putting them into a Part B therapy.

And, rightly or wrongly, the Medicare benefit is supposed to be about improvement. And, rightly or wrongly. You know. I just want to be clear here.

And, if it's really not doing that, then I guess there are questions about whether that should be going on, at least from the Medicare benefit point of view. And

again, not rightly or wrongly.

That, I see as a much different question than sort of fraud, or I'm just -- you know. I went from zero to a million in sixty seconds.

DR. CHERNEW: I just want to -- can I follow up on Mark just for one second?

In that dichotomy of sort of fraud-fraud versus overuse, we're not sure if it was right or not, or maybe it was more, how much of a problem would you put into the "We should have our discussion thinking about this in terms of fraud management detection" versus "We need to think about this discussion in terms of there is a big gray area; we need a policy to address that gray area?"

DR. AKAMIGBO: I think a good chunk of --

DR. MARK MILLER: I do not know the answer to that question.

DR. AKAMIGBO: I think the discussion should be focused on the latter, and I say that for a couple of reasons.

When you have average spending per user in Miami-Dade as we had in 2009, of $4,500 per person, compared to $500 for the rest of the country, that's a clear case of

massive fraudulent activity.

DR. CHERNEW: [Off microphone.] It could just be a different [inaudible].

DR. AKAMIGBO: Not when the differences are that stark. I think if you're talking from 1,000 or 1,100 to 1,500, then we could discuss practice patterns or, you know, some weird geographic variation that we don't know. But, when you're talking 4,500 or even 3,000 compared to 500, then I think we have some issues.

So, Louisiana; I think there's a clear case to be made for talking about fraudulent activities and the same thing with Brooklyn. You know, a couple counties in New York.

But, a big -- a lot of this -- because outpatient therapy, you have very few guidelines. There are no clear guidelines when you talk to people who work in this area. A lot of this is subject to interpretation. There's a lot of autonomy. The therapists have to decide whether a patient needs more therapy, and it's subject to very little oversight. So, I think there we're talking about overuse in a space where there are few guidelines to guide them as to what the right amount of therapy would be.

MR. HACKBARTH: I think we're getting pretty round two-ish here, and so I want to keep moving.

But, on this issue, you know, I don't think that they're mutually exclusive, that we have to say, oh, we're just going to have payment reforms that focus on overuse or we're going to just have recommendations that relate to potential fraud. We could do both.

Alice?

DR. COOMBS: Thank you for your excellent presentation.

One of the questions -- the last alternative I like a lot. But, in your evaluation and investigation into the private sector, what percentage of private payers will do preauthorization as a secondary for extension versus preauthorization from the very start of physical therapy?

MR. WINTER: Yeah, so we talked to our -- me and our contractors, NORC and Georgetown, talked to 11 plans and 3 benefit managers. So, this is not a national representative sample. So, I want to start off with that qualifier.

We did find cases where some plans were doing prior authorization up front, before the episode even began.

DR. COOMBS: Right.

MR. WINTER: But, it was more common that they would, you know, allow six to eight visits or even 25 visits initially, and then the therapist or the physician wanted the patient to get more visits, then they would go through a prior authorization process.

So, we saw examples of both, but more commonly, it was done after a set number of visits were reached.

DR. COOMBS: Do you have any idea of what the market looks like based on any kind of data in terms of prior authorization for extension?

MR. WINTER: Broader -- by that question, do you mean broader than the 14 people we spoke --

DR. COOMBS: Yes.

MR. WINTER: Fourteen plans we spoke with?

We don't know, but we can try to do some more looking around. But, I'm not sure if we're going to be able to find that answer because I don't think there's a robust literature on how plans are managing this particular benefit.

But, we can look and see what else is out there.

DR. AKAMIGBO: So, let me just add. Prior to the

discussion, these interviews with the plans -- the health plans and the private benefit managers -- we did do a search, just a general search across the country, internet search, to see what folks are doing, what's posted online, and it looks like the majority authorize a certain number of visits. Really, the outlier was at the lower end. It's more like 25 to 35 visits per year. And then, you need to get authorization to continue any additional therapy services.

And by then, we're talking about your therapist talking to therapist, or the nurse typically, to explain why you need more services and maybe submit additional records and things like that.

DR. MARK MILLER: But, Alice, I took your question to be how often does an exception get granted.

DR. COOMBS: No. The reason why I asked this question, if you were going to adopt a model that was comparable to the private sector and you really wanted to put some control over it, because the way I look at it is that the slide that Peter referred to looks like a kid with a great big giant cookie jar, and they could go into the jar as much as they want without anyone having any kind of

surveillance or any kind of assessment as to the efficacy of what they're doing. So if there were some boundaries and some framework for which private practice, physical therapists, or the relationships that exist between physical therapy and not just primary care doctors but orthopedic surgeons owning PT arrangements as well, I think that would be something that would deal with any kind of factors, whether it's overutilization or whatever.

DR. SAMITT: This was well done. Thank you very much. I'm going to go where Mark was leading, which is the exception process. That's the thing that's striking to me. And I'm just curious about how the exception process works. Who asks for the exception? Is it the physical therapist? And who grants the exception?

DR. AKAMIGBO: No one asks, really. If when you're getting therapy services, a beneficiary is getting physical therapy -- first of all, I should say the beneficiary should be under the care of a physician, so the physician signs a plan of care. Therapy services are initiated, say with a physical therapist, and after the beneficiary has hit the cap, the therapist decides, along with the patient, that they could use additional services.

And all that's required is a KX modifier on subsequent claims after that cap has been reached. Actually, it's around the time when you suspect you're reaching the cap -- because, remember, there's a lag -- to authorize additional services, and that's an automatic process, so Medicare pays those claims, assuming that the KX modifier is an attestation that additional services are needed and that the reason for those services are documented in the medical record.

DR. SAMITT: So how does the doctor know to apply the KX modifier?

DR. AKAMIGBO: The KX modifier is not necessarily placed by the doctor. It's placed on the claim by the provider who's delivering the therapy services. So if that's the doctor, yes, then the doctor puts the KX modifier. But in many cases it's the PT, the OT, the speech pathologist, and they place the KX modifier on the claim.

DR. MARK MILLER: Even in the instance that it's being billed under the doctor's ID, in all likelihood it's the outpatient -- it's the therapist who is doing the work and adding the modifier to the claim, and then it just goes out under the physician's ID.

MR. HACKBARTH: And so it's automatically granted.

DR. AKAMIGBO: Yes.

MR. HACKBARTH: There is no mechanism for any review of the exception.

DR. SAMITT: So I guess I would ask, why bother having a cap if it's automatic?

[Laughter.]

DR. AKAMIGBO: And that's what we see.

DR. MARK MILLER: You're thinking of a cap as a cap.

[Laughter.]

DR. SAMITT: I would think it would function as a cap, but I guess it doesn't function as a cap.

MR. HACKBARTH: I just want to be clear. So there is no mechanism in place for review of the exception, asserted exception.

DR. AKAMIGBO: The MAC could come back to the therapist -- in very rare circumstances they would do this, but they could come back to the therapist to review the medical record or, you know, to review additional information, basically to make sure that there is justification for the KX modifier. So there's a mechanism

in theory. How often it is exercised is a different matter. And from talking to different medical directors, it's rare that they do that.

DR. MARK MILLER: And just to have -- you know, I didn't mean to be flip about the cap. You know, if you talk to the providers, there's great concern that there are patients who need and could benefit from more. And so when the caps were put in place, there was a lot of pushback, as you might imagine, and the attempts to deal with it are two: one is they had a manual review, so it was sort of saying to the carriers that you have to review these requests, and there are many of these requests -- 15 percent, I guess, of the activity is above the cap? And so this became overwhelming, and they basically weren't doing it or saying that they -- they were also saying that they couldn't keep up with it. That's what led to this automatic process.

You know, if there's any drag on the system here, it's sort of, well, somebody could come behind that and ask you what documentation you have to justify the KX modifier. But in practice, it just pretty much goes.

MS. UCCELLO: Yeah, so in terms of this private sector approach of limit the number of visits plus pre-

authorization of additional visits, is there a sense that the private sector finds this a satisfactory approach? Or are they worried it's not doing enough?

DR. AKAMIGBO: I think it's an option that they feel they must implement in the absence of better alternatives. So in talking to the many people we spoke with, they don't have clear guidelines to do some, you know, pre-payment review to say, well, if you have this condition, you ought to have -- it's very unclear. So prior auth is -- my sense, I would characterize it as some reluctance. It's expensive to do a prior auth program. But it's the best they've got.

MR. WINTER: Only one of the plans we spoke with had no prior authorization requirements at all. They said they got rid of it and replaced it with a $50 per visit co-payment, which they found to be very effective at managing utilization.

MR. KUHN: Two questions. As you indicated, the benefit is pretty ill-defined, so I guess -- I'm not aware of but has CMS ever considered doing a national coverage determination to better define the benefit? And, furthermore, talking about the Medicare administrative

contractors and their medical directors, is there any differentiation around the country, do we have any LCDs around the country dealing with this particular benefit?

DR. AKAMIGBO: We do. I'd have to get back to you on the national coverage determination. I want to say, yes, I have one, that I have seen one, but I'm not certain. But there are LCDs from across the different MACs -- a couple of MACs, I should be more precise, that I've seen. There aren't too many differences just from what I've read. But, again, the LCDs that I've seen tend to focus around the same geographic region.

MR. KUHN: Right.

DR. AKAMIGBO: I haven't seen one covering the upper Midwest, for example. But I can get back to you on that.

MR. KUHN: Thank you. And the second issue, in terms of the functional status measurement tools, you talked in the paper about the photo and the optimal tool and some others that are out there. You also have had the conversations with the private sector and their management. But there are some other government entities that are involved in this space, specifically the NIH and the VA.

Did we look at what they're doing, and is there anything to be learned from them in terms of their management of the benefit -- the benefits that they provide?

DR. AKAMIGBO: The short answer is no, I did not look at the NIH or the VA's management of outpatient therapy, and I was not -- I can look into this to see if they're using any different -- if they have a standard tool, I would imagine such a thing, if it would exist, would exist with the VA. So, yeah, I can check into that also.

MR. KUHN: Thank you.

MR. ARMSTRONG: For me, the hard part about this is that physical therapy, occupational therapy, these services, they can be a very good investment in improving the overall health of patients, and sometimes we're not giving them enough of these services, but our payment structure just doesn't allow us to really assess that very well.

I think I know the answer to this question, but is there a way to profile utilization and cost patterns in our MA plans and compare that to this experience?

MR. HACKBARTH: [off microphone].

[Laughter.]

MR. ARMSTRONG: Right. Okay. Never mind.

MR. GRADISON: A quick follow-up to the question about the private sector experience. Did any of the plans you talked to quantify, give you any sense of the savings, if they had savings, as compared with the way Medicare goes about doing this?

MR. WINTER: No, they did not quantify -- they were not able to quantify what kind of savings they achieved from their different tools.

MR. GRADISON: This is my other comment. I can understand the effectiveness of the $50. I'm not so sure about it in the case of Medicare. Wouldn't it be picked up by Medigap for those who have Medigap coverage if there were a required co-payment?

MR. WINTER: Yeah, depending on the structure of their supplemental plan. If they covered all cost sharing for Part B services, then yes.

MR. GRADISON: Which typically it is.

MR. WINTER: Yeah.

MR. GRADISON: Okay, thanks.

MR. WINTER: And just to back up to your first question, they would sort of indicate that this approach had

worked better than others, but in terms of quantifying, you know, what the savings were or how it related to a more managed approach like Medicare, they didn't get into that. We just didn't have time in our interviews.

MR. HACKBARTH: Okay. Before you go on round two, George, I just want to ask the Commissioners in their round two comments to really focus on the options on the table. So if you would put up the overview, Slide 20, Adaeze, and look at these options -- there's more detail in the ensuing pages -- and give us your sense of which of these might make sense. We are, as you know, operating on a very short schedule, so we need to make some progress.

In that vein, let me just ask people in particular to think about the episode-based payment idea. This is very consistent with MedPAC traditional thinking about a problem like this when we've got potential overuse, that gray area use, under a fee-for-service system let's create some boundaries, and episodes are potentially a tool.

Now, I would point out that there are some similarities between the challenges here and those that we have in home health, and there we tried to solve those problems a decade ago using episode-based payment. I'm not

sure that it has worked all that well in home health. You know, we ended up with a pattern of more users, more episodes per user, and declining number of visits per episode, and very high levels of profitability in the home health business.

So reactions to the option framework overall, and in particular, on the episode-based payment idea?

MR. GEORGE MILLER: Well, thank you, and, again, I enjoyed reading this chapter. It was very well done. It raised more questions in my mind than it answered, and along with Peter's thinking, I think one of the things that I've heard -- I have no proof of it, but I just heard that a physician could own a practice, could bill, then send a patient to the practice he owns, and because they're different numbers could bill again. So I'm real concerned about the potential for either misuse, mismanagement, fraud, or whatever term we need to use, and then to try to address that issue, as well as the options before the Commission.

Obviously, we want to have Medicare have the ability to manage the system better in the short term. What tool or mechanism that should take I'm not quite clear on, but I believe we should move in that direction.

Like Herb, I would love to see what the VA is doing and see if that would be applicable to here. Obviously, they have a great deal of expertise in this space, and I wonder if that's applicable and we could use that approach and then use that as the basis for episodic-based payments.

DR. NAYLOR: So before I get to what you've requested, I wanted to reflect on what the Commission has been asked to do, and the first thing is to say how to improve the benefit so that it is better designed to reflect functional limitations and severity. And I think it would be appropriate to give some attention in this to the question or comment that Mark made, which is, rightly or wrongly, the benefit is now about improvement. And there are many, and there's evidence to suggest that a benefit moving forward should also pay attention to the great opportunity to prevent further decline. And preventing further decline for many enables us to prevent falls, to really prevent acute resource, et cetera.

So I would, for one, want us, beyond thinking about these three dimensions, which I think are spot on in terms of how to improve it, say this is also an opportunity

for us to think about a whole population whom we could better serve through these services to prevent more costly use. I mean, it is the one thing Medicare beneficiaries fear the most, limitations going to permanent disabilities, and permanent disabilities cost us all.

So, that said, on the management I really do think that many of the recommendations that you have to improve management of the benefit, particularly on this idea of the targeted or focused review of where we're seeing real high use and where we're seeing real low use of services is really important, along with all of the others that you recommended, eliminating use of V codes and so on.

On the issue of functional status, I think that this is critical as a path forward, that we get to standardized measurement of functional status.

And to Herb's point, there is some work -- and I'll share some of the contacts -- around this CMS, NIA, et cetera, that are really trying to figure out what they are and have some preliminary path forward, so it would be great if we could align some -- if it makes sense, to align some of those recommendations. And I do think changing the payment system around episode, as I heard the response,

makes sense. But I also think we've got to get to performance. And so I think this might be a short-term path, but unless there's some accountability for when we have a functional status measure in place to show that we are improving or, if we could, prevent decline, I think that would be important.

DR. HALL: I also wanted to compliment you on a wonderful presentation.

So, in terms of the policy options, I guess we all agree, number one, let's eliminate fraud. I mean, that goes without saying, I suppose.

Now, in terms of the various kinds of caps, I think there are kind of two issues that I'd like to talk about briefly. One is caps on the individual maximum number of services will inevitably disenfranchise some patients who would really benefit from services, as Scott already mentioned. So I'm a little bit worried about that.

The second thing, more importantly, if I wish to sort of utilize physical therapy to the max for whatever reason, I'll just do more patients. So we'll take each individual patient up to their max, and then we'll just add on another seven that they're also in SNFs. So it's a very

blunt instrument to try and get on top of that, so if I'm so smart, what should we do?

Well, I would say the one thing is that the idea of episodic payments but based on some concrete measure of function, as many people have said -- and Mary talked about it. I mean, this has been coming up over and over again as we look at bundling and everywhere, we desperately need to have the entire enterprise embrace functional assessment in a way that can actually dictate payment but also outcomes, which is so important.

The other thing we might want to suggest is that in an average SNF, people sit around a lot. They don't do very much just because of staffing or because of other things. But basically what do the patients tell you when you walk around? Well, they all have V codes. They're kind of non-specifically not feeling well. They have some low back pain. Their gait is a little bit abnormal. They might have difficulty walking, and they always have a lot of muscle weakness. This is baseline, and we have no incentives put in the system for these organized SNFs to develop other modalities that would be useful, such things as group activities, training of lower-level personnel --

not lower level but people with different kinds of training. And there must be some way to incentivize these SNF facilities to -- you don't even have to think out of the box. The techniques and modalities are there. They're just not being utilized, because the candy box says you can just continue to use these very highly skilled physical therapists -- by the way, who are in very much demand, they're very scarce, so the more we use them, the more problems we're going to have.

So I think multi-pronged, let's get rid of fraud, let's try and put some concrete functional assessment instruments in place, and let's think out of the box about what SNFs can do to accomplish what presumably these V codes are telling us we need to do.

Thanks.

DR. REDBERG: So an excellent report. It was very, very clear. And I do think, as Scott said and David alluded to, physical therapy or the outpatient therapy services are a really important service, and I wouldn't want to, in trying to get rid of fraud, deny people that really need the service. And that's the problem, and that's why I want to just get back to making that a separate issue,

because physical therapy for people that need it is great, and I think we should be doing more of it.

So I would, you know, like to look at the role of the RACs and, you know, perhaps in another conversation change -- because right now regional carriers are really incented on paying quickly but not paying accurately claims, and that's a big problem not just for outpatient therapy services. But for the outpatient therapy, I mean, there is potential to really increase quality of life and decrease cost with increased use of outpatient therapy services. Some of the examples you gave in the mailing, like, you know, for rheumatoid arthritis patients, you know, we have some very expensive and very toxic medications that we now give our rheumatoid arthritis patients who might be better off and feel better and, coincidentally, have less cost to Medicare with increased use of outpatient therapy. And the same with a low of back pain patients that are getting surgeries that may not be helping them, causing a lot of problems, and could be better with a more generous benefit.

And so for that reason, I would be concerned about the cost sharing as an alternative because I'm sure it would get rid of the fraud because if you really don't have

patients, you're not going to have $50 for cost sharing and so it gets rid of it. But it also gets rid of the people that really need the services.

So I think focusing on functional status assessments for physical therapy and then improvements in functional status and actually making it more generous, particularly if we're looking at it as an alternative to more invasive and other procedures with the same kind of problems, as I said, for rheumatoid arthritis or back pain, but probably for lots of other services as well.

And I would have concern about episode-based payment based on the home health experience, that it wouldn't achieve the goal we're looking for. And certainly, in terms of fraud, the focused reviews in the high-use geographic areas I think makes sense.

DR. NERENZ: A couple things. I guess I would appreciate just some continued clarity on exactly what problem we're being asked to solve here. I notice that we've discussed a lot about rising costs, geographic variation costs, potential fraud and abuse. But those don't seem to be directly in the charge we've been given. We're asked to talk about linking functional status and we're

asked to evaluate private sector initiatives. So I just want to make sure that when we talk about policy options, we're focusing on policy options to accomplish what aims specifically.

Then with that as preface, I would be basically yes on the standardized instrument. In fact, it seems like it must be automatically a yes given the first part of the charge. If you're going to link management of this benefit to functional status, you have to have some measure of functional status.

That said, it strikes me as very difficult to think of a standardized instrument, singular, that would work across the whole domain of therapies that we're talking about. The instrument that captures the essential features of improvement for back pain would seem quite different from the instrument that captures improvement for a swallowing disorder.

I understand some of the same structural features of an instrument might be there, but it would just seem that we may end up in a domain of standardized instruments, plural, as opposed to a single one. But there can be more detailed discussion about that.

The episode-based payments would seem to be positive, at least in a certain sense. If we link back to our discussion yesterday about some of the bundled approaches, there clearly are opportunities to bundle some of these therapies into other procedure-defined or illness-defined bundles, and so in some sense, some of that action solves some of these problems. And whether those then include a functional status component or not becomes perhaps someone else's problem who's responsible for the cost and the quality outcomes of a bundle.

I do understand, though, that there may be some episode approaches that are only about these therapies themselves, and in that case I defer to Glenn's comments about previous experience that the group knows more about than I do.

DR. MARK MILLER: If I could just follow up on two things, the charge is what it is and what it says. The issue that occurs with the Congress and why they brought it to us and why they asked us for such a short turnaround time is the exception expires every year, and this additional cost of what occurs above the cap is the Congress is sort of, well, how do I get control of this, I have this

exceptions process that I have to pay for every year, it doesn't seem to be -- it seems to be fairly fluid, is there another way to go at this, when you have conversations with what the objective of -- in asking us to do this, that's the problem that brings it to a head and brings it to a head immediately. And, you know, some of the thought was this mandate might help get at their overall problems and result in a better benefit.

I do want to say something about the single instrument because we spent a lot of time on this, and we brought in a crew of clinicians, researchers, carrier medical directors, and there may have been some other actors in that. This is a very interesting and useful discussion. I'm sorry to take the time, but I think there's some important things here.

The last 20-plus years, this field has been characterized by the different modalities and even groups within the different modalities each having their own instrument and arguing about this is the best way to do it. And some of the gridlock in this area is there has never been ability to kind of bring agreement on that.

What we found very interesting about this

conversation, when we got people in the room and were kind of pushing them, there was the sense -- and I don't want to say that anybody, you know, agreed or bought in because those weren't the ground rules. But we walked away thinking that there can be an instrument that actually cuts -- that is common to all of these modalities, and there was some level of agreement on this, and that the way this would work is this is the instrument that Medicare collects to build its payment system and make its payments. If the individual modalities want to use their own instruments for plan care, that is perfectly fine, and so this to us sort of felt like a good way of kind of moderating this big fight against my instrument and no one else's. Use that for your plan of care. Use this to have the underlying structure of the payments. My last comment. And, of course, the payments are always a little off, and that's why you have things like inliers and outliers and that type of thing, notwithstanding the experience of the episodes not working in other areas, which is yet a different problem.

DR. NERENZ: Again, you certainly have explored this already in more depth with these groups. If the area of common ground in a single instrument is something like an

SF36-type functional health status instrument, I guess I would suggest that those instruments already exist. So I would like to then learn more about what instrument that kind of cut across these modalities and the needs within modalities can be developed that does not already exist. I'm just curious about what that looks like.

DR. MARK MILLER: And an instrument that we're talking about building on does exist. It came out of one of the demonstrations, and we were sort of saying you don't have to build this out of scratch. You have to add to it, but there is an instrument, and we can put that in your hands.

DR. NERENZ: One quick thing. Whatever that instrument is, or instruments, plural, I guess I'd be interested in more discussion about that and the concept of how it's used, meaning one could conceivably pay for improvements specifically, and that's how it's use. Or one could conceivably pay for evidence-based treatments that in separate studies have been linked to improvement but are not explicitly linked to improvement in an individual payment for whom payment is made. So I would like some more discussion about how the link is made then between the

functional status measure and the payment, and it seems like there are some variations there that have to be discussed.

MR. HACKBARTH: Okay. Unfortunately, we're going to have to pick up the pace a bit here. We've got about 18 minutes left in this session, and today we need to stay on schedule because people have planes and trains to catch. So, please, let's move along.

DR. BAICKER: So just two quick points. One, to clarify on the common instrument, the instrument seems very important to me to have a standardized instrument, although whether you call it one or many for different conditions seems more like a semantic question -- you know, if back pain, go to this mode; if speech problem, go to this set of questions. To me, the commonality was less about the questions specific to the condition but, rather, the use in different settings or by different types of providers, that anybody who's going to get reimbursed for this type of therapy has to have completed this instrument. And that seems important to me, and then answering the second question about episode-based versus other types of management practices, that my natural inclination is towards the episode-based payments, but then the caveats that you

raise and the failures of those payments in other settings suggests -- or highlights the importance of a good instrument so that you can both flag what type of therapy is appropriate, but also the expectation of the amount of therapy that is appropriate. And if we don't have a good instrument for doing that, then I think the episode payments are even more likely to fail on the dimensions you mentioned.

So in the long run, I'd love to move toward the episode-based payments, but maybe we wont be ready for that until we've successful implemented the standardized data collection that would facilitate more specific payments.

DR. CHERNEW: I don't know ultimately what I will prefer, but I do know that whatever I will prefer, I actually won't like it.

[Laughter.]

DR. CHERNEW: So, that said, my concern is that without guidelines of what to do, we can go after fraud. But everything else we do, all the data gathering, all the auditing, all the other many things are going to add an enormous amount of administrative cost with virtually no gain. So I'm extremely skeptical of a whole series of

things that sound like they make sense, but I think in the end without guidelines about David's question, we're just making a lot of people jump through a lot of hoops to get us nowhere. And I'm worried about that, although I could be convinced otherwise.

I do want to make this distinction between episode and bundling. Bundling makes a lot of sense where someone's responsible in some broad bundled way. But an episode just within here I'm actually pretty strongly against because of the home care example. And, again, I think the problem is we're telling people we're going to pay you a fixed amount for something, you don't know what it is, you just have to tell us and then we'll pay you for a different thing, and you can do more of them, or whatever you want, and it's just not going to solve the problem, because the fundamental problem is we don't have good guidelines, connect whatever functional instrument we have to what then you should do, and we're not sure that even if we had the right instrument, that once we pay you based on an instrument, that the information you put on an instrument is so objective that we would trust that instrument when you actually had to pay on it.

So, you know, I can understand the instrument might work perfect in a research setting about what it predicts and what you do. That's very different than working in a payment setting where someone who might want to push the boundaries just has to certify some particular thing and you can't objectively measure all these functional -- if we could objectively measure all that stuff well, then I'm -- administratively, I'm for that. So that pushes me to something that I don't like, which is going to involve artificial limits or some other type of broad thing, which I really don't like. I want to go on record as saying I really don't like it. But I don't see a way around it, and at least it gets rid of certain administrative costs of something that I don't like, or some aspect of cost sharing that I want to go on record as saying I really don't like that, there's disparity issues that really worry me, but I do think that you could structure something where you get a certain -- instead of, I think, a cap, which says you only get this amount, at a minimum I would say here's the cap for what you get, and now you can get more but you have to pay, instead of 100 percent for the service, we're going to charge you less. That's better to me than a cap. So if a

cap was ten visits, instead of saying ten visits then zero, I would say ten visits, then you pay 20 percent, and then another ten visits, you pay 30 percent or some version of that. It's not something I like, but it allows the person to have to judge. And I don't know where the right caveats should be and how we should make exceptions for some people because of income. And maybe we just let the system be inefficient and say if you don't like it and the system's so expensive, go to a managed care plan which will do a lot better anyway, or we'll have ACOs that will do a lot better and not worry about it. But the only way I see around it without huge amounts of administrative cost, as much as I really hate to say it, is some cost sharing.

MR. HACKBARTH: I invite comments on cost sharing as a potential tool as well. Just a reminder, though, about the existing structure. So this is a Part B service subject to the Part B deductible and Part B co-insurance, correct? So there already is cost sharing, and in that sense this is different than the home health case that we considered where under the benefit structure there was no cost sharing.

DR. AKAMIGBO: Yes, and we have a slide up just to guide -- yeah.

MR. BUTLER: If you could put back the policy options slide, go back to the. I agree almost exactly with what Mike was saying, but I could never say it the same way, so I'll try to efficiently reaffirm the points, and I hope I'm consistent.

So I definitely think -- of the importance on the list, the first one, the short term is -- I'm most supportive of, and on cost sharing, I do think -- maybe I'd broaden the concept to shared decisionmaking even, because I think a lot of people that -- so not just the financial. A lot of people that are getting these therapies either are not -- if you talk to them, they say, "I'm not ready for them, I don't want them," or they're end-of-life issues, and there's not the engagement of the beneficiary themselves, financially or otherwise.

I'm supportive of the standardized instrument. I'm supportive of alternative two, and I'm pretty strongly opposed to one for the reasons articulated. I think you'll get more bundles, and I think you'll get fewer units of service provided. And I think this is particularly going to occur in this area because of the lack of homogeneity of definition. It just invites kind of underutilization pretty

easily. If it was a very clear service, you could then define whether it's being underutilized as a result or not. I'm just highly skeptical.

And, finally, I think about CMS, the logistics, the administrative work to even create the definitions of the episodes is probably not the best use of their time with so many other things. It's not an insignificant series of events to roll something like this. It's just not worth it.

DR. COOMBS: So I think with the discussion on hand, the episode-based payments doesn't do anything for the volume-driven care because you would ante it up to do more patients. And so that's the main point with that. And then the other issues that have already been discussed I think are important.

I agree with a fixed amount of visits for physical therapy, so a defined -- not necessarily time period but encounter, number of encounters per beneficiary.

The piece on cost sharing after the extension I disagree with only because I think there's some really vulnerable populations within the Medicare population that would be a disadvantage. If you have great scrutiny as to the extension, whether it's an authorization or fitting a

long menu list and a check-off list at that secondary stage, I think that might be enough to really drive some cost savings. But I wouldn't want patients to really need the therapy and not have access to it.

I think before you engage in a tool and an instrument and management, I would like to know a little bit more about the private sector before jumping off into a complete privatization type of model within the Medicare structure.

DR. SAMITT: Can we go back to Slide 21, just to be specific about some of these things? I'm very much in favor on a lot of these items, although permanently including services under caps, while my sense is the caps aren't really caps anyway, so why does this really matter, sure, do it, although I'm more concerned about the exception process, and that's really where the meat has to be.

Absolutely focused reviews. I think if we're concerned about fraud or even managing the benefit, I think we need these focused reviews. What I haven't heard a lot of is we've talked about doing these reviews at the provider level. I'd recommend we do these reviews at the referring physician level as well. I would be interested in knowing

which physicians have so many beneficiaries that are using physical therapy services. I'm a big fan of unblinding and publicly reporting utilization data at the physician level, and I think we need to understand this not just from the providers, which may hide something, but on the referring physician side as well.

I would reduce the certification period. I think we need a more formal methodology at the end of the cap before the exception as opposed to an automatic default. I think there should be some formal gate or some formal method that needs to be followed after a defined period of time.

And I am a believer in cost sharing. I think that without it there's a risk of moral hazard, and at some point in the future I'd be interested in discussing supplemental insurance, because I wonder whether supplemental insurance is creating a comfort level where a beneficiary should be involved.

In terms of the long-term solutions, yes, an instrument is likely to be necessary, and you may be surprised that I'm against the bundle in this case, because I'm afraid that we don't have a catch for the consequences of underutilization here comparable to what we discussed

yesterday with PAC. I'm in favor of a more global bundle, and that's why a bigger bundle solves this problem. If, in essence, this was part of a global bundle where you were now at risk for the consequences of poor physical therapy, then I could understand how a bundle would be effective. But if we bundle physical therapy services, I think there is a great risk of underutilization of those services with expansion of expenses elsewhere for the Medicare beneficiary.

MS. UCCELLO: I agree with Craig's kind of short-term thoughts of this. I agree with everybody on the need for the functional assessment stuff. And I agree with Mike and Peter on the concerns about the bundling. Conceptually, I think we all like that approach, but I think there are serious reservations about doing it in this area. So maybe something more along the lines of private sector approach, thinking about what Mike said almost in terms of tiering, you know, your first X amount are paid in such-and-such a way, and then after that -- but in terms of using cost sharing as a lever here, what does that really even mean when there's already cost sharing and a lot of that is already being covered by supplemental coverage.

So, you know, we can think back to our recommendations regarding the fee-for-service plan design more generally and the impacts on the supplemental coverage, but, you know, I just -- I don't know how effective that would be.

MR. HACKBARTH: Assuming we get through these last couple comments and have a few minutes, I'll come back to this issue of cost sharing and the interaction with supplemental coverage.

MR. KUHN: On the three areas that you have listed up here -- improving Medicare's ability to manage the benefit, obviously the focused reviews, we've all talked about that. Suspicious billing and coding patterns need to be identified, and it sounds like CMS is putting the infrastructure in place to deal with that. Reducing the certification period from 90 to 45 days, I am intrigued by that. I think that's something that might be worth looking at further. Obviously, the elimination of the V codes. And then, finally, we've talked about it already a little bit today, but I would like to understand a little bit more about the option of an NCD and kind of the variation across the country with current LCDs.

If we're talking about all this stuff in terms of a standardized tool to classify patients and all this activity, if we don't know what the heck we're trying to classify, I mean, what does that bring value to us? So let's really look at kind of what is this benefit and can we do better with that.

On the issues of the alternatives one and two of episode-based payments and private sector approach, I'm not as fearful of predetermined rates of an episode versus the per click arrangement that we have now with the piecework that's in the system as it is now. We've got episode payments throughout Medicare, whether it's DRGs or APCs or RUGs, or whatever the case may be. The program has wonderful experience with that, and they've developed it all across the system. So I'm not as fearful as others are of that. And I think it just beats, again, a per click system that we have now. So I think it is worth looking at.

Then, finally, on the private sector approach, I think there are some things that we can learn, that we can look at. As I've shared in the past, I'm not a big fan in the Medicare program of pre-authorization. I think it sets up some real difficult issues in terms of beneficiaries and

their ability to appeal adverse determinations on access to care. And I think it's a rigorous process to go through that appeal process. But I do think that prior authorization for providers that have been identified as being problematic, 100 percent prior auth for those kind of folks I think is just fine, and I fully support that kind of activity.

MR. ARMSTRONG: I, too, just briefly, would affirm -- I support the direction that's being described, both in terms of the short-term ways of trying to control the benefit or manage the benefit.

And with respect to these alternatives, not surprisingly, I think the private sector approach works well and that there's a lot to be gained from that. I don't fully understand all the concerns about the episode-based payments and our previous experience with it, so it might be worthwhile for us just to continue to get really clear about what the concerns there might be.

Glenn, you know, you just said we'll come back to it in a minute, but I think that there is real value in making sure that the out-of-pocket costs to the beneficiaries is really thought about and that we make sure

that it's designed here in this case in a way to get to -- or contribute to some of the outcomes that we're trying to get to.

MR. HACKBARTH: So on the issue of cost sharing, Craig put his finger on a central issue, which is people have supplemental coverage, that mutes or eliminates the effect of whatever cost sharing Medicare might require at the point of service.

So for the benefit of the new Commissioners, we spent a fair amount of time looking at the benefit structure over the last couple of years and in the spring made a series of recommendations. First of all, we said that the existing Medicare benefit package should be restructured without in the aggregate any increase in any beneficiary cost sharing. So we didn't think that overall the actuarial value of the benefit should be reduced and beneficiaries need to see higher costs at the point of service. But we didn't think the existing structure of cost sharing made a lot of sense, it was somewhat antiquated. And so we recommended that the Congress give the Secretary the authority to redesign the cost-sharing structure within the confines of the existing actuarial value, no net increase in

overall beneficiary cost sharing, and suggested that the Secretary be free to do that redesign using value-based insurance design principles. So you may want to vary the cost sharing, reducing it for service that are clearly of high value and increase cost sharing for services that are of more marginal value. And the Secretary can make those adjustments without going back and getting congressional authorization for every decision.

Then with regard to supplemental coverage, what we concluded was beneficiaries should be free to purchase supplemental coverage if they so desire. But when they make that decision to purchase supplemental coverage, they should face at least a portion of the additional cost that that results in for the Medicare program, the higher utilization. And so we thought that there should be an assessment on the supplemental coverage.

Of course, that then leads to the question: Would that alter the sort of supplemental coverage that people buy? And we think in the long term probably it would. How much it would change it in the short run is more difficult to say. So that was where we stood on that issue.

Okay -- oh, I'm sorry. I forgot our last two.

Tom and Bill, I apologize. Whenever I do this, starting in a new place, I always screw myself up.

DR. DEAN: I can agree with most of the comments that have been made. The one thing that I would emphasize is I really think it would be helpful to have the functional measure some sort of formal -- I get these requests frequently, and frequently the measurements I get, the forms I get, are really hard to interpret, and I can't really tell whether the person is improving or not. And it seems to me that whether we talk about episodes or whether we talk about a fixed number of visits or whatever, what's really important is: Is that patient benefitting from the service? And it's so variable, and that's why constructing these other limits is difficult.

It seems to me that the underlying guideline really ought to be that Medicare should continue to support this as long as the person is showing some benefit. But we've got to have a way to document and verify that. And right now, even though I get reports of all the things that are being done, I really have a hard time determining how does that compare with where they were to begin with and are we progressing.

If we could do that and make that the fundamental determinant of whether additional visits are justified, I think it would fit the clinical needs a lot better. Now, whether it's possible to do that administratively and so forth, I'm not sure. But from a clinician's point of view, that's what I need to determine if I'm going to sign off on that form.

MR. GRADISON: This is really to me a case of no good option. An example of one of the realities of the human experience is that every problem doesn't have an answer.

With regard to episodic payments, I think unless they're linked to an assessment of the functional status of the individual, it doesn't make a whole lot of sense. And, in particular, the notion that the same number of initial visits should be allowed for everybody regardless of what they're being treated for doesn't make much sense to me at all.

I would certainly lean towards the private sector experience because it seems to be working better than the Medicare experience, but I'm at a total loss to see how Medicare as it's currently organized can follow the private

sector experience. I think the sheer volume that would be involved in prior authorizations would make that -- likely make it unrealistic. So at the end of the day, I will eventually, when we have a proposal before us, vote upon it, but unless something knew comes up, it's not going to be done with any great enthusiasm that we will be contributing to an improvement in the program or dealing particularly effectively with the problems that you have so well identified.

MR. HACKBARTH: Okay. Again, Tom and Bill, I apologize for forgetting you at the end of the queue.

Just one question, and this came up in several Commissioner comments. What do we know about the effectiveness of the private sector tools? We went out and we talked to people, and we have a sense of what they are doing. Is there evidence of effectiveness, since that's an explicit part of our charge?

DR. AKAMIGBO: As long as we're defining -- just to be clear, effectiveness at controlling utilization and costs, I would say the prior auth process is relatively effective for the groups that saw significant growth prior to implementing a prior auth, and there were several. This

was an effective tool in controlling utilization and consequently costs.

MR. WINTER: Right, and that's what they reported to us. Again, as we experienced, we looked at prior authorization for imaging. There's a lack of literature that examines the effectiveness of these approaches using a control group. So, again, not independent confirmation.

MR. HACKBARTH: Well done. Thank you very much, and more on this next time.

And our last item is refining the hospital readmissions program.

[Pause.]

MR. GLASS: Good morning. The new hospital readmission reduction program will start October 1st. Today we'll review the Commission's position on readmissions, look at recent trends in readmission rates, review the new readmission policy, and discuss some issues that policy raises and possible policy options for dealing with those issues.

The Commission has been concerned with readmissions for a number of years, and recommended the hospital readmission policy in 2008. We have also

considered incentives targeted at SNFs and home health agencies to discourage avoidable admissions from those facilities, recognizing that responsibility for readmissions are shared by other actors in the health care system.

It's important to reduce avoidable readmissions because an avoidable readmission is a poor outcome for the patient. Reducing readmissions could represent improved care in the hospital, more help with transition, and better care coordination outside the hospital, all of which are better for the beneficiary.

Medicare spending on readmissions is substantial. We estimate reducing readmissions by 20 percent, which is CMS's current goal. It could save over $2.5 billion in one year. Although it is possible for hospitals to reduce readmissions, as we'll discuss on the next slide, the fee-for-service system creates a disincentive to do so because hospitals see additional revenue for each readmission.

A successful readmission policy has to create an incentive to reduce avoidable readmissions strong enough to overcome the loss of revenue the hospital will see. We said it's possible for hospitals to reduce avoidable readmissions. We have visited high-performing hospitals,

talked with their representatives, reviewed the literature, and found examples of hospitals that have reduced the rate of avoidable readmissions.

At a broad level, techniques they have used include -- they've identified the patients most at risk for readmission and targeted their efforts on that population, for example, patients who have been frequently readmitted. They have reduced hospital complications by improving the processes such as using check-listed surgery and to avoid central line infections.

They have improved the transition at discharge, Project RED and Project BOOST, for example. They can provide patient education such as teach-back and self-management. They can schedule follow-up visits and medication reconciliation before discharge. And they can make follow-up calls or visit the patient after discharge, and they can communicate better with physicians and post-acute care providers outside the hospital.

Now Craig will tell us if we can see evidence that hospitals have successfully decreased readmissions at the national level.

MR. LISK: In this slide, we are reporting how

readmission rates have changed since 2009. These are both all condition measures; that is, they include all hospital Medicare fee-for-service discharges. We've controlled for changes in the mix of patients discharged.

Controlling for changes in the mix of patients is important when looking at readmission rate trends over time because readmissions vary substantially by DRG and the mix of patients admitted to hospitals changes over time.

The first row shows an all-cause readmission major which identifies cases with readmissions occurring within 30 days of discharge from a hospital. By this measure, readmission rates have fallen about .3 percentage points from 15.6 percent to 15.3 percent in 2011.

The second row shows a potentially preventable readmission measure developed by 3M which includes an algorithm to identify readmissions that are clinically related to the prior hospitalization. It shows these readmission rates dropped by .7 percentage points over the same time period.

We note that the reduction in potential preventable readmission rate of .7 percentage points is greater than a reduction in the all-cause readmission rate.

This makes sense if hospitals are having greater success in reducing potentially preventable readmissions than ones that are not.

We also found that reduction for the three conditions in the current policy have, in most cases in the current readmission reduction program, have been greater than the reductions on average. 2009 is when Hospital Compare started reporting on hospital readmission rates, and 2010 was when PACA was passed. Thus, there appears to be some evidence that hospitals are starting to preferentially reduce readmissions for these three conditions. When the penalty takes effect in 2013, there will be greater incentive -- should be greater incentive to reduce readmissions.

We do see some variation in readmission rates across hospital groups and by beneficiary characteristics. Looking across hospital groups, high characteristics such as ownership and teaching status and add-ons such as DSH and IME, we find some limited variation and the details of that are in Table 3 of your mailing materials.

There is much more variation, though, within hospital groups from which we conclude that other factors

such as hospitals' programs to reduce readmissions, have more influence on these characteristics.

We also see differences in readmission rates by certain beneficiary demographics. We see some very slight differences by age and gender, and see larger differences by race and income. We use Medicaid status as a proxy for income in our analysis. African-Americans, Hispanics, and low-income beneficiaries are shown to have higher rates of readmissions.

Now I want to discuss the hospital readmission reduction program that was part of the Patient Protection and Affordable Care Act passed in 2010. The program starts this October, in less than 30 days, with three conditions: AMI, heart failure, and pneumonia, all conditions which Hospital Compare has reported on publicly since 2009.

The policy will add at least four more conditions in fiscal year 2015, in two years. These include COPD, CABG, and PTCA, and other vascular procedures, and those are DRG definitions there. The Secretary, however, can add more conditions in 2015, or thereafter, if he or she wants.

Essentially, this policy uses the Hospital Compare readmission measure. Hospitals that have had readmission

rates above average from July 2008 to June 2001 [sic] on any of those measures, three readmission measures, will receive a penalty starting in 2013. Non-IPPS hospitals are excluded, including CHs, are not included in this program.

The penalty is applied to all cases that the hospital has, but the size of the penalty is based on the excess readmissions for which these three conditions as a share of total hospital payments. We'll discuss the exact payment formula in a few slides.

The penalty is capped at 1 percent in 2013, 2 percent in 2014, and 3 percent in 2015 and thereafter, and the penalty is based on base operating payments and is not applied to hospitals, IME, DSH, or special rural payment add-ons or outlier payments.

Under the PPACA hospital readmission reduction program, a third of hospitals will have no penalty; 6 percent will have no penalty because they have too few cases for each of the three conditions. In other words, they have fewer than 25 cases in each of those conditions over the three-year period that is looked at.

Two-thirds of hospitals will have a penalty, and the reason why more than half of hospitals are affected is

because the penalty is calculated for each of the three conditions. So roughly half of all hospitals are affected for each condition, and since half are affected for each condition, we're doing three conditions, about two-thirds of hospitals are affected in some way.

9 percent of hospitals are at the payment penalty cap in 2013 of 1 percent of base operating payments. In aggregate the readmission reduction program penalty will equal about .24 percent of total payments to IPPS hospitals in fiscal year 2013. The average penalty per hospital receiving a penalty will be about $125,000.

This slide shows how the policy affects different groups of hospitals. The first column shows the share with the penalty, and you can see that there is -- see that there are some differences here. Major teaching hospitals have the highest share with the penalty and hospitals that do not receive IME or DSH payments are the least likely to receive a penalty.

Moving to the second column, we do not see much variation in the penalty as a share of total payments across hospitals. In fact, the difference as a percent of total inpatient payments is less than 5/100ths of 1 percent or

less across each of these groups. So there's very little variation in what the average penalty is across hospital groups.

Jeff will now discuss some long-term issues that we wanted to discuss with you on the readmission reduction program.

DR. STENSLAND: As David discussed, readmissions are a poor outcome for the patients and they're a poor outcome that's often avoidable. Craig explained how the current readmission penalty creates an incentive to reduce avoidable readmissions, and we find that following public reporting of readmission rates, we've seen a small decline in readmissions.

It appears from what we hear in the field that hospitals are increasing their efforts to reduce readmissions as we move closer to the start of the readmission penalty. Therefore, it appears that the penalty is serving its purpose of motivating hospitals to take action.

While the current penalty is an important improvement over the perverse incentives that existed prior to the penalty, there is room for improvement, and I'm going

to talk about four possible refinements to the penalty that can take place over the long term. The four concerns I'm going to discuss are, first, the computation of the penalty multiplier; second, random variation; third, unrelated and planned readmissions; and fourth, socioeconomic status and risk adjustment.

It should be noted that addressing these four issues would require a change in law. Therefore, we'll have to move carefully as we design ways to revise the current payment formula.

When addressing these four concerns, we've tried to keep four principles in mind. First, we want to maintain the incentive for the average hospital to reduce readmissions. The current incentive appears to be inducing hospitals to ramp up efforts to reduce readmissions. We want those efforts to continue.

Second, we want to increase the share of hospitals that have an incentive to reduce readmissions. Currently, some hospitals at the low end have no incentive because they're not facing a penalty.

We want the penalty to be a consistent multiplier of the cost of readmissions. Hospitals that have more

readmissions should face larger penalties. The current penalty formula does not achieve this objective.

And fourth, we want the penalty to be at least budget neutral to current policy with a preference for achieving budget neutrality through lower readmission rates rather than through higher penalties. Reducing avoidable readmissions is the goal of the program and, in the end, what the beneficiaries want.

The current readmission penalty formula can be simplified into two basic parts. The first box is the estimated cost of the excess readmissions. For example, if you were expected to have ten readmissions and you had 12, then you have two extra readmissions on a risk adjusted basis. If the payment for the DRG at your hospital is $10,000, the cost of those two excess readmissions would be $20,000.

In the second box, we have the penalty multiplier. Under current law, this is set equal to one divided by the national readmission rate for the condition. For example, if the readmission rate is 20 percent, the multiplier is five. A multiplier greater than one makes the penalty larger than the average revenue generated from the

readmission, creating a strong incentive to avoid the readmission.

Some would argue that a strong incentive is needed because the penalty only applies to three conditions, and to get institutional change from a penalty that only applies to three conditions, the incentive on those three conditions will have to be large.

However, given any size of a multiplier, a key question remains of how the multiplier should be computed. Right now, the multiplier is set at the ratio of one over the national readmission rate for a condition, and this creates two problems.

The first problem is that the penalty increases as the industry readmission rate improves. The decline in the denominator in the formula causes the multiplier to increase.

Second, the penalty multiplier differs for each condition. If the national readmission rate for a condition is 5 percent for one condition and 25 percent for another condition, the penalty will be five times as large for the condition with the 5 percent readmission rate.

And there are three steps we could take toward

addressing these concerns. The first step is to use a fixed multiplier. For example, the penalty could be set at two times the cost of excess readmissions. This is basically two times the extra revenue the hospital gets from these excess readmissions.

A second step is to use an all-condition potentially preventable readmission measure. This increases the incentive to reduce all types of readmissions, because all readmissions are included in the penalty formula, and it spreads the penalty over more conditions allowing for a lower multiplier.

An alternative option is to eliminate the multiplier entirely and set a lower target readmission rate to maintain budget neutrality. For example, the readmission target could be set at a fixed percentage of the historical average for a condition, for example, 80 percent of the historical average. And hospitals would then know in advance that if they made this target they could avoid penalties.

The target could be set so budget neutrality is achieved. This is similar to the current system that's used in New York for their Medicaid readmission penalty program.

Under this alternative, if the industry reduced its readmissions penalties would be reduced across the industry.

The second problem I want to talk about is random variation. The concern is that small hospitals may be subject to more penalties due to have greater random variation. Currently to address this problem, CMS shrinks the reported values toward the national mean, as we discussed in your mailing.

The problem with this solution is it reduces the incentive to improve performance and can distort the values that are presented to the public. One possible solution to this problem is to use an all-condition measure. This would expand the number of observations and reduce the random variation.

A second option is to use more than three years of data, as CMS currently does, with higher weights given to more recent years. Some may feel that four or five years of data would be looking too far back in time. However, others may say that blending the hospital's current performance with its past performance is better than what the current situation is where they blend its current performance with a simple national average.

Finally, we could allow hospitals to report their performance individually, but then combine their performance within a system for purposes of computing the penalty. This would increase the number of observations used to compute the penalty because you're using all the admissions in the whole system, and that would reduce random variation. It would also create peer pressure and create an incentive to share best practices within the group of hospitals that are in that system.

The third issue is unrelated and planned readmissions. For example, a pneumonia patient may be in a car accident following discharge. We may see that multiple trauma admission as unrelated. The current law says that CMS should eliminate unrelated readmissions, and it also says it must use an NQF-endorsed measure. The problem is that the current NQF-endorsed measures for the three conditions that are currently in the policy have relatively few exceptions.

However, there is a possible solution, and that's there are two all-conditions measures, one that's developed by Yale and one developed by 3M, and both these two all-condition measures have expanded the list of exclusions for

unrelated and planned readmissions. We could move toward one of those all-condition measures to help address this issue.

And I want to note that moving toward an all-condition potentially preventable readmission measure would not only help address this issue, it would also help address the other issues we just discussed about the computation of the penalty and the multiplier as well as the issue of a small number observations and random variation.

The fourth issue is that poorer Medicare patients tend to have higher readmission rates, and this has been commonly reported in the literature. This slide illustrates this point with respect to patient income and readmission rates.

First, hospitals with high shares of poor patients have higher readmission rates using SSI as an indicator of poverty. This is what you see in the first column. It shows that hospitals with less than 2 percent of their Medicare patients on SSI have an average heart failure readmission rate that is 92 percent of the national average.

In contrast, if you look at the bottom of that column, hospitals with over 19 percent of their patients on

SSI have an average heart failure rate that is 112 percent of the national average. We see similar patterns for AMI and pneumonia patients. The result is that hospitals serving more poor patients are more likely to face penalties, as we show in the second and third columns.

However, the second point I'd like to make in this table is that some hospitals, even with the highest share of poor patients, have a below average rate of readmissions. If you go to the last column and at the very bottom, you'll see that amongst those hospitals with over 19 percent of their admissions being very poor patients on SSI, still there are 25 percent of those hospitals that have no penalty.

This suggests that it is possible to reduce readmission rates for poor patients, but it may be more difficult than for reducing readmissions for patients that have more resources outside the hospital.

So we have four possible solutions with respect to the SES issue. First, we could leave the strong incentive in place for poor performers to continue to improve their performance and reduce readmissions for poor patients. The incentive would be for them to move toward the 25 percent of

hospitals that currently are able to achieve low readmission rates despite having a large share of poor patients.

The second option is to add SSI status to the risk adjuster to offset the higher readmission rate of poor patients. However, there are two concerns with this. First, it would vary differences based on socioeconomic status, and this may prevent us from identifying disparities that would exist, because these disparities would essentially be risk adjusted out of the system and we'd no longer be able to see them. In addition, we could be accused of accepting worst performance at hospitals that treat a greater share of poor patients.

A third option is to not include socioeconomic status or income in the risk adjustment model, but compare hospitals to ones with similar income level patients, basically compare hospitals to their peers. This would allow us to continue to monitor disparities because the disparities amongst different income classes wouldn't be buried in the risk adjuster, and also it would be prevent a disproportionate amount of the penalties going to poor hospitals because hospitals would be compared to like hospitals.

Another option is to leave the penalties alone, but provide financial assistance to hospitals with high shares of low income patients. And this is similar to the Commission's recommendation to redirect QIO resources, as we discussed in our June 2011 report. These QIO resources could be directed towards hospitals that have high readmission rates or to hospitals that have high shares of poor patients on SSI.

Now David will summarize for us.

MR. GLASS: In summary, we find that the hospital readmission reduction program which will take effect in October is moving in the right direction. It is creating some incentive to reduce readmissions which is better for beneficiaries and will save money for Medicare. As such, it represents a major improvement over the current fee-for-service program.

We find the magnitude of the penalty is reasonable and is limited to 1 percent of payments to any hospital in 2013. However, we also find there are four major issues in the current readmission policy that will need to be addressed in the longer term, and we have presented some options on how to address those issues.

Finally, we note that it's important to consider the savings from reduced readmissions, as well as the size of the penalty, when constructing policy options. Savings from reducing readmissions to the program may be much larger than any penalty if the incentives created are strong enough to get real action to reduce readmissions from a large number of hospitals.

We would like you to consider the following points in your discussion. Almost all the policy refinements discussed will require a change in law rather than administrative actions by CMS. Therefore, we must proceed carefully when recommending refinements.

To that end, we will be supplying you with more detailed analysis in subsequent meetings such as modeling all-condition readmission measures. Please let us know if there are additional analyses that you would like us to undertake.

Finally, are the principles we have proposed appropriate given your experience in the field? We will put these up now as a reminder. Now we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you for that. Lots

there to think about and discuss. Let me just say a word about the context here. So as was discussed in the presentation paper, MedPAC recommended that Congress legislate a readmissions penalty a number of years ago.

The context in which we made that recommendation was that we identified this issue with high rates of readmissions and a lot of variation in the rates of readmission, and we initially talked about addressing that problem through bundling, bundling post-acute services with the inpatient admission, and through that mechanism creating an incentive for people to care about what happened after the admission as over.

As we delved into bundling, it became clear to us that it raised a lot of complicated issues, both complicated issues about how to structure the payment system, as well as issues about how providers would have to reorganize themselves and create new relationships to work under a bundled payment system.

It was clear to us that some of those questions didn't have immediate answers, and in any event, would take some time to develop a bundling approach. So we said, another path to pursue might be -- it might be quicker to

adopt would be a readmissions penalty. And so, we made a recommendation for the readmissions penalty and you know what happened since there.

But we're still now, as our discussion yesterday indicated, still working on these two related but separate tracks, readmission penalty and bundling. And a recurring question for us is, does it make sense to continue both tracks or should we drop one track in favor of the other? And so, as you think about the readmissions issue, I just wanted to provide that additional context.

So let's see. Mary, would you like to begin with Round 1?

DR. NAYLOR: So your interim comments were really helpful, and this was a great report. I'm wondering, one other piece that's going on simultaneously -- multiple pieces are going on simultaneously, but the Partnership for Patients effort, the Community-based Care Transitions Program, and all the work that's going on to reduce readmissions through better in-hospital care. I'm wondering, in thinking about a readmission policy, the balance between carrots and sticks and penalties and the kind of motivation, so if you had thought about that.

And my second question, totally unrelated, is on the SSI. As you look at that slide that describes increasing share of people served in a hospital who are on SSI, it's almost when you get to the 10 percent mark -- and I'm wondering, can we learn anything from those hospitals that are doing well, the 20 to 25 percent, you know, are there characteristics of those places that could be helpful?

DR. HALL: Could you remind me --

DR. MARK MILLER: Wait, were we going to respond? [off microphone]

DR. STENSLAND: Yeah, we can certainly add in -- look at the Partnership for Patients and what they're doing, and I think one of the things we can think about is there certainly would be ways to make it penalty -- a carrot and a stick model that would still be budget neutral, and we could bring up some of those opportunities.

In terms of the SSI, I think generally it's a pretty clean movement from way at the bottom, 8 percent below, to way at the top, 12 percent above. And so I think that's pretty smooth, but there definitely are some opportunities that we can go and find out what some places are doing with some of their outreach activities outside the

hospital, like Denver Health has been noted at someone who has lots of poor folks, but also low readmissions rates, and that's another thing we can look into, so that's a good idea.

DR. HALL: Can you remind me the definition of readmission? Is it readmission to the same facility that --

MR. GLASS: Readmitted to any.

MR. LISK: It's readmission to any facility, and what we measured here is actually -- we didn't measure readmissions on our readmissions, so the person has an initial admission and has a subsequent -- had a subsequent readmission, is what we're measuring here. So that rate, just to define that rate, might be a little bit different from what you've seen from some other things because we're not measuring readmissions on a readmission, for instance, multiple readmissions.

DR. REDBERG: To any acute-care hospital, not any-

MR. LISK: To acute care, yes, it's only to acute-care hospitals. And then the policy is readmissions to critical access hospitals don't count under the current policy because they're not considered a section -- I can't remember what, 1886 D Hospital so -- because they're not

considered an 1886 D Hospital, a readmission to a CAH does not count, which is different from what's been reported on Hospital Compare. It's a slight technical issue, but I just wanted to clarify that.

DR. HALL: Do you know what the order of magnitude would be of patients being readmitted to another hospital? Is it 1 percent or 50 percent?

MR. LISK: I mean, it's -- I'm not sure. I'd have to check back. But it's probably 20 to 30 percent, from what I recall from previous --

MR. GLASS: [off microphone].

MR. LISK: Of readmissions, yeah, or to a different hospital.

DR. HALL: I think that might be a useful statistic. I mean, not that I'm suggesting that there's gaming going on, but it's conceivable; you shift the patient to another hospital.

MR. LISK: The policy applies to discharge to any hospital, though, so it's not going to help you.

DR. REDBERG: Thanks. Excellent report. I had two questions, one on Slide 8, and I have to say I work at a major teaching hospital, but I am curious why that had the

highest share with the penalty. It looked a lot higher than all of the others.

My other question was on Slide 14, and I was just wondering if you could say more about what the all-condition measures were proposed by 3M and by Yale.

MR. LISK: The major teaching hospitals having the higher share could be a combination of two things. It could be that they tend to have a higher share of patients who are poorer patients, who are more likely to be readmitted. There could be some case mix issues about the types of patients they're seeing are more likely to be readmitted. It could be a performance issue on major teaching hospitals as well. So we haven't done -- let's say we can do some more analysis to look at that specifically in terms of other factors contributing to that. We haven't done that.

In terms of the readmission measures, the 3M all-condition measure is one where you have -- potentially preventable readmission measure is one where you have clinicians look at conditions and say what are the types of things that may be related type of conditions versus not related. A lot of medical conditions following a medical condition -- initial admissions for medical, and if it's a

surgery afterwards, a lot of those will be considered not -- will not be considered potentially preventable readmission. But a lot of medical conditions will be. But it's a clinically based measure.

The all-condition measure is similar to the measure currently used in Hospital Compare and using HCCs and stuff to identify the risk, and then they do have some exclusions that they also had made that was done by some clinicians and stuff and thinking about exclusions.

So the 3M approach is more of a categorical model, so if you're in a particular DRG, you have this -- with these characteristics, you have a certain share, percentage of cases you would expect to be readmitted, and that's how that one is done. And the other one is a regression-based model.

MR. HACKBARTH: So let me just pick up on Rita's first question about teaching hospitals. Could you put that back up?

So my understanding of this calculation, first of all, is that this does not include any of the teaching payments in the denominator. This is just --

MR. LISK: Correct. And that's why also, even

though 88 percent of teaching hospitals had a penalty, their share of penalty is 0.29 percent, which is just 0.4 -- 0.04, four one-hundredths of a percentage point higher than average, is because the penalty is calculated as a share of total payments, and IME and DSH payments are not part of the calculation.

MR. HACKBARTH: And then the second point --

MR. LISK: No, not part of the readmission penalty. They're in the denominator.

MR. HACKBARTH: Okay, yeah. So then in each of these categories, I assume there's a fair amount of variation.

MR. LISK: Yes.

MR. HACKBARTH: So there are teaching hospitals that perform better than average, the overall average, and some that are worse.

MR. LISK: Yes.

MR. HACKBARTH: And that's true for all of the categories.

MR. LISK: Yes. There's more variation across -- within a group than across.

MR. HACKBARTH: Across the groups. That's what I

was struggling to say.

DR. NERENZ: Just quickly, on Rita's second question, the all-condition, it's still not clear to me. Does that phrase refer to all conditions in the index admissions or all conditions in the readmissions?

MR. LISK: It's all conditions in the index admission.

DR. NERENZ: Okay, thank you.

MR. LISK: We use the frame -- the terminology is "all-condition, potentially preventable" or "all-condition, all-cause." And so the current three measures that are used are all-cause readmission rates for pneumonia, heart failure, and AMI.

DR. NERENZ: Okay. But that, you just reintroduced the confusion. Preventable refers to the readmissions.

MR. LISK: Yes.

DR. NERENZ: All-cause, I just want to clarify, that refers to the index admissions.

MR. LISK: Yes --

MR. GLASS: No, no.

MR. LISK: No, I'm sorry. All-cause is the

readmission. All-cause and potentially preventable is the readmission. The index admission is either all-condition or a specific condition. Think of all conditions and all cause, are separate --

DR. MARK MILLER: Just a second [off microphone]. We've gone through this many times so if we could just slowly --

MR. GLASS: So currently they're looking at three specific conditions for the initial, and those are the initial conditions.

DR. NERENZ: Yes, yes.

MR. GLASS: But their measure is an all-cause readmission --

DR. NERENZ: Got it.

MR. GLASS: So any reason you come back to the hospital for one of those three conditions counts.

DR. NERENZ: Okay. So just to be sure, so the word "condition" refers to the index admission.

MR. GLASS: Correct.

DR. NERENZ: The word "cause" is the readmission.

MR. GLASS: Correct.

DR. NERENZ: As is prevent -- thank you. Just to

clarify.

MR. BUTLER: I'll make it a statement rather than -- make it a question rather than a statement. I do think that the major teaching hospital, if you look at your SSI and how much that explains of it, it would be a good thing to know, because I bet it does explain a lot of the variation that's in the major teaching hospital. That would be a good thing to know.

DR. COOMBS: So I was curious, being in the OR a lot, what surgical readmissions look like relative. Has anyone done any literature to look at surgical readmissions compared to the three diagnoses? Because it's really important, I feel, that you look at that as well, because there's opportunities for improvement in quality. And if that kind of parallels these three diagnoses, then that's really neat because you can actually do some things with surgical readmissions as well. So did you find anything in the literature?

DR. STENSLAND: I think in the literature -- when we look at the data, there certainly are various readmission rates for surgical readmissions also that are usually a little bit lower than the heart failure readmission rates,

but they're still material. And I think when we talk about the three-condition readmissions versus the all-condition readmissions, let's look at everything and try to improve everything, I think there's a little bit of a philosophical question there. And I think the movement from the three conditions to the all conditions could be along the -- similar to what you said of saying there's a lot of things that we can do to improve readmissions for all these different conditions. A lot of the interventions we do, like reconciling medications, improving hand-offs of post-acute care, these are things that could help all different types of readmissions, and maybe it's time to move to all these deficit types of readmissions and create the incentive for all of them.

DR. COOMBS: And then one other question I had relates to the fact that a lot of hospitals have put in some really robust follow-up programs, patient navigator programs. Have you seen a lot of information in terms of how the turnaround hospitals have been regarding implementation of navigator programs?

MR. GLASS: We've looked at some examples of that, and it does seem to work. Mary probably could tell us much

more in detail if you're interested.

DR. STENSLAND: We have gone to individual facilities and said let's talk about your project. Or we read about Project RED in Boston, or we go to another city and we talk to them about their Project BOOST, what the hospitals are doing, and lots of individual places are doing stuff, and they have individual success. So that gives us a lot of optimism. Probably what we haven't done yet is the really analytical stuff of saying let's look at these readmission rates or changes in readmission rates and relate those to changes in programs on the national basis. And I don't know if Mary knows of any ongoing studies that are doing that right now, but we haven't taken that next step.

DR. COOMBS: I'm aware that Boston, BU, has a program that's a navigator program, so that's an example.

MR. HACKBARTH: Mary, is there anything you want to say here?

DR. NAYLOR: I'm happy to send you data. We've done a review of the literature, and there's work ongoing to try to keep in touch with how the Health Care Innovation and the Community-based Care Transitions that CMS, the Innovation Center, has launched are moving. And, yes, the

navigator program is among those that's demonstrating positive outcomes early.

DR. SAMITT: I have two questions, one for the team and one actually for Glenn. Great job. Thank you.

It wasn't clear to me from the meeting briefing -- it was referenced several times, but it wasn't clear what the answer was, whether the penalty, currently or in the future, is greater than the revenue loss from the readmission. Have you done some modeling to see what the impact would be either when it reaches a 3 percent level or whether it would actually require all conditions to reach a threshold to make it significant enough to really focus intently on it?

DR. STENSLAND: For those three conditions, the current penalty is greater than the revenue from the readmissions, on the order -- excess readmissions, on the order of four to six times the revenue from the excess readmissions.

DR. SAMITT: Okay.

DR. STENSLAND: So there is a material incentive to look at those individual conditions. You might argue that maybe there isn't enough incentive to make

institutional change if the penalty in aggregate is only a couple hundred thousand dollars and the institutional change might -- the incentive might not be big enough to make an institutional change that would go across the whole system, go across all types of discharges. Does that make sense?

MR. GLASS: A little footnote on that. The way the excess is computed in the current system kind of mutes it somewhat because of the shrinkage for some hospitals where they bring it down to the national average.

DR. SAMITT: And the question for Glenn is in reference to your introductory remarks about how do we reconcile the notion of changing a readmission penalty process with the notion that yesterday we talked about absorbing readmission risk essentially as part of an inpatient post-acute care process. So it seems as if they're a bit conflicting, if we're going to recommend inclusion of readmissions in a bundle via our discussion yesterday versus a modification and a penalty today, which is it? Are we going to do both? Is one short term/long term?

MR. HACKBARTH: You know, that's the question for us collectively to answer, how we see these two. Are they

complementary or is one -- if we're able to make a bundling approach work and practical, does that supplant readmissions penalty? So that's not a question just for me. That's a question for us collectively.

DR. MARK MILLER: And the only thing I would add is, I mean, you have to be -- I think you have to be conscious that you've probably got the penalty at least for the nearer term, because if you pull it out, then there's a whole set of savings that are lost, and a loss of focus on this. And we have heard widespread responses to this that people have are really taking it seriously, so that would be something to keep in mind.

The other thing I would say is that you can formulate bundling options in which you have bundled everything and still leave the readmission as a penalty function across the providers, or you could bundle with it in. And I think even there you could imagine a penalty that continued into a bundling world, or not, but that goes back to the exchange you have.

MR. HACKBARTH: We touched on this yesterday, and the way it was phrased by David, Is bundling an end state that we may want to preserve in the long term, or is it just

a step towards, you know, broader bundling through ACOs or some other mechanism? So, you know, one approach -- and I don't want to put words in Mike's mouth --

DR. CHERNEW: You already have,

MR. HACKBARTH: -- but, you know, I think Mike was leaning towards, well, you may want to do the -- continue the readmission penalty, strengthen it, as we're discussing today, and use that as the short-term vehicle for dealing with the readmissions issue, not spend a lot of time and resources trying to do the episode bundling around an admission and focus instead on the big bundle of ACO, and that might be one approach to thinking about these things.

But, again, I think that's a question, a strategic question, for all of us to weigh in on.

MS. UCCELLO: Is there a reason that these three conditions and the next four were chosen? Are they particularly susceptible to high readmissions, or --

MR. LISK: Okay. So MedPAC had a report that had a table in it that showed these seven conditions, and they were conditions that were an example of conditions -- the first three actually were ones that had the most readmissions, but they were examples of readmissions and

those are what Congress to get set savings probably put in place, but they specifically referenced our table in the legislation.

MS. UCCELLO: Okay. So I assume that there are certain conditions that are more likely to have planned readmissions than others, so those are not evenly distributed. And I'll also assume that those conditions that are more likely to have planned or unplanned are not distributed evenly across hospitals. Is that right?

MR. LISK: Yeah, that could be the case. And that could be the case with surgeries, and that may be another reason why the teaching hospitals' rate is higher is that they may have more likelihood of patients who are going to be getting follow-up surgery or something after something, or something else is found. Or it could be someone with subsequent -- you know, somebody who has cancer is treated for pneumonia and is going to have some subsequent cancer treatment. The risk adjustment has some effect for saying those people are cancer, but they may be just more likely to occur in teaching hospitals, and so that could be the other factor that's going on, too.

So the planned readmission may not be related to

the initial diagnosis in some cases, too. Sometimes it's going to be. So there's some planned readmissions for people who have AMI that are excluded from the current policy, but they're for people who go in for a CABG subsequent for their AMI, as long as the initial -- the readmission wasn't for AMI.

MR. KUHN: A couple quick questions. One is kind of picking up where Rita asked the question about major teaching. This has always been a concern of mine because of the acuity levels that they have, and I noticed in the written material -- by the way, it was a terrific paper. But on page 8 in the second footnote, you talk a lot about mortality, and kind of the issue of the inverse correlation, you know, if you have higher readmissions, lower mortality as part of the process.

So, you know, I guess some of the things I've been talking to various folks around the country about is the fact that for major teaching hospitals, they really get the train wrecks. They get some of the really bad conditions, and they're saving a lot of these people. But as a result, those folks are so fragile, there is a high expectation there's going to be a readmission as a result of that,

versus perhaps if that went to another facility, that person might die, and then there's no readmission.

So is this going to be part of the continuing work that we're going to look at that particular issue?

MR. GLASS: I'm glad you asked that question. Jeff?

DR. STENSLAND: I have a prepared answer for this one.

[Laughter.]

DR. STENSLAND: This is part of the continuing work, and that's why we have a prepared answer. I think there's two stories you hear; there's two hypotheses that are brought up when you see this inverse relationship.

MR. KUHN: Right.

DR. STENSLAND: Sometimes you see it in two different areas. One, you see some hospitals that tend to have low readmissions -- lower mortality but high readmissions. And you also see it when you do racial breakdowns. You see African Americans tend to have lower mortality in the hospital but higher readmissions. And there's a couple different hypotheses that might explain this.

I think the first hypothesis, we could call it the low-mortality hospital. You know, you're really good. And what I have here is maybe two hospitals have the same number of patients that go into the system to be seen. They both admit ten patients, but the one is really good, and so it only has one mortality or 10 percent mortality; the other one has two people die and they have 20 percent mortality. But then the one that was really good, that person that they kept alive was really frail and so they got readmitted.

MR. KUHN: Right.

DR. STENSLAND: So that's kind of the story that some of these hospitals will tell you when they're maybe writing op-ed pieces, well, the reason we have high readmission is because we keep out people alive and then they can get readmitted.

But there's another story that could also explain the same phenomenon -- this would be hypothesis two -- and this is that maybe you could just be in a high admitting type system, or you could be in an area where people tend to get their care at the emergency room rather than at their doctor's office. So in this case, you're both seeing 100 patients, but the high admitting system admits 12 of them,

and the low admitting system admits 10. Now, the high admitting system, because they admitted some people that could be treated on an outpatient basis and maybe have some lower level of severity than you would just get from the risk adjuster we have, they only have two deaths, just like in the low admitting system; but because they had 12 admissions because they admitted a couple other people that maybe didn't really need to be admitted, maybe because of the decision the hospital made or maybe because of the patient's decision that they decided to seek care at the emergency room and that affects whether you're admitted or not, they have a lower mortality rate of 17 percent just because they have a bigger denominator and they're admitting more patients.

But then when you look at readmissions, maybe that same place is also more likely to readmit patients, maybe because when they're not feeling so well, maybe they can't get into their doctor or they don't get into their doctor, and they decide to go to the emergency room, and so they have higher readmissions.

So these are just two hypotheses, but the high readmitting story might fit more the African American story

of data, because if you do look at the data, you see a disproportionate share of African Americans go the emergency room, a disproportionate share of African Americans are readmitted initially, a disproportionate share of African Americans are readmitted, and there could be some system issues there, neighborhood issues or primary care issues or other things that cause them to be in this high admitting system hypothesis.

I hope that wasn't too much.

MR. GLASS: And there was at least one study showing a correlation between hospitals that admit a lot of people and also hospitals -- high admission rates and high readmissions.

MR. KUHN: Yeah, and I've seen some of that information, so, one, I was absolutely thrilled when I read the paper and I saw all of the information in that particular footnote. I think there's a lot of powerful conversation there that would give us some future research.

The other question I had was on Slide 15, and I'm curious in that third column on the median penalty. The data that was pulled together for that one, is that basically the base payments or is that total payments? When

I say total payments, I mean does that include outlier, DSH, other information. Because I think depending on how we calculate it, we would get some different results here, particularly since part of the DSH fraction is based on SSI. So I'm curious how this was calculated.

DR. STENSLAND: I'll have to go back and check, but I think that is the penalty as a share of just the base payments. I'll have to check.

MR. KUHN: Okay. It would be interesting to look at it if it had the supplemental payments on that.

And then the other question about this slide when you presented it, and also in the paper, kind of the supposition is there that since only 25 percent share no penalty, it is possible for some of these hospitals that have high SES to manage their readmissions. But I guess the question is: What's the assumption that we're looking at here in terms of the homogeneous nature of the attributes in the community that we're talking about here? Because I guess I'm curious about if those 25 percent have pretty good vertical integration, they've got good transitional care, they've got good coordination, that would be the expectation. If the other 75 percent don't have those

community assets and then would have to expend capital to build that capacity, that might be something for us to look at. I think it would be an interesting series of questions for us to look at.

MR. ARMSTRONG: Just, I don't think this is a question, maybe more just a comment on our own experience, but perhaps worth thinking about, and that is that a readmission rate is a function of both, the overall admissions and then those patients that are readmitted. Our experience, and very intentionally focusing on -- our target was actually to reduce the readmission rate by 50 percent.

At the same time, we're reducing the overall days per thousand. And so, what we found was it was harder for us to reduce the readmission rate while at the same time the overall days per thousand, or admission rate, was also coming down. And so, the overall -- in other words, there's a certain percentage of patients in hospital beds that don't belong there, and that will artificially lower the readmission rate.

You take those out of those hospital beds and it will put upward pressure on the readmission rate. And so, you know, you're nodding and you're saying, Yeah, we're kind

of aware of that, and I guess that's the only point that I wanted to make. You know, we focus on the readmission rate and the second variable, but it's really the first variable, also could have some bearing as we start getting traction on avoidable admissions to begin with.

MR. LISK: You actually make a very good point, and one of the things that we did in our analysis was control for changes in the mix of the patients that's happened over time. A lot of analysis and press reports that said, There's been nothing happening on readmission rates overall, and we do see actually, when we control for it, we do actually see some improvement, and I think it is because there are some cases fewer admissions that shouldn't be there. They're less likely to be readmitted.

So the people who are left in the hospital actually are more likely to be readmitted in some cases. So it's hard to say because I think the policies probably affect both sets of cases in terms of the programs that are out there.

DR. MARK MILLER: And just a little commercial for future work, and I can't remember where it's staged, but we're going to be looking at some preventable admission and

preventable ER use data and trends in the future to try and address some of this question. But your point on the denominator is understood and well-taken here.

DR. DEAN: You commented that within each of these groups there is a degree of variation within the groups. What's the range of that variation in terms of some best, worst? Is it roughly the same, compare one group with the other? Is the range roughly the same? Is it worse? Are there greater variations in some? Or what is the average range?

MR. GLASS: Well, you're talking about the types of characteristics of the hospital?

DR. DEAN: Yeah.

MR. GLASS: I think in every group there were those with no penalty and those with the penalty cap. Is that correct, Craig?

MR. LISK: Yes.

MR. GLASS: Yeah. So the range, in that sense, is similar for all the groups.

MR. LISK: Yeah. I mean, it's a range where there are some hospitals that have very few readmissions --

DR. DEAN: I just wanted --

MR. LISK: -- but the problem comes down, too, is also an end one, that small end problem, too, that you have just random variation in terms of who has readmissions and that's hard to control for ultimately, too, in some ways. So, you know, in any given year, some hospitals perform better and sometimes they perform worse. But there is quite a bit of variation now. And I can try to get you, next time, we can get you and show you some more variation about what that variation looks like.

DR. DEAN: Is that evenly distributed? Is it geographically related? I'd be interested to see that. I mean, I suspect that there might be, you know, since admission patterns and utilization patterns vary so much, I would suspect this might vary by geographic area. I'd just be interested. I don't know.

MR. LISK: There is geographic variation. If we look, the mountain region has the lowest average rate of readmission and Middle Atlantic has the highest. There's about a -- but it's about on an average basis about a 2 percentage point difference on both all-cause and potentially preventable readmissions. So in terms of average -- but within that group, again, there's a lot of

variation in terms of hospital performance.

And you can see that in terms of what's reported if you go into the underlying data on Hospital Compare, too, for the specific conditions.

DR. DEAN: And then you talked about excess readmissions. And maybe you said this and maybe I missed it. If I did, I apologize. How are the -- what is the base line over which they're considered excess? I mean, how are the expected level of readmissions -- is that an average for a group?

DR. STENSLAND: Under current law, it would be the national average for that type of person, risk adjusted. So given how sick your people are and given whatever their diagnosis is, the national average is this, and if you're above the national average, you get some sort of penalty, and the higher above the national average you are, the bigger the penalty gets.

Of course, that is a policy decision and some of the -- one of the options we discussed is maybe if you wanted to get rid of that multiplier, you could set a lower target. You could say, Let's don't have our target be the national average. Let's have our target be what's the 30th

percentile right now and let's move people towards that target. And that could allow some budgetary savings which could offset some of the multiplier.

MR. GEORGE MILLER: Yes. This is a fascinating report and I appreciate the information, particularly about Slide 15, which is up. Can you help me or do you know which of these hospitals would be safety net hospitals and where they're located? I'm intrigued, and I think Herb hit the point that those over the 19 -- like Denver Health, I think, was in the report, but they have a large network of health centers.

So while that's an excellent model, as Herb pointed out, that's a lot of capital dollars in infrastructure that may help them. So it would be interesting, at least for me, to know how many of those are safety net hospitals and who has that type of infrastructure or not have that type of infrastructure.

Again, this was already mentioned. I'm concerned about those folks who may get the care in ED. The slide you had was a perfect indication of some of the concerns that were expressed before, but that's a very good slide. But if some of the safety net hospitals are taking care of

patients, especially minorities or other socioeconomic status patients through the ED and get admitted through the ED, it creates, in my mind at least, a problem of the penalty.

And then finally, do you know the margins for these hospitals that have a higher share of the SSI compared to the rest of the hospitals, the operating margins now?

DR. STENSLAND: I can get back to you on the operating margins. In general, they tend to do pretty well under Medicare because they get DSH payments, but maybe not so well under total. So we can get back to you on total and Medicare because they tend to be hospitals that, Okay, I've got a lot of poor patients so I get DSH payments, Medicare and Medicaid looks good, but I have a lot of poor patients and some of them don't pay me. So overall, I don't look so good.

MR. GEORGE MILLER: Absolutely. And then I think Herb asked the question, then in a medium penalty, you think that's just base payment without DSH payments included?

DR. STENSLAND: We'll double check.

MR. GEORGE MILLER: Okay. Thank you.

MR. HACKBARTH: Okay. We're ready for Round 2.

Let me just invite comments on a couple things in particular. So earlier, we had a brief discussion about the relationship between the readmission penalty and bundling around an episode.

As Mark indicated, our premise, and I invite people to react to this, is that the readmissions program is in place. It can be refined and we've just heard a presentation on some of the issues and possible solutions. And our premise is it makes sense to keep this in place, keep it going, try to make it better.

Even though bundling, as an alternative approach, may have some conceptual appeal, it is not as yet an up and running live program, and so premise number one is this makes sense to continue and work to refine readmissions.

Then the second thing I invite reaction to is Slide 10, the principles for refining the policy. There's a whole lot of material here and a lot of really complicated issues, and people -- you're welcome to comment on any of the specific issues raised in how to deal with SES or any of the other issues.

But what I'd really like to accomplish today is to make sure that people feel comfortable with the principles

as a guiding framework for what we do in subsequent meetings about addressing specific issues. So if you can address those two things, I'd appreciate it. Mary?

DR. NAYLOR: So on the principles, I really, first of all, just like the overall direction where your proposed efforts are going and have a suggested refinement about collapsing one and two, to think about this as motivating and increasing all hospitals incentives to reduce all preventable rehospitalizations.

And I think that the language there is saying that, you know, we started something, we're targeting people or hospitals with excessive, but now we want to get everybody in this movement. I think of the issue of motivation increasing.

I do think that there is an absolute reason to do this, because many think about how -- we're talking about creating system change, so not just focused on a condition. To get to better care and outcomes for AMI, pneumonia, and heart failure, you have to better improve communication, transfer of information, and it should apply to everybody. So I think that this is a natural progression in terms of these efforts.

The change in language, though, would also suggest the opportunity to look at those carrots and sticks. I mean, there's a lot of, in addition to what we described, the emphasis on primary care and care coordination. Targeting high risk people can contribute if we give it the right incentives to motivating to help reduce readmissions, et cetera.

In terms of alignment with bundle, I think that this raises a big question, whether or not we need -- where we started was to think about 30-day readmissions, but whether or not performance in terms of getting to better care and reducing avoidable preventable readmissions under a bundled model could extend our thinking beyond that.

So if hospitals think about better partnerships with community providers, bundled payment, could we be thinking about readmissions that extend to 90 days or beyond? So that, I would think, would be great. Anyway, I love the focus. I love the orientation toward looking at SES.

I don't know how it will fly in terms of whether or not it's in the risk adjustment or not, I think, but I think it's critically important that we look at who's doing

well here. Maybe it is that the characteristics of they have a very well integrated community base care system, but we need to know that.

MR. HACKBARTH: Before you go, could I just ask one other question? I meant to ask this during the clarifying round. So back when we initially recommended the readmissions penalty, my recollection was that that was coupled with a recommendation about authorizing gain sharing, the idea being that this shouldn't all be about the hospital and they need some tools to get others to align with them in this effort. What is the status of gain sharing at this point?

DR. STENSLAND: Ariel can correct me if I'm wrong, but there is no law that says you can gain share. I think there's a couple things going on. One is that people can ask for exceptions, and the way I think the Government usually then says, Okay, we don't have any plans to prosecute you for doing any of this. So it's not a really warm and fuzzy because there's no clear safe harbor.

And the other is there is a lot of demonstrations going on and a lot of the bundling demonstrations say, you know, You can gain share. So there's some opportunities to

do it through these different avenues, but there's no broad law to do it.

MR. HACKBARTH: Programmatic.

MR. WINTER: And on the bundling program, it does all include -- I mean, most of the options include readmissions on some of those bundling.

MR. HACKBARTH: Okay. Bill?

DR. HALL: So I liked this report very much. I think this is actually a very exciting report, and I guess one principle is, if it ain't broke, don't fix it too much. So since 2008, 2009, at least there seems to be some modest improvement in terms of reduction of readmissions. So take credit for it.

On the other hand, there are some things that have been going on simultaneously in the health care industry over this period of time which are worth noting. One is that there's been enormous uptick in the introduction of and utilization of electronic medical records since 2008.

One of the virtues of the medical record is that it makes certain types of analyses and identification of risk factors very much more evident, and that's going on in most hospitals right now. One of those is an emphasis not

only on medication reconciliation, what is the post-hospital care plan, but such things as literacy, for example, which probably plays a huge role, or lack of same, whether it's health care literacy or overall literacy, in terms of readmissions.

So I think -- I don't think we need to ding people more than this. I think we've gotten their attention and I would say -- my only other thought was whether there was any gain sharing opportunities there to consider in the future.

DR. REDBERG: I wanted to make a comment on the point you were making about the relationship between appropriate admissions and readmissions, because I think particularly with regard to chest pain and AMI, it's a big issue, and you do also mention in the footnotes about the observation units.

I'm not sure how that plays into it, because I certainly think currently there's a lot of evidence that suggests there are a lot of inappropriate admissions for chest pain for a lot of different reasons that not are all related to avoiding readmissions, but concerns about liability and just kind of -- a funny culture, but a lot of people -- I mean, certainly in my own hospital a lot of our

very short inpatient stays are all these rule-out MIs that really, I think, because they come in through cardiology so I see them, shouldn't have been admitted.

I'm just wondering how we can account for that, or perhaps also address that problem in the readmissions issue because it's not necessarily in the patient's best interest to be coming into the hospital besides the increased cost.

The other comment I just wanted to make was on Slide 16 on addressing the effect of socioeconomic status on readmissions. I would suggest that instead of providing financial assistance, certainly directly to hospitals that have high level income shares, considering a program where hospitals, and I guess you could call it gain sharing, but if they had that money, but that would be used to actually award grants or programs that would help prevent readmission, because I don't think it's in the hospitals.

It's what happening at home after discharge that it's more likely to increase readmission rate in the low-income communities. And so, if that money was actually directed at either those patients themselves or at services to help those patients rather than at the hospital.

MR. GLASS: Yeah. The observation stay thing cuts

both ways. It could decrease your number of initial admissions or if it was used instead of a readmission, it could reduce your readmission rate. So it is complicating. It's a complicating factor and the use of observation days has been increasing a lot.

DR. MARK MILLER: You couldn't know this because it all happened before you got here, but when we went through the reformulation of the QIO dollars, there was this discussion of groups of providers coming together and trying to create a community solution and that dollars could be targeted to those types of things. It was kind of contemplated in that recommendation.

DR. NERENZ: Definite support for the principles here and just a couple areas of emphasis. One is in support of what others have said. I think we should continue to look very strongly at the SES risk factors, and I do like Bill's mention of literacy specifically. I've tried to look into this. The data are quite limited. But my daily experience suggests to me that that matters, and so we just ought to keep looking at that.

It's in the spirit of trying to not penalize hospitals for things outside their control. And then with

that in mind, I'd encourage staff and all of us to try to examine what's known about readmissions in order to try to more clearly lay out the pathways or drivers to readmission, and then try to categorize them as best we can in terms of those that are truly under the hospital's control and those that are perhaps, and then those that are likely not, and then try to tailor policies as much as possible to focus on those things that hospitals within their normal scope of responsibility and activity can do.

I realize that there's a fuzzy area around that boundary, but try to make it tight if we can.

DR. BAICKER: I like the principle a lot of expanding the share of hospitals that have incentives, and I think there's evidence from the pay-for-performance literature that these thresholds are not so great because anybody way above or way below has no incentive.

And it seems perhaps more important to expand the group of hospitals where there's an incentive than necessarily to get to an all-condition, all-cause measure.

To know the answer to how important that is, I'd love to see a little more information about the correlation between admissions for the conditions we're looking at --

readmissions for the conditions we're looking at versus others, in that you could imagine that it's a good proxy and highly correlated, or that it's actually harmful in that you devote all of your resources to avoiding these readmissions and readmissions elsewhere.

That doesn't seem so likely to me. But knowing how good a proxy this subset is would be helpful in knowing how important it is to expand the set of things we're measuring versus expanding the number of hospitals who have an incentive to improve on those things. Obviously those aren't mutually exclusive strategies and we probably want to pursue both.

MR. GLASS: And I think a two-sided strategy as opposed to penalty only would increase the number of hospitals.

DR. CHERNEW: I'm supportive of the principles outlined and I would just add that with regards to the SES adjustment, I think that reporting within groups of hospitals, which was, I think, one of the ones on the other slide, is probably where I would go in what is admittedly a very difficult topic.

MR. BUTLER: So when this came up four years ago,

I was a big supporter of this being an important lens through which to better understand Medicare spending, and why not start with the hospital, even though they're not accountable for all of this, and I'm still supportive of this as a direction. I would make four points.

The first one with respect to the principles is I support the principles. I think a fifth one, Glenn, might be your very point that you made, and that is that this remains a good area of focus, but it's a journey that has an end to it that really wants to pass along more risk and get more of the provider segment engaged in managing the health of the population and the related expenses. So it might be yet another principle. We don't want this to somehow slow down that longer term vision.

Now, along those lines, I'd just point out that when you sit here as a hospital, come October 1, now suddenly we're in the pay-for-performance world, or maybe paying for not performing, too. But we have the value-based purchasing. Think about the scorecard in the sky for the hospital right now. Starting October, you take away 1 percent of the DRG payments and you maybe you get some back for your HCAHPS score and your core measures.

And then you've got three very narrow conditions and readmission rates, and that's how we're moving money around starting in October in a very kind of bizarre set of limited measures.

And while it's good to get started, that's kind of hardly the robust kind of attention. So there's a fair amount of suboptimization of resources in institutions around these that is not necessarily exactly right, but it's as good as we can do. But it's something that's going to have to be modified over time if you want to kind of look at the bigger picture.

Second point is these adjustments that we've talked about, particularly related to planned or unrelated or SES, are kind of the devil in the details. I think we'll find that in a value-based purchasing world, as well -- all of the same institutions are going to kind of get negatively impacted by these measures. And so you find a collective impact that may be a little bit differently intended than you think.

The low-scoring HCAHP people are going to be the same ones with some of these high admission rates that have socioeconomic populations that are different and kind of

snowball a little bit if we're not careful.

The third point is simply working with others, and I would encourage those, whether you're in the audience or not. This is an area that's getting a lot of good data and a lot of good suggestions and it's an area where we really can, I think, learn from some others that are working on that, not just depend on our own staff.

And the final point is not something that maybe we can do about, but some states like Illinois have suddenly taken this readmission thing and just kind of run with it and multiplied it into a penalty that is far in excess of anything imagined in Medicare without much data, and whether it takes hold or not, other payers, particularly Medicaid and others, say, Well, I'll do that and I'll even do more of it.

So what we're doing here does have implications and is being grabbed on by other payers, and so I think we need to kind of think about that. We want that to happen where it's appropriately used, because we do want synchronization across payers, but we should be a little bit careful about what we're doing here and how it applies to others.

DR. COOMBS: I agree with the principles as stated and I agree with much of what has been said already around the table. The bullets I would like to hit, first of all, is the SES status, which I think it really is an important issue. And as I think about it, I was wondering if it was possible to consider it as an index with a calculation that would actually correct so that penalties would not be implemented based on the patient population of the various hospitals.

And as you aggregate data over larger groups of hospitals, I think it makes it a little safer, but at the same time, it's possible to really kind of conceal some areas that really need to be dealt with. So while we can say that it's probably a little bit more reflective, and I am one for not individual evaluations of hospitals in small settings because I think, as demonstrated by the slide, it only takes one or two patients rolling up at the wrong place, because they've been cared for at another institution, and that place not able to handle them in the same capacity if they were to go back to their original tertiary hospital, especially true in major interventional cardiac surgical cases and vascular cases.

So I think we have to be sensitive to that. And that being said, if there's a way to aggregate the data over larger groups of providers. I think that's very true in settings where you have a number of hospitals in a certain geographic locale.

As for the data regarding African-American patients, there's been a mixed bag on that data because archives of surgery actually looked at surgical patients, African-American, who were admitted to what we would call the elite hospitals, and under the dome of those elite hospitals, the African-American patients were actually taken care of by what we call low-volume providers, and actually had worse mortality and morbidity under that scenario.

So it may be that you look at a hospital that has really good data. The subset of the patients within the confines of that hospital may actually have issues that are concealed by the larger numbers just statistically. It's a statistical result. So those are a few of the things that I have to say.

I think we're on the right path in terms of trying to go to a system that -- I think this is a theme -- that would incorporate us being able to transition to a form of

integrated health care delivery system, is where we want to be. I think that we're going there.

DR. SAMITT: Just some quick thoughts. I think the principles are spot on. I would have just a few supplemental thoughts.

I would be in favor of expanding to additional conditions. I think the opportunity here is vast, and all conditions may be too far, but maybe it needs to be more than the subset that we've got, because I think there's a tremendous amount of low-hanging fruit here.

I'm not quite ready to give up on the notion of bundling, and the reason I'm not is because readmissions are not solely under the control of hospitals. We've done a lot of work in our system to reduce readmissions, and a tremendous amount of it is the receptivity on the physician side in terms of follow-up visits after hospitalization. So we can manage that easily in an integrated system. In less integrated systems, how do the hospitals engage the physicians if they're incented differently? And the readmission penalties don't address this issue. So we may want to think about the potential synergies of a bundling relationship in addition to the penalties.

Then I just wanted to comment on the SES. We haven't addressed it, but I really like the notion of comparing hospitals with similar populations because there may be high performers and maybe there's tremendous opportunity for best practice sharing if we say, well, are there examples of shining light with these types of populations that would help those with higher readmission rates. And so that comparison, I don't think we should be afraid of that. I think there'd be opportunity to mine that further.

MS. UCCELLO: I agree with the principles. I also think that there is some synergy between the relationships that hospitals need to develop with the non-hospital folks to address these readmissions, and that relationship building will help facilitate movement toward bundling or to ACOs or something like that.

In terms of the SES, I think that our goals are to move toward better quality regardless of who the patient is or where they seek treatment. And so I think it's a good idea to kind of look at some of these hospitals that are doing a good job with lower-income patients and that kind of thing to help give some more information. But I think then

what we can do with that is help target some payments to the hospitals that aren't doing as well and help them get toward better quality.

MR. KUHN: I'll speak to the principles in just a moment, but if I could talk on just page 13 on the issue 2 of random variation in small numbers of observations, you have three possible solutions. I might add a fourth that might be worth looking at, and it could be to approach readmissions with mortality as a combined adverse outcome. I think that might help us look at -- deal with small numbers, but also I think it might be a good indicator of good quality care. So just something else to look at.

Going back then to the principles, I'm in pretty good shape with those principles. I think they make sense, and I think that's a good guidepost for us as we continue to go forward. But just one observation on that, and that is, if we go through with these principles -- and that's kind of what we've been talking about here this whole process -- you know, the community at large has to understand that there's a sense of fairness here. So fairness in this regard is either a more elegant or a better risk adjuster as we go through the process. And we've talked a lot about SES here.

But let me put a little bit of a finer point on that from what David was talking about, and my concern here is that if we don't have a better adjustment and if we don't look at the SES very seriously -- and I know we are -- is that I think that could further serve to disenfranchise through an inequitable penalty to a community of hospitals that are working very hard to deal with a very difficult population. So I think it's really key that everybody understand that there's fairness in the system or else they get very disenfranchised pretty fast. So I know we're talking about it, we're going to do more research, but I think it's pretty important on that part.

And I know I've shared this with some of you in the past that we've done some work in Missouri, and we've looked at poverty rates by zip code, and it produces a very, very strong indicator in terms of which population are going to be readmitted. So to me, I think the evidence -- there's a growing body of evidence, and I hope we can continue to look at it very seriously.

MR. HACKBARTH: Herb, any reaction at this point on the idea of comparing hospitals to similar hospitals?

MR. KUHN: I've got some thoughts on that. I'm a

bit concerned about it, but maybe I can shoot you an e-mail and think about that one a little bit more.

MR. HACKBARTH: Okay.

MR. ARMSTRONG: Just briefly, I agree. I think the policies are appropriate. I think we've got enough experience with this that we're very good at coming up with all sorts of things to worry about. But I just think we should expand it to more patients and move with this, recognizing completely that we're dealing with near-term fee-for-service payment structure constraints at the same time we're trying to manage a broader payment for bundles or for, you know, populations of patients, and that's just the reality of the world we live in today.

DR. DEAN: I would echo what folks said. We really appreciate this effort because I think this really -- I think maybe it was Peter that said, you know, it's kind of a lens on the overall functioning of the system. It's much more than just hospital function, and so I think it's really fundamentally important. And I think the attention that it has gotten already, you know, all indications are it's making a difference, and we really need to support the efforts that especially individual facilities and systems

are making.

I certainly support the overall principles. You know, to get more specific, I was concerned about that multiplier. That seems to me to be just absolutely -- what's the word I want? -- bad, for lack of a better word. I mean, to have a higher penalty as you get better with your performance, it's obviously something that doesn't make any sense.

The issue of the hospital being the focus of these activities, it certainly is a fair argument that hospitals are being penalized for things that are oftentimes beyond their control, and I think that as much as I admit that that's not fair, it may still be just where we're at and we may not have any other choice. It's a first step. But I think we need to recognize that, and especially in relation to -- I think Herb just mentioned those hospitals that are dealing with more challenging populations. We know that there are ways to provide good services to populations that have a lot of special challenges, but the things that have to be done are not things that anybody can do overnight, and they're really major system changes. I mean, I think the Denver example is a great example, but they didn't build

that overnight. That is a decade or several decades of effort.

And so I think in terms of the socioeconomic impacts, we need to consider it. I don't think it should be built into the risk adjuster and say we accept higher readmission rates. But at the same time, I would say that we need to be looking at ways to look at, you know, what are the best practices, what direction can we provide, what kind of support can we provide to these, especially the safety net hospitals. And basically we need to focus more on carrots than sticks in this area because very often these are facilities that are already stressed and yet are providing vital services. And so we don't want to make it any more difficult than it already is.

At the same time, just because they're dealing with a difficult population is not an excuse for inadequate care either.

So, anyway, keep up the good work.

MR. GRADISON: First off, my sense is that the bundling issue isn't yet ready for prime time, and for that reason alone, I would be inclined to separate the readmission issue from the bundling issue.

I agree with the principles on page 19. I share the concern expressed by so many about socioeconomic status. I'm particularly interested in the part that may relate to the health care system as it affects SES. In particular -- and I'm not sure if I'm right about this, but my hunch is that folks in this part of our society are less likely to have a regular physician relationship and, therefore, the hospital may have a harder time even knowing who to be in touch with to try to do appropriate follow-on, which is so important, I think, in terms of readmission.

I would be interested in any data, if it's readily available, on trends in observation status, which I perceive to be one of the potential ways to game this thing.

MR. GEORGE MILLER: I agree with the principles, and most all of my colleagues have said what I wanted to say about the other issues. I think it is important that we are concerned about SES and the impact it could have on those patients, and a policy that reflects that I think is important. But, again, I agree with the principles. Our goal is for system change, and the fact that we're going down this path helps to make the system change, which I support. But at the same time, best practices that can be

used for education into how other hospitals are maybe struggling with this issue is important to recognize.

Again, I just want to echo what others have said, that hospitals are not in this alone. We seem to be taking the penalty -- there are any number of factors for readmissions, including patients we know are going to leave the hospital that don't have the resources to take the medicine to keeps them from being readmitted, and that's an SES issue.

Thank you.

MR. HACKBARTH: Okay. Thank you all. Very well done.

We'll now have our public comment period.

Before you begin, let me just see how many people are going to be in the queue.

Okay, so we've got four, and we're going to cut it off there because we are running late and we do have planes and trains to catch.

MS. LLOYD: Can you make it five, Glenn?

Can you make it five? I can get up here fast.

MR. HACKBARTH: Okay, five, but that's it. And, we'll have to manage this quite tightly. So, when this

light comes back on, I really need you to wind up. If you don't, I'm going to have to interrupt, and that's awkward for both of us.

So, please begin by introducing yourself and your organization, and remember, both the five in line and everybody else in the audience, this isn't your only or even your best opportunity to provide input on the Commission's work. The best opportunity, of course, is to interact with the staff. But, in addition to that, there still is -- Jim, am I correct -- a place in the web site for people to place comments as well that relate top our particular meeting this week, and please avail yourself of that.

Okay.

MS. FELDPUSH: Thanks. Hi. Beth Feldpush of the National Association of Public Hospitals.

Thanks for this great work and the really thoughtful discussion today. We were particularly pleased to see so much of the discussion centered around the impact of socioeconomic status on readmissions.

You've mentioned several of the innovative and really effective programs that have come out of safety net hospitals that have successfully reduced readmission rates,

such as those at Denver Health and Project RED, but safety net hospitals really do struggle every day to support their patients once they leave the hospital with education and resources for them to successfully self-manage and receive care in the community.

We know that these impacts are real. There is a growing body of literature that supports the impact of socioeconomic status on the risk of readmissions. And, you know, we thank you for your attention to it but really feel that the current Readmissions Reduction Program does not account for those differences as well as it should, and in fact that can lead to real inequities and unfairness in the program that can be biased against certain hospitals, particularly those that take care of vulnerable patients.

So, we would just encourage you to continue your work in this area and to provide some strong recommendations on how the current program could be improved so that those inequities go away.

Thanks.

MR. NANOF: Hello. I'm Tim Nanof, Director of Federal Affairs with the American Occupational Therapy Association. Also, I'm a co-chair of the Consortium for

Citizens with Disabilities Health Care Task Force.

Thank you for your discussion of outpatient therapy. I really appreciate that and MedPAC's willingness to work with the associations.

I wanted to raise one particular concern about the application of a permanent cap to hospital outpatient departments. Very specifically, the issue there relates to temporary versus permanent. The consequences of applying it permanently to the hospital outpatient setting would eliminate the access to care if the therapy cap were fully in place. In 1997, Congress explicitly allowed hospital outpatient settings to be exempted from the cap so that patients would have a way to access care.

Currently, it was mentioned that the exceptions process is that new pathway to care. The problem is the exceptions process is temporary, and that would be real concern if Congress was to fail to act because of budgetary reasons or political reasons.

So, please take that into consideration. Thank you.

MS. FAERBERG: Hi. Jennifer Faerberg from the Association of American Medical Colleges.

I just want to, at first, echo comments from Beth about a wonderful discussion that you've had this morning and really appreciate your focus on SES and how that impacts readmissions.

We've actually done a data analysis on this and have found, as you know from the literature that SES factors do have a statistically significant impact on readmissions.

We've done an analysis to use dual eligibles as a proxy for SES and have found some similar data about very high rates at our major teaching hospitals. We have, in looking at this data analysis, have come up with a recommendation in using a stratification approach based on dual eligible status that allows you to calculate the readmission rates based on the dual eligible patient population and non-duals, coming up with a blended approach which ultimately then tightens the curve on the payment penalty, doesn't give a pass, applies broadly to all hospitals and allows for some of that discussion being able to compare like hospitals.

So, we ask that you maybe consider that in your deliberations.

And, we're also in response to a prior comment

about working with others; we're happy to work with MedPAC staff on what we have found and moving forward.

Thank you.

MS. SATTERFIELD: Hi. I'm Lisa Satterfield from the American Speech-Language-Hearing Association, and I wanted to thank the panel for their discussion on therapy services.

I believe you have some information regarding the use of the National Outcome Measurement System that speech-language pathologists use in health care settings. About 15 to 20 percent of speech-language pathologists in health care settings utilize our NOM System.

And, we also wanted to show our support regarding the use and the discussions of the VA system in therapy services, as NOMS is also used in the VA and has been used for outcome reportings in that system.

We'd like to help the Commission with any of this information.

Thank you.

MS. LLOYD: Hi. Danielle Lloyd with the Premier Alliance.

We're an alliance of 2,500 hospitals around the

country, trying to improve quality and reduce costs. And, we very much support, obviously, the goal of reducing readmissions and holding hospitals accountable. We're a Partnership for Patients Hospital Engagement Network. We have over 400 hospitals working with us. We've had readmissions in our QUEST program for at least two years now.

So, I do want to make sure, as Mark said, everyone is diligently working on these issues. I wanted to underscore that.

We are a measure developer. We know that is very hard. The science of risk adjustment is very hard, building these robust measures. We work very much with Harlan Krumholz who created the CMS measures.

But, these measures aren't always able to accurately look at and rank hospitals. So, we're taking measures that don't necessarily statistically differentiate between hospitals, we're forcing a variation, and then we're attributing a payment penalty.

So, this is where it becomes really hard to get us out of this potential vicious cycle with the payment, of taking potentially money away from those safety net

hospitals that very much need that money to invest it in reducing the readmissions.

So, we want to make sure that we find some policies. We support this dual eligible proxy that the AAMC just mentioned, of segmenting those populations and using that to dampen the effect on the safety net, initially.

Of course, all of these things can grow and change as we move into these policies. But, right now, we're throwing on VBP and readmissions and soon this new HAC. And, there's going to be a lot of transitions, and we just have to be very careful that there are not unintended consequences.

The other thing I'll say is we very much support this idea of setting a target and moving towards that target, where everyone can potentially reach it. It's much more like the value-based purchasing program. In fact, we recommend that Congress put readmissions not as a standalone program but actually into VBP where you can have balancing measures like mortality and other things, and have a single approach with more common incentives across those different measures.

The last thing I'll say is I wouldn't be too quick

to jump to an all-conditions measure. One thing is that we do need to be working on systems and across measures, but there are a couple problems.

One is you kind of perceive it as boiling the ocean. Sometimes hospitals really need to be looking in particular areas. Just because you're good at -- you can be good at cardiology, for instance; you can be bad at pneumonia, at the same facility. So, unless they have sort of actionable information, it's harder to really make that change.

So, thanks.

MR. HACKBARTH: Okay. Thank you very much.

We're adjourned and see you in October.

[Whereupon, at 12:04 p.m., the meeting was adjourned.]