

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
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9:45 a.m.

## COMMISSIONERS PRESENT:

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

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

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

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

22 So why are we examining bundling again? Well, the

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

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

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

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

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

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

1 we provide a single payment for an array of services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 that they need.

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

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

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

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

1 we're going to simplify this discussion for now.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13           With that, we look forward to your discussion.

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

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

1 work on this in the back room right along.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 DR. HALL: And the motivation being?

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

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

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

1 days, whether or not we have the capacity on Table 3 to take  
2 the information that you provided about what showed  
3 variations in the post-acute spending, to show what it would  
4 look like over 90 days. And so now it's this spending plus  
5 30 days, and one way to think about how to get to higher  
6 value is to look at what are we seeing in terms of  
7 differences. And in that, I'm wondering if it's possible to  
8 clarify where readmission takes place.

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

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

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

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

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

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

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

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

6 MR. HACKBARTH: Never admitted.

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

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

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

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

7 MR. HACKBARTH: Clarifying questions?

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

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

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

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

8           MR. BUTLER: Okay. So then maybe go back to Slide  
9 8 that shows the -- no, what's the one that has the joint  
10 procedures on it? What I want to get at is within the joint  
11 procedures, there's one where we've already kind of  
12 addressed some things through, whether it's the 60 percent  
13 or 75 percent rule on IRFs and so forth. You don't have any  
14 data that shows the components of the post-acute care for  
15 what I would view as a fairly homogeneous set of activities  
16 or diagnoses without as much variation on risk around which  
17 you could have a prospective rate that includes the hospital  
18 piece and all the rest.

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

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

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

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

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

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

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

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

7 MR. HACKBARTH: Yes --

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

17 MR. HACKBARTH: Yes.

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

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

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

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

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

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

1 failure admission at the same time?

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

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

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

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

18 MR. LISK: It's time defined --

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

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

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

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

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

9 MR. LISK: In this data.

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

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

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

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

18 MR. ARMSTRONG: Just a couple of things.

19 Actually, building on the line of thinking Peter was  
20 pursuing, it really raises the question -- I mean, there's a  
21 lot of reasons for variation, and I think in your analysis,  
22 you just look at variation and don't distinguish between

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

6 MR. LISK: Yes.

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

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

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

22 MR. HACKBARTH: All of them combined?

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

4           MR. ARMSTRONG: Okay. So it's ten percent or so  
5 of the total annual Medicare spend. I don't need to be more  
6 --

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

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

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

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

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

16          MR. ARMSTRONG: Okay.

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

1 depends on what you mean by what you want to count in there.

2 But we'll give you an answer to it.

3 MR. ARMSTRONG: I know --

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

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

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

22 MR. HACKBARTH: This is where Bruce raises his

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

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

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

6 DR. STUART: [Off microphone.]

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

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

16 MR. LISK: Yes.

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

20 MR. LISK: Oh, yes. No --

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

22 MR. LISK: -- this is --

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

3 MR. LISK: Right. The tendency is --

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

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

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

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

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

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

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

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

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

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

13 DR. MARK MILLER: Right.

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

16 DR. MARK MILLER: Right.

17 MR. HACKBARTH: Ron.

18 DR. CASTELLANOS: First of all, great  
19 presentation.

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

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

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

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

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

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

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

9           [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

12           Were you finished, Bruce?

13           DR. STUART: Yes.

14           MR. HACKBARTH: George.

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

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

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

13 MR. GEORGE MILLER: Just getting started --

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

16 MR. GEORGE MILLER: Okay.

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

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

22 MR. GEORGE MILLER: Proximity, right.

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

3 MR. GEORGE MILLER: Okay.

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

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

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

18 MS. BEHROOZI: Off of what?

19 MR. LISK: Off of --

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

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

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

1 MR. LISK: Their historical pattern.

2 MR. HACKBARTH: For that provider.

3 DR. CARTER: These are case type negotiated rates.

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

6 MR. HACKBARTH: Yes.

7 DR. CARTER: For that provider.

8 MR. LISK: For that provider.

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

11 MR. LISK: Yes.

12 MS. BEHROOZI: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 MR. HACKBARTH: Could we check on that?

2 DR. CARTER: Yep.

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

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

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

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

3 MR. LISK: No.

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

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

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

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

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

7 MR. LISK: Yes.

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

10 MR. LISK: Yes.

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

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

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

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

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

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

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

15 MR. HACKBARTH: That's my recollection.

16 Okay, Round 2.

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

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

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

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

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

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

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

1 It kind of depends on what's available.

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

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

16 That's all.

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

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

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

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

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

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

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

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

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

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

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

22           So I think here is an opportunity to really think

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

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

14 Variation, I think obviously we need to -- this is  
15 a really good opportunity to prevent the variation in care  
16 and trajectories that I think look -- I like the fact that  
17 the quality domains have been identified, and I know we have  
18 a long term to get to the measures, and I would really  
19 emphasize how it is that we could use this, not to focus on  
20 30-day readmissions but longer-term value, 90 days.

21 MR. BUTLER: I have four points.

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

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

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

17 [Laughter.]

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

1 that's just a sidebar comment.

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

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

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

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

13 MR. LISK: Yes, it can.

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

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

21 [Laughter.]

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

1 of this comment without anyone saying --

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

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

4 [Laughter.]

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

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

11 Mike, Round 2.

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

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

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

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

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

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

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

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

22 [Laughter.]

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

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

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

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

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

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

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

21 MR. HACKBARTH: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 outcomes-driven.

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

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

1 help us come toward defining outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 Thank you.

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

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

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

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

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

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

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

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

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

10 Thank you.

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

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

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

1 that's going to affect these bundles.

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

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

18           [Laughter.]

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

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

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

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

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

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

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

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

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

1 talking about care coordination.

2 MR. GEORGE MILLER: Yes, I know.

3 MR. HACKBARTH: These two topics --

4 MR. GEORGE MILLER: -- can intertwine.

5 MR. HACKBARTH: -- overlap with one another.

6 MR. GEORGE MILLER: All right. Thank you

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

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

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

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

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

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

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

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

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

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

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

1 adjustment?

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

11 MR. HACKBARTH: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 each case.

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

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

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

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

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

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

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

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

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

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

2           And under, I guess it was Carol laid out the  
3 possibility of having complementary payment systems. There  
4 would be some services that would meet criteria for a  
5 bundled episode payment, but then all sorts of other  
6 services wouldn't. So we're going to have another payment  
7 system to administer simultaneously, and what is that? If  
8 we have 15 or 20 or 25 percent of care flowing through  
9 bundles, I'm not sure -- we still have to address the other  
10 75 or 80 percent and I don't know how, short of -- it's  
11 conceivable that maybe you're better off than you are now,  
12 but I could imagine us not being much better off than we are  
13 now.

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

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

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

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

1 not engaging the patients and making choices.

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

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

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

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

14           Whenever you're ready, Kate.

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

1 communicating effectively about managing the beneficiary's  
2 care.

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

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

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

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

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

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

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

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

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

22           At the narrowest end or the top box are changes to

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

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

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

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

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

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

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

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

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

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

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

1 principles of palliative care fit into this.

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

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

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

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

1 beneficiaries with serious illnesses and many complications.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Second, establishing both robust information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Was that the Mass General?

2 MS. BLONJARZ: It was.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. CASTELLANOS: Good. Thank you.

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

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

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

15 MR. HACKBARTH: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           The three that he identified as worthy of emphasis

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 But something that's being discussed out there a

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

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

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

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

1 disparities and how care coordination can deal with that  
2 issue.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 We have spent a lot of time considering how the

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

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

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

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

21           Thank you.

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

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

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

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

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

1 Thank you.

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

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

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



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

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

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

22           Therapy services may be furnished by the providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17           A couple of points about the caps:

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

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

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

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

20 Now, a significant share of therapy beneficiaries  
21 benefitted from the caps exceptions process. In 2009, about  
22 23 percent of users exceeded the physical therapy/speech

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 DR. AKAMIGBO: Yes.

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

10 DR. AKAMIGBO: Yes.

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

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

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

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

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

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

8 [Laughter.]

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

11 [Laughter.]

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

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

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

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

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

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

22           The second thing you can think of is whether upon

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

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

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

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

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

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

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

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

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

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

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

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

1 conversation as well.

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

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

7 DR. CASTELLANOS: Right.

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

12 DR. CASTELLANOS: Right.

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

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

17 DR. AKAMIGBO: Right.

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

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

1 highlight that's a thing --

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

3 DR. MARK MILLER: -- you could do.

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

5 Second, can you go to Slide 16? The ICD-9 codes

6 are very non-specific. Now, we're soon to have ICD-10

7 codes. Are you familiar with those with physical therapy?

8 And are they more specific?

9 DR. AKAMIGBO: I can't say how they sort of expand

10 or refine the current ICD-9 version with respect to physical

11 therapy codes. And I say that also knowing that the

12 implementation of ICD-10 has been delayed again. But it's

13 another sort of piece of the puzzle, but I don't know, I

14 can't say specifically what it does to the therapy

15 diagnoses, the usual therapy diagnoses.

16 DR. CASTELLANOS: Okay. Those codes are expanded

17 in every other field. I'm not sure what they are --

18 DR. AKAMIGBO: For therapy, right.

19 DR. CASTELLANOS: And we're still on

20 clarification, right? Slide 11, please.

21 MR. HACKBARTH: Yes.

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

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

3 [Laughter.]

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

7 [Laughter.]

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

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

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

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

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

1 beneficiary using the service.

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

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

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

7 MR. HACKBARTH: Oh, okay. I was reading it as  
8 they were combined \$1,800. So it's actually \$3,600 or  
9 \$3,700.

10 DR. AKAMIGBO: Yeah.

11 MR. HACKBARTH: But still, that's less than  
12 \$4,400.

13 DR. MARK MILLER: But --

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

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

20 DR. AKAMIGBO: Yes.

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

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

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

8 DR. BORMAN: Yes.

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

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

12 DR. AKAMIGBO: No, no. Yes.

13 DR. BORMAN: So they're uniform.

14 DR. AKAMIGBO: Yeah.

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

18 DR. AKAMIGBO: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 MR. ARMSTRONG: Right.

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

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

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

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

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

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

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

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

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

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

1    heck should we know?

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

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

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

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

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

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

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

10 DR. AKAMIGBO: I had thoughts, yeah.

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

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

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

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

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

19 DR. AKAMIGBO: Is Dan here?

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

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

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

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

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

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

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

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

18 [Laughter.]

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

22 [Laughter.]

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

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

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

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

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

19 MR. HACKBARTH: The caps aren't --

20 DR. AKAMIGBO: Yeah.

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

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

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

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

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

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

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

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

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

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

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

19 [Laughter.]

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

22 [Off-microphone discussion.]

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

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

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

17 DR. NAYLOR: Thank you.

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

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

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

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

16 [Laughter.]

17 DR. MARK MILLER: There is a transcript here.

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

20 [Laughter.]

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

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

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

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

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

15           DR. DEAN: No, this is all Medicare.

16           DR. AKAMIGBO: All Medicare.

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

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

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

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

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

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

14 DR. HALL: In '09.

15 DR. AKAMIGBO: Yeah.

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

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

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

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

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

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

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

10 DR. AKAMIGBO: In 2010.

11 DR. MARK MILLER: In one year. And her numbers  
12 were all 2009, so this wasn't in that number. But to your  
13 point, in 2010 there was a big jump. And I guess what Glenn  
14 was saying when I mentioned that to him is it sort of raises  
15 this question of oversight versus a new opportunity and  
16 exactly how you --

17 DR. HALL: Right, right.

18 DR. MARK MILLER: -- get an eightfold increase, if  
19 that's right, in one year. That's kind of the question.

20 DR. BERENSON: True, I guess. On Slide 16, where  
21 -- actually I've compared 16 with 17. With 16, the first  
22 five conditions here represent 15 percent -- I'm discarding

1 one because it's non-specific. We know about 15 percent of  
2 diagnoses. In 17, the first five HCPC codes were up to 75  
3 percent of services provided.

4 I guess what I'm interested in, have you looked to  
5 see if there's any way to sort of aggregate all of the  
6 different diagnoses so we actually can get some picture of  
7 what percentage is for back problems and what percentage is  
8 for gait or some meaningful categories so we can figure out  
9 how to hone in? In Round 2 I'm going to make a couple of  
10 other comments about honing in. Is that something you've  
11 looked at or can you look at it?

12 DR. AKAMIGBO: I can, yes.

13 DR. BERENSON: I was surprised at how small a  
14 percent -- we're already -- at the fifth condition we're  
15 only down to 3 percent of diagnoses, so I'm wondering if we  
16 could do that.

17 My second one would go to this difficult issue of  
18 figuring out if -- Ron, to use the word again,  
19 "appropriate," where therapy is appropriate. Have there  
20 been attempts by the administrative contractors or the OIG  
21 to do medical review looking at medical records and seeing  
22 if medical records provide information that one can use? I

1 mean, I think my suspicion is that in the area of physical  
2 therapy it's pretty difficult that there will be a loose  
3 diagnosis and therapy is indicated and probably not a lot,  
4 but do you know if there have been attempts to do that?

5 DR. AKAMIGBO: I don't know about attempts to look  
6 at medical records specifically by the OIG. They did do --  
7 they put out a study in December 2010 based on claims,  
8 looking at aberrant patterns by geographic area and some  
9 potential ways to begin to get a handle on that. But I  
10 don't remember -- I don't think they looked at medical  
11 records.

12 The MACs in the past couple of years where you've  
13 seen a major sort of either fraud issue and some of the  
14 Southern states have -- I believe when they developed edits  
15 to get at some of their billing concerns looked at lot at  
16 claims data, but, again, medical records specifically I'm  
17 not -- I'm not remembering anyone looking at those.

18 DR. BERENSON: Because it is, I think reasonably  
19 common practice where you see sort of a billing pattern of  
20 concern, you just do medical review, look at medical records  
21 and see if there's documentation for what's being claimed.  
22 And I assume in some cases there would be evidence that the

1 service wasn't provided. But my hypothesis is that, in  
2 fact, in many cases or most cases, the service is provided  
3 and the information in the medical record really doesn't  
4 help very much, but it would be interesting to know if any  
5 of the contractors actually have experience in that area, if  
6 there's a way to get that.

7 MR. HACKBARTH: Adaeze, part of our charge from  
8 the Congress is to look at what private payers do. Because  
9 this is so new, you haven't had a chance to really begin  
10 that part of the work yet. Is that right?

11 DR. AKAMIGBO: Not in earnest, no.

12 MR. HACKBARTH: Yeah, okay. Herb, Round 2?

13 MR. KUHN: One question before I -- I'd like to go  
14 up to Slide 20, if I could for a moment. I want to maybe  
15 add another category for us to look at. But before I get to  
16 that, I just want to ask a question about the CARE tool.

17 I went back and re-read the information that you  
18 shared with us, and you make an interesting observation here  
19 that, based on conversations with therapists and people who  
20 are actually doing the work, and others, CMS is having a  
21 difficult time getting individuals to sign up to help  
22 evaluate the tool that's out there. And, you know, maybe

1 this is an uninformed observation, but it seems to me if  
2 that's kind of the problem that they're seeing with this  
3 CARE tool now -- and we know that the facility CARE tool  
4 that RTI published a report on last month took seven years  
5 to get done, if they're having trouble with this particular  
6 tool getting therapists to even help demo it early on, that  
7 ought to be a good signal that maybe they -- instead of  
8 forcing that one through, trying to put a square peg in a  
9 round hole, and then three years later find out, oh, we got  
10 to go back and start again, it will be the end of the decade  
11 before we see a CARE tool on this thing.

12           So, you know, again, maybe an uninformed comment,  
13 but to me that's a signal that hopefully they get it right  
14 the first time, because I would hate to lose valuable time  
15 on the development of this CARE tool.

16           Anyway, the point I want to make on this one,  
17 you've got three areas that we could look at, but let me add  
18 a fourth. All these look at really kind of the payment  
19 system, but as there has been some conversations around here  
20 in Round 1, it seems to me that we could begin to talk a  
21 little bit more about the benefit itself and to better  
22 define the benefit that's out there. And what I would

1 suggest that we might want to do is like we did in the home  
2 infusion report, do a bit of a literature search here to  
3 kind of better understand the science behind this benefit,  
4 where the real value of the benefit is, to the extent that  
5 we can understand the science, if it tells us anything. And  
6 even to take a bit of a stretch here -- and I'm not saying  
7 this is where I think we ought to go, but I think it's worth  
8 a policy consideration -- if the science is suspect in this  
9 area, instead of making broad recommendations, we could say,  
10 well, hey, CMS, why don't you do a national coverage  
11 determination on outpatient therapy and have them take a  
12 look at that and see if that might be an option -- yes,  
13 Bob's laughing. Yeah, it's bold, but I think it's something  
14 we might want to add to the menu of things to at least  
15 consider. So just an option out there to think about.

16 MR. HACKBARTH: It's 3 o'clock, and so we're  
17 running behind. So as we go through Round 2, I'd urge  
18 people to be as concise as possible.

19 MS. BEHROOZI: Okay, really quickly, the thing  
20 that looked really great up there was, you know, putting it  
21 into episodes until we learned that it's really not  
22 connected to other treatments a lot of the time, so it sort

1 of goes back to more what Glenn said about global cap, which  
2 then, you know, it should be part of the whole comprehensive  
3 way you take care of a patient, as Mary said, can be  
4 preventive, right?

5           So then, yeah, that leads to looking at what the  
6 private sector does, whether it's MA plans or commercial  
7 insurers. We do visit limits with prior authorization for  
8 time beyond that, so that's somewhat related to the caps  
9 except that limits also kind of goes a little more to what  
10 the therapy is that's being received and requires a little  
11 bit more information, which I think is a really important  
12 point being made here, it requires much more information in  
13 the coding and the nature of the diagnosis and the nature of  
14 the patient and what the reason for the therapy is and,  
15 yeah, the fraud.

16           I do live in Brooklyn. I can't get away from  
17 whatever the infection is that's going on there, except that  
18 it is in a very small part of Brooklyn, and there's a lot of  
19 home health abuse there, too, and I don't live near there.  
20 But I can tell you that while Brooklyn and Queens counties  
21 appear on that list of high utilization, the Bronx doesn't,  
22 and I can't say that Brooklyn looks demographic or health

1 status-wise a whole lot different than the Bronx, certainly  
2 not better than the Bronx. So, you know, I can't emphasize  
3 enough the Secretary's authority and all the other tools  
4 that we could use to go after the fraud.

5 DR. MARK MILLER: One real quick thing. I know  
6 there's time. When you get that extra information, who and  
7 how do you get it?

8 MS. BEHROOZI: [off microphone].

9 DR. MARK MILLER: I'm sorry. We can talk [off  
10 microphone].

11 MR. HACKBARTH: George, Round 2?

12 MR. GEORGE MILLER: Concise.

13 DR. STUART: I was looking in the chapter about  
14 this drop-in business that apparently nursing homes are  
15 developing, and I couldn't find it. How do you determine  
16 whether a beneficiary is receiving therapy in a nursing home  
17 if that person is not a resident?

18 DR. AKAMIGBO: I went back and looked at some of  
19 the large post-acute companies, Kindred, for instance, you  
20 read their 10Ks, it's an explicit -- sorry.

21 DR. MARK MILLER: I think his question is more  
22 narrow. Don't we just get it through the provider ID? Is

1 that how you --

2 DR. AKAMIGBO: Maybe I misunderstand the question.

3 Go ahead.

4 DR. MARK MILLER: Is that what you're asking?

5 DR. STUART: Yeah. Is it the provider ID?

6 DR. MARK MILLER: Yes.

7 MR. HACKBARTH: How do we know the location?

8 DR. AKAMIGBO: That's pretty clear from claims,  
9 the provider ID and the -- we can tell with claims the  
10 billing site for each of these.

11 DR. CASTELLANOS: Consistent with our previous  
12 feelings of paying the same over the same site of service, I  
13 would like to permanently include services from HOPD under  
14 the therapy caps. It expires December, and I would like to  
15 make some recommendation that it's continued.

16 DR. BORMAN: The one thing that the fuzziness  
17 about both the diagnostic classification scheme and the  
18 service provision scheme suggests here is that maybe those  
19 are two criteria that cry out for a benefit management  
20 approach to this. I think what we're circling around is  
21 that there's enough "what the heck" in this that it does go  
22 down to the level of the individual in the record. And it

1 seems to me those would be the kinds of circumstances in  
2 which a benefit manager probably has the greatest value by  
3 virtue of being to engage at the individual level.

4 MR. HACKBARTH: And based on what Mitra described,  
5 that's sort of what you're doing. There's a certain amount  
6 that's automatically approved, if you will, and then when  
7 you go beyond that, there's got to be specific  
8 authorization, including document of the reason.

9 MS. BEHROOZI: Yeah. When you say automatically,  
10 it's still got to be justified by the diagnosis.

11 MR. HACKBARTH: Yeah.

12 MS. BEHROOZI: I think we require more than  
13 Medicare probably does.

14 DR. MARK MILLER: Yeah, we'll be curious about  
15 that.

16 MR. HACKBARTH: Round 2.

17 DR. CHERNEW: First I'll say that despite the  
18 banter, I think these actually really are very important  
19 services that we have to make sure beneficiaries have access  
20 to. And that said, my biggest concern is that as we move  
21 forward and examine these options, that we carefully weigh  
22 the administrative burden and other complexities of trying

1 to get the darn thing right, because I think with this much  
2 vagueness between outright fraud and stunning need, you  
3 know, there's a wide range in there that's going to be hard  
4 to get right away, and we have to think about the cost and  
5 the burden associated with that.

6 MR. BUTLER: I'm afraid what I might say, but I'll  
7 try to -- okay. I agree with this is a good list to work  
8 off of. The one thing that troubles me a little bit is  
9 where the patient fits into it, and based on personal  
10 experience and a number of incidences, the lack of or  
11 willingness of engagement, where does the -- you know,  
12 sometimes it's prescribed, and the patient -- you know, I've  
13 seen such cases, you've got to be kidding, they're not ready  
14 to do that. So I don't know how you get -- and it's not one  
15 of those things that you cost share on, but I'm not sure  
16 where that becomes a criteria, patients' willingness to  
17 engage in the therapy. It's a vague concept, but I think a  
18 lot of the utilization -- not a lot -- some may be without  
19 the engagement of the patient. It's not worth it, yet it's  
20 still prescribed.

21 MR. HACKBARTH: And I assume that the cost-sharing  
22 requirements are the same as for all Part B services,

1 subject to the deductible and 20 percent co-insurance.

2 DR. NAYLOR: Just to echo many of the comments,  
3 but I think this issue about the CARE tool is really  
4 important and wonder -- I honestly had conceptualized it as  
5 a tool that carried across multiple systems and functional  
6 status as a core measure in the PAC part of it. So I'm  
7 wondering if we can't come to some recommendation around how  
8 critically important it is that we have a tool that goes  
9 with the patient across these settings and that enables the  
10 kind of measurement of functional status and other core  
11 domains going forward.

12 DR. DEAN: Yeah, I wanted to say a few words about  
13 the whole attestation thing. It really is a concern. Karen  
14 outlined that. For the first certification, it often times  
15 is reasonably clear-cut. Certainly if it's somebody that I  
16 see in the office and recommend physical therapy, I'm  
17 certainly perfectly willing to take responsibility for the  
18 legitimacy of that order.

19 The ones that really are a problem are the  
20 recertifications, and we get a lot of them, and,  
21 unfortunately, I get a fair number of forms, some of which  
22 are legible and some of which are not, and that they want to

1 continue this, and it may well be somebody I haven't seen  
2 for a while, and do I go through all the rigmarole of  
3 bringing them back in, trying to figure out if they're  
4 progressing or not, or whatever? Or do I just sign the  
5 thing? And, like Karen says, it comes at the end of the day  
6 in the stack of the papers. And so, you know, you more  
7 often than not just sign it.

8           It seems to me that, you know, one thought that  
9 crossed my mind, why does it have to be a physician  
10 attestation? I would think the therapist attestation ought  
11 to be considered. I mean, they need to be able to take some  
12 responsibility that they really are showing some improvement  
13 and their documentation should verify that, it seems to me.

14           MR. HACKBARTH: So could I just ask a clarifying  
15 question about your first point, Tom?

16           DR. DEAN: Go ahead.

17           MR. HACKBARTH: You said there's a difference  
18 between the initial certification and recertification. Is  
19 the challenging part of the recertification the fact that  
20 often you don't have the patient in front of you? Or is it  
21 because there's something inherently different about the  
22 recertification, even if the patient is there, you know, how

1 much improvement have they made, or do they have potential  
2 to continue to improve? So is it just the lack of a face-  
3 to-face that makes it --

4 DR. DEAN: I would say they are almost never there  
5 for the recertification. All I get is the form.

6 MR. HACKBARTH: Right, and that's what makes it  
7 really tough, is the lack of patient contact at that point.

8 DR. DEAN: Yeah. And, certainly, some better  
9 measure -- "measure" isn't the right word, but diagnoses,  
10 some more precise diagnoses, and some measure of functional  
11 change. I mean, for instance, with speech therapy it's  
12 going to be really tough for me to decide, you know, what  
13 their progress is, have they reached a plateau, what are the  
14 prospects that they are going to continue to improve, those  
15 are judgments that I really don't feel qualified at all to  
16 make. I mean, the therapists are the ones that generally  
17 make that and I think appropriately make that judgment. And  
18 if that's the case, then it seems to me they should be the  
19 ones doing the attestation. So I don't know.

20 DR. BERENSON: I like Slide 20. I think this  
21 whole -- you're getting a good handle on this whole issue  
22 sort of as an overview, and I like the work that you've laid

1 out.

2 I think sort of consistent with Mike's notion of  
3 not making this more difficult than maybe it would be, I  
4 wonder if we can hone in a little bit. And my own  
5 experience with practice is that the indications for speech  
6 therapy -- and I agree, the continuation of speech therapy,  
7 I don't know, but identifying that there's a problem that  
8 would benefit from speech therapy, and I would say  
9 occupational therapy is much more straightforward than  
10 physical therapy where I sort of agree with Karen that  
11 everybody could benefit -- in fact, having sat here all day,  
12 I could --

13 [Laughter.]

14 DR. BERENSON: I could benefit from physical  
15 therapy.

16 I also note that on your data on Slide 7, by my  
17 calculation, 87 percent of the users of therapy are using  
18 physical therapy and 73 percent of the spending is in  
19 physical therapy. I'm wondering if we could hone in on  
20 physical therapy. I have one suggestion which may be to  
21 test my hypothesis. Whereas in Slide 11 you've done  
22 spending per therapy user, I'm wondering if we could also

1 erase spending per beneficiary and break it down by the  
2 three categories of therapy and see if there is a difference  
3 in the variation across the country with my hypothesis being  
4 that speech therapy, there won't be nearly the same  
5 variations in use and spending that there would be in  
6 physical therapy with occupational somewhere in the middle  
7 but closer to speech. If it turns out that the variation is  
8 really in physical therapy, maybe we don't have to worry too  
9 much about what's going on with speech and occupational,  
10 which isn't where the spending is anyway, and we could  
11 really try to hone in on how do we verify the need for  
12 physical therapy, which is tough. But it might permit us to  
13 focus a little more.

14 MR. HACKBARTH: Okay, thank you, Adaeze. Good  
15 start on this.

16 Let's see. Our next topic is reforming Medicare's  
17 benefit design. Whenever you're ready, Julie.

18 DR. LEE: Good afternoon. In today's  
19 presentation, we'll summarize our discussions to date on  
20 reforming Medicare's benefit design. First, we began with  
21 the policy goals; then we deal with the key design issues in  
22 changing the fee-for-service benefit, and go over the

1 illustrative benefit package from January's meeting,  
2 including a surcharge on supplementary insurance. Finally,  
3 we conclude with the Chairman's draft recommendation.

4           The Commission has been considering ways to reform  
5 the traditional Medicare benefit for several years to give  
6 beneficiaries better protection against the high out-of-  
7 pocket spending and to create the incentives for  
8 beneficiaries to make informed decisions about the use of  
9 care.

10           The Commission has been also particularly  
11 concerned about the potential impact of such changes on low-  
12 income beneficiaries and those in poor health. The  
13 Commission's discussions on potential changes in the fee-  
14 for-service benefit have focused on three key design  
15 elements.

16           First, an out-of-pocket maximum would protect  
17 beneficiaries from the financial risk of very high Medicare  
18 costs. The current fee-for-service benefit does not have  
19 such a limit on cost-sharing, and each year a small  
20 percentage of Medicare beneficiaries incur a very high level  
21 of costs. But without additional changes in the benefit, an  
22 out-of-pocket cap would increase the program spending.

1           A combined deductible for Part A and Part B  
2 services would be more intuitive and simple than the two  
3 separate deductibles that exist under the current benefit.  
4 In general, a deductible is mainly used to reduce the cost  
5 of other aspects of the benefit package such as the  
6 premiums, co-payments, and co-insurance.

7           For some beneficiaries, a deductible would be  
8 financially burdensome, but their overall costs might be  
9 lower if a deductible can buy down the premium and cost-  
10 sharing. The Commission has expressed a preference for co-  
11 payments rather than co-insurance for Medicare services  
12 because they are more predictable for beneficiaries.

13           Co-payments, which are set dollar amounts known in  
14 advance, would be easier to understand, compare, and respond  
15 to. Therefore, they could be used more effectively in  
16 creating incentive support beneficiaries to make better  
17 informed decisions about their use of care.

18           As we noted previously, a small percentage of  
19 beneficiaries incur very high cost-sharing each year.  
20 Therefore, an out-of-pocket maximum would lower their cost-  
21 sharing, but a larger percentage of beneficiaries would  
22 reach the out-of-pocket maximum at some point over time.

1 This slide compares the beneficiaries' hospitalization and  
2 spending over one year versus four years.

3 For example, in 2009, 19 percent of full year fee-  
4 for-service beneficiaries had at least one hospitalization;  
5 whereas, 46 percent did from 2006 to 2009. Similarly, 6  
6 percent of full year fee-for-service beneficiaries had  
7 \$5,000 or more in cost-sharing liability in 2009; whereas,  
8 13 percent had at least one year of \$5,000 or more in cost-  
9 sharing liability over four years.

10 In general, an out-of-pocket maximum would be  
11 valuable to the beneficiary in two ways. First, it will  
12 protect those who actually reach catastrophic levels of  
13 Medicare costs. And second, even those beneficiaries who  
14 don't reach the maximum level still would lower the risk of  
15 paying very high cost-sharing liability and for risk-averse  
16 beneficiaries that lower risk and uncertainty would be  
17 valuable.

18 We want to point out here that there's no one  
19 perfect or correct combination of design elements. We can  
20 trade off various levels of cost-sharing amounts and  
21 different definitions of the services to which they are  
22 applied. But a budgetary target for the new benefit design

1 will limit the set of feasible design combinations.

2           So the key question is, given the trade-offs  
3 between the design elements, can we find a combination that  
4 represents a reasonable compromise between competing policy  
5 goals within the budgetary target?

6           As we state at the beginning of the presentation,  
7 one of the policy objectives for reforming the fee-for-  
8 service benefit is to create the incentives to discourage  
9 the use of lower value services. As we have discussed over  
10 the past several years, beneficiaries tend to respond to  
11 higher cost-sharing by reducing both the effective and the  
12 ineffective care. This behavior is particularly worrisome  
13 for low-income beneficiaries and those in poor health.

14           Within the fee-for-service environment, however,  
15 change in cost-sharing may be the only policy tool  
16 available. Unfortunately, first dollar coverage provided by  
17 many supplemental plans effectively eliminates any price  
18 signals that might exist in Medicare's cost-sharing  
19 requirements.

20           The Commission has considered two approaches to  
21 mitigate the effects of first dollar coverage. Under the  
22 regulatory approach, we looked at different policy options

1 that restricted what supplemental insurance can and cannot  
2 do. At that time, the Commission expressed a strong  
3 preference for imposing a surcharge on supplemental  
4 insurance rather than regulating supplemental benefits.

5 So instead of restricting how supplemental  
6 coverage can fill in Medicare's cost-sharing, the surcharge  
7 would make the insurer pay for at least some of the added  
8 costs imposed on Medicare of having such comprehensive  
9 coverage.

10 There are two main effects of a surcharge on  
11 supplemental policies. First, it would provide the revenues  
12 to help recoup some of the additional Medicare spending  
13 associated with the supplemental coverage. Second, as the  
14 insurers pass along the surcharge by raising premiums, it  
15 may provide the incentives for beneficiaries to switch or  
16 drop supplemental insurance.

17 Here's an illustrative benefit package that shows  
18 some trade-offs between some design elements. If you  
19 recall, this is the beneficiary-neutral package from  
20 January. Under this package, average beneficiary cost-  
21 sharing liability would be about the same as under current  
22 law. We want to emphasize that this is for illustration

1 only, and the Commission is not endorsing this specific  
2 benefit package. It represents only one example of the many  
3 possible solutions to that design problem that we discussed  
4 earlier.

5           You are already familiar with this package, so let  
6 me highlight just a few elements. The illustrative package  
7 has a \$5,000 out-of-pocket maximum and a combined deductible  
8 of \$500 for Part A and Part B services. The co-payment on  
9 hospital is \$750 per stay and it has different co-payments  
10 for primary care and specialist visits.

11           This slide summarizes the relative change in  
12 annual Medicare program spending under the illustrative  
13 benefit package from the previous slide, combined with a 20  
14 percent surcharge. Before we look at the numbers, we want  
15 to repeat that this is only a one-year snapshot of relative  
16 changes and it is not a score. The table also lists our  
17 modeling assumptions which are discussed in your mailing  
18 materials.

19           So remember that the illustrative benefit package  
20 held beneficiary cost-sharing liability roughly equal to  
21 current law that resulted in an increase of program spending  
22 by about 1 percent. That's mainly due to the catastrophic

1 protection for high-cost beneficiaries.

2 In addition, the 20 percent surcharge on  
3 supplemental insurance generated revenue offsets of about  
4 1.5 percent. On net, the change in program spending was  
5 about 0.5 percent in savings, that is adding plus 1 percent  
6 and minus 1.5 percent equals minus 0.5 percent.

7 This chart you have seen before. It shows the  
8 results of simulating changes in out-of-pocket spending and  
9 supplemental premiums for 2009 if the illustrative benefit  
10 package had been in place. So let's start with the first  
11 bar on the left, which corresponds to the illustrative  
12 package without the surcharge.

13 At the bottom part of the bar, 9 percent of  
14 beneficiaries had their out-of-pocket spending go down by  
15 \$250 or more under the new benefit. On the other hand, at  
16 the top, a little over 20 percent of beneficiaries had their  
17 out-of-pocket spending go up by \$250 or more. Mostly these  
18 are the beneficiaries who are spending more out-of-pocket  
19 due to their deductible. But for 70 percent of  
20 beneficiaries in the middle part of the bar, their out-of-  
21 pocket spending basically remained unchanged.

22 Now, the second bar on the right shows the

1     distributional effect with a 20 percent surcharge on  
2     supplemental coverage. We made a very simplistic assumption  
3     that a 20 percent surcharge would mean that beneficiaries'  
4     annual expenses will be \$420 higher for those with Medigap,  
5     and \$200 higher for those with retiree benefits, even before  
6     we consider any changes in their cost-sharing liability.

7             You can see the effects of the surcharge reflected  
8     in this chart where we see a noticeably bigger change  
9     compared to the bar on the left. Looking at the top part of  
10    the bar, we now see that 70 percent of beneficiaries had  
11    their total out-of-pocket spending go up by \$250 or more;  
12    whereas, 7 percent of beneficiaries had a decrease, about  
13    \$250 or more. But the relative magnitude of the increase  
14    was smaller than that of the decrease. As a result, the  
15    average change in out-of-pocket spending was about \$220 to  
16    \$240 per year.

17            Here are some additional issues important to  
18    restructuring the Medicare benefit. First, with the new  
19    benefit applied to all beneficiaries or only new  
20    beneficiaries, as mentioned in the previous slide or earlier  
21    slide, a combined deductible is problematic for those  
22    enrolled in either Part A or Part B only. This issue would

1 need to be resolved in implementing the new benefit.

2           Moreover, if there's a shift in the distribution  
3 between Part A and Part B spending under the new benefit,  
4 Part B premiums would be affected. We haven't discussed  
5 this effect, but such a change in Part B premiums would be  
6 included in the CBO score as a change in offsetting receipts  
7 to the program.

8           Here is the Chairman's draft recommendation. It  
9 reads: The Congress should direct the Secretary to develop  
10 a new fee-for-service benefit design that includes an out-  
11 of-pocket maximum, a combined deductible for Part A and Part  
12 B services, co-payments that may vary by type of service and  
13 provider, Secretarial authority to alter cost-sharing based  
14 on the evidence of the value of services.

15           And we want to make two quick points here. First,  
16 the Secretarial authority to alter cost-sharing can mean  
17 either increasing or decreasing cost-sharing based on  
18 utilization and clinical evidence. And second point, we  
19 would like to clarify that in making such changes in cost-  
20 sharing, the Secretary would determine that they would not  
21 compromise the quality and the Office of the Actuary would  
22 certify that they would not increase program costs. The

1 second point is not yet in the paper, but will be included  
2 in the next draft.

3           So now returning to the draft recommendation, the  
4 last two bullet points read: No change in beneficiaries'  
5 aggregate cost-sharing liability, a surcharge on  
6 supplemental insurance. The draft recommendation may have  
7 the following effects: For the Medicare program, spending  
8 would depend on the levels of the cost-sharing and surcharge  
9 specified in the ultimate benefit package.

10           Under the new benefit and surcharge, most  
11 beneficiaries would pay slightly more on average for their  
12 Medicare and supplemental benefits, but an out-of-pocket  
13 maximum would provide protection against the very high  
14 spending and also reduce the risk and uncertainty of  
15 potentially very high spending. If the individual's cost-  
16 sharing were to go up, he or she is likely to reduce both  
17 the effective and ineffective care and some beneficiaries  
18 may experience worse health because of it.

19           Finally, those beneficiaries with supplemental  
20 insurance would pay the surcharge if they decide to keep  
21 their coverage. For Medigap plans, the surcharge would  
22 increase their premiums and some beneficiaries might drop

1 their Medigap or move to Medicare Advantage in response to  
2 the Medicare benefit change and higher Medigap premiums.  
3 The effects on employers offering retiree benefits are quite  
4 uncertain and will depend on various factors.

5 That concludes our presentation and we look  
6 forward to your discussion.

7 MR. HACKBARTH: Okay. Thank you, Julie. Well  
8 done. Let me ask a couple questions on Page 9. So in your  
9 modeling of this, you excluded dual eligibles. Could you  
10 just say a little bit about why and whether that might buy  
11 us the results one way or the other?

12 DR. LEE: So our simplifying assumption was that  
13 whatever happens to the fee-for-service benefit, the  
14 Medicaid will wrap around the cost-sharing of the changed  
15 benefit in the same way that they do now.

16 MR. HACKBARTH: And then on the bottom part of the  
17 page, the modeling uses the 20 percent surcharge. Could you  
18 just say a little bit more about why 20 percent as opposed  
19 to some other number?

20 DR. MARK MILLER: Probably not.

21 MR. HACKBARTH: That's fair enough.

22 DR. MARK MILLER: I mean, just to give you a sense

1 of a few things about this, if you look at the added costs  
2 that wrap around policies impose on the program, you  
3 actually end up with a larger number than 20 percent. I  
4 think some of our thinking was to have a placeholder number  
5 to kind of focus people's attention. The other thing about  
6 this is the surcharge, if the premium is higher because the  
7 benefit package is larger, then you're paying 20 percent of  
8 a larger number versus 20 percent of a lower number.

9 But this is just a placeholder. This number could  
10 be higher, smaller, whatever the case may be. But the one  
11 empirical point is, is the actual cost imposed is much  
12 higher than 20 percent.

13 MR. HACKBARTH: And then also in the surcharge, so  
14 this surcharge, of course, applies to individually purchased  
15 supplemental coverage. It would also apply to employer-  
16 sponsored insurance for retirees?

17 DR. LEE: That's correct.

18 MR. HACKBARTH: But it would not apply to Medicare  
19 Advantage plans on the basis that the Medicare Advantage  
20 plan is responsible for the full cost. So their structure  
21 of what we would think of as supplemental benefits, they  
22 fully bear the cost of that monthly?

1 DR. LEE: Yes. We think of it as within the  
2 Medicare Advantage program.

3 MR. HACKBARTH: Right, right. And then on Page 10  
4 in the bar chart on benefit changes with surcharge, as I  
5 recall our discussion at the last meeting, our working  
6 assumption, after consulting with actuaries, was that the  
7 surcharge, at least in the short-run, would not dramatically  
8 alter purchasing behavior of supplemental coverage, the type  
9 of supplemental coverage purchased. And so, this sort of  
10 assumes static levels of supplemental coverage. Is that  
11 right?

12 DR. LEE: That's correct. At least the actuaries  
13 that we consulted, among the current beneficiaries who have  
14 supplemental coverage, the switching was going to be  
15 relatively small. So for this particular chart, we have  
16 assumed static.

17 MR. HACKBARTH: Okay. And then my last one is on  
18 Page 12 with the wording of the draft recommendation. Since  
19 this is my draft recommendation, this should have occurred  
20 to me before, but it did not. So the wording is, the  
21 Congress should direct the Secretary.

22 It just occurred to me that some people -- that

1 could be construed in different ways. One potential  
2 interpretation of that is, we think this should be done and  
3 the details should be developed through a thoughtful process  
4 by the Secretary, and we have an illustrative package. So  
5 that's one interpretation.

6           The other interpretation is that this is a  
7 mandated study from the Congress to the Secretary of HHS.  
8 This is just something we think should be studied, because  
9 there's no further action beyond the Secretary working on  
10 it. I offered the draft recommendation with the first  
11 interpretation in mind. I didn't think of this as a  
12 mandated study to the Department. And we may want to think,  
13 for the final version, about how to modify the words to make  
14 that clear.

15           DR. MARK MILLER: And just so you know, we  
16 understood that that's your intent and that was what we  
17 meant when we wrote it, but I do see the ambiguity and we'll  
18 get that right.

19           MR. HACKBARTH: Okay. So let's move. Bruce, you  
20 look like you're primed for clarifying questions.

21           DR. STUART: Actually, I do have a clarifying  
22 question and it's on Slide 5. Glenn asked the question

1 about excluding duals. Can I assume that duals are excluded  
2 from this analysis?

3 DR. LEE: They are actually included, but they had  
4 to have been involved for the full four years.

5 DR. STUART: Harrumph. If you're a dual eligible,  
6 then you would not have any liability for these services.  
7 So I'm not sure what that would mean. If duals are included  
8 and duals are generally more expensive, then that suggests  
9 to me that less than 6 percent of the non-duals are going to  
10 have liabilities of 5,000 or greater.

11 DR. LEE: Actually, I think I would need to  
12 clarify the semantics, so the duals would have a cost-  
13 sharing liability, but they might not have out-of-pocket  
14 spending if Medicaid isn't paying for their liability. So  
15 this one is just showing the liability under Medicare.

16 DR. STUART: I'm not sure I understand that.

17 DR. MARK MILLER: The dual has liability.  
18 Somebody else pays it so they don't incur the out-of-pocket.  
19 So I think what she's saying is, this is a calculation of  
20 the liability.

21 DR. STUART: Well, in many cases, there is no  
22 liability because Medicaid pays at a lower rate and it's

1 just simply wiped off the -- you know, it's an accounting --

2 MS. BEHROOZI: Non-Medicare only.

3 MR. HACKBARTH: Yeah.

4 DR. STUART: Well, that was one question, a  
5 clarifying question, and so I would just suggest that we  
6 think about that, because I think that the message that I  
7 took away from this is that if people have a liability, then  
8 they're expected to pay for it.

9 But that leads to the other question and that is,  
10 do we have any sense of people who actually have the  
11 personal liability that would not be duals in that range of  
12 5,000 or more who actually pay the liability? Because if we  
13 look at the income distribution of the Medicare population  
14 and we take out the duals and we look at that big bolus of  
15 people that have incomes between 100 and 200 percent of the  
16 poverty level, they're not going to be paying \$10,000 out-  
17 of-pocket. They just simply don't have it.

18 And so, one of the factors here that I'm wondering  
19 whether you've had a chance to think about, is whether this  
20 is helping institutions with their bad debts or is it  
21 actually reducing the true financial obligations of  
22 beneficiaries.

1           MR. HACKBARTH: Is there any way to get at that  
2 question?

3           DR. LEE: In terms of bad debt, we actually would  
4 not know that from the claims data. One thing that I will  
5 just kind of raise is that even though the income and  
6 savings or people's assets are correlated, in some cases,  
7 people are using their savings. That's another source of  
8 their financial resources.

9           DR. STUART: Is that an assumption or do you know  
10 that?

11          DR. LEE: There are some studies that indicate  
12 that, suggest that. Now, I actually cannot say to what  
13 extent that we can generalize that.

14          DR. STUART: But there is information on assets in  
15 the MCBS, in the income and asset supplementation that you  
16 might be able to address this question. And, in fact,  
17 there's a question in that INA supplement about whether you  
18 have medical liability.

19          DR. MARK MILLER: And maybe you'll talk about this  
20 the second time through. I mean, notwithstanding the  
21 ability to quantify it, I think one of your statements  
22 stands, which is in some instances, what we're doing is

1 probably helping the institution because the beneficiary  
2 doesn't, in the end, end up paying that, although it can be,  
3 you know, there's peace of mind and that type of thing  
4 because they can be continued to be pursued for it, at least  
5 at some level.

6 And so, yeah, maybe the second time around you  
7 might, if there's some significance that that would lead you  
8 in a different direction, speak to it.

9 MR. HACKBARTH: George, clarifying questions?

10 MR. GEORGE MILLER: Just a quick one about  
11 demographically, do we know if this would have an adverse  
12 impact financially on inner-city or those who may have lower  
13 economic status? I think you've already covered dual  
14 eligibles. Have we broken this down by demographic  
15 information, race, in any way?

16 DR. LEE: This particular slide or the more  
17 general?

18 MR. GEORGE MILLER: The more general information,  
19 but this slide as well. Do we have a disproportionate  
20 impact just demographically?

21 DR. LEE: Demographic information as to age, sex,  
22 race.

1 MR. GEORGE MILLER: Okay.

2 DR. LEE: That information we can get.

3 MR. GEORGE MILLER: Okay.

4 DR. LEE: Income would not be, although we have  
5 used the Part D LIS status as an indicator, and I don't  
6 believe we have actually seen anything that's  
7 disproportionately.

8 MR. GEORGE MILLER: Disproportionately?

9 DR. LEE: Yeah.

10 MR. GEORGE MILLER: Okay. Yeah, I'd like to see  
11 that. Thank you.

12 DR. BAICKER: Two quick clarifying questions on  
13 the assumptions in Slide 9. So for supplemental coverage,  
14 you're assuming that the premiums stay the same except for  
15 the surcharge when you layer that on? I would have thought  
16 that premiums would change because the liability that the  
17 plan faces is changing because of the changing Medicare  
18 benefit.

19 DR. LEE: But overall, we held to the cost-sharing  
20 liability about the same, so we introduced out-of-pocket  
21 maximum, but we raised the cost-sharing on other parts, like  
22 home health. So the kind of aggregate remained about the

1 same.

2 DR. BAICKER: And that plays out the same? It's  
3 changing the composition in a way that's neutral to the  
4 Medigap policy because their coverage is the same across  
5 those different dimensions that you've changed?

6 DR. LEE: Yes, the kind of average we held it  
7 roughly the same.

8 DR. BAICKER: And then in terms of the behavioral  
9 assumptions, you're building in some elasticity based on the  
10 price. Is that only applying to people who don't have  
11 Medigap coverage? Because the people with Medigap coverage  
12 are still not seeing a price change, so you're getting very  
13 little behavioral change because it's only a few people?

14 DR. LEE: That's correct. So we applied the  
15 behavioral assumption to how -- you know, there have been  
16 changes in the cost-sharing liability. It works through  
17 their supplemental, so it changes whatever the change in  
18 out-of-pocket spending that comes out, and that's the number  
19 to which the behavior was applied. So it's the -- your  
20 supplemental status changes or not changes your out-of-  
21 pocket even though that Medicare benefit might have changed,  
22 and your behavior is a function of what you are paying out-

1 of-pocket.

2 DR. BAICKER: And then the last question under the  
3 assumptions, is the only change in Medigap policies that  
4 you're modeling is that a small share of people drop in  
5 response to the increased share -- in response to the excise  
6 tax or whatever --

7 MR. HACKBARTH: Surcharge.

8 DR. BAICKER: Surcharge, surcharge -- there are no  
9 taxes here -- in response to surcharge, but not the form of  
10 insurance coverage. So the plans all still look the same?

11 DR. LEE: That's correct.

12 DR. BAICKER: It's just some people don't take  
13 them out. Okay, thank you.

14 MS. BEHROOZI: Sorry. I thought of a question  
15 that I had when I was reading the paper. You do a chart of  
16 the Medigap policy, the standard policies and what they  
17 cover. K and L include more cost-sharing and then have the  
18 out-of-pocket cap a little bit later on, I guess, than some  
19 of the other ones do.

20 I know you've talked about this before. In what  
21 proportion do people who choose Medigap policies choose K  
22 and L? Are they down at the lower end or do people prefer

1 those?

2 DR. HARRISON: K and L are not popular. I think  
3 it's a total of less than 1 percent of policies. The newer  
4 N has become popular, though.

5 DR. BERENSON: Yeah, a couple are clarifying.  
6 Could you go to Slide 10, please? I just want to make sure  
7 I understand. The note says that you're not including  
8 beneficiaries enrolled in Medicare Advantage in Medicaid.  
9 You are including those without any supplemental insurance.  
10 So they would be in the second group, benefit changes with  
11 surcharge. They presumably wouldn't be affected by adding a  
12 surcharge because they don't have it. So they're included  
13 in that calculation?

14 DR. LEE: That's correct. So for that group,  
15 between the two bars, their underlying data would be the  
16 same.

17 DR. BERENSON: So I just want to pursue so I  
18 understand. First Glenn asked and then Kate followed up.  
19 The advice you've gotten from actuaries, was it that the  
20 surcharge, they wouldn't be willing to estimate with the 20  
21 percent surcharge that there would be any choice changes, or  
22 was it that with this whole benefit package change, they

1 would not be able to estimate how many people might drop  
2 getting supplemental insurance in the first place, or both?  
3 Would you clarify that for me?

4 DR. LEE: So their kind of opinion was that people  
5 who currently have a supplemental insurance, they like  
6 having that coverage. So their decision is going to be  
7 sticky because they're already starting with the state of  
8 having that insurance. So whether the benefit, the basic  
9 benefit has changed or that the price of their supplemental  
10 benefit has changed, it's relative how they are comparing  
11 the benefit -- the advantage of having the supplemental  
12 insurance versus the cost of having that insurance.

13 But it's at least among the current beneficiaries  
14 with the supplemental coverage, that will be not very  
15 sensitive. Now, they did also, I think, believe that if you  
16 are starting out at age 65 trying to decide whether to get  
17 supplemental coverage or not, then that decision probably is  
18 going to be different.

19 DR. BERENSON: Have you tried to quantitate for,  
20 let's say, the low user, the average user, and the high  
21 user? If somebody who has Medigap insurance today dropped  
22 it, what the net would be on their out-of-pocket spending?

1 DR. LEE: The short answer is that we have not.  
2 The -- yes, I'll end there.

3 DR. BERENSON: I guess if I were -- I'm not an  
4 actuary happily, but I'd want to know the degree to which  
5 the amount of benefit -- I mean, I'm assuming there would be  
6 some net benefit if you're no longer paying very high  
7 premiums and relatively high premiums and you're going to  
8 avoid the surcharge that's going to be applied.

9 At the same time you have more direct out-of-  
10 pocket spending for co-insurance, and now you have out-of-  
11 pocket protection for catastrophic expenses, that the net is  
12 going to be a positive. I think it might be helpful to sort  
13 of see how much we're talking about for different kinds of  
14 beneficiaries, to at least challenge the actuaries to, you  
15 really don't think people would make a different selection  
16 with this kind of savings?

17 If it turned out it was 38 cents, then maybe  
18 that's one thing. If it was in the hundreds of dollars, one  
19 might be in a better position to assess whether their  
20 judgment sort of has credibility. Does that make any sense?

21 DR. LEE: Yes. So I think one simple way of  
22 looking at the kind of a comparison that a beneficiary could

1 make, and this is just only in terms of what an expected  
2 benefit would be, is if you are paying \$2,000 a year for  
3 Medigap coverage, that means if you don't have it, that's  
4 \$2,000 in cost-sharing liability under Medicare that you  
5 could actually use those premiums for.

6 \$2,000 in cost-sharing liability, that implies  
7 more than \$10,000 into Medicare or spending for Medicare  
8 services. That's quite a high number. One thing that  
9 actuaries did point out is that with out-of-pocket maximum  
10 at \$5,000, that is statistically, it's good protection. But  
11 for some people, 5,000 is still too high and they want to  
12 protect, or maybe at 2,000 or at a lower level.

13 So supplemental coverage, the extra protection  
14 they are providing for 5,000 -- between 5,000 and 2,000, or  
15 some lower number, that still might be valuable to them and  
16 that might be one of the reasons why they might still  
17 consider it.

18 MR. HACKBARTH: I'm just glad Cori wasn't here to  
19 hear your hurtful comments about actuaries.

20 MR. GRADISON: Julie, this is a comment more on me  
21 than on actuaries.

22 MR. HACKBARTH: Bill?

1           MR. GRADISON: Could you remind me, Julie, what  
2 happens with beneficiary responsibility for preventive  
3 services?

4           DR. LEE: The idea is that they will be carved out  
5 of the cost-sharing.

6           MR. GRADISON: Do we have to specifically say that  
7 in a statement that says -- do we have to specifically  
8 mention that in this or would the provisions of the ACA  
9 cover that already? I don't know.

10          DR. MARK MILLER: We can discuss this.

11          DR. HARRISON: I think that would be contemplated  
12 in the Secretarial discretion to raise and lower co-payments  
13 by the type of service.

14          DR. HALL: But I thought we had sort of made the  
15 principle that it doesn't make a lot of sense to allow  
16 people to not take advantage of preventive services, that  
17 the cost is --

18          DR. HARRISON: We sort of assumed that preventive  
19 services would not have cost-sharing.

20          DR. DEAN: Does the calculations of what  
21 beneficiaries would end up paying, does that include Part B  
22 premiums? Because, I mean, do you have any projections to

1 what would happen with Part B premiums, because it seems  
2 like if the incentive is to use less low-valued care, those  
3 possibly could go down. On the other hand, if the benefit  
4 package changes, they might not. I mean, is there any  
5 projection about that?

6 DR. LEE: So this one of the items that we  
7 included on other issues because we have not actually  
8 included what the change in Part B premiums would be. Now,  
9 with cost-sharing changes, that's going to have an effect on  
10 Part B or Part A service use, and for Part B services, if it  
11 goes down, in our modeling of the illustrative package, it  
12 did slightly.

13 Then the 25 percent of the Part B costs will be  
14 smaller, so that the Part B premiums would decrease. But  
15 it's going to change and it will be -- even though we have  
16 not included it in our analysis, a score would include that.

17 DR. DEAN: I just wondered if that would offset  
18 any of these other costs, but I realize it's a lot of  
19 speculation.

20 MR. BUTLER: So you've really done a great job, in  
21 my mind, of taking a whole set of complex things and I can,  
22 I think, even understand them. So congratulations. Slide

1 9, to show you how well I understand them, maybe we  
2 shouldn't call it tax or surcharge. You're really only  
3 paying a portion of what the downstream impact on Medicare  
4 spending is. Something like that is what it's about.

5 And I understand from the chapter the individual  
6 is, on average, going to pay about \$420 more a year, the  
7 surcharge estimate for the average premium.

8 DR. LEE: For Medigap.

9 MR. BUTLER: For the Medigap policy? In other  
10 words, they will have out-of-pocket an additional 420 for  
11 their supplemental insurance, right? Now, the 20 percent  
12 Mark already said, he's not sure how he came up with it or  
13 you came up with it.

14 DR. MARK MILLER: Careful now.

15 MR. BUTLER: But this is you. You're fair game.  
16 I'm really nervous now. I assume one of the things is  
17 budget neutrality and kind of what makes sense and what  
18 might be bearable, and that's why I was thinking about the  
19 420. But then I was also trying to think of, if you were to  
20 have Cori here, what is the actuarial number that you would  
21 charge?

22 And you also say in the chapter it's a little over

1 8,000, on average, for the 90 percent that have Medigap, and  
2 it's about 5,800 a year for those that do not, although that  
3 does not have the risk adjustment in it, but you have a  
4 \$3,200 a year, if they were exactly the same populations --  
5 I'm jumping ahead -- you'd be paying for 420 of the \$3,200  
6 gap from an actuarial standpoint. Is that right?

7 DR. LEE: So the difference that is in the chapter  
8 is not adjusting for risk.

9 MR. BUTLER: Right.

10 DR. LEE: And the people who have just Medicare  
11 only, they tend to be younger and, you know, so that there  
12 are risk differences there.

13 MR. BUTLER: Less than 3,200. I don't know how  
14 much less, but I assume that the 420 is less than the  
15 actuary -- I'm just trying to get a sense. Is the 420 still  
16 a lot less than the actuarial -- than the impact on the  
17 strength of spending?

18 DR. LEE: Yes. So the conventional or the rule of  
19 thumb that the number that people use for the difference  
20 between people just with Medicare and people with  
21 supplemental or first dollar coverage adjusting for risk is  
22 about 25 percent higher spending. So if you kind of apply

1 that to a much smaller base of Medigap premiums, it is --  
2 the number is much higher than 20 percent.

3 MR. BUTLER: So it's probably covering less than  
4 half of the actual impact?

5 DR. LEE: Yes.

6 MR. BUTLER: Okay.

7 DR. MARK MILLER: That's correct.

8 MR. BUTLER: I'm trying to get it in my mind. So  
9 this isn't such a bad -- I'm trying to get the high-level  
10 message in my mind how I would sell this. And so, you're  
11 still not paying for the full impact of what the  
12 supplemental insurance is actually creating downstream?  
13 Okay.

14 DR. CHERNEW: I have a question about the out-of-  
15 pocket max. is constructed so that if there was low-value  
16 services used by people that had serious illness, so they're  
17 going to pay their out-of-pocket max, there would be no way  
18 to charge or use any financial incentive to discourage use  
19 of that service once they hit it?

20 DR. LEE: In our modeling, we have not made any -

21 DR. CHERNEW: I understand, but in the policy --  
22 the way that this is applied, if there was a service that we

1 thought was low-value, but it was used for people that had  
2 some other serious ailment, whatever it was, so they're --  
3 the other cost-sharing range, it would work the same as  
4 catastrophic in Part D works this way, which is no matter  
5 what you think you have in your cost-sharing requirements in  
6 Part D to discourage low-value use, if you're sick enough  
7 that you hit the catastrophic cap, there's no more cost-  
8 sharing no matter what it is. Is that the way this is  
9 envisioned?

10 DR. MARK MILLER: Yeah, let me draw a distinction  
11 between modeling and policy and then what D does, and some  
12 of the D folks, make sure that they're paying attention  
13 here. So the way this was modeled is, when you hit the  
14 catastrophic cap, you have no more liability. That's it.  
15 Okay? And, of course, you're saying, but that's not what I  
16 want to talk about. I want to talk about the policy. I'm  
17 with you.

18 And on the policy, as I understand D, when you hit  
19 the cap, it's not that you're relieved of all liability.  
20 What happens is the beneficiary still has a 5 percent  
21 liability. The plan, I think, has 20 or 15, somewhere in  
22 there. I'm getting some nods, but I can't tell the

1 difference between a 15 and a 20 percent nod. I'm getting a  
2 15.

3 And then the program takes the rest of it over.  
4 If you could think of some kind of wrinkle like that in  
5 here, but you almost had even a more precise one, which is,  
6 can I go in and go after a specific low-volume service.

7 DR. CHERNEW: Low-value.

8 DR. MARK MILLER: Sorry. I'm sorry. I mean  
9 value.

10 DR. CHERNEW: I think your answer is, that hasn't  
11 while you were thinking about it, but that's open for  
12 discussion.

13 DR. MARK MILLER: Absolutely. You could design  
14 the policy like D and say, the beneficiary still has a 5  
15 percent liability. You have to think about the  
16 distributional impacts that get set, all the rest of it.  
17 But yeah, D has that sliver that the beneficiary still is  
18 beholdng for.

19 MR. ARMSTRONG: Just for the record, I admire  
20 actuaries and thanks to them, I can ask stupid questions  
21 like the one I'm about to ask, and that is, so this is a  
22 little bit broader. I mean, a lot of this, 3 percent seems

1 like a small impact from some of these changes, but I just  
2 trust that that analysis was done right.

3 But stepping back half a step, I assume we are  
4 assuming through all of this work that we're really just  
5 focusing on the impact of the -- on the beneficiaries and  
6 the cost to the Medicare program of making these benefits  
7 available. But what kind of assumption are we making about  
8 the overall expense trends based on the net of these benefit  
9 design changes? Are we assuming that there's no impact on  
10 that? Or is that really part of this analysis?

11 MR. HACKBARTH: There is a net fiscal effect of  
12 minus 1.5 percent when you take into account the increased  
13 outlays from the beneficiary-neutral policy, benefit  
14 redesign with the offsetting effect of the 20 percent  
15 surcharge. The net effect of those two is the 1.5 percent  
16 reduction in Medicare outlays.

17 MR. ARMSTRONG: That's exactly what I wanted to  
18 hear. That's kind of what I was counting on. But we keep  
19 talking --

20 DR. MARK MILLER: Can I just pin a fact down? The  
21 net effect is minus 1.5 or 0.5.

22 MR. HACKBARTH: Oh, I'm sorry. You're right. I'm

1 sorry.

2 DR. MARK MILLER: You have to do the arithmetic  
3 and the way I would have answered Scott's question is, what  
4 this does is, is it says off of baseline. You're at half a  
5 point less, but I don't think we're making any assumptions  
6 about changing the growth trajectory. So in a sense, if  
7 this is what the line looked like, it's a half a point lower  
8 as you net those two numbers out. Right?

9 DR. LEE: It is just the one year. We just took a  
10 snapshot of what this new benefit would mean in terms of how  
11 people's spending changed.

12 MR. ARMSTRONG: Okay. So I think that does answer  
13 my question and on Round 2 I'll make it --

14 MR. HACKBARTH: Okay. Karen, clarifying  
15 questions? Bill?

16 MR. GRADISON: I just want to make sure I  
17 understand this. So I'm picking up from Bruce's point,  
18 which is, as I understood it, focused on the impact on very  
19 low-income beneficiaries of the cap, of the \$5,000 or  
20 whatever. The bottom line, I think I can support this, but  
21 my understanding is that there could be a fair number of  
22 people whose income is just above the poverty line,

1 therefore not dual eligibles, that are going to get hit as  
2 part of the 68 percent who are in the plus \$250 to \$999 a  
3 year.

4           And I just think if we go into this, we ought to  
5 do it with our eyes open because there are going to be a lot  
6 of low-income folks that aren't going to think this is a  
7 very good idea. I kind of like it because I think it does  
8 correct a defect in the program, but on that point, I'd just  
9 like to think a little bit more about it.

10           And I've worked with accountants and actuaries for  
11 a long time and I never could quite it get clear which way  
12 it was. Some people said that accountants are people that  
13 are good with numbers, but don't have the personality to be  
14 actuaries. And others said it was the other way around.

15           DR. STUART: Let's see. Where do we go with this?  
16 I'm worried politically. I'm on Page 10 right here. I'm  
17 worried politically about the right hand bar because if you  
18 do the -- there are a couple ways you can do the math. If I  
19 split that 24 percent into half, gain a little half, lose a  
20 little, I still end up with about 80 percent of the  
21 population worse off. And some of them are worse off by a  
22 lot. And it's not just the 68 percent.

1           That 2 percent at the top actually worries me.  
2   And that sounds like just a tiny number of people, but we've  
3   got a program that has almost 50 million people, and that  
4   means about a million people are going to be facing higher  
5   annual costs, higher than \$1,000, and that's really big.

6           The other thing when I put this in trying to  
7   figure out how we should go about modifying this program, I  
8   really do think that there are two pieces here. I'd like to  
9   see them separated. And the first piece is, what do we do  
10  about the current benefit design? Forget about  
11  supplementation at this point. Let's just make this more  
12  rational, which is the left-hand column.

13           And that left-hand column, to me, makes a lot of  
14  sense, although to be honest, I'm a little worried about the  
15  1 percent at the very top, but that's not my major issue.  
16  The way I would look at this on the left-hand column is to  
17  say, that is budget neutrality as we have applied it on the  
18  reimbursement side.

19           In other words, what we're trying to do is to come  
20  up with a policy that some people are going to win, some  
21  people are going to lose, but on net, there's not going to  
22  be any greater or lesser outlay for the program.

1           MR. HACKBARTH: Just to be clear, the left-hand  
2 column is not budget neutral. It results in an increase in  
3 program outlays of about 1 percent.

4           DR. STUART: Of 1 percent. Okay, all right.  
5 Well, that's a good point because that kind of makes my  
6 point. I mean, that increases it 1 percent and the other  
7 column decreases it 1.5 percent. So I guess what I would  
8 think would be, let's have one that is truly budget neutral  
9 and then let's think about supplementation and its implicit  
10 subsidy of the Medicare, current Medicare beneficiaries in  
11 the Medicare program. That's been around for, you know,  
12 that's been around since year one.

13           That's an important issue, but to me it's a  
14 different issue. And one can think about that issue in  
15 saying, Okay, for the long term sustainability of the  
16 program, let's phase out this subsidy and let's phase it  
17 out, as we've talked about other kinds of payment reforms  
18 that affect providers. So it wouldn't be just the 1.5  
19 percent cut. It would be the whole shebang, whatever that  
20 happens to be. But it would be put in in phases over time,  
21 because I think that's really a different question than  
22 changing the current budget, than changing the current

1 benefit structure.

2           And if you had the two together, I think you might  
3 have a better chance of actually having Congress look at it  
4 favorably because, frankly, making 80 percent worse off, I  
5 think, is politically--you know, it's just not going to fly.  
6 I just think that's going to be a very --

7           MR. HACKBARTH: So that's a useful way of framing  
8 the issue. So the left-hand column that results in a one  
9 percent increase in outlays, we looked at both versions. We  
10 looked at making it a program neutral restructuring, or a  
11 beneficiary neutral restructuring. This is the beneficiary  
12 neutral version. And the reason that we went to that was  
13 because of the significantly higher deductible that was  
14 required to make the program neutral model work. Now, in  
15 fairness, there are different ways you can do it. You can  
16 greatly increase the catastrophic limit or increase the  
17 deductible. Julie, help me out. If you kept the  
18 catastrophic constant and tried to do it on a program  
19 neutral basis, the deductible had to increase by how much?

20           MS. LEE: So the program neutral package that we  
21 considered in January was the deductible was the 700 and it  
22 also had, you know, higher copays and I think SNF stays.

1 But mainly that it was the deductible that had to move  
2 noticeably.

3 MR. HACKBARTH: Yes. And so when we talked about  
4 that, there was some preference for keeping that deductible  
5 lower, the number as low as possible, as we opted for,  
6 therefore, the beneficiary neutral approach, but it cost the  
7 one percent.

8 DR. MARK MILLER: And the way I would think about  
9 this, Bruce, because I think there's kind of a difficult  
10 choice whichever way you go. I mean, if you say, okay, I  
11 want to build the left-hand side and I want to rationalize  
12 the benefit, and I'm using our terms, and I want to remain  
13 program neutral -- program neutral -- then you're taking the  
14 average liability for the beneficiary up. And so you will  
15 have increased cost sharing widely through that distribution  
16 and that bar will look very different. And the same problem  
17 that you run into of, wait a minute, the beneficiaries  
18 aren't going to like it, that's is going to occur there, as  
19 well. And the right-hand side, it's basically saying,  
20 you're putting the cost on an item, and I know that there  
21 are issues with income and poor, but you're putting on an  
22 item that's a choice for the beneficiary.

1 DR. STUART: I guess I'm thinking of it two ways.  
2 One, I think that if we go with the Chairman's  
3 recommendation, which includes a surcharge on benefits, on  
4 supplementation, then nobody is going to pay any attention  
5 to the left-hand column because we're going to be saying  
6 what we're really looking at is that right-hand column, or  
7 some variant of that. Everybody recognizes that this could  
8 be redone and would be redone.

9 I'm just afraid of giving a recommendation that  
10 might just be dead in the water and so that it won't be  
11 considered. So I'm actually in favor of changing the  
12 program so that that implicit subsidy, in fact, is recouped.  
13 But if it were done over time, then I think that it would be  
14 more likely to be considered as opposed to what it looks  
15 like here.

16 MR. HACKBARTH: Yes. So help me understand,  
17 Julie, the numbers here. We say that a 20 percent surcharge  
18 represents only a fraction of the downstream effects of the  
19 decision to buy supplemental coverage. What is that  
20 fraction?

21 MS. LEE: Umm -

22 MR. HACKBARTH: If we were to set the charge,

1 surcharge to offset the full downstream effect, how high  
2 would it be?

3 MS. LEE: I think one time we calculated what the  
4 back-of-the-envelope number was, so, like, 70 percent -

5 MR. HACKBARTH: Yes.

6 MS. LEE: -- so --

7 MR. HACKBARTH: So we're talking about a small  
8 first step in your phase-in to the full effect, and you're  
9 saying, oh, I can't even accept this, it's going to make  
10 this politically unacceptable, while you come in and say,  
11 well, this is the first of four steps, and that will be a  
12 political problem.

13 DR. STUART: [Off microphone.] I think there are  
14 two issues and I'm worried about putting them together.

15 MR. HACKBARTH: And you're absolutely right.  
16 There are two distinct issues here. There's no disagreement  
17 with that.

18 Any other points, Bruce, that you want to make?  
19 George. Mitra.

20 MS. BEHROOZI: So, I'll start with what I like. I  
21 really do appreciate in the evolution of this work that I  
22 really feel like you have listened to all of the commentary.

1 I feel like I've been heard. I really appreciate that. I  
2 think that you have not just looked at it, with all due  
3 respect to my dear economist friends -- can I pick on them  
4 now that the actuaries have been picked on? I know it's  
5 going to come around to lawyers eventually. It always does.  
6 Lawyers always, always --

7 [Off microphone discussion.]

8 MS. BEHROOZI: We'll get it in the end. But  
9 anyway, it's not just about the numbers. I feel like the  
10 emphasis has shifted more to look at the impact on people.  
11 So I really do appreciate the evolution of the work and of  
12 the recommendation, I think, that's come out of that work.

13 So would you mind putting on Slide 12, please. So  
14 what I like about the recommendation. An out-of-pocket  
15 maximum, I think, is fine. It's good. I'm not against it.  
16 I share Bruce's concern that it's not necessarily going to  
17 benefit that many beneficiaries, and I think I tried to get  
18 at this a little bit the last time we talked about it, you  
19 know, the ten percent of people who don't have any kind of  
20 supplemental coverage are the -- they're poorer, but they're  
21 also healthier. They're younger, so less than six percent  
22 of them are the ones who are likely to exceed the \$5,000,

1 that whole thing. And they will more than likely go into  
2 the bad debt and charity pool. I don't think that's a good  
3 way for society to deal with coverage of health care costs.  
4 So it's a good thing. It's fine.

5 I'm going to skip over number two.

6 Copayments that may vary by the type of services  
7 and provider that allows for all the kinds of things that  
8 we're talking about in all the other discussions that we  
9 have. Secretarial authority to alter -- I would add, or  
10 eliminate cost sharing based on the evidence of the value of  
11 the services, because I think that goes to the point that  
12 Bill Hall raised earlier about, so what does that mean about  
13 preventive services, let's be explicit, and all of that.

14 MR. HACKBARTH: And that's what was intended, was  
15 to go all the way to zero if the Secretary deemed it.

16 MS. BEHROOZI: Great. No change in benefits -- in  
17 beneficiaries', I'm sorry, aggregate cost sharing liability.  
18 I'm going to come back to that in a minute because that, to  
19 me, relates to the second point. I'm sorry -- yes, the  
20 second point.

21 And then the last point, a surcharge on  
22 supplemental insurance. I came to that somewhat reluctantly

1 just because there is a lot of concern about the added cost  
2 brought on by supplemental insurance. I think that people  
3 like their supplemental insurance. They're not looking just  
4 for out-of-pocket -- I'm sorry, maximum spending,  
5 catastrophic coverage. There's a reference in the paper to  
6 auto insurance and the catastrophic coverage. Actually, I  
7 was talking about this with colleagues the other day and  
8 somebody said, yes, right. When you decide what kind of  
9 coverage you get on your car, of course, there's the  
10 insurance that covers collision and all that, but then you  
11 can also buy a maintenance contract and that's what people  
12 are looking for, it seems to me, in the Medigap policies  
13 that they're buying, right. So I don't think it's  
14 necessarily a bad thing. I think that's the value that  
15 people are looking for in their coverage, not just insurance  
16 coverage but health care coverage. It's a broader kind of a  
17 package.

18 But to the extent that that extra cost should be  
19 recouped and paid for differently, I would suggest that we  
20 don't necessarily need to recoup a percent and a half so  
21 that the net savings in this whole thing is a negative-  
22 point-five. Maybe we can look at balancing it out to more

1 of a zero. Twenty percent is a lot. I would suggest that  
2 we look at varying it by the value of the plan, by how much  
3 additional coverage there is.

4           And I also think that it would be good if we could  
5 say something -- there's a text box in the paper about a  
6 public plan -- oh, God, I almost said public option. I  
7 don't want to open that can of worms. A public Medigap plan  
8 that has a lot of apparent advantages, not least of which is  
9 to lower the load, the administrative cost, and allow for  
10 policy choices to be made that are consistent with the kinds  
11 of things that we're encouraging the Secretary to look at.  
12 So I would sort of put that a little more up front, maybe  
13 recommending that the Secretary study the viability,  
14 perhaps, of a publicly financed Medigap plan.

15           But then to the unified deductible, the combined  
16 deductible. And my big problem with that is that I just  
17 really don't agree with some of the premises, I think, that  
18 underlie it. I don't find it more intuitive or simple. You  
19 know, I talked with colleagues in the benefit design world  
20 and I say, yes, and so to pay for the out-of-pocket max  
21 they're talking about a combined deductible. They're, like,  
22 why? Why would you combine the deductible?

1           You know, they are different dollar amounts right  
2 now, the Part A and Part B deductibles, but there's a  
3 reference to them being relatively -- to bring them -- yes,  
4 they're relatively out of whack or whatever. But the thing  
5 is, relative to the benefit they're paying for, they're not  
6 so out of whack. And if you look at the benefit design, the  
7 potential benefit design that you've suggested, that  
8 relatively to have the same -- the one deductible for both  
9 hospital and, say, physician services, but then you're okay  
10 with charging a \$750 copayment for a hospital stay but only  
11 a \$20 copayment for a primary care doctor visit. So the  
12 person who's now paying \$140 deductible until they get  
13 coverage for their doctor's visit would have to pay \$360  
14 more, which relatively is the value of 18 primary care  
15 doctor visits, or nine specialist doctor visits, just in our  
16 proposed alternate plan. But the deductible would be even  
17 less than the copay for one hospital stay.

18           I mean, I'm not trying to, like, say, okay, so it  
19 has to be this or it has to be that, but I don't think there  
20 is an intuitive logic to making it one deductible for both  
21 sets of services, both types of services.

22           MR. HACKBARTH: To help me understand, Mitra, if

1 we were to have two separate deductibles, holding everything  
2 else constant, and set them at a level so that all of the  
3 numbers balance out in terms of not increasing the cost of  
4 the package, would you prefer that relative to a single  
5 combined deductible of equal actuarial value?

6 MS. BEHROOZI: I think it's consistent to keep  
7 costs on the doctors' side lower, whether by deductible or  
8 by copayment, with everything else that's been said in the  
9 paper about cost barriers. You know, there's a phrase in  
10 there, mitigating the impact of first dollar payment, of  
11 first dollar coverage. Well, I would say mitigating the  
12 impact of cost barriers is essential. And everything that  
13 we have in here about bigger impact on lower-income people  
14 and, you know, that includes more minorities, we're going to  
15 exacerbate disparities by loading more costs onto the front  
16 end.

17 So that's where I get to the second-to-last point,  
18 no change in beneficiaries' aggregate cost-sharing  
19 liability. It's not about aggregate. That's what matters  
20 to the Medigap payer, perhaps. That's what matters to the  
21 Medicare program, perhaps. But to the individual  
22 beneficiary, it matters a lot where those costs come in, if

1 they're paying for it in a premium that's knowable and all  
2 that or if they're paying for it at the point of service,  
3 which will deter them from getting the service.

4           So the answer is, yes, I recognize that that means  
5 that you have to find the dollars elsewhere. I do think  
6 Julie's comment about how \$5,000 is still a lot -- for the  
7 people who it's going to matter to, it's going to matter a  
8 lot. I don't know that maybe \$10,000 isn't the right out-  
9 of-pocket maximum, especially if you take into consideration  
10 what Michael said about keeping some copayments on services  
11 beyond a certain point to drive behavior.

12           There are other ways to do it. I mean, Part D  
13 imposes doughnut hole later on. But that up front point of  
14 service, not letting somebody get to the doctor until they  
15 have paid for 18 visits' worth, basically -- I mean, you  
16 know, they don't go 18 times, but it's the value of 18  
17 visits' worth in addition to what has already been the  
18 deductible, I don't think is enlightened benefit design. I  
19 don't think that makes it a better benefit, particularly for  
20 those ten percent with no additional coverage who are less  
21 likely to get to the hospital but more likely to need doctor  
22 services.

1           MR. HACKBARTH: So as we go through the rest of  
2 the second round, if people could react to some of the ideas  
3 that have already come up. Two in particular that I'd like  
4 people to react to are this idea of having two distinct  
5 deductibles and a lower deductible on the Part B services,  
6 again, assuming that it's all within a fiscal constraint,  
7 and we've got to make the numbers add up. Do people prefer  
8 that to a single combined deductible or not.

9           The other issue that I invite reaction to is on  
10 the idea of, well, let's structure the combination of the  
11 two, the surcharge and the benefit redesign, to net out at  
12 zero. And at the end, I'll explain why I didn't do that,  
13 but I invite people to react to that idea, as well.

14          DR. MARK MILLER: Can I just ask one thing? So  
15 just to understand what you are saying, Mitra, because I  
16 have to think about, when we go back, how to design this, if  
17 there's any place where we have to let off steam as a result  
18 of moving these deductibles, I also seem -- I don't want to  
19 put words in your mouth -- seem to hear you're saying, and  
20 if the catastrophic cap has to either go up or the  
21 beneficiary has to share some cost above that catastrophic  
22 cap like D, that's okay.

1 MS. BEHROOZI: I think that's a better thing.  
2 It's not my favorite thing. You know, I don't like cost  
3 sharing altogether. I like other forms of management. So  
4 it's a little hard for me to advocate for what I would  
5 suggest beneficiaries should be paying for more than, you  
6 know, is recommended. But, yes, I think the worst place to  
7 put it is right up front before any services are paid for,  
8 so someplace later, or spreading it across different silos  
9 in different ways, that kind of thing.

10 MR. HACKBARTH: And as you well know, Mitra,  
11 that's where the challenge here is, that changing  
12 deductibles have big dollar impacts, and so that means there  
13 need to be significant changes other places when you reduce  
14 them.

15 MS. BEHROOZI: I would just say, you know, the  
16 question earlier about do people choose K and L very much,  
17 no, people are willing to pay higher premiums for more  
18 comprehensive coverage. I'm not advocating that premiums go  
19 up, but I do think there is some evidence that people will  
20 choose to take on that total aggregate cost in a premium way  
21 rather than --

22 MR. HACKBARTH: Absolutely, and that's why we

1 reached the collective judgment that we would not interfere  
2 with that choice, but there needs to be -- at least some of  
3 the additional cost to the program and the taxpayer needs to  
4 be reflected, and that's the reason for the surcharge.

5 Kate.

6 DR. BAICKER: Okay. So first to react to the  
7 question about the separate versus unified deductibles,  
8 there's clearly an argument that the deductible poses a cost  
9 barrier and that you want to set the deductible at the  
10 appropriate level, and you're maybe arguing for the  
11 deductible to be smaller. The separate deductible, to me,  
12 seems like if you're going to have a car accident and say,  
13 you know, my insurance covers the motor with this deductible  
14 but the bumper with this deductible and you're getting hit  
15 from the front, in some ways, having those separate  
16 deductibles doesn't change much. It's the marginal cost  
17 sharing, where you're saying people are not going to go to  
18 the physician if the cost sharing is too high. That might  
19 suggest a lower deductible overall but then dialing up the  
20 cost sharing in a value-based way so that the marginal cost  
21 for the extra physician visit is relatively low compared to  
22 the marginal cost for the extra service of lower value.

1           Now, the question of whether people are willing to  
2 pay a deductible up front, there's a little bit of a  
3 disconnect there to me between saying people are willing to  
4 pay a \$100 higher premium, but they're not willing to have a  
5 \$100 lower premium and a \$100 deductible for care where  
6 they're almost surely going to consume more than \$100.  
7 That's really a marketing or psychological question. If  
8 everybody's consuming some health services, whether you call  
9 it a deductible or premium, in some sense, they're paying  
10 the same thing out of pocket with very high certainty. So  
11 I, in some sense, from an economics perspective, you're sort  
12 of neutral on that if you think everybody's going to be  
13 above that deductible. How it appeals to people is not  
14 really a question of economics.

15           That said, Slide 9 makes me very nervous, Figure  
16 1, for I think -- or Slide 10 -- Slide 10, Figure 1 -- for  
17 slightly different reasons from Bruce. I really like the  
18 text box on the value of insurance. You know I'm all about  
19 the insurance value of insurance. In some ways, I worry  
20 that that text box leaves people with the impression that  
21 it's a rationale -- it's an apology for still having cost  
22 sharing despite the fact that people value insurance rather

1 than touting the fact that changing the benefit design in  
2 this way makes the Medicare benefit better. This means that  
3 imposing an out-of-pocket maximum provides people with  
4 something that they value highly and there's sort of no meat  
5 on that part in the text box.

6           And then that's what makes me nervous about  
7 mapping to a picture like this. Because people are risk  
8 averse, they're willing to trade off means for variance.  
9 And I know we can't say it like that. I know that. But you  
10 know what I mean.

11           Suppose, on average, everybody's costs went up by  
12 \$5, but variance disappeared. People would be better off.  
13 And we're telling half that story. This picture is telling  
14 the means story but it's not telling the variance story.  
15 And so you're left with the impression that imposing an out-  
16 of-pocket maximum makes everybody worse off somehow and that  
17 can't be the story that we want to convey. So that makes me  
18 a little nervous about displaying things this way, is it  
19 makes it -- we're characterizing people's losses in a way  
20 that doesn't build in some of the gains that I think they're  
21 getting.

22           Now, the gains are actually undermined by the

1 existence of these first dollar Medigap policies that are  
2 basically filling in the value that people wish they could  
3 get out of Medicare and are willing to pay for in Medigap.  
4 So we know they value it. And it's not an efficient way to  
5 provide that kind of backstop. It comes with all of these  
6 costs that we've been talking about.

7           So then the fact that we're not getting any  
8 aggregate benefit out of the package that we're proposing,  
9 if you look at these graphs, is because of that first fact,  
10 that we're maybe not capturing the risk reduction that  
11 people are getting, but also the fact that because of the  
12 assumptions that are sort of necessary to make the model  
13 tractable at this point, we're also assuming away all of the  
14 gains and efficiency that we think we're going to get by  
15 replacing this Medigap inefficient backfilling of the  
16 failure of the basic Medicare benefit with a better Medicare  
17 benefit that would then have less of a bad Medigap wrap-  
18 around. We've assumed away the gains that we get from that  
19 shift by not really letting people switch to more efficient  
20 Medigap policies, by not allowing the types of Medigap  
21 policies that are offered to change in response to this.

22           We kind of assumed away all of the reasons for

1 doing this switch in the first place because we're moving  
2 from a world in which people have Medigap filling in the  
3 holes into a world in which there are fewer holes. That's  
4 kind of all the same if you thought they were equally  
5 efficient. We think that they're not, but we're not letting  
6 those gains come through in the behaviors that we're trying  
7 to promote.

8 That was very roundabout. I hope you get a sense  
9 of what I was getting at.

10 MR. HACKBARTH: So the bottom line is that, in a  
11 sense, these are sort of worst case, sort of, presentations  
12 of the impact, because, as you say, they assume away some of  
13 the desirable --

14 DR. BAICKER: All of the good stuff.

15 MR. HACKBARTH: -- impact.

16 DR. BAICKER: So there's two things. There's that  
17 and there's the absence of this other dimension that I  
18 realize is harder to quantify but that we're not talking  
19 about enough.

20 DR. MARK MILLER: I did follow what you said, and  
21 --

22 DR. BAICKER: Good for you.

1 [Laughter.]

2 DR. BAICKER: Tricky.

3 DR. MARK MILLER: No, I really do think I did -- I  
4 do think I followed it, and I think the -- all right. One  
5 thing that we did is a different slide, of which I have  
6 forgotten which one, but the one where we were trying to  
7 show the impacts over multiple years was one way to bring  
8 some information to that. You know, it may be only a couple  
9 of percent in the one year, but over four years, more people  
10 would be helped. So there was a bit of that.

11 I mean, I suppose on the key slide that has  
12 everybody hung up -- and it is the most conservative and  
13 we're also trying to be very clear about what people are  
14 walking into -- you know, the actuaries that we consulted  
15 were very adamant that, in the short run, people wouldn't  
16 change. I suppose we could try some kind of sensitivity,  
17 and I don't know how much evidence there is out there to  
18 vary something and say that picture could look like this.  
19 You know, the actuaries we consulted said no change in the  
20 short run, but over the long run, if X percent changed --  
21 and this definitely goes to what Bob was saying -- but wait  
22 a minute. If the arithmetic looks like this, why wouldn't

1 people shift?

2 We could try to play around with something like  
3 that, or am I getting a look from you guys of, like, this  
4 guy is really killing me here.

5 DR. HARRISON: I might remember a few iterations  
6 ago, we had the same charts but instead we had the  
7 regulatory policy where you couldn't have Medigap. Well,  
8 that looked wonderful because you were taking away the value  
9 of insurance, which is invisible, and you were cashing it  
10 all out and so the benes looked like they were much better  
11 off. So there is an optical problem that we haven't solved  
12 yet.

13 DR. BAICKER: And the fact that people won't  
14 switch in the short run is surely true. But then if that's  
15 all you're willing to graph, what you're basically saying  
16 is, we've assumed that there's no movement along this thing  
17 that we said was the cause of the problem because everyone  
18 was responding to it. So I think that's what drives the  
19 disconnect, that if you're not willing to say that people  
20 will move in response to the change but you're attributing  
21 where they are to the preexisting incentives, then you've  
22 stacked the deck against being able to find the thing that

1 we think should definitely emerge over time, in which case  
2 it's not clear that that's a useful exercise. To assume a  
3 problem exists and then assume that the absence of the  
4 pathway that caused the problem doesn't fix the problem,  
5 you've doomed yourself.

6 MR. HACKBARTH: Kate, are you aware of any  
7 literature that we could use to try to construct a model  
8 that is different than the assumption the actuaries gave us  
9 of no change in the short run?

10 DR. BAICKER: Not from the Medigap literature.  
11 There's an older literature looking at the responsiveness of  
12 insurance purchase to copayments and to -- and to tax rates  
13 or -- not taxes -- the surcharges. I am so untrainable.

14 [Laughter.]

15 DR. BAICKER: That you could port over and there'd  
16 be all sorts of reasons to be hesitant about porting  
17 something from a commercially insured population over to a  
18 Medigap purchase. But in some sense, the assumptions that  
19 drove the initial discussion and then the assumptions that  
20 show up later are a little bit in conflict with each other.  
21 So you might just not want to do that exercise and try to do  
22 instead back-of-the-envelope calculations about what the

1 value of insurance protection is and how you would expect  
2 that to change. I don't know what the graphical answer is.

3 DR. MARK MILLER: [Off microphone.] I know we are  
4 getting jammed on time, but the other way maybe to bring  
5 these thoughts together is to think about what Bob said  
6 early on the first round, if I was following that, where  
7 maybe there is some arithmetic we can bring out of the model  
8 that the beneficiary distribution of the cost of the  
9 supplemental versus the change in the benefit and showing  
10 some of the arithmetic and least being able to say, you  
11 know, if these actuaries aren't right, this is what the kind  
12 of cost frontier that people are facing, and maybe more  
13 people would be willing to move with this kind of arithmetic  
14 facing them and maybe we can draw that out. Maybe we can  
15 also do some kind of sensitivity assumption to get to your  
16 point, because this is clearly vexing more than just you  
17 here.

18 The other thing I think you said that I don't want  
19 to lose track of -- and I want to have this discussion when  
20 we get back -- she's also kind of made this point off of  
21 Mitra's point of, you know, if I'm not willing to -- I don't  
22 want to face a deductible, why am I willing to pay the

1 premium for the Medigap, and there is definitely a logical -  
2 - and I want to think about that more. So I don't want to  
3 lose that point. I wanted to say it out loud and make sure  
4 that we, after we get out of here, start talking about that.

5 Okay. I'm really sorry.

6 MR. HACKBARTH: Okay.

7 MR. KUHN: I don't think I have anything to add on  
8 the lower deductible. It's something I want to think about  
9 some more.

10 In terms of the net out to zero that you kind of  
11 mentioned earlier, that doesn't bother me. The narrow band  
12 that you have of the negative one and a half, I'm fine with  
13 that.

14 And generally, I think the draft recommendations -  
15 - obviously, we're going to be doing some refinements here,  
16 it sounds like, as we go forward, but I think what you've  
17 laid out is a pretty good framework to continue the  
18 conversation.

19 DR. BERENSON: Well, first, I want to be able to  
20 say some of my best friends are actuaries, but I don't have  
21 any --

22 [Laughter.]

1 DR. BERENSON: But more seriously, picking up on  
2 what sort of Bruce got us into is the optics, and then  
3 Mitra's discussion of the deductible, and Kate, who I think  
4 I'm pretty much on board with how you said it, and I think I  
5 support what I said in round one, if Mark thinks he  
6 interpreted it right.

7 Two questions around -- could you go back to  
8 Number 10, the famous Number 10. In the second one, and I  
9 agree with Bruce, the optic of 80 percent of people worse  
10 off is a problem. How much of that is because of the  
11 combined deductible, I guess is my question. I assume --  
12 well, you are moving a lot of people -- 80 percent of people  
13 who are not hospitalized are now paying a much higher  
14 deductible and 20 percent of people are getting some  
15 benefit. So is that a major factor for this, the fact that  
16 more people are worse off?

17 MS. LEE: For the one on the right, that went down  
18 to 70 percent --

19 DR. BERENSON: Right.

20 MS. LEE: -- increased out-of-pocket spending,  
21 that is actually the surcharge, because, you know, even  
22 before anything happens with your cost sharing, you have

1 \$200 or \$400 that has increased. The one on the left gives  
2 you a better sense of what that deductible is doing.

3 DR. BERENSON: Yes, and I misspoke. You're right.  
4 So the one on the left, with people being worse off, is that  
5 a major function of the combined deductible?

6 MS. LEE: If you do not have hospitalization and  
7 only Part B spending, that combined deductible, since it  
8 compares to \$140, that is a significant factor.

9 DR. BERENSON: Okay. Well, I mean, in the handout  
10 you gave us, we only have, like, two sentences for why we  
11 think a combined deductible makes sense. It's intuitive and  
12 simple and it's easier to track. I think it would be good  
13 for us to try to articulate the benefits of a combined  
14 deductible. I'd be interested in Scott's view and others'  
15 about sort of the tradeoff. I think that's an important  
16 thing. I personally could go either way with it. I'd like  
17 to be convinced that the combined deductible does make sense  
18 and it does affect these distributions.

19 And I guess the second question I would have in  
20 terms of optics is can we do the calculations of both, of  
21 benefit changes only and benefit changes with surcharge,  
22 over a multi-year period, also? We can't do that -- you're

1 shaking your head -- to demonstrate what we want to  
2 demonstrate, that more people -- fewer people are negatively  
3 affected when you go out. We can't do that?

4 MR. HACKBARTH: You do have --

5 DR. HARRISON: In the future, we may have more  
6 years of data, but we really only have one year of data for  
7 this exercise.

8 MR. HACKBARTH: You can see the table, though --

9 DR. BERENSON: No, I saw the table, but that would  
10 be in terms -- again, I think I'm -- well, I don't think.  
11 I'm clearly with Kate that if we just lay out this by  
12 itself, it gives a very different picture of what it is that  
13 we're proposing and we do need to work a little bit. It's  
14 nice to have that other table around, but I think we've got  
15 to work on presentation here because I actually think we're  
16 in better shape than this table would suggest.

17 DR. HALL: Well, if we go back to the original  
18 objectives of this whole exercise, I think this plan  
19 addresses them. I mean, one thing we can't do is suggest  
20 change that makes people more responsible for health care  
21 decisions without causing some pain. No matter what plan we  
22 talk about, we're going to deal with that.

1           I think a single deductible rather than -- or  
2 combined deductible rather than pay me now, pay me later, is  
3 going to cause a lot of confusion. And so I agree with Bob  
4 that I think what we're talking about here is we have sort  
5 of a marketing problem rather than a fundamental problem of  
6 meeting the objectives that we started out with here.

7           DR. DEAN: I'm out of my element here. I don't  
8 really have strong feelings either way. It seems to me that  
9 Mitra's concerns about the combined deductible makes some  
10 sense, but I really don't have a good understanding of the  
11 implications of all of that, and how much we try to recover  
12 from a surcharge, also, I don't have a real clear sense of  
13 it.

14           MR. BUTLER: No strong feeling on the separate  
15 deductibles. I do think this 20 percent needs a little bit  
16 more rationale behind it rather than we're just trying to be  
17 a little bit better than budget neutral. So it'd be easier  
18 to say, if we were to be budget neutral to the program, this  
19 is the number and actuarially, given the downstream impact,  
20 this is what it would be if you really wanted to capture all  
21 of it and then let them make some judgment. It would be  
22 another way to frame it.

1           I do think we're losing a little bit of sight of  
2 maybe -- we're almost tinkering with something that is very  
3 important and it's going to enter a political context, as we  
4 talked about earlier in the day, that's going to have much  
5 bigger things, like are we going to start at age 65 or 67,  
6 or are we going to do this or are we going to do that. And,  
7 I think, let's not lose sight of the major points we're  
8 trying to make, and that is that the supplemental insurance  
9 really has a downstream impact on utilization. I don't  
10 think in health reform that was acknowledged at all because  
11 of the minimum basic packages for Medicaid expansion, some  
12 of these things, just, you know, not taking those kinds of  
13 things into consideration at all. So let's not lose sight  
14 of some of that point as well as the benefit redesign, that  
15 this doesn't make much sense, even though only ten percent  
16 of the people are really subjected to that, that don't have  
17 supplemental insurance. So those are my points.

18           DR. CHERNEW: So I agree with a lot that was said.  
19 A few basic points. The first one is that I don't think we  
20 should constrain in the recommendation there to be one  
21 single deductible. I actually think if you spent more time  
22 thinking about this, you'd realize for many cases, it's

1 crazy to have an inpatient deductible. There's no incentive  
2 effect. It's just a tax on people that get sick, right.  
3 Whereas the outpatient deductible has these remarkably  
4 complicated properties. On one hand, it discourages  
5 overuse. On the other hand, it discourages really  
6 appropriate use and you need to think about it more  
7 intelligently. We're not going to resolve all of that now,  
8 but I wouldn't constrain in our recommendation the Secretary  
9 to have a combined deductible. I think that's too limiting.

10           The second thing I would say is I have some real  
11 problems with aspects of the out-of-pocket max because I  
12 think there's a lot of low-value services that will be  
13 consumed above the out-of-pocket max, and I don't want to  
14 discuss that, but I recognize the risk issues and I think  
15 Kate was 100 percent correct on that.

16           But I would want to make sure that if you were a  
17 Medicare Advantage plan, you wouldn't be constrained, for  
18 example, not to charge some high cost sharing on some low-  
19 value services that really expensive people use. So within  
20 this fee-for-service world where there's not management, I  
21 think there's an appropriate risk thing.

22           In terms of the optics related to that, and again,

1 I agree completely with everything Kate said, and Mark, I  
2 think you gave the exact right answer, presenting this over  
3 a long period of time so that people understand that even if  
4 you're in the top two percent in one year, you could save a  
5 ton of money if you have a heart attack or if you have  
6 whatever it is. That's what has to be conveyed.

7           And I really would try -- I recognize the  
8 importance of not completely ignoring the politics, but I  
9 really would try to strive with starting out with what we  
10 think the most sort of efficient set-up is to the extent  
11 that we can get there, and then we kind of finagle how we  
12 can present it in a way that convinces people, as opposed to  
13 start with a premise of we need to make sure that more  
14 people are winners than losers and so we need to end up with  
15 a design that does this or does that. We're never going to  
16 get this perfect, obviously. And again, we have a low bar  
17 in the current system.

18           So I would focus on the two key deficiencies of  
19 the current system. The first one is that the supplemental  
20 insurance has a big distortion. That's what Peter said.  
21 The second one is there's way too much risk for people to  
22 bear. We don't do a good job of managing the risk in that

1 way. We don't think about the right behavioral responses.

2           The other thing I would say just in general, which  
3 is by way of just a huge compliment, is I believe employers  
4 are going to start cutting back on the subsidies that they  
5 pay for retiree health insurance, and a lot of times when we  
6 think about the world that people are going to be in when  
7 they face this market, we don't really fully understand the  
8 fact that a lot of people aren't really paying the premium.  
9 Someone is subsidizing the premium and stuff is going on.  
10 But when employers start dropping, which I think commonly  
11 they will, this is going to become a much, much bigger  
12 issue. So it requires, I think, a lot more thought.

13           So, essentially, the type of recommendations you  
14 have, I could always nitpick one way or another, but I think  
15 this is completely on the right track.

16           MR. HACKBARTH: So let me just ask Scott about the  
17 intersection of this with Medicare Advantage. One of the  
18 points Mike just made is he doesn't want to tie the hands of  
19 MA plans to have high cost sharing on low-value services  
20 even after a catastrophic limit. It used to be that there  
21 were no restrictions on plans' ability to have high cost  
22 sharing on services. Then there was a reaction to that and,

1 as I recall, there were some restrictions imposed by  
2 legislation/regulation. What do those restrictions now say?

3 DR. HARRISON: Right. Well, it used to be that  
4 you couldn't charge discriminatory cost sharing --

5 MR. HACKBARTH: Right.

6 DR. HARRISON: -- so you'd be discriminating  
7 against the sick. But now --

8 MR. HACKBARTH: And that was loosely interpreted.

9 DR. HARRISON: Right.

10 MR. HACKBARTH: So there were very -- was very  
11 high cost sharing in some MA plans on oncology services, for  
12 example --

13 DR. HARRISON: Right.

14 MR. HACKBARTH: -- and that was found consistent  
15 with non-discriminatory --

16 DR. HARRISON: Although it turns out that if you  
17 have low cost sharing on other things and have the Medicare  
18 level on some things, it's also considered high, but --

19 MR. HACKBARTH: Yes, right.

20 DR. HARRISON: But now they actually have out-of-  
21 pocket caps on all -- plans have to have an out-of-pocket  
22 cap, and it's somewhere just under \$7,000, I think.

1           MR. HACKBARTH: And it's an absolute cap once the  
2 --

3           DR. HARRISON: It's an absolute cap, and if they  
4 have a lower-level cap, and I'm forgetting exactly where  
5 that is, somewhere around \$5,000 -- it might even be a  
6 little lower -- then CMS doesn't look as hard at the cost  
7 sharing on individual services.

8           MR. HACKBARTH: Yes.

9           DR. HARRISON: So you'll see two clumps of where  
10 the caps are.

11          MR. HACKBARTH: Okay. Scott.

12          MR. ARMSTRONG: So, at this point, I'm probably  
13 amplifying a number of points that have already been made,  
14 but I'd like to do that briefly.

15                 First, I think this work is fantastic. It doesn't  
16 have to be said, but it probably just should be said again.  
17 The importance to MedPAC in our role of complementing our  
18 provider payment work with this kind of work, I think, is  
19 really important.

20                 I think it's long overdue. Generally, my view of  
21 this conversation, the recommendations, is we're being too  
22 conservative and too slow to make changes that are already

1 the standard in our industry and that -- and to a point  
2 several of you have made, I think we're seriously  
3 understating the value to our beneficiaries of some of the  
4 things that we're doing in here, like the out-of-pocket caps  
5 and some of the other things.

6 With respect to two different deductibles, I don't  
7 have a strong point of view on that, but I'm just not aware  
8 that that works anywhere else, and so I think it's good that  
9 we'll continue to talk about this, but I wouldn't have come  
10 into this discussion encouraging us to really do that.

11 The 20 percent surcharge on the supplemental  
12 plans, to me, is a very conservative approach to dealing  
13 with what we've acknowledged is a significant issue, and I  
14 think we're going down this path of a surcharge as opposed  
15 to some other regulatory change or elimination of the  
16 supplemental plans altogether and I don't remember -- I  
17 mean, I don't know what the right solution is, but the  
18 underlying problems created by the availability of the  
19 supplemental plans and their ability to mask the real  
20 problems we have with a core benefit, to me, are still only  
21 superficially addressed with a 20 percent surcharge on these  
22 plans.

1           And then, finally, I made this point earlier, but  
2 we look at the objectives that we've laid out for this work  
3 in general and we talk about reducing the beneficiaries'  
4 exposure, requiring cost sharing to discourage low-value  
5 services, being mindful of the impact on low-income  
6 beneficiaries. I really agree with all those things. But I  
7 think we also have to balance those with our other  
8 obligation and that is to be stewards for the overall cost  
9 trends for the Medicare program. I just -- I think we need  
10 to be a little more assertive about balancing the impact of  
11 these program changes on the overall expense trends and just  
12 recognize that -- or at least my view is we're being far too  
13 sensitive to the impact on the beneficiaries themselves in  
14 the absence of weighing that against this other goal.

15           DR. BORMAN: I do think this is one of the most  
16 important avenues or items we explored, and certainly in the  
17 time that I've been here, and you've really done strong work  
18 yet again at a staff level.

19           I think that this is -- there's so much that's  
20 good here, but I do think that there's a tremendous  
21 marketing burden, if you will, and marketing is not  
22 something that is intrinsic to Medicare, and I think that

1 will be a huge challenge. And I'm struck by some of the  
2 things that physicians are accused, for example, of always  
3 talking about changes in relative risk rather than absolute  
4 risk as we present interventions to patients.

5           This is somewhat the same in the beneficiary  
6 viewing this in terms of what happened to me this past year,  
7 what I know I paid, as opposed to what might happen to me  
8 and the fact that if it happens to me, it's 100 percent for  
9 me versus zero percent for me. This is going to take just  
10 an enormous amount of explaining and thinking about when  
11 your natural tendency, I think, as you age, is probably  
12 going to be to get more scared of the expense that you may  
13 face.

14           And so I think that we need to somewhere be pretty  
15 eloquent about the education and -- marketing maybe isn't  
16 the best term, but something, really the education and  
17 conveying that is going to be a huge piece of this if it's  
18 going to work the way that we want it to work and to meet  
19 all the laudable goals.

20           In terms of the specific piece about the  
21 deductible, I could go both ways on it except there's a  
22 piece I really like about the combined deductible in that it

1 makes no sense to me that we allow someone to be injured, if  
2 you will, for Part A when we believe that the services that  
3 they receive under Part B are of such value -- that so many  
4 of them are of such value and there's things that we want  
5 them to have. I mean, why would we want Part B to be  
6 voluntary, and essentially what this does is it converts it  
7 to involuntary, so that while politically the word  
8 "involuntary" probably is a death knell, if we can find some  
9 other word, I think there's really value to just getting --  
10 to acknowledging -- that to say one piece of care, you've  
11 absolutely got to have without having that other piece, I  
12 think, is -- to fix that is probably a good outcome of  
13 having a combined deductible. Getting people to understand  
14 the arithmetic of it, I think, is a huge issue and, I think,  
15 will present challenges.

16 In terms, Glenn, of your specific question about  
17 discomfort with zeroing it out or whatever, I'm fine with  
18 that.

19 MR. GRADISON: Talk about deja vu, I was burned  
20 pretty badly, like a lot of people, as a member of Congress  
21 when this came up the last time. We remember it as Medicare  
22 Catastrophic but often forget that this legislation also

1 included for the first time a Medicare prescription drug  
2 benefit. What killed it was a relatively small proportion  
3 of high-income people were objecting to the income-related  
4 premium which they would have to pay and that sunk the whole  
5 thing. A handful of us stayed with it right to the end.

6 I support this. Consistency being the hobgoblin  
7 of little minds, I am trying to be consistent. But what  
8 does strike me about this as compared with the prior  
9 experience is that, here, the increase is actually not  
10 limited to people at the top at all, who will hardly notice  
11 the fact that they've got to pay 20 percent more on their  
12 Medigap policies, but a much larger percentage than was true  
13 then of people of far more modest means.

14 Finally, though, I recall one of my favorite  
15 members of Congress from years ago whose aphorism was, when  
16 in doubt, do right, and I think that's about where I end up  
17 on this.

18 DR. CASTELLANOS: Well, I'm going to be a little  
19 outspoken, as usual. Like Tom, I think I'm way out of my  
20 element, so I would like to be in my element, which is  
21 called the real world.

22 Scott, you say we're not very sensitive to the

1 impact -- we shouldn't be as sensitive to the impact on the  
2 beneficiary. I just remind you that the beneficiaries are  
3 the voters for Congress and Congress wants to do one thing.  
4 They want to get reelected. And when you have 80 percent of  
5 the people that are worse off, I don't think Congress is  
6 going to take this with a lump of sugar at all. I think we  
7 have a real, real issue there.

8 I think what this is going to do, it's going to  
9 cause you a lot more business because it's going to force  
10 everybody into MA. Why would you want to stay in fee-for-  
11 service? I think you want to go into MA, and I think we  
12 have to realize that's what's going to -- in my opinion,  
13 that's what's going to really happen.

14 I also have -- you know, Karen's point is  
15 extremely important. We need to have a better beneficiary  
16 and provider education on these options to at all get  
17 anywhere.

18 I guess another concern I have, and maybe it's  
19 really not a concern, but it's a concern, is that when we  
20 present -- if this is presented as it is now in the  
21 Chairman's draft recommendation to Congress, I just wonder  
22 what the real world is going to think of MedPAC's

1 credibility.

2 MR. HACKBARTH: So, there's a lot here that I  
3 could touch on, but let me just focus on one point because  
4 we're very late. You know, I think this is a controversial  
5 recommendation and I think the most controversial piece of  
6 it is the surcharge. And so the question is, people want  
7 comprehensive coverage, as evidenced by their decisions on  
8 purchasing supplemental plans, but they want first dollar  
9 coverage without the management of the care that goes with  
10 it in Medicare Advantage. So they want the cake and eat it,  
11 too, and the current arrangement allows people to shift the  
12 cost to the taxpayers and that's the policy problem. And  
13 people like that, but in the current fiscal situation, for  
14 my money, that's a situation that we can no longer tolerate.

15 And I think if people want first dollar coverage,  
16 they should be entitled to buy it, but they should see at  
17 least some portion of the additional cost that the taxpayers  
18 incur because of that. And then there are lots of different  
19 ways that you could think about whether it ought to be 20  
20 percent or some different number. But for me, that's the  
21 bottom line. If you want the combination of open system, no  
22 management of care, and comprehensive coverage, you need to

1 see some of the cost of that choice.

2           The other alternative for the Congress is that as  
3 we face these increasingly severe fiscal pressures, the only  
4 way we can get that money is take it out of the providers.  
5 Beneficiaries, no, it's always too controversial to touch  
6 the beneficiaries. We'll just continue to take it out of  
7 the providers. And I think I'm all in favor of taking some  
8 out of the providers. We spend 90 percent of our time  
9 talking about the best ways to try to do that. But I think,  
10 at the end of the day, the beneficiaries are going to have  
11 to contribute some piece to it, and that's what brings me to  
12 this conclusion.

13           DR. MARK MILLER: The other thing I was going to  
14 add to that, after Kate's comment and Bob's and yours and  
15 some over there, maybe Mike, I mean, the other way you could  
16 almost express that right-hand column is how much the  
17 subsidy is now and then how much you're asking the  
18 beneficiary to pay of the subsidy, because you could express  
19 that as the people who are getting Medigap now. There's a  
20 subsidized portion of that and we're saying, okay, there's  
21 some charge against that now, and maybe reconfigure how we  
22 express that using that kind of a metric. So I'm just

1 trying to think about how to operationalize some of the  
2 things that you've been --

3 MR. HACKBARTH: And just one last thought. You  
4 know, one of the properties of the surcharge is that the  
5 payment, the amount the beneficiaries pay, will be directly  
6 related to the costs incurred in their area. Unlike the  
7 Part B premium, which is a flat national amount and the low-  
8 cost parts of the country are probably overpaying their fair  
9 share and the high-cost parts of the country are  
10 underpaying, this is a way to introduce some beneficiary  
11 contribution to the program that is directly related to the  
12 costs incurred in their parts of the country and also by the  
13 supplemental insurance coverage that they purchase. If they  
14 choose a more elaborate package, a richer package, they'll  
15 pay -- the 20 percent would be a higher dollar figure than  
16 if they choose a leaner version. And I think those  
17 properties are an important way to add -- if we're going to  
18 have some more costs for the beneficiary, I like those two  
19 features of the surcharge.

20 Okay. So we're not quite to the finish line on  
21 this. Obviously, we'll be back in touch and talking with  
22 people more about this in the next few weeks.

1           Thank you, Julie and Scott. Terrific work.

2           And now we will move to our last session of the  
3 day, which is the mandated report on rural health care.

4           DR. AKAMIGBO: Good afternoon. So this is the  
5 final presentation on the rural report which began in 2010.  
6 We've presented various components of the report in detail  
7 in prior meetings, and you have a draft of the report in  
8 your mailing materials. We will summarize the highlights  
9 today, and we look forward to any comments you may have for  
10 us before we submit the final report in June.

11           Before we start, we wanted to take a moment to  
12 thank David Glass and Joan Sokolovsky who've contributed  
13 immensely to the report, and our RAs - Matlin Gilman and  
14 Kelly Miller.

15           So this report, as mandated by the Patient  
16 Protection and Affordable Care Act, requires that we examine  
17 four issues. The first is access to care, which we  
18 discussed last February. Second is quality, which was  
19 discussed in October. Third is adequacy of rural payments,  
20 which was discussed in detail in each sector in December and  
21 summarized in January, for rural areas specifically. And  
22 the last issue was payment adjustments to rural payment

1 rates, which we discussed last September.

2 I will start with a summary of our findings on  
3 access to care. We have found, as others have, that there  
4 are fewer physicians per capita in rural areas,  
5 subspecialists are even more likely to concentrate in urban  
6 areas, and recruitment of physicians continues to be a  
7 serious challenge for many rural communities.

8 However, despite these differences, we showed back  
9 in February that access to care is relatively equal in both  
10 rural areas and urban areas as measured by volume of  
11 hospital services, physician visits and utilization of  
12 skilled nursing, home health and pharmacy services. So,  
13 equal volumes may be explained by the fact that rural  
14 beneficiaries get about 30 percent of their care in urban  
15 facilities.

16 So in some cases, rural residents may have to  
17 drive further distances to access care and average travel  
18 times were slightly longer for rural residents. While, on  
19 average, that difference in travel time was about 7 minutes  
20 higher, or longer, for rural residents, there is some  
21 variation about that average as evidenced by one finding  
22 that 41 percent of rural versus 25 percent of urban

1 residents drive for more than 30 minutes to access their  
2 care.

3 Our analysis of Medicare surveys confirmed that  
4 beneficiaries' satisfaction with their access in rural and  
5 urban areas were relatively equal. For example, among the  
6 very few beneficiaries who expressed concern with their  
7 access, the same share of rural and urban beneficiaries  
8 cited travel as the source of their concern.

9 So while we don't find significant differences in  
10 service use among rural and urban Medicare beneficiaries, we  
11 do find more pronounced differences by what region of the  
12 country beneficiaries live in. Here, we see that overall --  
13 nationally, in bold there -- rural urban differences in  
14 service use is negligible, but when we look at regions of  
15 the country with high utilization rates per beneficiary,  
16 like Louisiana, we see higher rates for rural and urban  
17 areas, like Monroe. Low use areas like Wisconsin show the  
18 same rates for both rural areas and urban areas, like  
19 Madison. In some, access and use of services tend not to  
20 differ by very much, by rural-urban status, but there are  
21 differences by geographic region.

22 So given our findings on rural access to care, the

1 Commission has developed guiding principles to examine rural  
2 health care for Medicare beneficiaries. The principle for  
3 access posits that rural beneficiaries should have equitable  
4 access to services. Equity in access can be measured by  
5 volume of services, visits, prescriptions as well as  
6 beneficiaries' reports of their experience. And when we  
7 discuss equity in access, we recognize that some rural  
8 beneficiaries may drive longer distances than their urban  
9 counterparts.

10 The quality findings we presented in October 2011,  
11 which informed our principles, are summarized on this slide.  
12 Overall, we found that rural and urban quality, as measured  
13 in each setting, is similar in skilled nursing facilities,  
14 home health agencies and dialysis facilities.

15 On the other hand, hospital quality across rural  
16 and urban areas is mixed. First, readmission rates are  
17 roughly equal between urban and rural areas. Process  
18 measures, as reported on Hospital Compare, were generally  
19 worse for rural providers and tended to worsen as providers  
20 became smaller. Mortality rates are worse in rural areas.  
21 And while, on average, larger hospitals have lower mortality  
22 rates than smaller hospitals, hospital volume only partially

1 explains the gap between rural and urban providers. It  
2 could be that it is more difficult to achieve high  
3 performance scores when hospital clinical staff see certain  
4 patients less often and there are potentially different  
5 staffing levels and ratios in rural areas.

6           Now on to guiding principles for rural quality of  
7 care -- first, the quality of non-emergency care delivered  
8 in rural areas should be equal to that of urban areas. This  
9 reflects the reality that for non-emergency care, where  
10 there is a choice of whether to treat the patient locally or  
11 transport them to a larger urban facility, the rural  
12 facility should be held to the same standards as the urban  
13 facility. The small rural facility should be as good as the  
14 alternative site of care.

15           However, emergency care is different. There may  
16 be no alternative and small rural hospitals are obligated to  
17 treat those patients. In these emergency situations, our  
18 expectation for outcomes at small rural hospitals may not be  
19 as high as they are for larger facilities. Our  
20 expectations, therefore, should reflect the inherent  
21 limitations that exist in small rural hospitals compared to  
22 large urban hospitals.

1           Finally, most hospitals are currently evaluated on  
2 the care they provide to Medicare beneficiaries, and their  
3 performance is publically reported on Hospital Compare.  
4 However, critical access hospitals have been exempted from  
5 some quality reporting requirements.

6           And as the Commission has stated, providers should  
7 be evaluated on all the services they provide. This  
8 includes measures common among rural and urban providers as  
9 well as measures that are specific to rural providers such  
10 as timely communication of patient information after a  
11 transfer. The Commission's principle here emphasizes that  
12 evaluations should include measures common among rural and  
13 urban providers and measures that are more specific to rural  
14 providers.

15           So to allow equal access to information for all  
16 patients, all hospitals should be subject to public  
17 disclosure of their performance scores. This may improve  
18 accountability and hopefully improve the quality of care  
19 delivered in small facilities.

20           Jeff will now pick up with our findings and  
21 principles for payment adequacy and special payments.

22           DR. STENSLAND: As we discussed in January, rural

1 and urban payments are adequate for most sectors. In  
2 general, volumes of care, other indicators of access, profit  
3 margins are all similar in rural and urban areas and  
4 indicate adequacy of payments for physicians, home health  
5 agencies, skilled nursing facilities, hospices, IRFs and  
6 hospitals.

7           However, there is one area that needs further  
8 work, and that's dialysis. There's a new payment adjuster  
9 for dialysis facilities that started in 2011 that will  
10 increase payments for all low volume facilities including  
11 many rural facilities. While the low volume concept fits  
12 with the principles we will show you in this paper, there is  
13 some concern that the dialysis policy is not targeted to  
14 isolated facilities, and we'll be examining the issue in the  
15 fall of 2012 when the new data become available.

16           For hospitals, we find that payments are adequate  
17 relative to urban payments. However, this differs from the  
18 MedPAC's finding from the 2001 report, and I have a graphic  
19 here that will explain a little bit why it differs.

20           As you can see on this slide, rural Medicare  
21 margins for hospitals were far below urban margins from 2000  
22 to 2002. And during this time I think there were two

1 problems that the Commission identified. One was that the  
2 payment rates were biased towards large urban providers, and  
3 the Commission recommended some changes. Second, small  
4 isolated providers that had suffered from low volumes, in  
5 part due to low population density and not due to any  
6 shortcomings of their own, were not getting the help that  
7 they needed, and the Commission also recommended a low  
8 volume adjustment which fits into the principles we've  
9 talked about here. And when those two policies were  
10 enacted, the gap between rural and urban margins started to  
11 close.

12           Then there was also a series of other adjustments  
13 that took place, and the gap not only closed, but now rural  
14 margins tend to be slightly above urban margins.

15           This slide shows a list of recently enacted  
16 payment adjusters for rural hospitals, and it starts at the  
17 top with a couple that MedPAC recommended. And I guess the  
18 main points from this slide are:

19           First, that there are many different adjusters.  
20 That's the one point.

21           The second is some of these adjusters and some of  
22 these changes were necessary for fairness and for access.

1 And I would say some of the fairness adjusters were the  
2 first two adjusters where we moved rural payments up toward  
3 the urban rates, their base payments, and some of the things  
4 that might be necessary for access may be a low volume  
5 adjuster for the isolated hospitals if we didn't have the  
6 critical access hospital program.

7 And third, as we discussed in the past meeting,  
8 some of these adjusters do not meet the principles the  
9 Commission has discussed and developed over the past year,  
10 and we'll turn now to those principles.

11 The first principle is that low volume adjustments  
12 should be targeted to isolated providers. It does not make  
13 sense to provide a low volume adjuster to two competing  
14 providers that are ten miles from each other.

15 Second, we want the amount of the adjustments to  
16 be empirically justified. With respect to low volume  
17 adjustments, the adjustment should be tied to the total  
18 volume of patients and not just Medicare volume. In  
19 addition, the low volume adjustment should not duplicate  
20 other adjustments as they currently do for some hospital  
21 payments.

22 Finally, it's important to think about incentives.

1 Different ways of payment carry different incentives. While  
2 all hospitals have some incentive to control costs due to  
3 receiving prospective payment from some payers, Medicare  
4 creates stronger incentives for cost control to the degree  
5 that its payment are prospective and reduces incentives for  
6 cost control to the degree that its payments are based on  
7 cost.

8           So that's the summary of the findings in the full  
9 report, which you've all received in your mailing materials,  
10 at least in draft form. We've tried to summarize the  
11 principles the commissioners developed over the past year,  
12 and now we'd like to hear your comments on the principles,  
13 the draft report and its finding, and any other guidance you  
14 have as we move forward to finalizing the report over the  
15 next month or so.

16           I now turn it back to Glenn.

17           MR. HACKBARTH: Thank you.

18           So as you might imagine, we've had lots of  
19 conversations about both the content of this report and how  
20 particular issues are framed and discussed. In the last  
21 week or 10 days, we've had multiple conversations with Tom  
22 and Herb about the report, and I think those conversations

1 have been very productive, and we're working towards a  
2 better product than we would have without them.

3           There have actually been some changes made that I  
4 don't even think are in the materials that were distributed  
5 for the meeting. So the briefing materials went out last  
6 Thursday or something, and even some modifications have been  
7 made since then. Again, I think they've been making the  
8 report better.

9           Two common themes, and I'm going to turn it over  
10 to Tom to lead off the clarifying round.

11           Two common themes in these conversations have been  
12 that the important part of the message is that the various  
13 changes that Jeff summarized, that have been made in the  
14 payments for rural providers, have done a lot of good things  
15 and helped a lot of institutions that otherwise would have  
16 had a very difficult time financially and may have closed  
17 with detrimental effects for the populations they serve. So  
18 that's an important message that should come through in the  
19 report.

20           The second theme is that we've talked a lot about  
21 averages, and by definition, there is always variation  
22 around the average and there are always exceptional cases

1 and circumstances. And we need to take care that in  
2 reporting about averages, people don't lose sight of the  
3 variation that exists around them.

4 In some instances, we try to enrich the discussion  
5 by doing subcategories of rural, and of course, as everybody  
6 well knows at this point, the label "rural" covers hugely  
7 different circumstances around the country. And so in many  
8 instances, we use various gradations of rural to try to get  
9 at some of that variation. But even after all of that,  
10 there are still exceptional circumstances that we need to be  
11 cognizant of.

12 Now to be fair, that's not just true when we talk  
13 about the rural label; that's also true when we talk about  
14 the urban label as well. It's just the nature of the issues  
15 that we deal with.

16 At the end of the day, you cannot have a sensible  
17 conversation about these things without talking about  
18 averages. You can't talk about every individual institution  
19 or adapt payment to every individual institution.

20 The only payment mechanism that is adapted to  
21 every institutional -- individual institution is cost  
22 reimbursement, which comes with its own problems, some of

1 which are discussed in the report. And among them are  
2 consequences that can be quite detrimental to Medicare  
3 beneficiaries. If we use cost reimbursement to prop up  
4 institutions that are really not a reasonable size and not  
5 able to do a good job for Medicare beneficiaries, that's a  
6 problem too.

7 So I'm afraid there's no way of talking about --  
8 getting around talking about averages or using payment  
9 mechanisms that are often based on averages, but we do need  
10 to acknowledge that there is, of course, variation.

11 With that, Tom, let me turn it over to you. I  
12 think what I'm going to propose is since we've been over  
13 this topic I don't think we need to do a clarifying round.  
14 And why don't we just focus on going right to our round two  
15 comments and questions?

16 Tom.

17 DR. DEAN: I do have a couple of clarifying  
18 questions.

19 MR. HACKBARTH: Well, you're entitled to do that.

20 DR. DEAN: Okay.

21 MR. HACKBARTH: As opposed to going around two  
22 times, we'll just do once.

1 DR. DEAN: There were a couple of things in the  
2 report, that just I didn't quite see a long list of  
3 concerns, but that just didn't quite fit. One of them was  
4 the map on page 31 which is basically the counties where  
5 people had to drive a significant distance for pharmacy  
6 services, and it shows none of those counties in Wyoming,  
7 for instance. That just doesn't fit with my knowledge of  
8 what the geography of Wyoming is.

9 And also -- I mean, it's also Arizona, California,  
10 Washington, Oklahoma. These are very sparsely populated  
11 areas, and it just didn't fit.

12 DR. STENSLAND: Well, I guess the clarifying  
13 comment on this map is this was developed by Acumen, and  
14 they looked at the addresses of every beneficiary and every  
15 pharmacy, and looked at the different distances traveled.

16 And first, I'll say what they're not saying.  
17 They're not saying no one in Wyoming traveled more than 18  
18 miles to get to the pharmacist.

19 What they are saying is that all the counties in  
20 Wyoming, for the people in that county, the average travel  
21 time was less than 18 miles. And that could mean that you  
22 would have maybe one town that would be here and most of the

1 people live in the town and very few people live out in the  
2 ranching area, or whatever else, and most of the people have  
3 less than an 18-mile drive. So that's, I think, why you see  
4 things like that in Wyoming.

5           And maybe in some other towns, like when I think  
6 of some of these counties that I've been to, like in  
7 northwestern South Dakota, you do have little towns around  
8 there -- what I would call grain elevator towns -- where  
9 maybe you're not big enough for McDonald's but you've got a  
10 grain elevator. And in those kinds of places, those people  
11 might be commuting into the main town and it might be more  
12 than 18 miles on an average for those people to go into the  
13 main town and county that happens to have that pharmacy, or  
14 to the next county over that has the pharmacy.

15           And we can show you maps where they -- and give  
16 those to you, where it has little dots for every person and  
17 where they're traveling to.

18           DR. DEAN: I guess -- I mean, I don't disagree  
19 with that. The question is: Does this map really represent  
20 what the real issues are or the real problem is?

21           So I mean, I don't know. I don't know what the  
22 answer is.

1           By the way, grain elevators are disappearing  
2 because they're inefficient and OSHA is insisting that they  
3 may be closed down, but that's probably not -- doesn't need  
4 to go into the report.

5           We'll keep it -- [laughing.]

6           The second issue, there was talk -- and I know  
7 some of this has already been changed -- about home health  
8 agencies and the profitability and so forth. But it was a  
9 concern, and I think you've heard me talk about this before,  
10 that provider-based home health agencies are not included.  
11 And the justification has always been that well, we can't  
12 really trust those cost reports because of hospital CFOs  
13 shifting cost and so on.

14           But they tell me that they have to fill out a  
15 separate cost report for their home health services. I  
16 mean, is that true?

17           DR. STENSLAND: That is true, but they take some  
18 of the hospital overhead and it goes onto the home health  
19 agency. So the question is: Is that really overhead  
20 allocation correct?

21           And I think part of the reason they might think  
22 it's not profitable anymore is now if you're a critical

1 access hospital you're getting cost-based reimbursement.  
2 And then, you have a home health agency that's getting paid  
3 prospective payment. If you take some of your costs away  
4 from the hospital and shift it, shift some of the overhead  
5 onto your home health agency, you're going to get less cost-  
6 based payment for your outpatient and inpatient services  
7 from Medicare because there's less cost to be allocated to  
8 those two services.

9 DR. DEAN: Okay. I mean, I'm certainly no  
10 accountant, but we've had several in my area where they've  
11 actually closed because they said they couldn't support the  
12 cost. And I don't think you would do that if you were  
13 worried just about accounting issues. So I don't know what  
14 the answer is, but I have some concerns about that  
15 explanation.

16 And I guess I'm particularly concerned because in  
17 South Dakota, as you've heard me say more than once, you  
18 know probably three-quarters or more of the home health  
19 agencies are provider-based. In fact, there's only about --  
20 there's only two-quarters of the state where we have any  
21 free-standing facilities.

22 MR. HACKBARTH: Tom, there are two distinct points

1 here. One is that, for the reasons that Jeff described, it  
2 doesn't make sense to routinely report separately the costs  
3 of hospital-based home health agencies. It does not follow  
4 from that, that we're saying that every hospital home health  
5 agency is, in fact, profitable. Some of them may lose  
6 money.

7 And so, both things can be true. This isn't a  
8 good way to look at the profitability of the home health  
9 business, and not all of them are profitable.

10 It just, I guess, makes me uncomfortable; they  
11 don't even get included in the analysis, but -- you know.

12 MR. HACKBARTH: The effect would be to distort the  
13 analysis and make it a less clear picture of the financial  
14 performance, but that's not to deny that there are some that  
15 lose money.

16 DR. DEAN: Okay. The final one on the  
17 clarification issues, you talked about the hospital -- rural  
18 hospital margins being now better than urban although if you  
19 look at that graph, rural hospital margins were -2 in 2000  
20 and they're still -2. The change is not in rural hospitals;  
21 it's what's happened to urban hospitals, which have been  
22 basically hammered by cuts. So I think it's a little -- it

1 isn't entirely accurate to say that.

2           You know, some of these programs clearly have  
3 helped rural hospitals, but to say that they have done well  
4 isn't exactly, I think, a good representation. I think the  
5 problem -- where the changes come -- is in urban hospitals.  
6 So I'm not sure that statement is really justified.

7           MR. HACKBARTH: You don't need to do it right now,  
8 but why don't you show us which statement that goes along  
9 with this graph you think is inaccurate?

10          DR. DEAN: Okay, we can do that later.

11          DR. MARK MILLER: The other thing is if you were  
12 to fold CAHs into it, it would look different because there  
13 are 1,300 hospitals that are paid on cost that are not in  
14 that picture, in an attempt to be fair, to show PPS to PPS.  
15 But if you're just showing urban and rural, there are 1,300  
16 hospitals that aren't on that graph.

17          DR. DEAN: I'm not sure how that would -- I don't  
18 think we can say how it changed because at least the  
19 information I have is that roughly 40 percent of CAHs have  
20 negative bottom lines.

21          MR. HACKBARTH: Medicare -- they'll have positive  
22 Medicare margins, and these are all Medicare margins.

1 DR. DEAN: Okay. Well, again -- okay.

2 DR. MARK MILLER: [Off microphone.] In some ways,  
3 this chart could have looked much --

4 DR. DEAN: Yes, okay.

5 Okay, but on to the more general things, you know,  
6 there's a lot -- as critical as I've been about some of  
7 this, there's certainly a lot of good observations in this  
8 work, and I know that there's a lot of work that's been  
9 done. So I don't want to sound too critical or too  
10 negative.

11 On the other hand, I am really worried that  
12 there's a risk of misinterpretation for a number of the  
13 statements that are in here. And I think it's going to be  
14 read by a number of people that really aren't particularly  
15 familiar with these particular areas or these particular  
16 issues, or the unique problems that exist. And I think the  
17 problems are unique in some sense, not always. But I guess  
18 that's where my worry is.

19 You know, we -- I understand, Glenn, the issue of  
20 averages. I've complained about focusing on averages. And  
21 to some degree, we don't have any choice although I think  
22 whenever we do use an average it's also important to state

1 what the variation is and what the range is, and what the  
2 high and low numbers are, and that oftentimes did not show  
3 up in some of these numbers. So that's one concern I have.

4 I'm also concerned about the tone in a number of  
5 areas. And just to pick out one, there was a comment about  
6 independent pharmacy closure, and the statement, I think, in  
7 the report is something about most of the pharmacies that --  
8 most of the independent pharmacies that closed were in  
9 communities where there was a competing pharmacy.

10 Over that period of time, there was about, I think  
11 you have 922 closures or something. And it's true; the  
12 majority of those were in communities where there was  
13 another pharmacy. On the other hand, 30 percent of those  
14 closures were in communities that did not have another  
15 pharmacy. So there actually were 30 percent of those that  
16 actually lost access to pharmacy service in their community.

17 I think -- and that wasn't mentioned, and I think  
18 that's -- 30 percent is enough that it needs to be mentioned  
19 because it tended to sort of -- I'm concerned that it tended  
20 to kind of gloss over something that is really a significant  
21 problem.

22 I don't have a solution for it, but I think there

1 is a problem there that wasn't really identified in the  
2 area.

3 Another concern I have is there were some places  
4 in the report where it wasn't really internally consistent.  
5 For instance, in the discussion about process measures,  
6 there was some really good analysis of the problems with  
7 using process measures to define quality -- the fact that in  
8 many cases they are poorly correlated with outcomes -- and  
9 yet, in other parts of the report we seem to put a lot of  
10 emphasis on process measures.

11 And I think we need to do -- we need to be  
12 consistent, that if we really don't quite trust these  
13 measures, then we shouldn't be overstating their effect in  
14 terms of the measurement.

15 On the issue of quality, this is a hard one. I  
16 probably am a little defensive. I've worked in these  
17 facilities for 30-plus years. And it's hard. I mean, these  
18 are complex issues, and the struggle between determining the  
19 drive that we all have. None of us want to defend poor care  
20 or sloppy care or incomplete care. At the same time, we're  
21 talking about small staffs, extremely broad ranges of  
22 responsibility.

1           And we don't want to be -- if we -- I think it  
2 came up earlier. If we let the perfect be the enemy of the  
3 good, we will end up doing damage, and I don't think anybody  
4 wants to do that. So understanding where the balance is, is  
5 really tough.

6           So I can't really -- I don't have an answer, but I  
7 think I don't -- on one hand, I don't want to support care  
8 that's inadequate. On the other hand, I don't want to say  
9 to overly criticize care for situations where there are  
10 barriers to quality that we don't really or certainly don't  
11 identify.

12           So I think it's a tough thing. It's something we  
13 struggle with. And like I say, I get uneasy about it, and  
14 I'm not sure what the answer is. But I think we need to be  
15 careful that we're not too quick to use some relatively  
16 simple parameters that may or may not really be fair to the  
17 situation.

18           DR. MARK MILLER: Can I say something before you  
19 go on to your next point?

20           DR. DEAN: Sure.

21           DR. MARK MILLER: On that one, what I thought the  
22 Commission came to because of the very things that you

1 pointed out in previous conversations and our own site  
2 visits -- the principle that the Commission came to is in  
3 the emergent situations you should expect a difference, and  
4 I feel like in some ways the Commission report tried to take  
5 your very point. And it's not a solution, but the point of  
6 the report is this should be recognized when you look at  
7 judge -- when you look at quality in a rural setting.

8           So there may be tonal statements that you want us  
9 to look at in the report, but the landing point was to try  
10 to absorb that very comment.

11           DR. DEAN: Yes, and there is -- you know. I'm not  
12 sure that it's as complete as it needs to be, but there was  
13 that in there.

14           I guess I will -- there's -- you know, I could go  
15 on, but I won't.

16           I guess I would -- one -- this one last point. I  
17 think the observation that there's more difference in  
18 regional variation than there is in rural/urban variation is  
19 a very important and extremely useful observation.

20           Having said that, I think we need to be careful  
21 that we don't just automatically assume, well, then  
22 everything is okay. I mean, Minnesota is oftentimes

1 identified as a low utilization state, and it is. But I  
2 know, talking to the folks in Minnesota, there are  
3 significant access problems in some of the remote parts of  
4 Minnesota. And so, they are very -- they're low  
5 utilization, but it's probably too low in some areas, and  
6 it's not uniform across the states.

7 So, you know. I don't know.

8 I think we probably are not using the right  
9 parameters to really break it down, but we do what we can, I  
10 guess. So, anyway.

11 MR. HACKBARTH: On the Minnesota issue, that's one  
12 that you've rightly pointed out before. Just so the other  
13 commissioners are aware of that, when we looked into that,  
14 we found that in fact what you were reporting was correct.  
15 The people in Minnesota said the primary problem is not  
16 Medicare payment being inadequate; it's there are a lot of  
17 other factors involved here as well.

18 DR. DEAN: It's a complex issue. I don't -- well,  
19 I'm not sure that's exactly what they say. That isn't  
20 exactly what they told, but I know. I know.

21 DR. MARK MILLER: I know.

22 DR. DEAN: We've had the discussion, but I-

1 DR. MARK MILLER: But I do want to say something  
2 else, rather than just dispute that point. When we're on  
3 the phone, they said, you guys aren't the problem. Medicaid  
4 has pulled out -- pulled back its rates and some counties  
5 had pulled back some funding, and that was the problem.

6 But nonetheless, what I also want you to know, and  
7 others to know, is we have also changed the document, which  
8 you don't have in front of you, to be very clear that these  
9 utilization levels; these aren't statements about them being  
10 the correct utilization levels and that even though you see  
11 this variation, in no way is this statement that that's the  
12 right level.

13 And so, we went -- based on your comments, we went  
14 in and made changes there as well because I think your  
15 fundamental point is I still think -- you speaking -- there  
16 may be people not getting the services that they need, and I  
17 think that's your main point.

18 DR. DEAN: Yes, and I think we had the discussion  
19 about we keep trying to struggle to figure out what the  
20 right level really is. And we don't -- we're not very -- we  
21 don't really know very well.

22 And I guess even if you accept the issue that

1 Medicare is not the problem, the reality is you've got  
2 significant areas where Medicare beneficiaries do not have  
3 access. So, whatever the problem is.

4 DR. BERENSON: Yes, I wanted to talk about two  
5 things. First, I like the report very much. I think you  
6 did -- I support the recommendations.

7 I wanted to raise one issue that -- I mean, I'll  
8 have some comments for editing, but I wanted to ask about  
9 one topic, which is the low volume adjustment. And it's a  
10 very compelling table you present in the paper: Low volume  
11 policy favors hospitals with larger non-Medicare shares.  
12 I'm wondering if you could even buttress that argument, but  
13 I need to know a little more of the data.

14 If, in fact, of the -- you have a column that says  
15 Private Payer and Other Discharges, what the mix is between  
16 private payers and Medicaid there. Because from the other  
17 work that you've done, and the Commission has done, I assume  
18 that a low-volume rural hospital for private payers either  
19 has a contract with pretty high rates because there's no  
20 competition, or they just are getting paid charges and  
21 there's no contract in place at all so that they're actually  
22 doing very well on the -- relatively well on the non-

1 Medicare side.

2           So disproportionately giving hospitals that have  
3 larger non-Medicare shares is even compounding. I mean,  
4 they have less of a compelling need unless they have a high  
5 proportion of Medicaid patients.

6           And so, I'm just wondering what we know about that  
7 and whether my reasoning makes sense, question one.

8           DR. STENSLAND: I don't have the Medicaid number,  
9 but from the AHA data we do have the profit margins and the  
10 private pay numbers. And they aren't huge. They're  
11 somewhere around -- everybody is like 30 percent. But  
12 nevertheless, if you have a lot of private pay, you're going  
13 to be doing better.

14           DR. BERENSON: I think you could even buttress the  
15 argument then because I think the way this has been  
16 constructed just is the wrong way, and I think you have a  
17 stronger argument to make.

18           The second one, I just wanted to briefly comment  
19 on Tom's concern about process versus outcome measures, and  
20 I actually am sympathetic to -- I mean, I thought the  
21 chapter starts getting into some very important issues  
22 around the emerging literature -- that process measures, at

1 least for hospitals, don't seem to predict outcomes very  
2 well. And it's worthy saying I hope we actually pursue that  
3 more fully outside of burying it in a rural report.

4           But it is the existing paradigm right now. I  
5 mean, Hospital Compare uses those measures. The value-based  
6 purchasing program at CMS is going to use those measures.  
7 There are some people who don't necessarily agree with sort  
8 of the direction of your argument, and which I think is  
9 basically right, and would still have a high priority on  
10 process measures.

11           So I don't -- I guess what I'm saying is I don't  
12 think this is the place for MedPAC to sort of take a strong  
13 statement and say we really don't think process measures are  
14 what we should be evaluating plans on. I mean performance  
15 on, in rural areas. The fact that there's also a problem on  
16 mortality rates, I think, suggests that there is a  
17 difference probably in quality.

18           So I guess there's probably a balance to find,  
19 which is that we need to follow this over time. But at  
20 least right now, it is reasonable to make some inferences  
21 based on the performance on process measures, if that makes  
22 any sense.

1           MR. KUHN: Let me first start by thanking Jeff and  
2   Adaeze for putting this report together and getting us to  
3   this point. You've done some terrific work here and thank  
4   you for that.

5           I also want to thank you for taking all the time  
6   to go out and visit a lot of rural areas across the country  
7   and also meeting with a lot of the various stakeholder  
8   groups that have come in to meet with you, to talk about  
9   this report. I suspect there will be many more to come in  
10  now that we've got a draft report, to talk to you about more  
11  details on that.

12          And then also, I want to thank Glenn and Mark for  
13  allowing me to bend their ear many times on this report. I  
14  know Tom, as well, and George have also done that. So thank  
15  you for your sensitivity and your efforts on this.

16          Like others, I'm going to have a lot of edits to  
17  share with you and will do that after this meeting, but let  
18  me just touch on some kind of major themes I have, or some  
19  highlights, in the three areas of the report -- the access,  
20  the quality and the payment.

21          First on the access, one of the findings in this  
22  report is that there are fewer local -- there are fewer

1 physicians in rural areas than urban areas, not a big news  
2 flash there. I think we've all known that for years, if not  
3 decades.

4 But what I think this report shows is that  
5 individuals who live in rural areas are getting basically  
6 equal access or levels of care that folks in the urban  
7 areas, and I think that is news.

8 But my takeaway from the report is that in order  
9 to achieve that both rural providers as well as rural  
10 Medicaid -- Medicare beneficiaries are having to work harder  
11 in order to access that care, and I think that is news. And  
12 I think that's important.

13 Now I think the real question for a lot of us is:  
14 Is that a sustainable model into the future?

15 I know I've asked a couple times in the past, and  
16 I think the data are hard to come by, but is there a way  
17 that we can kind of stratify physicians by age in rural  
18 areas versus urban areas so that we can kind of do a little  
19 bit of a look forward, to say okay, it's stable now, but  
20 look out with perhaps retirements in the future?

21 So that would be something still that would be, if  
22 that's possible, and if not, at least something that we can

1 talk about in the report a little bit more.

2           The other kind of takeaway on the access, to me,  
3 is kind of the underlying culture with rural populations  
4 that allows them to feel okay about their care even though  
5 they have to work harder to get access to it. And we see  
6 that in terms of the self-reported ADLs that are part of  
7 their -- as well as the CAP scores. So that too was kind of  
8 news to me, and fascinating, that they feel pretty good  
9 about their care that's out there and kind of what's going  
10 on.

11           But having said that, I think kind of going to  
12 Glenn's point of averages; I think in order to continue to  
13 sustain that, some of the special adjusters that are out  
14 there have done a lot to kind of stabilize the care that's  
15 out there.

16           So I think we have to be very careful and a little  
17 bit kind of what Tom was talking about in terms of the tone  
18 of the report, that people don't interpret some of these  
19 things incorrectly because it has created, I think, an  
20 interesting equilibrium out there. And so, I think there's  
21 got to be some caution here of how these things are  
22 described because I think we've reached, like I said, a good

1 equilibrium in rural care in terms of access.

2 Let me now kind of talk a little bit about, or  
3 share some thoughts on, the quality side. And there are the  
4 gaps in the process measures that are out there. And so,  
5 what I did is I went back and looked at the 2005 report, in  
6 June 2005, on critical access hospitals. MedPAC's report,  
7 that is. And it was interesting for me in that two things  
8 that were kind of pulled out in the report.

9 One is that critical access hospitals, and I  
10 suspect other rural hospitals, are very thinly staffed. So  
11 because of that, obviously, their ability to code as  
12 accurately as urban hospitals is probably -- was the case  
13 then, as acknowledged in that report, and probably still the  
14 case today, which could mean some of the differences that  
15 we're seeing in terms of some of those process measures but  
16 particularly the coding of the comorbidities and activities  
17 that are out there.

18 Plus, as you indicate, we have 1,300 critical  
19 access hospitals across this country and there's no  
20 incentive for them to code more accurately for all those  
21 comorbidities.

22 So I think some of the gaps that we're seeing

1 there and then the fact that we see in those self-reporting  
2 ADLs show two different stories. I think if we could talk  
3 about that a little bit more in the paper so folks have a  
4 better understanding of that, it might be something we could  
5 discuss more as we go forward.

6           Also, in the report, I think on page 39 you talk  
7 about mental health and the fact that there's not a lot of  
8 information on there. But I would just share this  
9 observation about mental health and what we're seeing in our  
10 State of Missouri, and I suspect in others out there.

11           There's kind of this bad joke among hospital  
12 executives, both urban and rural, but a lot more in rural.  
13 A lot of them have opened their new mental health unit.  
14 It's called their emergency department. People are being  
15 flooded in the EDs with behavioral health cases.

16           And I will tell you in rural areas it's  
17 particularly problematic because when you get someone in the  
18 emergency department with behavioral health issues and you  
19 have no place to transfer, particularly at critical access  
20 hospitals, I've heard of some critical access hospitals  
21 having to board someone for up to six or seven days. It's  
22 very disruptive when they're not in a position to manage

1 that.

2           And then, what we're seeing, of course, is for the  
3 ambulance crews to transport them when they do find a place,  
4 to move that patient. Generally, a lot of rural ambulance  
5 crews have a ring of a 50-mile radius. Some are going up to  
6 250 miles, and now you're pulling that ambulance out of that  
7 community for the entire day as a result of that transfer.  
8 So that's an issue.

9           And I don't know if there's something we can add a  
10 little bit about those issues and maybe capture some of that  
11 in that ambulance report that's newly required, that's out  
12 there.

13           The final thing on the quality I would just  
14 mention is something that we talked about, I think at the  
15 last meeting, and Karen had some comments on this, but it  
16 has to do with kind of the mortality issues out there.  
17 Again, in that 2005 report, MedPAC at the time kind of  
18 speculated that one of the reasons you might have higher  
19 mortality in critical access hospitals in rural areas is the  
20 notion of people come home to die. They want to be close to  
21 family, friends. They want to be with local caregivers who  
22 they know and in a facility that they know that's out there.

1           Karen, at the same time, talked about that she  
2 sees some that come into the urban areas for that very  
3 reason.

4           And so, one of the things I would be curious about  
5 is: Are there some new data or new literature that says in  
6 2005 MedPAC kind of made this assertion and then can we  
7 still make it today, or has something changed over the last  
8 7 years that has got us?

9           So let me stop for that, if I can get you to  
10 answer that, and then I'll finish up here.

11           DR. STENSLAND: I think we said that in 2005, that  
12 this is a possibility. And as we go on with looking at this  
13 study and looking at more studies, it seems a little less  
14 probable.

15           And there are a couple reasons. One is that we  
16 looked at the spectrum of outcomes and volume, and we see  
17 this kind of clearly ticking up in your mortality as you go  
18 down in the size of the hospital. So for it to really hold  
19 true it would have to be that they're going only to the  
20 really small hospitals to die, and not the larger hospitals.

21           I think this is also something that has a --  
22 another way to look at this would be looking at the critical

1 access hospitals, and we did see a little bit worse  
2 performance in the smaller critical access hospitals than  
3 the bigger critical access hospitals. So it would kind of  
4 have to be that they want to go to the smaller critical  
5 access hospitals with the fewer physicians but not the  
6 bigger critical access hospitals with the more physicians.

7           And then, this was also kind of a reoccurring  
8 theme that was connected into they don't have hospice maybe  
9 in some of these rural communities or they useless hospice  
10 in the rural communities. We wanted to see, well, maybe  
11 that maybe that is the situation. Maybe you're not --  
12 you're going to the hospital to die rather than stay in the  
13 hospice.

14           And I think we have a couple of good data points  
15 on that. First, in the new -- that study by Joint and  
16 Ashish Jha, they included hospice as a discharge category as  
17 one of their control variables in their study, and they  
18 still saw that differential.

19           And then, when we ran back and ran our numbers to  
20 see, well, what happens if you put up the share of people in  
21 the county that are using hospice. And that is a smaller  
22 share in the more isolated areas, like 30-something percent

1 versus 40-something percent. And that didn't really affect  
2 that differential at all. It just didn't come up as  
3 significant in the regressions.

4 So this is kind of a long answer. Sorry.

5 The bottom line why I think why the hospice effect  
6 might not really turn out as big as we think it is has a lot  
7 to do with exactly how we're measuring mortality. And the  
8 way we're measuring mortality is did you die within -- not  
9 in the hospital but within 30 days after you were  
10 discharged.

11 So if someone goes to the rural hospital and they  
12 stay there for 30 days and then they die, or they stay there  
13 for 40 days because there's no hospice and they die in the  
14 hospital after 40 days, that counts as a mortality for the  
15 rural hospital.

16 If someone goes to the urban hospital, in there  
17 for 20 days and then they get discharged to hospice and  
18 they're in hospice for 20 days and they die, well, that  
19 counts as a mortality for the urban hospital.

20 So because we're counting the mortality on anybody  
21 who dies 30 days after discharge and the average hospice  
22 stay is only 17 days, I think it explains some of the reason

1 why we don't see the effect of whether using hospice or not  
2 really affecting the mortality rates and that relationship  
3 between size and mortality.

4 MR. KUHN: Thanks, Jeff. That information is  
5 helpful.

6 Like I said, MedPAC postulated on that notion back  
7 in 2005, and I think kind of drawing that information into a  
8 little bit more of a conversation of what we think the  
9 literature shows now, or what the data shows now, I think  
10 would be helpful to kind of close that gap.

11 Finally, on payment, a couple things here. One is  
12 on page 69 and 70 in here we kind of lay out that set of  
13 principles in payment -- you know, to preserve access, the  
14 isolated provider, the empirically justified and the control  
15 of costs. But on those pages, there's a chart that only  
16 lists the last three; that is, the isolated provider, the  
17 empirically justified and control costs. The preserving  
18 access is not part of that. And if there's a way we can  
19 complete that chart, to make sure all those things are  
20 captured as part of that process, I think would be helpful.

21 The other part on payment is cost base. And  
22 again, going back to the 2005 report, while it did

1 acknowledge that cost base is not as strong an incentive in  
2 terms of incentives to hold down -- as strong an incentive  
3 on payment. There, nevertheless, were incentives in cost  
4 base, and those are kind of absent in this report. So I  
5 think carrying that forward from 2005 to be consistent would  
6 be helpful.

7           And then, finally, we've talked quite a bit about  
8 the beneficiary co-payment section, and we still have a  
9 conversation on that.

10           One final thing there is that we don't kind of get  
11 to address this, but at least with the empirically justified  
12 conversation and others there are some assumptions that,  
13 ultimately, some facilities may merge or close as part of  
14 the process as we go forward. And if you look at some of  
15 the regulatory underpinnings out there right now with CMS,  
16 there are some regs recently in terms of what happens with  
17 mergers with critical access hospitals.

18           So if two that are close together want to merge,  
19 the one that closes in one community, it's hard to maintain  
20 any kind of services, outpatient services in that facility  
21 because of these regulations.

22           Likewise, if a hospital decides to give up its

1 cost status, or change and go back to PPS, at least  
2 currently, my understanding is CMS requires them to get a  
3 new provider number. So it makes it very difficult for them  
4 to kind of recapture their sole community or Medicare  
5 dependents.

6 So I'd like us to also talk about that if we are  
7 going to do some movement in this community in the future at  
8 least we ought to acknowledge that there are some regulatory  
9 barriers that make that very difficult, and some  
10 conversation about those would be helpful as well.

11 Thanks.

12 DR. MARK MILLER: Jeff, on one of his earlier  
13 points about the age of the physicians, we either did or are  
14 doing something with that? Can you just remind me?

15 DR. STENSLAND: Okay, I'll try to do these really  
16 quick.

17 With respect to the age, there are a lot of state-  
18 by state studies, some saying rurals are older, some saying  
19 rurals are not. I think there was a nice study by the  
20 people at WWAMI, who do a lot of work. That's in the  
21 University of Washington. They do a lot of workforce stuff.  
22 And I think the key statistic there -- and we'll put it in

1 the report -- is amongst primary care physicians in rural  
2 areas, 27 percent are above age 55, and in urban areas it's  
3 25 percent are above age 55, on a national basis.

4 So everybody can kind of judge on their own, how  
5 big a magnitude they think that is and how big of a  
6 difference it is in the problem.

7 DR. MARK MILLER: And then on the regulatory  
8 stuff, you did take a look at it, and I remember the  
9 conversation. There is some drag there, and we would put --  
10 go ahead.

11 DR. STENSLAND: Yes, we can address that, like if  
12 there are two people next to each other and they both have a  
13 necessary provider, if they actually are 35 miles away from  
14 anybody, then there's no problem.

15 But if there are two people next to each other and  
16 they both have necessary provider criteria, and there is  
17 still somebody, a third one, that's 15 miles away or  
18 something, then it might make sense to have some sort of  
19 regulatory waiver where if they set up a hospital that's in  
20 between these two they can move in between the two with a  
21 new hospital. That's one option.

22 The other option that does exist in current

1 regulation is you can have this one continue to be a  
2 critical access hospital and this one can be a rural health  
3 clinic because the rural health clinics have a waiver in  
4 that regulation so they can still be a rural health clinic  
5 and have that outpatient capability.

6 But I think if what you're saying is if they do  
7 decide to build a new hospital in between the two, which  
8 might make perfect sense, maybe there is a need for a new  
9 regulation that would make that allowable.

10 The other kind of background story is the one  
11 thing they probably wouldn't want to do is allow them to  
12 move closer to somebody else because when this was coming up  
13 and this critical access hospital was talking about moving,  
14 particularly, I remember talking to somebody in one place.  
15 And the PPS hospital was kind of mad that the critical  
16 access hospital was over here and they got their necessary  
17 provider designation. The PPS one is here, and the critical  
18 access hospital wanted to move its building over here  
19 because there are more people over here, and that is  
20 probably not such a good idea.

21 MS. BEHROOZI: I'll try to be brief. So I think  
22 you've done a really great job of putting out the facts and

1 not being -- and not just sort of reciting truisms that I  
2 think people -- I would have been willing to accept. You  
3 know. Old or sick or poor in rural areas, not so, the  
4 evidence shows.

5 I mean, I'm just looking at the paper. With  
6 respect to poverty, it's slightly lower rates of poverty in  
7 rural areas than urban residents after adjusting for the  
8 cost of living. I mean, all the facts have to be taken into  
9 account.

10 And there isn't a normative standard of what's the  
11 right amount of care, so you have to do relative. I get  
12 that. And so, you have to compare averages.

13 But I guess I'm sort of on the other side of the  
14 coin of Tom's concern about averages, and I've expressed  
15 this before, that taking every area that has 50,000 people  
16 or more, right -- that's the threshold -- and calling that  
17 urban really does not get at the variability, one of the  
18 points that Tom raised, doesn't get at the variability  
19 within urban.

20 Sorry, just a little off-track. Off the top of my  
21 head, I have a question about this. Does this reflect all  
22 payments like IME and DSH and that kind of stuff?

1           Like, off the top of my head, it seems to me we  
2 ought to include critical access hospitals in there too, and  
3 that will really show so-called urban and so-called rural  
4 hospitals. As you said the lines will be that much more  
5 different from each other.

6           I think that would be a fairer comparison, if all  
7 the adjustments -- I get those are PPS adjustments, but  
8 still, all the extra payments are in on the "urban" side.  
9 That's where the major teaching hospitals and whatever are.  
10 I mean, I'm sure there is some DSH or whatever on the rural  
11 side.

12           So anyway, just back to the comparative thing,  
13 comparing rural to urban, you know a theme of mine is always  
14 about looking at socioeconomic status and disparities based  
15 on socioeconomic status and race. And a big concern of mine  
16 is that you have more variability, more heterogeneity in the  
17 urban group.

18           And just based on what it says in the paper about  
19 African-American and Hispanic concentrations in this so-  
20 called metropolitan urban side, I just think we're not --  
21 it's not a -- a comparison that doesn't really examine all  
22 the underlying problems of access within what we call urban.

1 There are lots of problems of access by poor people, by  
2 people of color, by people in inner cities, people in  
3 whatever suburban areas within adequate public  
4 transportation, but people are poor so they don't have their  
5 own cars. There's a lot of that going on under that 50,000  
6 -- or above that 50,000-person threshold.

7           So, as I said before, it's a great thing that  
8 Medicare has addressed, or Congress has addressed, a lot of  
9 the issues for rural areas, but I think it's time to turn  
10 attention to whether it's urban areas. I don't mean to set  
11 it up as a competition, but maybe looking at access by lower  
12 socioeconomic status beneficiaries across wherever they live  
13 because if you have money you can get care no matter where  
14 you live.

15           MR. GEORGE MILLER: Yes, I also want to thank you  
16 for this report and certainly thank -- I did send comments  
17 in to Mark. I trust he got them last Thursday, concerning  
18 the report. I sent an email in late. Maybe?

19           DR. MARK MILLER: [Off microphone.] No.

20           MR. GEORGE MILLER: No, did not. All right.

21           DR. MARK MILLER: [Off microphone.] I've been all  
22 over, and I got all of this.

1           MR. GEORGE MILLER: Yes, I know. I know. You  
2 sent me an email.

3           DR. MARK MILLER: [Off microphone.] To be clear,  
4 I've been at work.

5           MR. GEORGE MILLER: Yes. I've had -- I'm in a  
6 rural area.

7           DR. MARK MILLER: [Off microphone.] Seriously, I  
8 didn't find --

9           MR. GEORGE MILLER: Okay, I'm in a rural area.  
10 Maybe my internet didn't get out. I'll go back and check  
11 because I sent about two pages.

12           Both Herb and Tom, we have been talking. They  
13 have commented on most of what I will cover. So I won't  
14 bore you with some of the same things except for one or two  
15 things.

16           In the report, I don't know if this has been  
17 changed, but it does say -- and I'll read it -- "There is  
18 room for improvement in rural hospital quality." I served  
19 on the joint commission. There's room for improvement in  
20 all quality.

21           So I'm not sure why that was picked out in that  
22 way and characterized that way. There's room for

1 improvement everywhere, and we won't dispute that.

2           The other issue that Tom brought up, about 30  
3 percent of the pharmacies have been closed, is in my mind an  
4 astounding number and is compelling, and I think more  
5 attention certainly should be paid to that, that point.  
6 That's significant for those communities that have had that  
7 one pharmacy close in their community.

8           The other issue that Herb brought up that I think  
9 is important to highlight and just to take a second or two  
10 to talk about it is that the rural beneficiaries; they like  
11 their physician, their hospital and the care that they're  
12 receiving. And the point is that in the paper it talked  
13 about the fact that they're getting the same volume of  
14 services, as percentage-wise the access to services is  
15 there, but there are fewer providers. So as a result, being  
16 fewer providers, they're working harder and the  
17 beneficiaries certainly appreciate they're both working  
18 harder.

19           So that issue will have to be addressed at some  
20 point, as Herb mentioned.

21           The comment about the rural health care is often  
22 asserted as the rural populations are older, sicker and

1 poorer, but your literature said that was not true. But,  
2 your literature talked about the Medicare population.

3 The comment that was quoted, that rural  
4 populations are sicker and poorer -- the Medicare population  
5 may not be in those rural communities, but the overall  
6 population is sicker.

7 So in my mind, you're comparing apples with  
8 oranges because you first said they're not sicker, all rural  
9 populations, but then you quote the Medicare population in  
10 that community. So I think there's a difference there, and  
11 we certainly can take a look at that.

12 Also, the comment about slightly lower rates of  
13 poverty from urban residents after adjusting for the cost of  
14 living -- well, USDA released their new poverty index that  
15 says it's much higher nationally in rural areas. So I  
16 encourage you to at least look at data from the USDA to see  
17 and reconcile who's right. Rural poverty and urban poverty  
18 have been converging with the majority of the persistent  
19 poverty.

20 Now I agree with Mitra about the amount of  
21 disparities in urban areas, but still, there's rural poverty  
22 as well.

1           And then finally, on the tone of the report -- and  
2 I agree with Tom's comment about you get a staff that reads  
3 this in the tone. Without knowing all the intricacies and  
4 doing the talking, the background that you did in the  
5 report, they may read this report and get a different  
6 opinion. So I agree with the comments about the tone.

7           DR. CASTELLANOS: I think you did a great job.  
8 It's been fun to watch you go through this project. It's  
9 been educational to all of us, and I really think you did  
10 exactly what they asked you to do. They asked you to  
11 evaluate what's happening in the rural area.

12           We're all talking about comparing one to the  
13 other, but that's not what they asked you to do. They asked  
14 you to evaluate, and that's what you've done. You called.  
15 You said what was happening. You may have said it in  
16 comparison to something else, but I think you've done  
17 exactly what you should have done.

18           I think it's well studied. It's well written and  
19 very, very well structured. And I congratulate you for  
20 doing exactly what they asked you to do.

21           MR. GRADISON: In addition to joining in  
22 congratulating you, I have a request that as we get the next

1 version, somehow I'd like you to pinpoint the differences  
2 from this version. To be frank, I would have found it  
3 helpful with this version as well. I don't mean every word,  
4 but any substantive changes, because it's been a while since  
5 I've gone over it and there are 90 pages in this document.  
6 So I just think that at least for myself it would make it  
7 easier to do my job, if I had that crib sheet on the side.

8 Thank you.

9 DR. BORMAN: To me, the benefit redesign work and  
10 also working on this report have some similarities in that  
11 they've presented us some opportunities to really make some  
12 comments but offer some significant pitfalls that we've  
13 tried to -- you know, we've had to try and avoid. So I'm  
14 going to add enormous congratulations to you for the way  
15 that you've handled this and for what I perceive as a really  
16 balanced attempt to look at this.

17 I spent 25 years of my professional career at  
18 institutions that were sort of on the receiving end, really  
19 focal to being on the receiving end. And I, in that, am  
20 struck by the absolute tragedy of care that didn't get  
21 delivered to those people. On the other hand, I've been  
22 struck by the seeming ka-ching mentality of care that was

1 delivered in terms of tests done or things done when it was  
2 very clear from the get-go that that patient needed to be  
3 elsewhere soonest as they're best. And I don't mean just in  
4 the emergency situation.

5           So I think that there are -- no matter how you  
6 look at it, it is -- unfortunately, you can't always get it  
7 by the average out, but you can try and present both sides  
8 of the equation and try to achieve what is equivalence,  
9 given that there are constraints about what you can deliver  
10 with a thinner staff, with fewer resources, and whatever.  
11 And so, in my mind, you've done a really nice job of  
12 bringing what are the data out there.

13           The only suggestion I would have -- and it's  
14 pretty late in the game. I would just wonder if there's a  
15 place for saying that this is a mandated report and  
16 structured in this way, but we feel a responsibility as the  
17 Commission just about the sustainability and vision for the  
18 program in general, and that we have -- that's also been  
19 part of the lens through which we've looked at this and that  
20 we've had to consider our recommendations, first, what is  
21 appropriate to these populations and these facilities, but  
22 that we've also considered it in the context of the future

1 of the program for everyone.

2 And there may be some value to saying something  
3 like that. My feelings will not be hurt and my life will  
4 not end if that doesn't somehow appear in the report.

5 MR. ARMSTRONG: I would only -- if you're going to  
6 -- first compliment the work as others have done that.

7 If you are going to try to modify the tone a  
8 little bit, just the one additional point I would add is  
9 that we tend to under-represent the fact that actually in  
10 our rural communities there are solutions to some of the  
11 issues we're talking about that we, frankly, should be  
12 paying more attention to and applying to the urban  
13 communities. We seem to be sort of worried about assuring  
14 that in rural communities everything is up to our standards,  
15 but in fact, in many ways, it offers insight into how  
16 standards should be applied to some of the other markets.

17 DR. CHERNEW: So, admittedly, I did not read this  
18 with the same scrutiny or sensitivity or experience as some  
19 of my colleagues, but I have to say I didn't pick up on the  
20 tonal issues that have been discussed in the same way and  
21 maybe I'm more ignorant in that regard.

22 But I think the broad message; I think you did a

1 wonderful job. And the message that I took from it was that  
2 there are some really important and special issues that  
3 rural areas have, and I think you've discussed them.

4 Frankly, I read this, not knowing what other  
5 people do, as they weren't as serious as I otherwise might  
6 have thought they were. We could argue, I guess, about some  
7 of the data, but I thought it was at least reasonably  
8 convincing.

9 And I agree with what Mitra said, that other areas  
10 have special issues as well.

11 I think the real challenge here is to understand  
12 that when these issues arrive, to think about what  
13 Medicare's responsibility is. So there's a part of this  
14 where we run through a whole bunch of things and statistics,  
15 and blah, blah, blah. But even when you find a problem,  
16 it's not always clear what Medicare's issues are and whether  
17 the goal is that everything should be equal between the  
18 different places.

19 My general view is that they shouldn't be equal  
20 between the places necessarily, but they certainly have to  
21 be good enough in all places.

22 The sort of general concern I have, of course, is

1 what we would do when there are problems in this very cost-  
2 constrained world. And I guess a lot of people look to this  
3 and read this to think that well, if there's a problem in  
4 the rural areas relative to urban areas, we have to figure  
5 out how to give more to the rural areas.

6           And that may be true because I think there  
7 probably are certain places where there's access issues or  
8 not although I have to say in general -- let's take  
9 physician issues. One of the challenges might be that we're  
10 overly generous in maybe urban or other areas.

11           So it might not be we just equalize by giving more  
12 to rural. You know you could equalize in a lot of different  
13 ways, and we seem to be in a world where we're taking away,  
14 not in a world where we're giving.

15           So I'm not arguing we should take anything away  
16 from anybody in this comment. I'm just saying there's a  
17 tendency, or at least I perceive a tendency, to read reports  
18 to look for places where there's problems and figure out how  
19 to give more there.

20           And I think that it's going to end up -- you know  
21 all of the stuff we do is just sort of budget-neutral, this  
22 kind of view in what we're doing, and everything is going to

1 get really tough.

2           So I very much appreciate what you did, and I  
3 agree exactly with what Ron said. I think you did exactly  
4 what you were asked to do, and I think you did that well.

5           But the policy ramifications of what we should do  
6 where there are areas of problems -- and I do think there  
7 certainly are, as there are everywhere, as George said --  
8 I'm just really not sure what the right overall solution  
9 would be.

10           And I don't think it's -- you know, it's not  
11 appealing to me to pick one area and say, oh, here's a  
12 problem; let's do this. I think it has to be more  
13 comprehensive across all the providers, all the areas, all  
14 the other stuff, which wasn't our charge.

15           MR. BUTLER: So my reading was that it was pretty  
16 objective, almost too objective in the sense that it didn't  
17 comment on both the values of the rural or values of urban.  
18 And I understand if you had a bias going in, how the wording  
19 would not maybe satisfy you or you would interpret it  
20 differently.

21           So I was going to really make Scott's point but  
22 even be more specific because I think we've heard in some

1 sessions, including from myself, some specific examples of  
2 where rural care may be done better.

3 Now I'm one who brought up tele-health, and it's  
4 reported on although it kind of just says well, they've got  
5 it but not all that much, where I can point to examples  
6 where I see how it's been very effectively used. As much as  
7 it's been anecdotal and I don't have the science, I think  
8 there are some superb examples how they've made great use of  
9 tele-health.

10 So maybe if you look back in some of the previous  
11 comments, and we not only say there are lessons to be  
12 learned, but maybe highlight three or four kinds of things  
13 that are worth further emphasizing. It just kind of sets a  
14 little different tone maybe, or a little more positive tone.

15 DR. NAYLOR: I thought it was an outstanding  
16 report, and I appreciate the depth of knowledge colleagues  
17 bring, but I really also thought it was a really balanced  
18 view.

19 And I didn't walk away with any sense other than  
20 this is a real celebration of MedPAC's investment, and  
21 others, over time, and we have a lot to, I think, be really  
22 proud of. The Commission does. I had no parts of it.

1           I also thought this process of establishing  
2 guiding principles and figuring out how a report evolves  
3 from that was really quite extraordinary. So the integrity  
4 of the process, I really think it's something to celebrate.

5           I also thought the focus on the major outcomes  
6 that we do know about -- mortality, where there are only  
7 very slight differences, and readmissions -- was a real  
8 acknowledgment of what has been accomplished.

9           And so, I don't have anything else to say other  
10 than congratulations and thank you for the introduction to  
11 new language about rural micropolitan, adjacent rural  
12 frontier. I really, honestly, had no understanding, and I  
13 really appreciate all that I've learned.

14           MR. HACKBARTH: So this is our last discussion of  
15 this report as a Commission. Bill, the only way you will  
16 see the next iteration if you sign up as a reviewer with Jim  
17 on your blue sheet.

18           MR. GRADISON: I already have.

19           MR. HACKBARTH: You already have, okay.

20           So that's where we are in this process.

21           Thank you, Adaeze and Jeff, for your heroic  
22 efforts on this report. You did a great job.

1 [Applause.]

2 MR. HACKBARTH: And also, thanks to Tom and Herb  
3 and George who have, in particular, spent a lot of time on  
4 this project. As I said at the outset, I think the final  
5 report will be better for their efforts.

6 So that's the end of our session today, save for  
7 the public comment period, for those intrepid people in the  
8 audience who have stayed to the very end.

9 And before you begin, sir, let me just quickly say  
10 what the ground rules are. Please begin by introducing  
11 yourself, your name and your organization. You will be  
12 limited to two minutes. When this red light comes back on,  
13 that signifies the end of your two minutes. And I would  
14 remind people that, of course, this is not your only or your  
15 best opportunity to provide input on the Commission's work.  
16 Use our website and, of course, continue to talk to staff,  
17 as people have in the past. Sir.

18 MR. MOORE: Great. Well, good afternoon. I'm  
19 Justin Moore, the Vice President of Public Policy at the  
20 American Physical Therapy Association and also a licensed  
21 physical therapist.

22 As you know, physical therapy allows individuals

1 to regain function and mobility to remain independent in  
2 their homes and communities. The value to improving this  
3 quality of life to Medicare beneficiaries is well supported  
4 in science and practice. Without physical therapy, Medicare  
5 beneficiaries would likely incur higher costs downstream due  
6 to patient loss in function, falls, and more intensive  
7 interventions or inpatient care.

8           The major concern of physical therapy is not so  
9 much that value of the service, which provides 14 percent of  
10 the beneficiaries' care at three percent of the cost. The  
11 concern is its variance and its volume.

12           We believe reform needs to be both immediate and  
13 in long term. Immediate reforms will begin this year. In  
14 addition to the legislation which mandated the report to  
15 MedPAC, it also took some necessary steps to better  
16 understand the benefit and to apply immediate reforms.

17           To understand the benefit, CMS will begin to  
18 collect data on functional status from the claims form  
19 beginning on January 1, 2013. To reform, CMS will begin to  
20 require medical manual review of all services that exceed  
21 3,700 beginning on October 1 of this year.

22           Finally, APTA [phonetic] is developing a refined

1 payment system for the outpatient physical therapy services  
2 that would consolidate our code set and represent the  
3 severity of the patients we serve with the intensity of  
4 services needed. We found these consistent with a lot of  
5 the work that this Commission is doing and look forward to  
6 working with the Commission to continue their work in this  
7 area.

8 Thank you.

9 MR. CONLEY: Good evening. You've had a long day  
10 and I'll be very brief. I'm Jerry Conley and I'd like to  
11 speak as a physical therapist on behalf of three  
12 organizations, of private practice physical therapists  
13 across the country, over 4,000 of them; PTPN, which is a  
14 managed care rehabilitation network in 23 States; and Focus  
15 on Therapeutic Outcomes, which is a national outcomes  
16 database providing quality and functional status outcomes  
17 information to patients and to providers, clinicians, in all  
18 the States and in over 3,000 settings, both hospitals and  
19 other settings, as well.

20 I greatly appreciate the levity that you brought  
21 to the discussion around outpatient therapy, but I hope  
22 that, in seriousness, you will take Commission Mike's

1 comments to heart, and that is this is a critical benefit  
2 and it's very important to provide and restore function to  
3 the Medicare beneficiaries who are eligible for this  
4 function -- for this benefit.

5           There's a wide variety of conditions that physical  
6 therapists treat and treat effectively, not the least of  
7 which is ambulation. But the comment that if a person was  
8 able to walk into a skilled nursing facility to get Part B  
9 benefits means that they don't get them shows that there  
10 really needs to be, if less levity, then certainly more  
11 understanding of what physical therapy is and how it is  
12 provided and how it is accessed.

13           So there are a number of functional status  
14 outcomes organizations that measure function for patients  
15 and that provide information to the therapists and to the  
16 providers around the country. One of those is Focus on  
17 Therapeutic Outcomes, which has measures all over the place  
18 in all States, recognized by NQF, has provided information  
19 to CMS. Now, are these and others widely used across the  
20 nation? They are. Are they broadly used across Medicare?  
21 No. Are they required? No.

22           As Justin has just said, because of this latest

1 extension on SGR and the therapy cap exceptions process, CMS  
2 will be required to access and refine this exception  
3 process, accessing data collections information. MedPAC can  
4 enhance and refine and assist that by making a  
5 recommendation to CMS that this information should be  
6 functional status information. That would help with the  
7 recertification process, because you will know as a  
8 physician whether or not the patient has plateaued or has  
9 continued to improve. It will help driving the benefit  
10 toward more effectiveness and toward, more importantly, the  
11 quality of the care that is delivered.

12           So outcomes information, which can be available  
13 and is available, needs to be available and required through  
14 the Medicare program, and MedPAC can help by moving CMS more  
15 in that direction. It also will help the interpretation of  
16 whether this utilization -- one Commissioner said, well, we  
17 don't know whether this increase in utilization is a good  
18 increase or if the decrease is bad decrease. Outcomes  
19 information and functional status information will answer  
20 that question. So it will help cultivate and create the  
21 most and best use of the Medicare benefit with respect to  
22 outpatient therapy.

1           So the latest SGR extension does require that CMS  
2 grab that -- gather that collective, that functional status  
3 information, and I would urge CMS -- or MedPAC to urge CMS  
4 to make sure that that is functional status information and  
5 that that be required across all settings so that you can  
6 gather information as to where that benefit is used all  
7 across the PT benefit exposure.

8           Thank you very much.

9           MR. HACKBARTH: Okay. We are adjourned until,  
10 let's see, 8:00 a.m. tomorrow morning.

11           [Whereupon, at 6:23 p.m., the Commission was  
12 adjourned, to reconvene at 8:00 a.m. on Friday, March 9,  
13 2012.]

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## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, March 9, 2012  
8:00 a.m.

## COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair  
ROBERT BERENSON, MD, FACP, Vice Chair  
SCOTT ARMSTRONG, MBA  
KATHERINE BAICKER, PhD  
MITRA BEHROOZI, JD  
KAREN R. BORMAN, MD  
PETER W. BUTLER, MHSA  
RONALD D. CASTELLANOS, MD  
MICHAEL CHERNEW, PhD  
THOMAS M. DEAN, MD  
WILLIS D. GRADISON, MBA  
WILLIAM J. HALL, MD  
HERB B. KUHN  
GEORGE N. MILLER, JR., MHSA  
MARY NAYLOR, PhD, RN, FAAN  
BRUCE STUART, PhD

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Medicare coverage of and payment home infusion therapy - Joan Sokolovsky, Kim Neuman	3
Issues for risk adjustment in Medicare Advantage - Dan Zabinski	60
Care coordination programs for dual-eligible beneficiaries - Christine Aguiar, Carlos Zarabozo	116
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1 P R O C E E D I N G S [8:00 a.m.]

2 MR. HACKBARTH: Good morning. We have three  
3 important sessions this morning, the first on a mandated  
4 report on home infusion therapy, followed by a session on  
5 risk adjustment for Medicare Advantage, and then dual  
6 eligibles. Today we will be on time, I promise.

7 So who is leading? Kim.

8 MS. NEUMAN: Good morning. Today we are going to  
9 continue our discussions of home infusion for a  
10 congressionally requested report. I won't dwell on this  
11 slide, but I wanted to briefly remind you of the issues that  
12 the Congress has asked MedPAC to examine. Previously, we  
13 discussed the third and fourth bullets. Today we're going  
14 to discuss the remainder.

15 So this morning, we'll review Medicare coverage of  
16 home infusion, and then we'll focus on the cost of home  
17 infusion. As requested, we'll assess sources of data on the  
18 cost of home infusion that could be used to construct a  
19 payment system, and we'll assess the cost implications of  
20 broader home infusion coverage for Medicare. And then Joan  
21 will discuss design issues that could be considered if  
22 Congress wished to expand home infusion coverage.

1           Before we do that, we'd like to thank Kelly Miller  
2 and Evan Christman for their contributions to this work.

3           So you have seen this slide before. It summarizes  
4 Medicare's current coverage of home infusion. Medicare's  
5 coverage is spread across different payment silos. Coverage  
6 for the drugs is split between Part B and Part D. Part B  
7 covers roughly 30 drugs requiring a durable medical  
8 equipment pump. Part B also covers parenteral nutrition for  
9 patients with a permanent impairment and intravenous immune  
10 globulin, or IVIG, for patients with primary immune  
11 deficiency. Part D covers drugs not covered by Part B that  
12 are on the plan's formulary and that meet any plan prior  
13 authorization criteria.

14           If Part B covers the drugs, the supplies and the  
15 equipment are also covered, except for the case of IVIG. If  
16 Part D covers the drug, it does not cover supplies or  
17 equipment. Nurse visits as well as limited supplies are  
18 covered under the home health benefit if the beneficiary is  
19 homebound.

20           Now we will turn to cost. We were asked to assess  
21 sources of cost data that could be used to construct a  
22 payment system for home infusion. The data on the cost of

1 providing home infusion are limited. An industry-sponsored  
2 by Abt Associates estimated the per diem cost of home  
3 infusion, which they defined as all pharmacy costs except  
4 the cost of the drug itself and nurse visits.

5 This study has limitations that make it not well  
6 suited to rate setting. It is based on cost information  
7 from a limited number of pharmacy companies. Much of the  
8 cost information is obtained at the aggregate level, and the  
9 study had to make assumptions to extrapolate those aggregate  
10 costs to the drug level, so results would be sensitive to  
11 assumptions. We also have some concerns about what types of  
12 costs were and were not included, and we were not able to  
13 make a judgment about that.

14 In terms of other options for cost data, Medicare  
15 payment rates for other services might serve as a benchmark  
16 such as payment rates for nurse visits under the Medicare  
17 home health benefit or the DME fee schedule rate for  
18 infusion pumps and supplies, although caution would be  
19 needed here since the DME fee schedule pricing in general is  
20 thought to be high. Another option might be competitive  
21 bidding.

22 So next we are going to turn to the issue of the

1 cost implications of broader home infusion coverage for  
2 Medicare. It may seem intuitive that providing infusions in  
3 the home would be less costly than providing them in a  
4 skilled nursing facility or other settings. But it turns  
5 out that the cost implications for Medicare of broader home  
6 infusion coverage are complex and uncertain.

7 To look at this issue, we first reviewed the  
8 literature and then we did additional analysis. In terms of  
9 the literature, most studies are dated and do not examine  
10 the implications of home infusion from Medicare's  
11 perspective. The main finding in most studies is that a day  
12 of home infusion costs less than a day of inpatient hospital  
13 or SNF care.

14 There is one study that models the effect of a  
15 hypothetical Medicare home infusion benefit for antibiotics.  
16 The authors conclude that broader home infusion coverage for  
17 antibiotics would save Medicare money, but they include a  
18 sensitivity analysis that demonstrates that if they modified  
19 some of their assumptions, it would be a net cost rather  
20 than net savings.

21 So to look at this issue, we developed a  
22 conceptual framework of the various effects expanded home

1 infusion coverage could have on Medicare expenditure, and  
2 the overall effects depend on many factors.

3 First, it depends on what payment rates Medicare  
4 establishes for home infusion services and then how those  
5 rates compare to how much Medicare would pay for infusions  
6 in other settings.

7 So, for example, there is not likely to be  
8 significant inpatient hospital savings. That's because if  
9 broader home infusion coverage led to shorter hospital  
10 stays, Medicare payments to hospitals in most cases wouldn't  
11 change because Medicare makes a DRG payment.

12 There might, though, be savings on SNF care for  
13 some patients if there are beneficiaries who are candidates  
14 for home infusion but who enter SNFs because of the out-of-  
15 pocket costs associated with home infusion.

16 It is also possible that there could be savings  
17 from avoided home health episodes for some beneficiaries if  
18 the only reason they are receiving the Medicare home health  
19 benefit is for assistance with infusion services.

20 Now, compared to ambulatory settings like hospital  
21 outpatient departments or physician offices, home infusion  
22 might save or cost, and it would depend on many factors:

1 the payment rates established for home infusion, how much is  
2 paid for the drug in different settings, how frequently the  
3 drug is administered, are home nurse visits needed  
4 periodically or for every infusion, and would the patient  
5 receive separately paid nurse visits or nursing through the  
6 Medicare home health benefit.

7           So in addition to site-of-service shifts, we also  
8 would have to consider the potential for Medicare  
9 expenditure to increase due to a crowd-out effect and a  
10 woodwork effect.

11           Expanded Medicare coverage for home infusion would  
12 crowd out spending by other payers since some beneficiaries  
13 currently receive infusions in the home with supplies,  
14 equipment, and nursing paid for by employer supplements,  
15 Medicaid, or beneficiaries themselves. With expanded  
16 coverage, Medicare would pick up those costs instead.

17           There would also likely be a woodwork effect,  
18 meaning that expanded coverage of home infusion would likely  
19 result in more beneficiaries receiving intravenous drugs  
20 than otherwise would have been the case. For example, some  
21 individuals who might have been previously prescribed an  
22 oral drug might now get an IV drug, and this would likely

1 increase Medicare expenditures. And, finally, sort of the  
2 bottom line of whether Medicare saved or incurred additional  
3 costs overall would depend on the combined effect of all of  
4 these dynamics.

5 So where does all this leave us?

6 First, there are a couple of key points that come  
7 out of this. The cost implications of home infusion  
8 coverage for Medicare vary by drug and in some cases also by  
9 diagnosis. There is a better chance of savings for drugs  
10 where home infusion substitutes for SNF stays or possibly  
11 home health episodes. And the likelihood of savings is  
12 higher if a nurse's presence is only needed periodically and  
13 not for every infusion. And, of course, whether or not  
14 Medicare would save or incur additional expenditures would  
15 depend on the payment rates that were established for home  
16 infusion.

17 So to make this more concrete, we developed some  
18 illustrative scenarios of the potential cost implications of  
19 home infusion for two drugs where it seems there may be a  
20 possibility, although not a certainty, of savings. We did  
21 this for antibiotics covered by Part D and for IVIG covered  
22 by Part B for patients with primary immune deficiency.

1           To construct these scenarios, we had to make  
2 assumptions about how Medicare might pay for home infusion  
3 services, including assuming hypothetical payment rates for  
4 home infusion nursing, supplies, and equipment. We used  
5 several hypothetical rates to illustrate the financial  
6 effects of varying payment levels, and all of the scenarios  
7 were for illustrative purposes, not to suggest an actual  
8 payment structure or payment amount. The detailed tables  
9 are in your materials.

10           This next chart summarizes the results, and I'll  
11 walk through the antibiotics example. The IVIG example is  
12 very specific to that product and a particular diagnosis, so  
13 I'm not going to go through it, but we could discuss it on  
14 question.

15           So if we look at the antibiotics column, the first  
16 few rows show the potential effects on Medicare expenditures  
17 of shifting antibiotic infusions to the home from alternate  
18 settings. If antibiotic infusions shifted from SNFs to the  
19 home, there generally would be savings. How much savings,  
20 though, would depend on how many people are getting IV  
21 antibiotics in SNFs and how many of them would be capable of  
22 receiving that care in the home.

1           If antibiotic infusions shifted from hospital  
2 outpatient department to the home, it might save or cost  
3 Medicare money depending on the payment rates for home  
4 infusion, frequency of nurse visits, and other factors.

5           Also, with broader coverage of home infusion,  
6 there might be some avoided home health episodes, and  
7 whether this saves or costs depends on assumptions, but the  
8 savings possibilities would be greater if the infusion  
9 therapy occurred over a very short time frame, one that's  
10 shorter than the 60-day home health episode.

11           And then, as we discussed earlier, we would expect  
12 Medicare expenditures to increase due to a crowd-out effect  
13 and a woodwork effect. And the net of all of these various  
14 effects on Medicare expenditures is uncertain, and I know  
15 that's not necessarily satisfactory. It's uncertain for a  
16 couple reasons. It depends on how many beneficiaries are in  
17 each row of this table, and we don't generally have data to  
18 speak to that. It also depends on the amount of additional  
19 savings or costs per beneficiary in each row, which depends  
20 on the many factors we've discussed, including the payment  
21 rates that would be established for home infusion.

22           So now I'm going to turn it over to Joan who will

1 talk about potential policy options.

2 DR. SOKOLOVSKY: So we have come up with three  
3 potential options

4 The first option is actually to leave the current  
5 system in place. Medicare beneficiaries are accessing home  
6 infusion at an increasing rate under the current payment  
7 systems.

8 For example, Part D drug costs for home infusion  
9 drugs grew at an average annual rate of 47 percent between  
10 2006 and 2009, and the number of beneficiaries receiving  
11 home infusion grew at an average of 21 percent per year  
12 during that time.

13 With respect to Medicare Part B-covered home  
14 infusion drugs, Medicare spending increased at an average  
15 rate of about 17 percent per year, and the number of  
16 beneficiaries grew at an average rate of 6 percent during  
17 this same 2006-09 period, despite the decline of the fee-  
18 for-service population during this time.

19 Alternatively, the Congress could decide to fill  
20 in some of the coverage gaps that we've identified, for  
21 example, providing nursing services for beneficiaries  
22 receiving IVIG with primary immune deficiency disease.

1           Thirdly, the Congress could design a demonstration  
2 project testing the effects of broader coverage for home  
3 infusion antibiotics. For either of these two options, as  
4 Kim emphasized, it would be necessary to take into account  
5 increased spending due to the crowd-out effect of current  
6 coverage sources and the potential woodwork effect.

7           Because Medicare home infusion coverage is divided  
8 among so many different payment silos, it's not surprising  
9 that coverage gaps exist. Remember, the extent of coverage  
10 depends on the prescribed drug, the patient diagnosis, and  
11 equipment needs. Congress could fill gaps on a limited  
12 basis, for example, covering nursing and related services  
13 for primary immune deficiency patients. This has the  
14 advantage of dealing with a small population with a specific  
15 diagnosis so could be more easily monitored. People with  
16 primary immune deficiency disease need IVIG on an ongoing  
17 basis. By statute, beneficiaries with this diagnosis can  
18 receive IVIG under Part B at home. However, nursing and  
19 related services are not covered. And, generally, a nurse  
20 must infuse IVIG directly into the patient's vein during  
21 each administration. Without coverage for nursing and  
22 related supplies, the patient may be unable to use this

1 benefit and may use the more expensive subcutaneous IG  
2 instead. Subcutaneous IG requires a pump that's paid for  
3 under DME, so the supplies in that case are covered. The  
4 expansion of coverage might increase Medicare costs, but we  
5 do have some ideas about ways to help offset this increase.

6           On the third option, Medicare could fill gaps more  
7 broadly, for example, covering supplies and equipment needed  
8 for IV antibiotics. However, managing this broad expansion  
9 within FFS would be difficult. The potential for a  
10 significant woodwork effect is high, so it could be costly.

11           A third option would be setting up a demonstration  
12 project to test the effects of expanded coverage for  
13 antibiotics under fee-for-service. It could allow us to  
14 evaluate whether a home infusion benefit for antibiotics  
15 improves quality and saves money compared to current  
16 options.

17           Recall that MA plans already have the ability to  
18 implement an integrated home infusion benefit and many do.  
19 Fee-for-service presents a much greater challenge. The  
20 demonstration would need management controls like prior  
21 authorization. CMS or its contractors could provide this  
22 oversight, but given the agency's limited resources, it

1 could be a challenge.

2           Perhaps the biggest challenge is determining an  
3 appropriate control group. One strategy might be to select  
4 demonstration areas and identify diagnoses that are  
5 associated with use of IV antibiotics. The evaluator could  
6 measure Medicare payments for episodes of care for all  
7 beneficiaries in the areas with these diagnoses, whether  
8 they have home infusion or not, and compare it to similar  
9 areas outside the demonstration. They could also look at  
10 changes over time. However, it may be difficult to  
11 disentangle the effects of the demonstration from other  
12 unrelated effects if infusions are a low-frequency event  
13 even for beneficiaries with these diagnoses or if they  
14 account for a small share of their overall expenditures.  
15 The evaluator would have to address other methodological  
16 issues as well.

17           Some of the design questions would include: Who  
18 would participate in this kind of demonstration? Since home  
19 infusion requires coordination among multiple providers, we  
20 can imagine partnerships among physicians, home infusion  
21 providers, and home health nurses, for one example.

22           What would the payment cover? It could cover

1 supplies, equipment, services, and nursing. If it includes  
2 drugs, it would involve another set of issues related to  
3 payment and coordination with the beneficiaries' Part D  
4 plan.

5           One of the more difficult issues would be how the  
6 payment is set. The most common method used in the private  
7 market is a separate payment for drugs and nursing and a per  
8 diem for supplies, equipment, and other services. The range  
9 in payments for the per diem is high, and current data are  
10 insufficient to determine a "right price" for Medicare,  
11 although Medicare provides some benchmarks, as Kim has shown  
12 you. Medicare could use competitive bidding to determine  
13 payment rates.

14           So now I want to briefly summarize what we've  
15 found on the issues that Congress asked us to look at. We  
16 were asked whether there was useful literature on the  
17 comparative costs of providing Medicare coverage for home  
18 infusion therapy. Although there is some literature on the  
19 costs of home infusion, it is old and does not take into  
20 account the costs of a home infusion program under fee-for-  
21 service Medicare. Based on our analyses, whether home  
22 infusion yields costs or savings depends on the settings

1 which beneficiaries would otherwise use, payment rates, how  
2 frequently the drug is infused, and how often home nursing  
3 visits are needed. Shifting beneficiaries from SNFs is  
4 likely to yield savings.

5 We were asked whether there were data sources that  
6 could be used to construct a payment method for Medicare.  
7 Data on the costs of home infusion services are very  
8 limited. We've had some frustration on this. Some Medicare  
9 payment rates might serve as benchmarks.

10 Are the payment methods used by private plans  
11 applicable to Medicare? As we noted before, the most common  
12 method used in the private sector is a drug payment, a  
13 separate payment for nursing, and a per diem for supplies,  
14 equipment, and services, and this payment method could be  
15 applicable, although other methods are also possible.

16 Lastly, what are the issues surrounding potential  
17 abuse of a home infusion therapy benefit in Medicare? As we  
18 discussed in November, the plan representatives we  
19 interviewed did not find evidence that abuse is more  
20 prevalent in home infusion than in any other service. They  
21 all use utilization management techniques like prior  
22 authorization and post-utilization review. And some

1 wondered how this kind of oversight could be implemented  
2 within fee-for-service.

3 So this concludes our presentation. We welcome  
4 your comments. And are there any issues that we have not  
5 addressed that you would like to see further explored?

6 MR. HACKBARTH: Okay. Thank you.

7 Could you put up Slide 10, Kim? I like this  
8 slide. I'm trying to get sort of a handle, a construct to  
9 think about these issues, and this creates a nice shell.  
10 But it raises the question: Is there any way that we can  
11 get more data that would help us fill this framework out  
12 more completely?

13 MS. NEUMAN: So there are, I think, at least three  
14 big data holes that we have, and two might be fillable, one  
15 is much more difficult. The first is that we do not know  
16 which beneficiaries in SNFs are getting IV antibiotics, what  
17 those antibiotics are, and for how long they're getting  
18 them. And, potentially, you could require more complete  
19 reporting on the part of SNFs through claims or the MDS. So  
20 that's one hole that you might be able to fill.

21 The second hole relates to the idea of how many of  
22 these patients would be candidates for home infusion, so

1 you've got people in SNFs getting IV antibiotics or people  
2 in hospital outpatient departments getting IV antibiotics.  
3 How many of them actually would be able to do it in the  
4 home? That's a much harder question. The person who is  
5 probably best positioned to know that information is  
6 actually the hospital discharge planner, who would have been  
7 in collaboration with the physician deciding where to place  
8 the patient. So, hypothetically, you could do a survey of  
9 hospital discharge planners to collect this kind of  
10 information. It would need to be nationally representative.  
11 It would probably need to be in a field for a long time. It  
12 would probably cost a lot. But, theoretically, it's  
13 possible.

14           The last piece is the woodwork effect, so how are  
15 prescribing behaviors going to change now that there's this  
16 broader coverage in the home? That I'm not sure there is  
17 any way to collect data on prospectively, so that's a gap  
18 I'm not sure we could fill.

19           MR. HACKBARTH: Let's go to Round 1 clarifying  
20 questions, Mike.

21           DR. CHERNEW: A lot of the challenges in this is  
22 because we're paying a bundled payment somewhere. So if you

1 add something else on to, say, cover something in the home,  
2 you don't actually save the money that you would say you  
3 saved because it was actually lumped in some other bundle.  
4 So my first clarifying question is: Is that basically  
5 right? So, for example, if you have inpatient care or --

6 MS. NEUMAN: Yes, hospital definitely. On the SNF  
7 side, we are paying a per day rate there, so --

8 DR. CHERNEW: But you would have to avoid the  
9 whole day.

10 MS. NEUMAN: You would have to avoid the whole  
11 day, or potentially the --

12 DR. CHERNEW: Or the walk-in.

13 MS. NEUMAN: -- argument that folks make is you  
14 could avoid the whole admission.

15 DR. CHERNEW: Yes. If you avoid the whole  
16 admission, that part I understand. But the question I had  
17 is: Is there some mechanism if this was cheaper? Refresh  
18 my memory as to how the actual rates for areas where this  
19 would be important, the DRG rate or whatever, would be  
20 lowered, because now there's a more efficient way of doing  
21 it. So if you were really running this system and someone  
22 said, look, it's a lot cheaper to do this at home, we could

1 discharge you from the hospital a day earlier, or whatever  
2 it is, is there a mechanism for the whole DRG rate on a  
3 average to be lowered to reflect the efficiency? Would you  
4 have to wait for that to work through the cost system for  
5 that to happen?

6 MS. NEUMAN: I think you would have to wait for it  
7 to work through the cost system, and then the other piece of  
8 it is that -- and the hospital people should check me on  
9 this. When they recalibrate the DRGs, they do it in a  
10 budget-neutral way. So if the costs of the DRG for people  
11 who have an infectious disease goes down, the payments for  
12 the other DRGs go up. So that, on net, the way the system  
13 currently works, you wouldn't save.

14 DR. CHERNEW: So now I have to ask another  
15 question. This is a clarifying question, though. Are you  
16 telling me that if the hospitals become more efficient in  
17 any given DRG, there's no way to save money by lowering the  
18 price for that DRG because the system automatically gives  
19 that efficiency back to every other Deregulation?

20 DR. MARK MILLER: In the short run, that's true.  
21 You might see that, for example -- if you just let things  
22 run -- and I'll give you two ways to think about it. So

1 let's say they get more efficient, and then maybe the need  
2 for an update over time becomes less than it would. Of  
3 course, in this world that's probably not going to be  
4 something that's going to be very big. But it may be a  
5 thing.

6           The other way, if you did something like this, is  
7 to mechanically -- and, you know, the hospital industry  
8 needs to take a deep breath here -- say, okay, we're doing  
9 this, and so we are going to assume that these savings are  
10 coming out of here, and at the time of the legislation make  
11 some adjustment in the overall payment rate. Then you would  
12 capture the savings at the time that the change was made.  
13 There would be much controversy around, given this, how  
14 would you estimate it and know, and there would be a hard  
15 argument to make.

16           DR. CHERNEW: But at least you could be consistent  
17 between the savings you were assuming in one way and the way  
18 you were capturing it.

19           DR. MARK MILLER: Well, there's just one other  
20 thing I want to say on this. So, for example -- you've  
21 definitely seized on the right example to have this  
22 conversation about, about the hospitalization. But the

1 other issue -- and you need to check me on this, Kim -- is  
2 let's say you set this up and in theory if you move a person  
3 from SNF to home, you would save, right? If they're in  
4 there for that sole reason -- which we don't know and all  
5 the rest of it, but let's pretend. But, of course, the  
6 nursing home has to be willing to let that happen, or at  
7 least at the discharge planning stage this has to be  
8 captured and moved to the right place. And the nursing home  
9 may not have a motivation to do that. So that's the other --  
10 - that's another problem of capture --

11 [Inaudible comment off microphone.]

12 DR. MARK MILLER: And that's why we have that.

13 Can I just say one quick thing before we move off  
14 of Mike? That exchange that you and Glenn had, can we just  
15 capture that in a paragraph or two and put that in the  
16 report, just to make sure we don't lose that thought?

17 MR. BUTLER: I'm just a little unclear about fraud  
18 and abuse and woodwork effect and some of these things that  
19 you brought up.

20 First, it wasn't a ringing endorsement. It said  
21 in interviews there's no reason to think this is any  
22 different from any of the other services. It didn't say --

1 you know, so it was a little bit -- it wasn't -- you know.

2           And then are we worried about particularly the  
3 home health for-profit kind of -- not woodwork, but Dade  
4 County effect? Is that the issue? I'm just trying to  
5 understand the concern about excessive utilization, where it  
6 may occur, and who are the likely suspects that we would  
7 want to make sure are monitored.

8           DR. SOKOLOVSKY: On your last point, I would say  
9 yes. With nobody really monitoring it -- because what the  
10 plan said was they monitor so carefully in terms of both  
11 prior authorization and then post-utilization review and  
12 they know things that are flags, and if those flags come up,  
13 then they can do something quickly about it. And they  
14 wondered how fee-for-service could have that same kind of  
15 structure to be able to monitor.

16           MR. HACKBARTH: It seems to me there's sort of a  
17 fundamental tension here. As things move from institutional  
18 settings out to the home, you know, there are real benefits:  
19 convenience for the patient, perhaps in some instances  
20 better adherence with needed care, and on a unit cost basis  
21 potentially a lower unit cost of production. Whether  
22 Medicare realizes that or not obviously is a function of

1 what the payment rate is. So in that sense it's all very  
2 attractive.

3 But it presents challenges. When you move out of  
4 institutional settings, there's less oversight, fewer people  
5 around to say is this the right thing to be done, and it  
6 becomes more difficult to bundle and create incentives for  
7 appropriate utilization. And so there's a real fundamental  
8 tension, and in that bundling is the Medicare's principal  
9 tool for dealing with utilization issues, and it becomes  
10 harder as it moves to home settings.

11 Now, I don't think the home health benefit, where  
12 we tried to do it through an episode payment, is, frankly a  
13 resounding success in showing bundling in the home setting  
14 really works well to control costs. And so we're torn  
15 between these two things.

16 Private payers, if I read the report correctly,  
17 address that tension through intensive oversight, you know,  
18 prior authorization, close monitoring retrospectively of  
19 claims patterns and the like. But those are tools that have  
20 been difficult, if not impossible, for Medicare to use. And  
21 so we're trying to fit this development into a framework, an  
22 insurance framework, where really it's pretty awkward. It's

1 really challenging.

2 DR. NAYLOR: I just wanted to, getting back to  
3 Glenn's question, as I understand it, are you saying that we  
4 don't know in skilled nursing facilities who's receiving  
5 infusion therapies and what their costs are?

6 MS. NEUMAN: So we know if somebody's getting an  
7 infusion. We don't know what's being infused. And they do  
8 report charges on their claims, but it's not going to be  
9 specific to this person's getting vancomycin or this person  
10 -- so we don't know to the level of detail that we would  
11 need to know to be able to say there's this many people in  
12 the SNF getting this antibiotic. We can't say that.

13 DR. MARK MILLER: And I also think a key thing we  
14 don't know is whether that person is there for that reason  
15 alone. So you kind of know somebody is getting infusion,  
16 and that would be the person who could move to the home.

17 DR. NAYLOR: Right.

18 DR. MARK MILLER: Whereas, if there were other --  
19 are you with me on that?

20 DR. NAYLOR: Yes.

21 DR. DEAN: I guess I would just ask, your recent  
22 comment, Glenn, we've talked about using pre-authorization.

1 Why would it not work in this setting? Because it seems to  
2 me this is a procedure where pre-authorization is quite  
3 appropriate. But does Medicare not have a structure to do  
4 that?

5 MR. KUHN: A couple things, Tom, on that.

6 One is a lot of entities that do pre-authorization  
7 have their own algorithms and their own processes they use.  
8 Those are proprietary items, and if they were to use that in  
9 the Medicare program, they would have to open those black  
10 boxes, and many have been unwilling to do that.

11 The second thing is if a beneficiary is denied,  
12 then you have to set up an elaborate appeal process that  
13 ultimately could go all the way to an ALJ for review of it,  
14 and the appeal process could be lengthy, or they could do  
15 stuff on a short period of time, but it could be expensive  
16 and costly. So to a large extent, except in real cases of  
17 fraud and abuse, particularly in the DME area, Medicare has  
18 pretty much passed in terms of a pre-auth in the fee-for-  
19 service program. But Bob might have more to add.

20 DR. BERENSON: And there's one other problem which  
21 I faced when I was trying to get the agency to do some very  
22 targeted prior authorization, which is that the cost of the

1 prior authorization is on the administrative side and the  
2 administrative budget; the savings is in the mandatory side,  
3 so you can't spend \$1 to save \$5 because you don't -- I  
4 mean, somebody's got to be reviewing those cases. And so it  
5 goes to the problem of having separate walls between the two  
6 sources of funding, and so that's a very practical problem.  
7 But, again, in the long run, in our advanced imaging we made  
8 a specific recommendation, and I think in coverage policy, I  
9 think there's some very good opportunities to do pre-  
10 authorization. So it's not something we should drop. But  
11 we would have to recognize the current limitations.

12 DR. DEAN: Thank you.

13 DR. HALL: I think this is a very special  
14 circumstance here that we might start barking up wrong trees  
15 here. But let me just say at this stage, I think I heard  
16 you say that we have no ability to get at clinical  
17 indications for the use of parenteral nutrition or  
18 antibiotics, just taking two of the classes, that that  
19 information is not available to us?

20 MS. NEUMAN: Can you say a little bit more?

21 DR. HALL: Okay. So we are worried a lot about  
22 woodworking effect, which I think I would challenge that

1 there is much woodworking effect in this particular  
2 situation. But -- well, I'll just put it this way: I think  
3 the most telling table was actually in the reading material,  
4 Table 1, where you had the prices and the number of  
5 recipients by the major classes that are being used here.

6           Just as an example, there are two drugs there,  
7 trepostinil and alpha 1-protease inhibitor, that account for  
8 a little under 50 percent of all the spending, and it  
9 applies to 1,500 bodies, human beings. The other 50 percent  
10 is in antibiotics and in parenteral nutrition. That's about  
11 the same percentage, a little bit higher, and it covers  
12 56,000 Medicare --

13           MR. HACKBARTH: Can you give us the page number?

14           DR. HALL: It's page 14. So you've got apples and  
15 oranges here. The biggest burden of cost in this whole  
16 system is that biologics are not regulated in terms of cost  
17 or competitive bidding. They're priced outrageously, and  
18 they, as always, benefit greatly very few numbers of people.

19           So in terms of analysis -- maybe I'll have more to  
20 say on this in part two, but in terms of analysis, I think  
21 we really need to know what's the breakdown of indications  
22 or diagnoses for parenteral nutrition, because there, there

1 might be some opportunities. And with antibiotics, I think  
2 we want to worry about woodworking effect. Generally  
3 speaking, the antibiotics that are used there are because  
4 people can't take the oral form of the drug, would probably  
5 be the main reason, but I can't imagine that there are too  
6 many situations where people are consciously deciding to use  
7 an IV drug at home rather than an oral drug. It just kind  
8 of boggles my imagination.

9           So we could also find out what the breakdown of  
10 antibiotics are. Generally, these are going to be used for  
11 people who have very serious infections that require long-  
12 term treatment, like infections of a heart valve, certain  
13 infections of the brain, or who have a very resistant  
14 organism. And, by the way, that's one of the reasons why  
15 you don't want to keep these people in a hospital, because  
16 they're nuclear weapons about to go off.

17           But I think that the analysis part of this would  
18 be just to find out, taking these two big classes -- we  
19 can't do much about the biologics, but the two big classes  
20 of antibiotics and parenteral nutrition, and see if we can  
21 get some clinical data on that.

22           DR. SOKOLOVSKY: Just one thing I wanted to

1 mention in terms of woodwork effect. The Cleveland Clinic  
2 did a study, which they brought in infectious disease  
3 doctors to look at all of the patients coming through the  
4 clinic who were prescribed IV antibiotics. And of those  
5 patients -- and it had to take a while because it's just not  
6 frequent an event -- 29 percent, the infectious disease  
7 doctors said, either they could have taken an oral drug or  
8 the drug they were being prescribed was incorrect. So from  
9 that, they concluded that without that kind of oversight,  
10 there was this potential.

11 DR. HALL: Well, that shows an area for cost  
12 savings then, if that's reproducible nationally.

13 DR. BERENSON: I would have endorsed everything  
14 you had said in terms of the doubt about woodwork effect, so  
15 I'm interested in that finding.

16 I wanted to do things. One is just establish the  
17 scope of the spending in this. In the paper, not in the  
18 presentation, I have two numbers here: 602 million for Part  
19 B drugs, equipment, and supplies and 422 for drugs covered  
20 by Part D, and not including the home health episodes that  
21 might be created in Medicare Advantage. That is the total  
22 spending, really, we think for this activity, for home

1 infusion?

2 MS. NEUMAN: It currently is.

3 DR. BERENSON: So that's about \$1 billion. So by  
4 my back-of-the-envelope calculation, we're talking about  
5 maybe 0.2 percent or something of Medicare spending. So in  
6 terms of coming up with lots of demonstrations and things  
7 like that, I just think we want to keep that in perspective.

8 Having said that, I wanted to pursue what Mike's  
9 questions were around the hospital. I assume down the road,  
10 if the hospital cost structure -- if there's a shorter  
11 length of stay because some patients aren't there for 30 or  
12 45 days getting long-term antibiotics, that somehow, maybe  
13 imperceptively, finds its way into a lower-cost structure  
14 and ultimately there is savings, without getting into that  
15 detail right now, my major concern was just what Bill said,  
16 is that we shouldn't have a system in which people are  
17 staying in hospitals for antibiotics.

18 Do we know -- and this goes to the issue of  
19 whether we should do a demo of antibiotics as a specific  
20 benefit. Do we know whether hospitals actually have  
21 problems finding alternatives for home infusion, given all  
22 the alternatives, outpatient, SNF, home health? Do we know

1 if there are a lot of patients who actually stay in the  
2 hospital simply to get drug treatment?

3 DR. SOKOLOVSKY: From our interviews, which is,  
4 you know, not perfect by any means -- we can't tell it from  
5 the data, but we didn't hear much in the way of many people  
6 staying in the hospital.

7 DR. BERENSON: Okay.

8 DR. SOKOLOVSKY: What we did hear were people  
9 going to SNFs to get anti --

10 DR. BERENSON: Okay, so the hospitals are finding  
11 some way to discharge these patients given the current  
12 incentives in the DRG system. I mean, that's what I was  
13 hoping you would say. Obviously, it's qualitative based on  
14 interviews. That would affect my views of how much effort  
15 we would want to spend on that particular demo.

16 MR. HACKBARTH: Bill's comment about the  
17 woodworking effect is a really important one, and that's why  
18 it's good to have physicians around.

19 For me that raises another question. If I  
20 understand the report correctly, private insurers are using  
21 prior authorization, which suggests to me that they think  
22 there is a woodwork problem here and some inappropriate use.

1 Those programs cost money to run, and, in fact, there are  
2 instances where they have dropped prior authorization  
3 because they find that they're, you know, approving all the  
4 claims. And so if we could find out more concretely about  
5 their experience and are they denying a lot of claims with -  
6 - or denying a lot of requests for services under their  
7 prior authorization programs?

8 DR. SOKOLOVSKY: I think that we didn't hear much  
9 initial denials so much as looking when it wanted to go  
10 longer than they thought was appropriate, kind of stopping  
11 it.

12 MR. KUHN: Joan, when you were talking about the  
13 notion of the demonstration, you mentioned the notion of  
14 maybe competitive bidding as maybe an option. Obviously,  
15 there's a lot of design difficulties here, but I think  
16 there's a lot of design difficulties with any demo that CMS  
17 tries to put together.

18 But we also know that it takes a long time to do a  
19 demonstration from the development of it, to running it,  
20 then doing the evaluation.

21 If it was done through competitive bidding, would  
22 that truncate the process? Or does it really matter, length

1 of time, whether it's a regular demo or whether it's one  
2 that's done through competitive bidding? Or are they still  
3 probably the same length of time to run them the whole time?

4 DR. SOKOLOVSKY: I think we think it's the same.  
5 It would help to get -- given our lack of data on what the  
6 payment rate should be, it would help in that area. But I  
7 don't necessarily think it would help in terms of figuring  
8 out is this a cost or a saver for Medicare.

9 MR. KUHN: Thank you.

10 DR. BAICKER: Even though this punchline was  
11 uncertain, I thought it was really helpful to see the  
12 different categories of where we might get information,  
13 where it's really hard to get information, to think about  
14 the cost side.

15 You mentioned in passing in the chapter about best  
16 practices for certain conditions. I wondered if we had a  
17 sense of on the benefit side patient outcomes in the  
18 different settings or patient satisfaction with the care in  
19 the different settings. Should we be balancing these  
20 unknown costs against any way to quantify the benefits?

21 MS. NEUMAN: So in terms of outcomes data across  
22 settings, there's no a lot of literature that has done head-

1 to-head tests. But what we heard in our interviews is that,  
2 you know, with antibiotics and IVIG, which are ones that,  
3 you know, you hear a lot about in this area, that patients  
4 generally want to go home if they can. There are some who  
5 don't feel comfortable doing it at home, but big portions of  
6 them would prefer to go home. That's what we heard  
7 anecdotally.

8 MS. BEHROOZI: Just back to the topic of fraud, I  
9 don't know, it could be a leading indicator, because  
10 sometimes once somebody figures out how to do it, then  
11 suddenly there's an explosion as opposed to, you know, a  
12 gradual build-up. So it struck me when you cited a separate  
13 analysis of Part B claims data found roughly 50 percent more  
14 beneficiaries receiving infusion pumps than infusion drugs.  
15 Is that as big a deal as it looks? And not that they've  
16 figured it out, they can do it. So that's one question.  
17 And then the second question is: What can Medicare do about  
18 that? What should we be thinking of doing about that?

19 MS. NEUMAN: Okay, so a couple of things.

20 First, that's on the Part B side, so we're not  
21 talking about lots of beneficiaries. It's on a smaller  
22 base.

1           The second piece is that, you know, we've been  
2 looking at that to try to figure out if there's some other  
3 explanation besides inappropriate billing and, you know,  
4 done some talking with CMS about that, and at this point  
5 it's still unclear. So we're kind of leaving it open-ended  
6 that we see this pattern, it's a potential area for more  
7 looking. It could be inappropriate billing, but a lot of  
8 work would have to be done to figure that out. So we kind  
9 of -- I know that's not satisfactory, but that's kind of  
10 where it's at.

11           MR. GEORGE MILLER: Yes, Herb hit on the point I  
12 wanted to raise, and let me see if I can put a different  
13 twist on that. From the competitive bid demonstration  
14 model, could we -- or have you considered designing a system  
15 where we would let someone like Kaiser -- or you mentioned  
16 in your information the Cleveland Clinic -- design a  
17 competitive bidding process where you have the endgame in  
18 mind and see if that would -- with a control group, and  
19 design a system where they would take both the risk and then  
20 a benefit for seeing if we could move patients to a home  
21 setting and have cost savings to that group? Would that be  
22 a way to come at the problem from the standpoint of having a

1 design, without going through the entire system, but with a  
2 demonstration, a competitive bid demonstration find the  
3 desired effect?

4 DR. SOKOLOVSKY: I think that in our ideal world  
5 it would be a place like Cleveland Clinic that would  
6 participate in this demonstration. Exactly how they would  
7 do the payment rate could be many models, but I think that  
8 would be our ideal. But as far as Medicare Advantage, a  
9 Kaiser plan, about 219 MA plans are already doing this.

10 MR. GEORGE MILLER: So are there conclusions to  
11 drawn from that and see if it's applicable across a wider  
12 space?

13 DR. SOKOLOVSKY: Again, the issue there is that  
14 they can monitor it, they can control it, and so to what  
15 extent can we transfer this to fee-for-service.

16 DR. MARK MILLER: George, I took your question  
17 this way -- is this what you were asking? That if you -- I  
18 think Herb was asking about getting at the price through a  
19 competitive bid. But were you saying would you design the  
20 demonstration to say for an entity -- I'm making this up --  
21 you have some control of a geographic area, and you're sort  
22 of at risk for how this benefit goes and at risk for whether

1 the net spend which might be associated with these patients  
2 -- which is the \$64,000 question, but let's pretend -- goes  
3 up or down? And then you would set up something where the  
4 fee that's paid to the entity somehow reflects how well they  
5 control the expenditure, that's what you're asking, is could  
6 we design a demo that way?

7 MR. GEORGE MILLER: Yeah. You said it much better  
8 than I did, but yes.

9 DR. MARK MILLER: And I think you could design  
10 this demonstration a few different ways. One could  
11 contemplate a thing like that where you say, okay, this is a  
12 geographic area, some entity, either proprietary or making  
13 their black box known, would say, okay, I'll take  
14 responsibility for this. But there are still gigantic  
15 issues about how you define the control and know what would  
16 have happened in the absence of that, given what these guys  
17 went through. But you could contemplate models like that.

18 DR. STUART: I would like follow up on a point  
19 that Bob made about the difficulty of discharging  
20 individuals from hospitals that require infused medications.  
21 I recall after the SNF prospective payment system went into  
22 place that there was a lot of talk about difficulty among

1 hospital discharge planners in getting patients into SNFs  
2 because the nursing homes found these to be really high-cost  
3 patients and they were losing money on them so they didn't  
4 want to admit them.

5 Has that changed? In other words, have the drugs  
6 moved from the A to the D side and, therefore, made it more  
7 profitable for nursing homes to admit patients directly from  
8 hospitals that require infusion?

9 MS. NEUMAN: On the SNF side, the drugs continue  
10 to be covered under the Part A SNF benefit and are bundled,  
11 except for chemo drugs. So the same incentives exist today  
12 as existed previously as far as SNFs having to consider how  
13 much total money they're going to get from the RUC payment  
14 and whether that's going to cover the cost of the drugs or  
15 not.

16 In general, we heard in our interviews that in a  
17 number of areas they were able to place patients in SNFs.  
18 We did hear for some very high cost drugs there might be  
19 some unwillingness to take these patients in SNFs.

20 DR. STUART: Were you able to then correlate that  
21 back to the hospital in terms of extra days that are spent  
22 in the hospital because of that?

1 MS. NEUMAN: No, we don't have the data at that  
2 level to be able to look at that.

3 MR. HACKBARTH: So let me just pick up on that.  
4 When we've talked about SNF payment and improving the  
5 accuracy of SNF payment, one of the issues has been how the  
6 payment system currently deals with the non-therapy  
7 ancillaries, which includes the drugs, as I recall. And I  
8 think we've been saying that they're underpaying for the  
9 non-therapy ancillaries in the current construct, and we've  
10 made specific recommendations that would shift the dollars  
11 around so that there would be better payment for those  
12 things. And that may influence the profitability of  
13 handling patients with significant drug expenses and the  
14 desirability.

15 DR. STUART: I think that's a really good  
16 observation because it says that if there is a problem --  
17 and I think what you're saying is we don't know if there is  
18 a problem of people staying in the hospital because -- some  
19 people, who knows how many? -- because they can't be  
20 discharged, that this would be a more reasonable policy  
21 alternative than going down the line and trying to, you  
22 know, create this new benefit that would be provided in the

1 home.

2 DR. MARK MILLER: And the only thing I would  
3 remind -- everything that you said is correct. The only  
4 thing I would remind you of is the Commission's thinking on  
5 SNF at the moment, and this is going to be a highly  
6 scientific chart here. We're saying, yes, non-  
7 therapy/therapy in terms of the relative payments, and so  
8 we've made recommendations to make that more equal, and  
9 that's the conversation you just had. But we've also said  
10 there's overpayment occurring, and so some of those  
11 incentives may have changed in the sense that if they found  
12 the PPS more profitable over time, in general there may have  
13 been some effect there.

14 DR. STUART: I think we all recognize that there  
15 are moving parts here and we have to think of them together.  
16 I just think -- I guess what I'd like to see is in this  
17 analysis that we recognize that this policy is implicitly  
18 tied to other policies regarding SNF payment.

19 MR. HACKBARTH: As Mike or somebody alluded to  
20 earlier, this also links directly to our discussion about  
21 bundling around post-acute services. In fact, a question  
22 that I had was can we say how many of these people would

1 fall within a 30-day post-admission window? Is that a  
2 number that's available?

3 MS. NEUMAN: We don't have it. It's something we  
4 could see if we could calculate.

5 MR. HACKBARTH: Okay. Ron, clarifying questions.

6 DR. CASTELLANOS: Thank you. First of all, I live  
7 in this world with antibiotics and it's very confusion.  
8 It's a tremendous amount of silos. And the real -- excuse  
9 me, I always bring this in the real world -- it's the  
10 discharge planner in the hospital that really makes these  
11 differences to where that person goes, depending whether he  
12 or she has insurance, type of insurance. I mean, it can go  
13 all the way from the SNFs to having medication given in my  
14 office. But this is a real serious problem with silos.

15 Two other points. One is the woodwork effect.  
16 Bill, I agree with you, and Bob, I agree with you. You  
17 know, I think we -- I know you mentioned the Cleveland  
18 Clinic Group study. I think we should look at it a little  
19 differently. Instead of a crook behind each tree, I think  
20 we ought to look at it maybe at appropriateness and clinical  
21 guidelines and education of the medical community for  
22 appropriateness. I'm not saying there isn't some fraud or

1 abuse, but generally, I think, as Bill said and as Bob said,  
2 I don't think it's pervasive in this field, but it could be.

3           And the third point I wanted to make is I know  
4 there's a bill in front of Congress now, the Medical Home  
5 Infusion Therapy bill. You didn't mention anything about  
6 that. Do you have any information on that? It's a bill  
7 that apparently gets around a lot of these silos, but I'm  
8 not sure where it stands or what it really means.

9           MS. NEUMAN: So there's been a bill in Congress  
10 for the last few years to expand Medicare coverage for home  
11 infusion to cover the services and supplies and nursing and  
12 to leave the drugs in Part D. And so it's in Congress right  
13 now pending, and that's the most I can tell you about it.  
14 As far as -- I mean, it's hard to know prospects and all  
15 that.

16           DR. CASTELLANOS: Would that get around some of  
17 the other silos?

18           MS. NEUMAN: It would. It would in the sense that  
19 it's expanding coverage, creating this new coverage. So it  
20 would get around silos, but it would create its own silo in  
21 a way, you know what I'm saying?

22           DR. CASTELLANOS: Thank you.

1 DR. MARK MILLER: I mean, when they went through  
2 and set up the gaps that occur under fee-for-service at the  
3 beginning of the talk, what that bill does is said, okay,  
4 those gaps are now filled. So it's just -- it's saying the  
5 fee-for-service benefit now pays for the nurse, pays for the  
6 equipment in each of the settings. And the \$64,000 question  
7 is does it save or cost money, and that's what we're  
8 discussing. And I think Congress's desire is to fill the  
9 gap, but they also can't quite figure out whether it will  
10 cost and whether it will lead to the outcomes that they want  
11 to achieve.

12 MS. NEUMAN: And one point I should add is that  
13 there isn't a score on the current bill that's in the  
14 Congress, but previously, our understanding is it's been  
15 scored as a cost.

16 MR. GRADISON: I want to inquire a little bit  
17 further about the MA program's experiences in two ways.  
18 First, because of the preauthorization and so forth, I just  
19 wonder if you can give us any sense directionally of when  
20 these plans tend to approve home infusion and tend to say  
21 no.

22 And the second question is whether it's possible

1 to obtain from the plans any even rough idea of the costs  
2 that they experience in these instances. Thank you.

3 DR. SOKOLOVSKY: Well, Kim thinks -- to give you a  
4 real answer. I will give you a fake answer.

5 [Laughter.]

6 DR. SOKOLOVSKY: But let me say, we did talk to  
7 many plans. Nobody really was willing to share data on that  
8 level. It's not surprising because it is proprietary. But  
9 what they did ask, on their prior authorization, they would  
10 want to know the diagnosis. They would want to know the  
11 beneficiary's age. They would want to know the drug. And  
12 they would want to know the expected duration. And a  
13 medical director on that basis would make the decision about  
14 whether it should be covered or not. And if it went beyond  
15 that duration, there would be another authorization  
16 necessary. Oh, and I forgot to mention, and how much  
17 nursing would be expected.

18 MR. HACKBARTH: Joan, if I understood you  
19 correctly earlier, you said that most of the action is not  
20 on denial of the initial request, but it's around the  
21 duration, extension of the duration? Did I understand that  
22 correctly?

1 DR. SOKOLOVSKY: They would tell us things like,  
2 if this goes beyond X weeks, that's a red flag. That was  
3 the expression we would often hear. This is a red flag.

4 MR. GRADISON: Well, that's very helpful because a  
5 red flag to them might be -- thank you.

6 DR. BORMAN: In your conversations, did you  
7 encounter anything to suggest or to predict that given some  
8 new drug that's on the way or some disease pattern that's  
9 emerging, that we should anticipate a significant change in  
10 the number of people that would appropriately require or  
11 come to use these kinds of services?

12 DR. SOKOLOVSKY: I don't think we heard that  
13 specifically, but we did hear of one new oral antibiotic  
14 that's quite expensive and that can, in fact, replace IV  
15 antibiotics, and under a Part D plan, a stand-alone Part D  
16 plan, it was often not on the formulary and rejected because  
17 that plan wouldn't recoup any kind of savings if there were  
18 savings from not having to have the IV.

19 DR. BORMAN: So that at least on a pure basis, the  
20 -- looking to the future, it is consistent, at least with my  
21 personal experience, that we are ever moving toward oral  
22 substitutes for many things that have been given

1 perineurially [phonetic], whether IM or IV, so that it would  
2 seem that at least in the care, quality, risk sort of  
3 evaluation that the needs for these services may, in fact,  
4 if anything, be diminishing over time rather than  
5 increasing.

6           Just as sort of a guess about, again, as Bob tries  
7 to say what percentage of the pie are we looking at here and  
8 how much time and energy is appropriate, I'm trying to get  
9 at is this -- seem to be something that's getting ready to  
10 explode as a need or potentially stay the same or diminish,  
11 and I would say that it's more likely to stay the same or  
12 diminish in the Medicare population.

13           DR. SOKOLOVSKY: The one thing that goes in the  
14 opposite direction that I could say that's not really from  
15 this study but the work we did previously on biologics,  
16 there are so many biologics in the pipeline now and it's  
17 much easier -- because they're big molecules, it's much  
18 easier to produce them as injections or infusions --

19           DR. BORMAN: Right.

20           DR. SOKOLOVSKY: -- than as orals, even though  
21 oral would be the desire.

22           DR. BORMAN: But the majority of those require

1 almost continuous monitored setting to give because of the  
2 potential side-effects, yes? I mean, it's pretty rare, I  
3 would think, to give very -- I mean, most of the biologics,  
4 at least in terms of when we heard drug administration codes  
5 and went through a whole big revamp of that through the CPT  
6 process not that many years ago related to the fact that  
7 they had to be in these fairly carefully monitored settings  
8 and that it would be the rare family that would be prepared  
9 to detect that. Mary may have some sense about that from  
10 the nursing side. But I believe that most biologics are  
11 viewed as almost like giving chemotherapy, really. They are  
12 sort of a subset of chemotherapy, depending on how you want  
13 to think about the definition. So I agree with you that if  
14 the biologics become safer, that would be the growth market  
15 here, and certainly that's something to think about.

16 I think that one of the big problems in this is  
17 that -- my guess would be that relatively seldom is this the  
18 sole reason that the patient was admitted to the hospital.  
19 This is going to be somebody that came in with some  
20 manifestation of unknown fevers, with a new heart murmur,  
21 with change in mental status, with trauma and ended up  
22 having a diagnosis of endocarditis or osteomyelitis or

1 things that need prolonged antibiotics, so that the notion  
2 that there's somebody who comes in specifically to receive  
3 IV antibiotics is really a dwindling population

4           And certainly the EDs that I've been associated  
5 with in the last ten years are certainly very aggressive  
6 about even sorting patients in the emergency department if  
7 they have some sort of complex laceration or something that  
8 they think needs some home antibiotics. They don't even  
9 touch down in the hospital. I mean, they have ways to link  
10 them up with that service the next morning.

11           And so Scott may have some experience with that in  
12 terms of administering for his group, but I think that the  
13 number of patients where it's solely that is vanishingly  
14 small. So I think -- and coming at that number, I agree  
15 with you, is going to be -- there's just no way to pick  
16 that, I don't think. I don't think anything on claims data  
17 is going to begin to get you close to that number, so I  
18 think we've got to kind of quit thinking about that we're  
19 going to understand that.

20           I think that, as somebody pointed out, some of  
21 these drug infusions are for prolonged periods of time --  
22 six weeks of antibiotics for X, Y, or Z -- and certainly you

1 would think there are some savings there. The question will  
2 be, does that same person who has osteomyelitis or a bad  
3 bone infection need to be in a very intensive physical  
4 therapy setting at the same time. So it's not necessarily  
5 so much the antibiotic that keeps them there. It's that  
6 they have this conjoint need.

7 Another thing about accessing these, or where they  
8 go to get these managed is how they're getting the drug. If  
9 it's a peripheral IV line and not a port, those are more  
10 easily teachable to families. There's a lower skill set in  
11 terms of facility that's needed. Getting a patient  
12 transferred more often seemed to hinge on if they have an  
13 implanted venous access device. That's a little bit  
14 different skill set and that might be the barrier that where  
15 you would otherwise normally send them will not deal with  
16 accessing that port.

17 So I think there are so many nuances to this and  
18 it is such a relatively small thing, I'd be really careful  
19 about getting caught up and trying to nitpick this to that.

20 MR. ARMSTRONG: Yes. My question and a comment,  
21 and my question is actually in part a reflection of the  
22 questions we've been asking. And I just have to say, I'm

1 honestly not sure what the problem is that we're trying to  
2 solve. Is it that costs are inflating at a trend that's  
3 worrisome to us? Is it a concern about quality of care  
4 provided in home for these patients? Is it, as a couple  
5 people just recently said, that we anticipate some explosion  
6 and we want to try to kind of get a handle on what's  
7 happening before services go crazy? And what was it that  
8 inspired the mandate that we put this report together,  
9 because I feel like we're kind of fishing for, well, what  
10 are the problems that we want to analyze?

11 DR. MARK MILLER: All right. And you guys should  
12 offer your opinion, as well. This is my sense of it, that  
13 what motivated the Congress, and it was that there are  
14 clearly gaps in the fee-for-service benefit and I think a  
15 genuine desire of, well, if a person needs this, are they  
16 are or are they not getting the support that they need, and  
17 perhaps some instinct, and I think a lot of the starting  
18 questions kind of point to this, is, well, clearly, say for  
19 antibiotics, if you move the person out of the hospital,  
20 that has got to save money, right?

21 MR. ARMSTRONG: Right.

22 DR. MARK MILLER: And so I think when they've

1 offered these ideas and run into scores from CBO that says,  
2 no, not so straightforward, they've kind of come to us and  
3 said, what gives? That's kind of my take. But I think the  
4 instinct is there's a population -- and some of these  
5 populations, just to be really clear, I mean, some of them  
6 have very sympathetic and strong arguments on their  
7 situations and I think you have an emotional element that  
8 kind of runs through some of this, as well.

9 I'm not sure some of the questions about biologics  
10 coming on or going off, that kind of thing, at least in some  
11 of the instances, those kinds of things are really driving  
12 it. It's more the immediate, I think.

13 Do you guys have a reaction here? And just for  
14 the record, we only give fake answers in the most extreme  
15 circumstances, right? It doesn't happen a lot.

16 [Laughter.]

17 DR. SOKOLOVSKY: I can't believe this is up to me.

18 DR. MARK MILLER: Very extreme, then we'll go to  
19 the fake answer.

20 [Laughter.]

21 MR. ARMSTRONG: I mean, I asked it, in part, we  
22 have limited resources. We've got a huge agenda. And I

1 know this is a required report, but we have some decisions  
2 to make about how we want to invest in demonstrations and  
3 studies and stuff like that --

4 DR. MARK MILLER: I want to say to you guys, at  
5 least in terms of our efforts here, I mean, what I see  
6 happening here on this report is kind of laying out the  
7 product of this discussion, saying that the Congress can  
8 move in a few directions, which we've laid out for them, but  
9 there is a huge deficit in information. We've tried our  
10 best to inform you and at least give you the cells and the  
11 way to think about it. But we've done what we can.

12 MR. ARMSTRONG: Yes.

13 DR. MARK MILLER: I mean, we can't create and  
14 manufacture data, notwithstanding our fake answer approach  
15 to things. But, I mean, we can't do that, and so we're  
16 going to have to say to them, this is what we know. And I  
17 think Kim has said to you, I know this is unsatisfactory.  
18 When we communicate this with the staff and ultimately the  
19 Congress, I think they're going to be frustrated, too. You  
20 didn't give us the answer. And it's going to be, there has  
21 got to be a lot more information collected to give them the  
22 answer.

1 MR. ARMSTRONG: Okay.

2 MR. HACKBARTH: Okay. It is 9:07, so we're  
3 already, after round one, seven minutes over our budget for  
4 this topic. Could I see the hands of people who have an  
5 additional comment or question that they want to make? So I  
6 have Mary, Tom, Bill, Bob --

7 DR. MARK MILLER: Peter.

8 MR. HACKBARTH: -- and Peter. Anybody else on  
9 this side? Okay. So why don't we go through those people.  
10 Peter.

11 MR. BUTLER: Yes. So I'm a little bit with Scott  
12 on this, that it's not just a woodwork effect. This is like  
13 a can of worms effect or something like that. And I would  
14 caution about the degree to which we can really be specific  
15 in our recommendations.

16 I do think that, for me, going to Bill's example  
17 of a valve infection or something, I mean, it should be  
18 about the beneficiary and not about the cost so much, and if  
19 a course of treatment at home, I would think, would make --  
20 we want to make sure that the patient can get the right  
21 treatment in the right place at the right time, and if there  
22 are abuse or all these other things, I mean, we ought to

1 find ways to be able to address that.

2 My last -- this is a little out-of-the-box  
3 thinking. It's too bad you can't link this to, like, an ACO  
4 or some -- if they were more tightly configured and you felt  
5 there was somebody overseeing it, you could say, okay, a  
6 pioneer ACO, you can have the benefit if you're sitting in  
7 there. Of course, you don't always know who your members  
8 are. That's the problem. But if there were some oversight  
9 structure that would naturally align with this, then you'd  
10 say, okay. For those people, we'll provide the benefit. So  
11 maybe there's something like that we could do.

12 DR. NAYLOR: So I think that one possible way to  
13 frame this is under option three to think about -- because  
14 you have answered the question really well about whether or  
15 not we have current data that helps to know the costs and  
16 benefits of home infusion therapy, and the answer is we  
17 don't have robust data to really get that. So I think one  
18 way to frame it is if we were to pursue -- if a study -- and  
19 I wouldn't use the word "demo" -- is to pursue this  
20 question, then maybe some of the ways in which we could  
21 benefit more than from home infusion understanding is how do  
22 you stratify groups and at what point of time can you

1 stratify them to say whether or not they would benefit most  
2 from hospitalization, skilled nursing facility, or home  
3 infusion.

4           What are the characteristics of those patients?  
5 What are the characteristics of the families? And it's a  
6 real question about whether or not people in hospitals can  
7 really assess the capacity and willingness of families to be  
8 able to do this. So I'm not sure that I would rely on the  
9 existing systems to do that.

10           And then whether or not this also represents the  
11 opportunity to test out a payment bundle in the way we were  
12 describing that model yesterday as a payment mechanism, that  
13 if we put all in, that we could really come to it.

14           And finally, I think this issue around the quality  
15 metrics that need to be examined as part of that study, if  
16 that's the direction people want to pursue. I would stay  
17 away from demo and talk about CMMI as a potential area to  
18 pursue under their innovation option or something like that.  
19 But I think that builds a little bit on George's notion, you  
20 know, where you have a chance to do some comparison with an  
21 organization that wants to do this and test against a  
22 community or comparison group that doesn't have that

1 availability and is using the traditional mechanisms.

2 DR. DEAN: Just one -- just to sort of make it  
3 more confusion, you know, one thing we have not talked about  
4 is ta some point, the home situation has to be evaluated  
5 because everything else can be appropriate and if you don't  
6 have the proper people and settings at home -- I mean, I was  
7 a recipient of home infusion therapy for about six weeks  
8 after I got an infection after my hip fracture and, you  
9 know, it went fine and it was a great benefit. But there  
10 were, even though I know a little bit about this and my wife  
11 is a nurse, there was a lot of stuff we had to learn. And  
12 so there are a lot of home situations where it just may not  
13 work even though everything else is appropriate.

14 DR. HALL: Well, first of all, Joan and Kim, I  
15 think this was such an excellent report. I don't think  
16 there's anything like this anywhere in the health care  
17 literature that really looks in depth at this whole process  
18 and my hat is off to you for that.

19 And I'm informed by the discussion. Just to give  
20 you sort of a clinical example, sometimes -- physicians will  
21 relate to this -- you do an extensive work-up for someone  
22 who thinks they have very serious disease and you end up and

1 you say, I've got some really good news for you. You don't  
2 have cancer. And you see this tremendous look of  
3 disappointment on their face that you didn't come up with a  
4 diagnosis.

5 And I would say, to really stretch an analogy,  
6 we've looked at this carefully and we probably found that in  
7 the scope of major problems we have to deal with, that this  
8 doesn't rank way up there in terms of some of the things we  
9 look at.

10 And if I were to make any suggestion at all, it  
11 would be that it sounds like the quality control and  
12 regulatory apparatus here is a little bit loose, and maybe  
13 that's where the biggest bang for the buck might come.

14 DR. BERENSON: Yes. I'm pretty much where Bill  
15 would be and where some of the other Commissioners have  
16 indicated. I wanted to just say one thing. If we wanted to  
17 propose a demo in this area, I'd be giving more emphasis to  
18 an ability to test how CMS could administer prior  
19 authorization, because that is something we've talked about.  
20 I'm actually a proponent of very targeted prior  
21 authorization, where you've got essentially a concise  
22 clinical issue that's informed by objective data, a non-

1 emergency situation where there is some evidence of misuse  
2 or overuse and it suggests -- the Cleveland Clinic study  
3 suggests that that might be going on here.

4 I would also have a criterion of very high unit  
5 cost so that your investment in that activity has a payoff,  
6 and I guess that's the one place I have some concern. It  
7 looks like the average drug cost, anyway, was \$1,200 or  
8 something like that, and so I'm not -- I don't see a  
9 compelling reason, frankly, to do a demo in this area, but  
10 if I did, it would be to really sort of learn operationally  
11 how to get some experience with prior authorization.

12 MR. HACKBARTH: Okay. Thank you, Kim and Joan.  
13 Good job.

14 We'll now move on to Risk Adjustment in Medicare  
15 Advantage. We're 15 minutes behind schedule, which we must  
16 make up, and so what I propose we do is we'll end this  
17 session right at 10:30, so as opposed to an hour-and-a-half,  
18 we'll do an hour and 15 minutes on risk adjustment so that  
19 we've got the allotted time for the dual eligible discussion  
20 at the end.

21 DR. ZABINSKI: Okay. Last fall, the Commission  
22 made recommendations to improve risk adjustment for PACE

1 plans, and today we'll broaden the scope of that work and  
2 discuss improving risk adjustment for the Medicare Advantage  
3 program in general.

4 In Medicare Advantage, plans receive monthly  
5 capitated payments for each enrollee where each payment is  
6 the product of a local base rate and the risk of the  
7 enrollee. CMS drives these risk scores from the CMS  
8 hierarchical condition category CMS-HCC risk adjustment  
9 model. And the risk scores represent each enrollee's  
10 expected annual Medicare spending relative to the national  
11 average.

12 The CMS-HCC uses data from each enrollee to  
13 determine the enrollee's risk score. The enrollee's data  
14 falls into two broad categories, demographic and conditions.  
15 The medical conditions are from diagnoses coded on claims  
16 for hospital inpatient stays, hospital outpatient visits,  
17 and physician office visits that occurred the previous year.

18 These diagnoses are then categorized in the  
19 broader condition categories called HCCs and there are 70 of  
20 them in the current version of this model. CMS then uses  
21 the demographic data, the medical conditions, and Medicare  
22 fee-for-service spending in a regression model that produces

1 coefficients for each demographic variable in each HCC,  
2 which CMS then uses to determine risk scores.

3           As an example of how risk scores are determined,  
4 consider a female who's aged 76 on Medicaid and has been  
5 diagnosed with COPD. For this beneficiary, the following  
6 coefficients from the CMS-HCC apply. For a female aged 75  
7 to 79, .46; for a female on Medicaid and aged, .18; and for  
8 any beneficiary who has COPD, .40.

9           To determine this beneficiary's risk score, you  
10 simply add all the coefficients that apply to get a total of  
11 1.04. So this person has a risk score that is close to the  
12 national average, which is 1.0 each year.

13           The general purpose of the CMS-HCC is to adjust MA  
14 payments so that they accurately reflect how much each  
15 enrollee is expected to cost. Accurate payments prevent  
16 systematic overpayments and underpayments with respect to  
17 each enrollee's characteristics. From this perspective, the  
18 CMS-HCC is much better than the demographic model that was  
19 previously used to adjust capitated payments.

20           However, concerns remain over the CMS-HCC. First,  
21 there may still be systematic overpayments or underpayments  
22 for enrollees with specific characteristics. Therefore,

1 plans can benefit financially depending on the profile of  
2 their enrollees. That is, from favorable selection. Also,  
3 research from the Dartmouth group indicates there are  
4 regional differences in level of service use in fee-for-  
5 service Medicare that leads to regional differences in  
6 coding of conditions and risk scores.

7           And if these regional coding differences carry  
8 over into Medicare Advantage, plans that are in regions  
9 where coding is most intensive will have higher risk scores,  
10 and payments and plans that are in areas where coding is  
11 less intensive.

12           Finally, CMS estimates the coefficients in the  
13 CMS-HCC using constant diagnosis data from fee-for-service  
14 beneficiaries. However, there's research by Newhouse and  
15 colleagues that indicates that the cost of treating  
16 conditions may be very different between fee-for-service  
17 Medicare and MA. Therefore, it may be beneficial for plans  
18 to attract enrollees with some conditions and avoid  
19 enrollees with other conditions.

20           Over the following slides, we'll discuss each of  
21 these issues in more detail. An important feature of an  
22 effective risk adjustment model is that it addresses enough

1 of a variation in beneficiaries' costliness to minimize  
2 possibilities for plans to financially benefit or be  
3 disadvantaged simply because of their enrollees' risk  
4 profiles.

5           A concern some have about the CMS-HCC is is that  
6 it accounts for about 11 percent of the variation in  
7 Medicare spending. And this may sound very low as it  
8 suggests that 89 percent of the variation is not explained.  
9 But that's not as bad as it sounds because much of the  
10 variation is strictly random and cannot be predicted by any  
11 risk adjustment model.

12           Research by Newhouse and colleagues estimates that  
13 a lower bound on the variation that plans can predict is 20  
14 to 25 percent. The remaining is random and not predictable.  
15 Therefore, the CMS-HCC may be explaining about half of the  
16 predictable variation.

17           So is explaining half of the predictable variation  
18 enough to eliminate selection problems? Well, that's not  
19 clear, but it's possible that some problems are still  
20 present.

21           Another issue regarding selection is that for  
22 beneficiaries who have the same condition, the CMS-HCC

1 adjusts payments by the same rate no matter the level of  
2 severity. But patient severity and cost do vary within each  
3 HCC, so for a given condition, plans could benefit if they  
4 attract the lowest cost beneficiaries who have that  
5 condition. At the same time, plans that focus on the  
6 sickest beneficiaries, such as SNPs and PACE, may be at a  
7 disadvantage.

8           And due to data limitations, it is difficult to  
9 definitively determine whether favorable selection is  
10 widespread in the MA program, but we did an analysis that  
11 may suggest, but doesn't confirm, whether MA enrollees are  
12 on average lower risk than their fee-for-service  
13 counterparts.

14           In particular, we examined beneficiaries who were  
15 in fee-for-service Medicare throughout 2007 and divided them  
16 into two groups, those who stayed in fee-for-service  
17 Medicare into 2008 and those who enrolled in an MA plan in  
18 2008, and then we compared the 2007 costliness of the two  
19 groups.

20           We found that on average, those enrolled in MA  
21 were 15 percent less costly than those who stayed in fee-  
22 for-service, and perhaps more importantly, in 68 of the 70

1 HCCs, those who enrolled in MA were less costly than those  
2 who stayed in fee-for-service. I want to again emphasize  
3 that these results give no indication of the costliness of  
4 beneficiaries while they are in the MA program. They only  
5 indicate that those who enroll in MA are less costly while  
6 in fee-for-service Medicare than those who stay in fee-for-  
7 service Medicare.

8           For today's presentation, we'll consider three  
9 options that might improve the predictive accuracy of the  
10 CMS-HCC and reduce problems related to selection. In one  
11 option, we added socioeconomic variables, in particular,  
12 measures of race and income to the standard CMS-HCC. In the  
13 second option, we added number of conditions that each  
14 beneficiary has to the model where number of conditions is  
15 simply the number of HCCs that each beneficiary's conditions  
16 map into.

17           Then in a third option, we used two years of  
18 diagnosis data to determine each beneficiary's HCCs, rather  
19 than the single year that CMS currently uses. Before we  
20 cover our results, though, from each of these options, I  
21 want to introduce measures that we used to evaluate the  
22 models' predictive power.

1           One measure is the R-squared, which indicates how  
2 well the CMS-HCC accounts for variations across individuals.  
3 However, attempts to attract favorable risk are typically  
4 based on groups of beneficiaries defined by specific  
5 characteristics, not on specific individuals.

6           Therefore, many analysts have used predictive  
7 ratios, which measure how well a model predicts cost for a  
8 group of beneficiaries with the specific characteristics  
9 such as a condition. And for a group of beneficiaries, the  
10 predictive ratio is simply the costs of the group as  
11 predicted by the CMS-HCC divided by the actual costs for  
12 that group.

13           And the closer a predictive ratio is to 1.0, the  
14 better the model has performed. And if the predictive ratio  
15 is less than 1.0, the model is said to have under-predicted  
16 costs, and if a predictive ratio is greater than 1.0, the  
17 model is said to have over-predicted costs.

18           We evaluated whether adding variables for  
19 beneficiaries' race and income improves the predictive power  
20 of the CMS-HCC. The race categories we added included  
21 black, white, Hispanic, and other races. The income  
22 variable is the mean income for the beneficiaries' county of

1 residence.

2           When we added race and income to the standard CMS-  
3 HCC, we found virtually no improvement in the models'  
4 predictive power. In particular, R-squared for both models  
5 is .11, and we evaluated predictive ratios for a number of  
6 condition groups and there's almost no change in this  
7 measure when we add race and income to the model.

8           On this table, we listed predictive ratios for  
9 some of the groups we evaluated. If you look at the first  
10 three lines, you can see that for specific conditions, the  
11 CMS-HCC performs quite well with or without race and income  
12 in the model. But the final four lines indicate that the  
13 CMS-HCC under-predicts for beneficiaries who have no  
14 conditions, over-predicts for those who have a few  
15 conditions, and then under-predicts again for those who have  
16 eight or more conditions. And this is true with or without  
17 race and income in the model.

18           So I think the main thing to take away from this  
19 slide is that for a given condition, the CMS-HCC pays  
20 accurately, on average. Before a given condition, it  
21 underpays for those who have that condition, plus several  
22 others. Therefore, plans that focus on the sickest

1 beneficiaries such as SNPs and PACE may be at a  
2 disadvantage.

3           We also evaluated whether adding number of  
4 conditions for each beneficiary would improve the  
5 performance of the CMS-HCC. We found that adding the number  
6 of conditions would do little to improve the models' R-  
7 squared as it stays at .11. Also, the first three lines of  
8 this table indicate there would be little change in the  
9 predictive ratios for specific conditions.

10           However, adding the number of conditions to the  
11 model would improve the predictive ratios for groups defined  
12 by number of conditions. On the one hand, the standard  
13 model under-predicts for those with no conditions, over-  
14 predicts for those who have a few conditions, and under-  
15 predicts for those who have eight or more conditions.

16           On the other hand, a CMS-HCC model that includes  
17 categories for number of conditions predicts accurately for  
18 each of those groups. Therefore, adding categories for  
19 number of conditions to the CMS-HCC may be helpful to SNPs  
20 and PACE, and may help reduce the extent to which plans  
21 benefit simply because of the risk profile of their  
22 enrollees.

1           A feature of the CMS-HCC that I mentioned earlier  
2 in passing is that CMS uses a single year of beneficiaries'  
3 diagnoses to estimate the model and determine beneficiaries'  
4 risk scores. Using just one year of diagnosis data may  
5 present some problems because we have found that  
6 beneficiaries who have a chronic condition appearing on a  
7 claim in one year often do not have that condition appearing  
8 on a claim in the following year.

9           We found this is true both in fee-for-service  
10 Medicare and the MA program, but it is less pronounced in  
11 MA. Problems that are generated by inconsistent coding over  
12 time of conditions are that the coefficients on conditions  
13 in the CMS-HCC may not reflect the true cost of those  
14 conditions, and also, there's greater year to year  
15 fluctuations in beneficiaries' risk scores resulting in less  
16 stable revenue streams for MA plans.

17           Using two years of diagnosis data to estimate the  
18 CMS-HCC and determine beneficiaries' risk scores would  
19 mitigate these problems. For example, we evaluated changes  
20 in beneficiaries' risk scores from 2008 to 2009 using risk  
21 scores based on one year of data and then risk scores based  
22 on two years of data. The correlation coefficient between

1 the 2008 risk scores and the 2009 risk scores is .62 when  
2 using one year of data, but it goes up to .80 when using two  
3 years of data.

4 We also found that using two years of data to  
5 estimate the CMS-HCC and determine risk scores would provide  
6 a small improvement in the predictive accuracy of the CMS-  
7 HCC for the sickest beneficiaries. For example, the last  
8 line of this table indicates that the predictive ratio for  
9 beneficiaries who have eight or more conditions would  
10 improve from .95 under the standard CMS-HCC to .97 under a  
11 model that uses two years of diagnosis data.

12 Our next point of discussion is regional  
13 differences and coding of conditions. Song and colleagues  
14 from Dartmouth show that in fee-for-service Medicare,  
15 conditions are coded more intensively in regions with high  
16 service use, resulting in higher average risk scores among  
17 fee-for-service beneficiaries in those regions.

18 If these regional differences in coding also occur  
19 in MA, plans that are in regions with relatively intensive  
20 coding would receive higher payments for an otherwise  
21 identical beneficiary compared to plans in regions with less  
22 intensive coding. However, all MA plans have an incentive

1 to code conditions as intensively as possible. And studies  
2 by CMS and GAO indicate that plans have responded to this  
3 incentive, as the number of conditions coded has increased  
4 more rapidly in MA than in fee-for-service Medicare over  
5 time.

6 Therefore, it is possible that regional  
7 differences in coding are smaller or non-existent among MA  
8 plans. CMS has begun collecting cost and diagnosis data  
9 from MA plans that should allow us to determine the extent  
10 of regional differences in coding among MA plans. And if  
11 there are regional differences in coding intensity among MA  
12 plans, how should this issue be addressed?

13 Once enough data are available, we may want to use  
14 an approach similar to Song and colleagues and determine  
15 whether any regional differences in coding in MA lead to  
16 regional differences in risk scores. We could then adjust  
17 the MA risk scores in each region based on how much coding  
18 differences affect the average risk score in the region. In  
19 the regions where coding is relatively intensive, you could  
20 adjust risk scores downward. In regions where coding is  
21 less intensive, you could adjust risk scores upward.

22 For example, if coding intensity raises the

1 average risk score in a region by 10 percent above the  
2 national average, you could reduce all risk scores in the  
3 region by 10 percent so that that region matches the  
4 national average.

5           Then a final issue for discussion centers on the  
6 fact that CMS uses data from fee-for-service beneficiaries  
7 to estimate the CMS-HCC, even though CMS uses the model to  
8 determine risk scores for MA beneficiaries. On several  
9 previous occasions, the Commission has held the position of  
10 financial neutrality between fee-for-service Medicare and  
11 the MA program, meaning that capitated payments for MA  
12 enrollees should equal what each enrollee would cost in fee-  
13 for-service Medicare.

14           From this perspective of financial neutrality, use  
15 of data from fee-for-service beneficiaries to estimate CMS-  
16 HCC is appropriate. However, there's a paper by Newhouse  
17 and colleagues that indicates that in the large MA plan, the  
18 relative cost of treating many conditions differs between  
19 fee-for-service Medicare and MA.

20           For some conditions, the relative cost is higher  
21 in the MA plan than in fee-for-service; for others, it is  
22 lower. If these large differences are widespread in the MA

1 program, plans could benefit financially by attracting  
2 beneficiaries with some conditions and finding ways to avoid  
3 beneficiaries with other conditions.

4 This is a particularly relevant issue because CMS  
5 has begun collecting cost and diagnosis data from MA plans  
6 with the intent of using those data to estimate the CMS-HCC.

7 So a summary of today's discussion is as follows.  
8 We considered alternatives for improving the predictive  
9 ratio of the CMS-HCC and we found that adding race and  
10 income to the model would not help; adding number of  
11 conditions for each beneficiary would help, especially for  
12 the sickest beneficiaries; and using two years of diagnosis  
13 data to estimate the model and determine risk scores would  
14 help, to a lesser extent, but it will also make risk scores  
15 more stable over time.

16 We also discussed the possible effects of regional  
17 differences in coding intensity, and that issue needs more  
18 analysis. Finally, in light of a finding in a recent paper,  
19 a question will arise over whether to use MA or fee-for-  
20 service data to estimate the CMS-HCC.

21 So in the future, we would like to further our  
22 analysis of the CMS-HCC in the following ways: First, we

1 would like to evaluate a version of the CMS-HCC that has  
2 both the number of conditions for each beneficiary and then  
3 uses two years of diagnosis data. Also, we would like to  
4 investigate a model that accounts for potential interactions  
5 between a specific condition and number of conditions each  
6 beneficiary has.

7 For example, we may be able to tease out the  
8 extent to which diabetics who have several other conditions  
9 are more costly than those diabetics who do not have any  
10 other conditions. Finally, we'd like to consider a model  
11 that has more conditions than the 70 HCCs in the current  
12 model. CMS has begun using such a model for PACE plans and  
13 has chosen not to yet implement the same model for all MA  
14 plans. Now I turn things over to the Commission for  
15 discussion and questions.

16 MR. HACKBARTH: Thanks, Dan, nice job. Kate, do  
17 you want to start with clarifying questions?

18 DR. BAICKER: I don't have any.

19 MR. HACKBARTH: Okay. Herb?

20 MR. KUHN: Just a quick question on the coding  
21 intensity issue and just to help me kind of understand how  
22 that plays into the overall effort of the scores. For

1 example, on the fee-for-service side with hospitals in the  
2 last three years, we've made recommendations on the DCI  
3 adjustment, and not only to make that adjustment, but also  
4 to take money back out of the system as a result of that.

5 How does coding intensity play into -- does it  
6 play into the HCC scores or is that a different part of the  
7 MA plan? I'm just trying to understand the interaction  
8 there.

9 DR. ZABINSKI: Well, the way we have thought about  
10 it is that yeah, it would play into the risk scores.  
11 Consider a situation where you've got, if you can like clone  
12 a person, put them in two different areas so that they're  
13 basically identical. Well, if, you know, you have more  
14 conditions coded for that same person in one area than  
15 another, they're going to have a higher risk score in the  
16 place that codes more conditions.

17 MR. KUHN: I get that. I guess the question is,  
18 how does the MA plan that adjusts for that coding intensity  
19 -- you know, again, CMS has made adjustments in home health  
20 and SNF and in the hospital inpatient. How do they make  
21 those adjustments in the MA side?

22 DR. ZABINSKI: Right now there is no adjustment

1 for that on the MA side.

2 DR. BERENSON: This was a very clear and excellent

3 DR. MARK MILLER: Excuse me.

4 DR. BERENSON: I'm sorry.

5 DR. MARK MILLER: I'm really sorry. Okay. What I  
6 would have said there, and maybe I didn't understand. What  
7 I would have said is, is that whatever adjustments are being  
8 taken in fee-for-service end up getting reflected in  
9 whatever the relative values in constructing the weights for  
10 the HCC. Okay? And so, in a sense, all other things being  
11 equal, they will be in the underlying structure of the HCC  
12 when they manifest themselves on the MA side.

13 And then the only other thing -- and I wasn't  
14 quite sure whether you meant this. There are efforts on the  
15 MA side that when they have seen coding increase faster than  
16 fee-for-service, they have pulled that up.

17 So I would have said yes, there are. It's not SNF  
18 and it's not hospital, which is what you were answering and  
19 you're correct on that point, but there is a broader effort  
20 that says that they've observed these trends that are much  
21 higher coding on the MA side and pulled payments back.

22 MR. KUHN: So there's linkage to fee-for-service

1 overall between the two, plus when they see --

2 DR. MARK MILLER: Through the weights.

3 MR. KUHN: Through the weights. And then when  
4 they see coding that is in excess of the CMI or coding that  
5 is more intensive than for what the patients are ill, then  
6 they've made adjustments there as well? So it's consistent  
7 with fee-for-service in terms of the kind of adjustments  
8 that are going on?

9 DR. MARK MILLER: I think so and I think -- sorry  
10 -- that the relatives for any sets of patients in setting  
11 the weight kind of reflect all the adjustments that occur in  
12 fee-for-service. End of thought. Second thought, if the  
13 coding practices on the MA side divert significantly than  
14 fee-for-service, then there's a payment adjustment to the  
15 payments. Are you okay with all that?

16 DR. ZABINSKI: Yeah. Just the thought that -- I  
17 mean, the adjustment that they make on the MA side is sort  
18 of for -- you know, it's an across-the-board adjustment  
19 irrespective of region. But if there's regional differences  
20 in coding, those aren't adjusted for.

21 DR. BERENSON: Yeah. As I was saying, this was  
22 terrific work and I have two questions. One is around Slide

1 7. I just want to understand the implications of the  
2 analysis you did in relationship to what the plans are  
3 reporting now as their risk scores. I mean, this suggests  
4 that there is more favorable selection than the plans that  
5 Scott, as I remember you presenting overall nationally, it  
6 was about 1.0 or so. They were right about the same risk  
7 score as fee-for-service.

8 So I guess my question would be, what could  
9 explain the difference? One would be coding, I assume, and  
10 two would be that plans have figured out a way to get more  
11 favorable patients within HCC categories? Are those sort of  
12 the plausible explanations?

13 DR. ZABINSKI: Yeah. Those are two, and I would  
14 say a third one is that if you have an individual who's  
15 relatively healthy, you know, decides to go into an MA plan,  
16 and after they get in the MA plan, you know, the classic  
17 term is they regress to the mean.

18 And that's the limitation of this analysis, is  
19 that it doesn't look at people while they are in a plan, so  
20 you don't know what's exactly going on while they're an MA  
21 enrollee. It just says that before they enroll that they're  
22 relatively healthy, but once they're there, you don't know

1 what's going on.

2 DR. BERENSON: But presumably that regression  
3 happens over a longer period of time?

4 DR. ZABINSKI: Presumably.

5 DR. BERENSON: Okay. The second one is more  
6 technical. It goes to your topic of adding the number of  
7 conditions, which is based around Slide 11, but I'm really  
8 going to refer to what you put in the written material. I  
9 was actually at CMS when we, under some pressure from the  
10 plans, agreed to create a CMS-HCC model rather than the  
11 full. And as you've said, there were 189 categories in the  
12 full model and 70 in the CMS model.

13 At the time, I remember that that translated into  
14 about 9,000 ICD-9 codes for the full model and about 3,000  
15 for the reduced model or the CMS model, and I didn't know  
16 how that was reducing burden, which was the argument that  
17 the plans were making, that somehow managing 3,000 codes was  
18 somehow a lot easier than 9,000. Once you're over three, I  
19 think you've got -- I'm exaggerating a little bit.

20 So I guess in terms of understanding the -- and  
21 so, we then did our work to find that the predictive value  
22 wasn't seriously affected, at least at that time, and so we

1 were willing to make that accommodation. It also, by the  
2 way, Bruce, was the time we gave up getting encounter data,  
3 which would be another way to create full HCC scores.

4 Do you have any views on sort of this  
5 administrative burden issue? Is it worth taking on this  
6 possibility of having a much more robust set of conditions?  
7 Do you get the predictive value gain? Is it worth it in  
8 terms of what the plans have to do to produce all of that?

9 DR. ZABINSKI: I would say yeah. At one point  
10 today, I mentioned that there's sort of a more advanced  
11 model that's in use for the PACE plans and CMS considered  
12 it. But it has not implemented it for the MA program in  
13 general. And there are some things in that model that are  
14 kind of nice to have in it. One I really focus on is  
15 there's an indicator for dementia, which is in that more  
16 advanced model, but not in the current version. And as you  
17 know, you know, dementia is becoming a more prominent, you  
18 know, condition. So that would be a nice thing to have  
19 added in.

20 DR. BERENSON: It is possible that you could then  
21 target a couple of specific conditions to add to the 70  
22 rather than going to the full 189 or something?

1 DR. ZABINSKI: Right, yeah.

2 DR. BERENSON: So there's some intermediary kinds  
3 of things like let's get some codes for dementia in there to  
4 increase predictive value, but not go to -- although I would  
5 need to be convinced that there is significantly more  
6 administrative burden with the full model rather than a  
7 smaller model. But thank you.

8 MR. HACKBARTH: Could I just piggy-back on Bob?  
9 Could you go back to Page 7, Dan?

10 I have a question about the third bullet, and I  
11 recognize there are limits in this approach as a way for  
12 assessing what the magnitude of risk selection might be.  
13 But just for the sake of discussion, let's say we had the  
14 perfect method, and we concluded that MA enrollees were 15  
15 percent less costly on average. Wouldn't it matter, the  
16 pattern by which that 15 percent is arrived at? So if it's  
17 spread evenly across a broad population, you know, just a  
18 little bit here and there, the people who enroll in MA plans  
19 tend to be healthier than their fee-for-service  
20 counterparts, that leads you to one set of policy options.

21 If, however, you get that average by differences  
22 in a small number of patients, for example, MA plans look

1 very much alike for the broad enrollment, but they don't  
2 have the very expensive patients, you might look a very  
3 different place for your policy solutions.

4           Is there any way to get at that pattern of where  
5 the differences are? If it tends to be concentrated in a  
6 few patients, then, you know, you may be thinking about,  
7 okay, what we need is some sort of policy, mandatory  
8 reinsurance where the government shares in the cost of high-  
9 cost patients and reduces the average rate across the board  
10 so plans that don't have high-cost patients are sort of  
11 overpaying for the reinsurance?

12           DR. ZABINSKI: I think that's one possibility, the  
13 reinsurance. And I'm going to stick my neck out a little  
14 bit and say I think the idea of adding number of conditions  
15 that a person has to the model also might be helpful in that  
16 sense, because particularly if you have something like your  
17 conditions interacting with number of conditions, like a  
18 diabetic with plus zero other conditions, one other  
19 condition, up to however many you want, eight, nine, in the  
20 model, you might be able to get some pretty good teasing out  
21 of the differences in the costliness within -- patient  
22 severity within an HCC.

1 MR. HACKBARTH: Yeah, and perhaps it's not an  
2 either/or, that you do more conditions or the other. But  
3 adding conditions and trying to do that approach, it seems  
4 like inevitably it is going to underpredict at the extremes.  
5 And if your problem exists at the extremes, you may need to  
6 do other things to --

7 DR. ZABINSKI: Yeah, that's sort of why I said I  
8 feel like I'm sticking my neck out a little bit when I say  
9 that.

10 DR. MARK MILLER: But on that, as long as your  
11 neck is out --

12 [Laughter.]

13 DR. MARK MILLER: On that, don't some of your  
14 results suggest that when you do the numbers of conditions,  
15 you are kind of scooping up the missed variants at the  
16 extreme?

17 DR. ZABINSKI: Right, yeah.

18 DR. MARK MILLER: And the other thing I would say  
19 is I don't see -- to your number of conditions, to your  
20 question -- and this doesn't rule out the reinsurance policy  
21 at all. But you are going to be exploring the numbers of  
22 conditions question. That's what you were saying on the

1 last slide.

2 DR. ZABINSKI: Yes.

3 DR. MARK MILLER: And, remember, these things are  
4 not mutually exclusive. It may be two years of data,  
5 numbers of conditions, adding conditions to the model, and  
6 then at that point you ask the question: Do you still need  
7 a reinsurance policy if you feel like you're falling short  
8 at some point in time? I still think there's even steps  
9 here that...

10 DR. HALL: Dan, just on that same issue, is there  
11 any information available, maybe from MA, about the dynamics  
12 of this selection process where it seems like sicker people  
13 stay with their fee-for-service and less sick move into MA?  
14 It would seem that a lot of people with active medical  
15 problems have sort of reached equanimity with the evil they  
16 know, the doctor that takes care of them, the drug companies  
17 that they have to deal with, or the drug exchanges, and  
18 they're not so attracted by MA saying you can have  
19 eyeglasses and dance lessons as they are with the hassle  
20 factor. And so I just wonder whether this is just a  
21 psychological thing that causes these people to stay out of  
22 MA. And then the advertising in MA is certainly not geared

1 -- "If you are a really sick person, would you like to join  
2 our plan?" is just not inherently what happens.

3 DR. ZABINSKI: Yeah, you know, intuitively that  
4 makes a lot of sense, and I'm not sure if there's any  
5 literature that specifically gets into that. There probably  
6 is and I just haven't looked at it yet. But, yeah, as I  
7 said, intuitively that makes sense.

8 MR. HACKBARTH: Years ago, weren't there some  
9 studies of differences in selection between plans that  
10 required people to change their physicians versus big  
11 network IPAs where people can keep the same physician? I  
12 vaguely recall there are some differences. And you would  
13 expect there to be some differences there.

14 DR. NAYLOR: So as you explore the issues around  
15 numbers of conditions, there has also been a lot of  
16 attention these -- and you mentioned it in the case of the  
17 76-year-old with COPD about severity. And any work done to  
18 help -- not absent numbers or other co-existing co-morbid  
19 conditions, but any work to uncover severity of primary  
20 conditions?

21 DR. ZABINSKI: Not within the context of risk  
22 adjustment, I don't think.

1 DR. CHERNEW: I want to go to what in the written  
2 materials was Table 4. I can't remember what slide it was.  
3 It's the one that talks about when you add two years of  
4 data, I think.

5 So one of the things that is complicated with  
6 these slides is that the number of people in the groups  
7 change. So I imagine what happens is when you shift to two  
8 years of data, the number of people with zero conditions  
9 drops dramatically. It drops. Okay. So I guess my  
10 clarifying question was the number of people with zero  
11 conditions is conditioned on how many years of data you were  
12 using, just in how you did this.

13 DR. ZABINSKI: Correct, yes.

14 DR. CHERNEW: And so my then sort of related  
15 comment is: What sort of matters is not how well you're  
16 predicting for certain types of people, but if you could  
17 somehow lump these people in synthetic plans to know how  
18 you're predicting for the plan is almost more important than  
19 knowing how you're predicting for a certain type of patient  
20 for the particular disease. So, for example, if you were  
21 way off on COPD and way off on cancer but all plans had the  
22 same mix of COPD and cancer, it wouldn't matter as long as

1 you were right on average. And so figuring out how these  
2 people are -- how big the distribution of these traits or  
3 any other set of traits, how big the distribution across  
4 plans varies matters. So it matters if you have one plan  
5 that is all CHF, one plan that is all COPD, one plan that is  
6 all eight or more conditions, and one plan that is all no --  
7 you know, that's the grouping that really matters for how  
8 far you're getting off for a plan as opposed to a particular  
9 type of person.

10 DR. ZABINSKI: That's clever.

11 MR. ARMSTRONG: I read somewhere, I think, in the  
12 written report that we've recommended using two years of  
13 diagnostic data once before and that it didn't go anywhere.  
14 I was just wondering why that didn't get any traction then.

15 DR. ZABINSKI: I'm not sure why it didn't get  
16 traction, and you are correct. It tells you how long I've  
17 been here. I mean, I was an author on that report as well.  
18 That was from 2000.

19 MR. ARMSTRONG: Was it as good an idea then as it  
20 is now?

21 DR. ZABINSKI: Yeah, same concept applied.

22 [Laughter.]

1           MR. ARMSTRONG: Okay. Just the only other brief  
2 comment I would make is that I work with a group of 1,000  
3 physicians. Part of their practice is MA, and they're  
4 convinced that our MA patients are far sicker than the  
5 average MA or fee-for-service patient.

6           [Laughter.]

7           DR. BORMAN: I really think I understood this,  
8 which is scary, but I think you did a really nice job of  
9 laying it out. And I'll save my comments for Round 2.

10          DR. STUART: Yeah, I have a number, and you can  
11 tell me when I've crossed the line from 1 to 2 here.

12          I'd like to go back to Slide 6 and focus on that  
13 number of 20 to 25 percent of explained variance. This was  
14 a study that was done by Newhouse and others that actually  
15 used data from the RAND health experiment. They got up to  
16 20 percent for all services combined and about 25 percent  
17 for ambulatory services. And what they had is they had all  
18 of the information that we currently have available for the  
19 HCC, and they had clinical information. And this gets to  
20 the point that Mary was talking about, that if you want to  
21 increase the predictive power of this thing, what you need  
22 is you need clinical data. So if you're looking at somebody

1 that has COPD, what you would want to have is lung function.  
2 If you're looking at somebody that has CHF, you'd want to  
3 know the severity, you'd want to know whether it's diastolic  
4 or systolic or various other features.

5           If you're interested in the severity of diabetes,  
6 well, it turns out that the ICD-9 coding is pretty good  
7 about that. And, in fact, there are either five or seven --  
8 the number actually escapes me now -- individual HCCs within  
9 the diagnosis of diabetes. And so if somebody has  
10 complications, if somebody has an amputation for diabetes,  
11 then they've got a higher HCC score than if they have just  
12 plain old garden variety diabetes.

13           And that brings up the second point, which is the  
14 HCC actually does -- is an accounting mechanism as you went  
15 through. For each additional one of these conditions,  
16 you've got extra point on your score. And so for that  
17 reason, it's not surprising that adding condition counts  
18 does not increase the overall predictive amount that -- the  
19 R-square, because it's basically the same information that's  
20 there in the first place.

21           So my guess is -- and the fact that you get better  
22 predictive ratios by condition counts is obvious. I mean,

1 it's like putting the same thing in a regression model on  
2 the right-hand side and the left-hand side, and voila, it  
3 looks really good.

4           So to be honest, I'm not sure where the payoff is  
5 going to come in terms of just working with the elements  
6 that we currently have in the HCC, and this gets back to the  
7 point that Bob raised about the original HCC model that was  
8 developed by -- well, the people are now in RTI -- that had  
9 189 conditions. And for the issue in terms of difficult in  
10 terms of managing that, that's an old problem. I can't  
11 imagine that any self-respecting MA plan doesn't have the  
12 capability of just going through and counting all diagnostic  
13 codes as we do when we look at claims volume. But the point  
14 being that the 189 had an R-square of, I think, 12 as  
15 opposed to 11. And so the extra hundred-and-whatever, you  
16 know, did very, very little in terms of overall prediction  
17 of the costliness of these patients.

18           That model, by the way, also included a whole  
19 bunch of interactions, and some of those interaction terms  
20 were statistically significant. But when you're assessing  
21 these models on literally millions of claims and  
22 individuals, everything is statistically significant. And

1 so you're not getting a whole lot of bang for your buck in  
2 terms of overall predictability by manipulating these types  
3 of information. So there are two angles that I think we  
4 should head, and then I'll stop for this point.

5           The first is we should be looking at ICD-10, and  
6 we should -- this is around the corner. It's going to  
7 happen. We ought to see whether, in fact, these scores are  
8 going to go up, as I would expect they are because the  
9 diagnoses are more precise. So that's the first thing.

10           Then the second thing would be to think about how  
11 you're going to integrate EMR data when we finally get that  
12 in terms of being able to use that for risk adjustment,  
13 because then you're back to Slide 6 here, where you have  
14 information that you have the same information in essence  
15 that the plan does in terms of selection, and so you have  
16 much more flexibility in terms of being able to address the  
17 questions of overselection by the plans.

18           Then I'll end with just one final note. I believe  
19 that it's not overt selection by the plans that leads to  
20 favorable selection in every MA plan except Scott's but,  
21 rather, that it is de-selection by or non-selection by  
22 relatively sicker beneficiaries. And the reason for that is

1 that if you're in the fee-for-service sector and you're  
2 sick, it means that you've got probably a bigger network of  
3 physicians that you depend upon, and so the cost of moving  
4 to an MA plan is much higher because you have to give up  
5 those relationships.

6 MR. GEORGE MILLER: Thank you, and, Dan, this is  
7 good work, and I appreciate reading the information.

8 If you could go to Slide 5 please, and I was just  
9 wondering if the regional differences in coding for the MA  
10 plans mirror the same as the other areas that we've looked at  
11 and if there's a pattern that we can learn from. As an  
12 example here, Miami-Dade County -- I mean, Dade County, is  
13 that the same issue here? Or is it different as far as the  
14 original regional differences in coding? Or have we looked  
15 at that and tried to map that? Is there a correlation  
16 between other areas that we've looked at as far as excessive  
17 or higher coding?

18 DR. ZABINSKI: Well, we know there has been  
19 research done that in fee-for-service the regional  
20 differences that exist also are reflected in the coding. In  
21 MA, we don't know yet. Nobody has -- the information just  
22 isn't there yet to do it. But CMS is collecting the data

1 that should allow us to eventually do it.

2 MR. GEORGE MILLER: Okay. All right. I would be  
3 interested in seeing that, if there's a pattern here.

4 MS. BEHROOZI: I have two quick Round 1, and then  
5 I won't have Round 2.

6 Can you please turn to Slide 7, Dan? I have a  
7 question about duals. Did you exclude duals or are they  
8 fully in the group that you looked at to make this analysis?

9 DR. ZABINSKI: They're fully in.

10 MS. BEHROOZI: So of the people staying in fee-  
11 for-service Medicare, there would be a lot of duals, right?  
12 Because if they've already got coverage through Medicaid,  
13 they would -- you know, irrespective of their sickness  
14 level, they've got a lot of extra coverage, so they have  
15 less incentive to go into an MA plan. Is that the correct  
16 line of thinking or not so much?

17 DR. ZABINSKI: Empirically, I don't know.  
18 Intuitively, once again, that makes sense.

19 MS. BEHROOZI: Okay, because that might have a  
20 fairly big impact on the costliness, and it might be related  
21 to how sick duals are, or it might be related to their  
22 costliness because of their income level. And I know that -

1 - and this is the other question. I know that when you did  
2 race and income level, you didn't see an impact, but I  
3 wonder if you separated them out -- I mean, you know, in the  
4 next paper we see that duals comprise 18 percent of the  
5 population but account for 31 percent of the costs. And it  
6 feels like what you've done here suggests that that's just  
7 because they have more conditions, but I don't know that  
8 lumping race and income together necessarily tells you the  
9 impact of either one, particularly of income by itself.

10 DR. ZABINSKI: In regard to the duals, being dual  
11 is an indicator in the model, and when making this  
12 comparison -- hopefully I did it properly -- I adjusted for  
13 health status and the effects, including being dual, that  
14 would have on somebody's costliness. So I think I, you  
15 know, have adjusted appropriately so that being dual or not  
16 dual doesn't really influence the results.

17 DR. MARK MILLER: And the other thing I would say,  
18 I mean, you can certainly pull out populations and look at  
19 different effects, but I think part of our motivation here  
20 is that I think the plans' view of this is I am a kind of  
21 plan that is focused on certain kinds of patients, often  
22 duals and often multiple chronic conditions, and the risk

1 adjustment system is not backing in behind me very well.  
2 And so I think one of the motivations here was to say so how  
3 could you -- and to Bruce's point, you're right, it's not  
4 jacking the explained variation up a lot, but what it's  
5 trying to say is can I calibrate the equity of payment  
6 better across different types of patients. So leaving them  
7 in and trying to get the model to explain that variance --  
8 because it goes right to his point, which is if I'm a plan  
9 who says I'm going after those patients, I'm a SNP, you  
10 know, we're trying to make sure that the risk adjustment  
11 backs in behind that decision and the fact that I'm focused  
12 on that tail of the distribution, which is why we wanted  
13 them in because we're trying to get that variance.

14 Now, that's not to dispute your point. You could  
15 pull them out and look at separate effects of variables.  
16 But in the end, for policy, you want them in and make sure  
17 that when they select that person we haven't underpaid them  
18 accidentally.

19 MR. HACKBARTH: So I want to go back to Bruce's  
20 comments for a second, which made a lot of sense to me. One  
21 thing that Bruce said was that he thought it's likely that  
22 the issue is not so much overt selection by the plans as

1 opposed to self-selection by the enrollee. That makes sense  
2 to me certainly at the enrollment end of the enrollment end  
3 of the process.

4 The other place where selection can happen is at  
5 the disenrollment and what the profile is of the people who  
6 disenroll. And I know there used to be studies that looked  
7 at the disenrollees from Medicare Advantage or its  
8 predecessors and their costs that they incurred upon re-  
9 entering fee-for-service. And my recollection was that the  
10 disenrollees tended to have much higher than average costs  
11 when they go back into fee-for-service.

12 Could you say a little bit about that?

13 DR. ZABINSKI: Yeah, it's actually in the paper as  
14 well. I didn't include it in the presentation, but yeah, I  
15 got the same result again. Those who disenrolled in their  
16 first year back into fee-for-service, they were about 16  
17 percent higher than average than the people who stayed in  
18 fee-for-service the whole time.

19 MR. HACKBARTH: Yeah, okay. I don't know. It  
20 just seems to me that, again, what you try to do to solve  
21 the problem might vary on whether it's a self-selection  
22 problem at the enrollment and/or an effort by plans to

1 disenroll people when they're found to have high costs.

2 There are different sorts of problems to deal with.

3 DR. BAICKER: So it makes all sorts of sense to me  
4 to bake in as many of the interactions and number of  
5 conditions as you can to try to predict better, and that  
6 seems relatively low cost and likely to improve fit. And  
7 then that brings up the question of what's going on across  
8 regions between fee-for-service and MA, and there seemed to  
9 be two separate issues to me. One is differential coding  
10 across regions where actually nothing real has changed.  
11 Some places are better at ticking the right boxes, or  
12 ticking the wrong boxes, and that's about administration and  
13 ease with that. And then there's a second question which is  
14 some areas actually then treating conditions more  
15 intensively for a given set of patients, and there something  
16 real has changed in terms of resource use.

17 And so there's a question of how you want to deal  
18 with differential ticking of the boxes that go into the  
19 HCCs, and then a separate question of how you want to deal  
20 with differential weights attached to those HCCs based on  
21 how people with those conditions are treated in different  
22 regions. And those seem separate issues to me, and that

1 gets to the ultimate question of what you want your risk  
2 scores to be targeting in terms of cost. Do you want  
3 separate ones for people enrolled in MA because treatment  
4 patterns are different? Or do you want to keep targeting  
5 the way treatment patterns are in fee-for-service when you  
6 make those adjustments? And I think part of the goal is to  
7 move people into more efficient, higher-value modes of  
8 treatment. So if MA plans are really good at treating  
9 patients with diabetes and there's a big wedge between the  
10 costs for those patients in an MA plan versus the cost for  
11 those patients in fee-for-service, I don't think we want to  
12 erase that difference in the risk adjusters when people  
13 select into MA plans because we want those people going into  
14 MA plans if MA plans are better able to manage their  
15 disease.

16           So I think you want to keep having a wedge between  
17 -- you want that wedge between the costs to be advantageous  
18 for enrollment in MA if that's the more efficient mode to  
19 treat those people in. What you don't want to have is a  
20 reward for a greater ability to check the box that people  
21 are actually in that diabetic risk category. So that to me  
22 suggests more of an adjustment for the differential coding

1 and a different strategy for adjusting for differential  
2 costs.

3           Now, if some regions are treating diabetics much  
4 more cost intensively in fee-for-service than others, I  
5 don't think you want MA plans in low-cost regions to benefit  
6 from the fact that fee-for-service treatment for those  
7 patients in other regions is really expensive. So you want  
8 to adjust across -- you want to take into account the fact  
9 that some regions are more expensive in the sense that you  
10 don't want to then build that into your MA reimbursements.  
11 But you want to build in the fact that MA plans are more  
12 efficient at treating some disease classes within a region  
13 than others. So maybe that's three buckets.

14           At this point I have even puzzled Mark.

15           [Laughter.]

16           MR. HACKBARTH: [off microphone] -- different HCC  
17 factors by region? Is that what you're saying?

18           DR. BAICKER: I guess what I'm saying is that you  
19 don't want to -- there's certain kinds of things we want to  
20 reward and certain kinds of things that we don't. So when  
21 the fee-for-service plan in a local area spends a lot of  
22 money on diabetic enrollees, we don't want to say,

1 therefore, the MA plans should also get a lot more money for  
2 those diabetic enrollees. So I think we don't want to  
3 adjust regionally that way.

4           When local plans are better at marking the box  
5 that this person is diabetic, I think we want to net that  
6 out. So we don't want to differentially pay for better  
7 ability to flag who's diabetic, but we do want to pay for  
8 differential ability to manage diabetic patients better and  
9 lower their resource use.

10           DR. MARK MILLER: [off microphone].

11           DR. BAICKER: I'm backing away from [off  
12 microphone].

13           DR. MARK MILLER: [off microphone] we can get  
14 through this. I'm not quite with you yet, I honestly will  
15 say that, but let me ask you this -- because when you went  
16 through answering his question, it sounded like the last  
17 thing that you said about the ability to check the box  
18 immediately triggers in my mind more the notion of  
19 differential coding, and that there's always the MA versus  
20 fee-for-service, but there could be two managed care plans,  
21 and I could be doing it more than him. And you're sort of  
22 raising that as a --

1 DR. BAICKER: I'm punting on that. I don't think  
2 we're going to do such a -- I don't think we have the  
3 ability to differentiate between MA plans in the same area  
4 and their ability to check the box.

5 DR. MARK MILLER: Fair enough [off microphone].  
6 But then that would sort of lead us to, yeah, you're right,  
7 there may be differences in coding and, like we're doing now  
8 -- whether we're doing it well or not -- we should continue  
9 to try and make sure we capture that back.

10 But to your first and I think more important  
11 question, on the geography and relative to fee-for-service  
12 and whether you're creating incentives, because I'm not sure  
13 I follow, so I'm going to ask this question: Do you think  
14 if you built the weight using fee-for-service -- sorry,  
15 using managed care data, you would address that issue?

16 DR. BAICKER: I don't think you want to build the  
17 weights just based on MA use patterns because we're trying  
18 to incentivize efficiency over --

19 DR. MARK MILLER: That's what I thought you were  
20 saying [off microphone].

21 DR. BAICKER: Right, so that I like having -- now,  
22 do you want it to be just the fee-for-service weights in

1     perpetuity --

2                   DR. MARK MILLER:   That's what I thought you were  
3     saying, too [off microphone].

4                   DR. BAICKER:   -- that's a question.   But I don't  
5     think you want to ignore the fee-for-service -- the weights  
6     that fee-for-service use would generate because, to the  
7     extent that you're improving more over what's going on in  
8     fee-for-service, that's a good thing.   And ignoring what's  
9     going on in fee-for-service when you calculate your weights  
10    would eliminate the incentive to drive people differentially  
11    towards MA when MA is doing differentially better by them.

12                   DR. MARK MILLER:   Right, and so that's kind of  
13    what I -- that's why I was confused, because I thought  
14    that's what you were saying.   I've been thinking of this  
15    problem -- and we're going to have to face this problem.  
16    You know, someday Bruce is finally going to be right, and  
17    we're going to have the encounter data.

18                   [Laughter.]

19                   DR. MARK MILLER:   And I swear to God, if he's not  
20    here, I'm driving to his house, we're going to break open a  
21    bottle, you know, throw it down.

22                   But, you know, when we finally get the day, the

1 way I've been conceiving this problem and having this  
2 conversation with Dan is are we building weights with fee-  
3 for-service, are we building weights with MA? And what I  
4 think Kate is saying is, remember, if there's some distance  
5 there, that's a signal to the MA plan that they ought to do  
6 that and reap the reward of it. And now she's confused the  
7 hell out of me because I used to have just two things to  
8 focus on, and she's saying you might want to think of some  
9 combination of those things, maybe. Weights based on fee-  
10 for-service and MA, kind of? Is that where you're going?

11 DR. BAICKER: Well, for a slightly different  
12 reason from what I think you just said, we can have fake  
13 questions, too, in addition to fake answers. No.

14 So the reason to focus -- to include the fee-for-  
15 service-generated weights is that if fee-for-service is  
16 expensive and I'm an MA plan and I can do it better, I  
17 should be wanting to attract those people. So that argument  
18 says you should stick with the weights generated by just  
19 fee-for-service.

20 The caveat to that is that we want the plan,  
21 Medicare, to reap some of the benefits, too, and you don't  
22 want to say in perpetuity the MA plans, when fee-for-service

1 is inefficient, all of the benefits of the improved  
2 efficiency should forever accrue to the MA plan. So the  
3 argument for a blend would be that you want to share the  
4 gains. Do you want the MA plan to have some of the gains so  
5 that they do more of it when they're providing better  
6 disease management, but we want to get some of that for the  
7 program also? So that would be my reason for moving toward  
8 the --

9 MR. HACKBARTH: You do that at the rate level.

10 DR. BAICKER: Yeah.

11 MR. HACKBARTH: How you set the overall rate as  
12 opposed to doing it by condition.

13 DR. BAICKER: Yeah, I think so.

14 DR. BERENSON: Yeah, this has been a very  
15 interesting discussion. I think I strong want to support  
16 Bruce's notion of trying to get a hold of ICD-10 and rather  
17 than just replicating work that has already been done,  
18 although it has been a while, and ICD-9 codes using multiple  
19 conditions in the full, robust model, and I think Kate has  
20 added a very important idea here about not wanting to  
21 control out the efficiencies of Medicare Advantage. I think  
22 that's an important thing.

1           I guess I would get a little narrower on just a  
2 couple of things. In terms of additional work, I generally  
3 support what you said in terms of next steps, which you had  
4 sort of three bullets. I think the one that seems easiest  
5 that doesn't involve burden that was proposed 10 years ago  
6 or longer was the two-year model, and I certainly think that  
7 we should -- I think that's the ripest one for advancing the  
8 current HCC model. And I'd want to understand the  
9 reluctance to go in that direction.

10           I'm not sure we would get very far by adding  
11 number of conditions or going through the full model of all  
12 -- the full HCC model or some other modification. And I'm  
13 concerned in that we then have to -- well, I want to  
14 understand more about administrative burden. I think I'm  
15 with Bruce and others that it really isn't significant  
16 administrative burden, but if it doesn't add much to  
17 predictability and it does bring in the specter of different  
18 coding practices in diverting attention at the plan level  
19 and to more attention to coding every diagnosis and less on  
20 managing patients, I'm not sure what the gain would be if we  
21 go there.

22           So I'm more than happy to have you model it, but

1 that's one full step away from us wanting to recommend that.

2 So I'd like a little more about the administrative burdens

3 in that area

4           And the other thing, Bruce, you were mentioning  
5 the EMR as what is down the road, but pharmacy data I assume  
6 is readily available now, and the question is around models  
7 that include prescription drugs ordering, I thought was more  
8 robust. Would you say something about that?

9           DR. STUART: I'd be happy to. I'd like to put  
10 that in the context of when we moved into using these  
11 prospective models from cost reimbursement, and cost  
12 reimbursement obviously uses as the metric what was actually  
13 provided, and then you had these accounting mechanisms for  
14 putting dollars on it.

15           The problem with using actual utilization for risk  
16 adjustment is that it provides an incentive under certain  
17 circumstances to provide that service so that you get paid  
18 for it. So in a way it's kind of moving back to cost  
19 reimbursement, at least theoretically.

20           Having said that, I think it's certainly a way to  
21 kind of diagnose whether there are issues associated with  
22 severity. One of the things I was going to suggest to Dan,

1 for example, is to use COPD, as Mary pointed out. If you  
2 are really interested in whether somebody under the current  
3 system was less likely -- a more severe COPD patient was  
4 less likely to go into an MA plan, you're right, I would  
5 look at, among other things, the Part D drug files. I'd  
6 want to know whether they were taking -- you know, had  
7 consistent use of reliever medications, whether they were  
8 hospitalized for acute exacerbation of COPD, whether they  
9 were taking oxygen. All of these are proxy variables for  
10 severity.

11           Having said that, I wouldn't use any one of those  
12 in a risk adjustment model because of the potential for  
13 gaming. And I don't want to push that too far, but I'm just  
14 kind of theoretically opposed to using utilization measures  
15 in risk adjustment if I can get away from it.

16           If you were to just take those three measures that  
17 I just indicated in the fee-for-service, you could tell --  
18 on Chart 7, you could tell whether people who had COPD,  
19 whether they were using these surrogate measures for  
20 severity, whether they were more likely to stay in fee-for-  
21 service as opposed to going into managed care. And you  
22 could use drugs for a lot of other conditions, but I would

1 be, again, hesitant to use those in an actual active risk  
2 adjustment model.

3 DR. BERENSON: Although the actual cost of the  
4 drug presumably would be more than the marginal increase you  
5 get, or maybe -- I mean, it probably doesn't make sense for  
6 a plan to do that, but we can have a side conversation about  
7 that.

8 I wanted to make one final point. I wanted to  
9 just -- didn't MedPAC do work that partly answers George's  
10 question about the Miami-Dade situation and comparison  
11 episode groupers between Minnesota and South Florida, that,  
12 as I remember the findings, Miami has lower-cost episodes  
13 but many more episodes per beneficiary, to suggest -- I  
14 think that's sort of comparable to the song at all findings  
15 -- and that was one was specific to Miami. Is that  
16 basically right? So that's --

17 DR. MARK MILLER: We took his question to mean and  
18 the way it was answered was: Do you see this same pattern  
19 in the coding of the MA data?

20 DR. BERENSON: I see [off microphone].

21 DR. MARK MILLER: Because all your statements are  
22 true, his statements are true, everybody is correct here,

1 but we're all talking about fee-for-service, and we thought  
2 he meant do you see that when you see the -- right.

3 MR. HACKBARTH: Comments [off microphone]?

4 DR. NAYLOR: Just briefly, I see the problem in --  
5 first of all, excellent report. It was just outstanding.  
6 The opportunity here is to take a look at the  
7 recommendations as it relates to the HCC system itself, and  
8 I do think taking a look at those 70 original conditions in  
9 light of science about which factors, conditions contribute  
10 to poor outcomes is really going to be important. Cognitive  
11 impairment is really important in looking at -- we know now  
12 how it accelerates poor outcomes among chronically ill  
13 people.

14 On the numbers of chronic conditions, I think also  
15 placing attention on what we're learning about clusters of  
16 chronic conditions and this notion of active versus numbers  
17 of chronic conditions, so active meaning those for which  
18 there is treatment, seeing maybe -- so just kind of the  
19 refinements in at least the science related to it.

20 And then this building on -- gosh, I hope I got  
21 what Kate was saying, but this notion of risk being as you  
22 look at it comparing fee-for-service and MA or looking at

1 what MA is doing, this importance of looking a  
2 longitudinally, you know, a good plan can reduce risk over  
3 time, and so you don't want to penalize plans for doing  
4 that.

5 And the last thing has to do with, although it's  
6 not a part of your recommendations, the work on regional  
7 variation and the critical need to look within regions and  
8 variations within regions as well.

9 DR. CHERNEW: So the first thing that I want to  
10 say is I don't think that the extra coding is just, oh,  
11 we're better at coding. There's things that happen in  
12 regions, like if you have people come back to the doctor's  
13 more often, you practice more intensively, they naturally  
14 get more codes, and those codes may actually be the right  
15 codes. When you code someone in the high coding places,  
16 it's not to imply that, oh, they don't really have those  
17 things. They actually may, and by doing more prevention or  
18 other things or having people screening, you may actually be  
19 legitimately picking stuff up. It's not just, oh, we're  
20 doing a better job at checking a box in those areas.

21 So it's always a challenge, and I think another  
22 part of that challenge is, related to the presentation, that

1 coding isn't really a regional thing per se. It's not that  
2 everyone in Cleveland codes one way. It has to do with the  
3 different delivery systems, and it may vary between the MA  
4 plans and the non-MA plans and what you're using. And that  
5 makes all of this in some broad conceptual way  
6 extraordinarily hard to get right. And so I think -- and I  
7 really don't mean to be so unambitious, but our goal, I  
8 think, has to be to just do sort of well enough and avoid  
9 the worst kind of problems and to make sure we have a  
10 monitoring system where we can pick up the most egregious  
11 examples of what we think is going on, and we're going to  
12 have to constantly sort of play that. And the amount of  
13 resources we could spent through ICD-9/10 -- which, if I had  
14 to do it, I think is probably more effort than it's worth,  
15 but that's not my call. In any case, the idea of trying to  
16 get every micro thing right and putting a ton of effort into  
17 it is probably not where I would go.

18           The other thing that I want to say is I want to  
19 reiterate strongly what Kate said, and I want to say it  
20 slightly differently, about how we want to use -- whether  
21 we're going to use MA claims or fee-for-service claims, and  
22 here's the way that I would have said that.

1           The first thing is, if our goal is to make sure  
2 that MA plans are not profitable -- so that's our basic goal  
3 -- then we want to think about really what the MA costs are  
4 and adjust sort of within the MA system.

5           I don't think that is our goal, and so another way  
6 to think about our goal is we want to pay the MA plans what  
7 we would have paid for that person if they were in fee-for-  
8 service. Then you want to use the fee-for-service weights  
9 because that's telling you what would have been spent there.  
10 And we could, again, fiddle with complicated blending  
11 things. My personal view is we have a tendency in our  
12 efforts to get it right to completely underestimate the  
13 phenomenal administrative burden associated with getting it  
14 right.

15           And so I think sort of a simple view, if I were  
16 picking, I would stick with the fee-for-service claims to do  
17 this. That I think has the better incentive properties. If  
18 the MA plans were able to attract the sicker people, cure  
19 them better, do a good thing and we're paying basically the  
20 same amount as we would in fee-for-service, I would  
21 basically say, "Halleluia." And because of the bidding  
22 system in MA, a lot of that gets returned back in terms of

1 better benefits and other things anyway.

2 So to a first-order approximation, that's what I  
3 would do there, and I would then think much more about  
4 monitoring how much heterogeneity there was across plans.  
5 If you saw plans entering for just one type of person, that  
6 really might be a red flag for profitability, and I would  
7 think about monitoring that way.

8 MR. HACKBARTH: And just to pick up on that, for  
9 years MedPAC's position has been neutrality. It has not  
10 been to try to take the profit out of the Medicare Advantage  
11 business but, rather, have a neutral system.

12 MR. ARMSTRONG: Just briefly, I would say I  
13 understand risk adjustment methodology far better now than I  
14 did yesterday, and I want to thank you for that. I think I  
15 want to thank you for that.

16 [Laughter.]

17 MR. ARMSTRONG: Remember the comments about how  
18 much we really appreciate our actuaries from yesterday?  
19 That's really relevant now.

20 The only other point I would make is to endorse  
21 that the work we're doing to try to improve the accuracy of  
22 this coding I think is headed in the right direction. I

1 appreciate the report. Thanks.

2 DR. BORMAN: I would only want to second what Mike  
3 said about underestimating the administrative burden at  
4 multiple levels in the system. And in the pursuit of  
5 precision, we have to balance that with some sniff test of  
6 reality.

7 DR. STUART: just a very quick point. In 2008,  
8 CMS added additional diagnostic boxes to the physician  
9 claims form, and it increased the number of diagnoses from  
10 four to eight. And we've done some work on that, and it  
11 turns out that if you look at data for 2008, you tend to  
12 find more people that have conditions like hypertension and  
13 hyperlipidemia, conditions that tend not to be coded on most  
14 physician forms in the top positions because they generally  
15 aren't the reasons why the individual goes into the office  
16 for care.

17 The reason that that is important is that in the  
18 old system, when the RTI was developing this back in the  
19 last decade, most of the diagnostic codes that were actually  
20 used to develop these HCCs came from hospital claims,  
21 because hospital claims you got up to ten diagnoses.  
22 Hospitals have a very strong financial incentive to code

1 everything they possibly can so that the grouper puts them  
2 into a higher DRG category.

3 And so it might be worthwhile just seeing what  
4 happens when you use 2008 data here in terms of some of  
5 those conditions that might be treated in different ways in  
6 MA plans than you would in fee-for-service.

7 MR. HACKBARTH: Thank you, Dan. Very well done.

8 And our last item is dual eligibles.

9 [Pause.]

10 MS. AGUIAR: Thank you. Today, Carlos and I will  
11 discuss integrated care programs for dual eligible  
12 beneficiaries. These individuals receive Medicare and  
13 Medicaid. They are high-cost and require a mix of medical,  
14 long-term care, and behavioral health services. There are  
15 approximately 9.9 million dual eligibles.

16 This slide gives an overview of today's  
17 discussion. As you remember, in the fall, we discussed our  
18 analysis of PACE providers. During today's presentation, we  
19 will focus on dual eligible Special Needs Plans, or D-SNPs.  
20 We will also focus on a subset of D-SNPs called Fully  
21 Integrated D-SNPs, or FIDE-SNPs. We have been looking at  
22 these programs to assess whether they improve quality of

1 care and reduce spending. We have also been analyzing  
2 whether these programs can be expanded to enroll more  
3 beneficiaries.

4 During today's session, we will also update you on  
5 the CMS demonstrations on integrated care programs that are  
6 currently underway, and we will, at the end of the  
7 presentation -- we will end the presentation with a  
8 discussion of issues that the Commission can explore moving  
9 forward.

10 Before we begin, we would like to thank Scott  
11 Harrison and Carol Carter for their assistance on this  
12 project.

13 First, I'll briefly go over some backgrounds. D-  
14 SNPs are Medicare Advantage plans that only enroll dual  
15 eligibles. They are not integrated with Medicaid. However,  
16 they can be if a D-SNP also has a State contract to cover  
17 Medicaid benefits. D-SNPs are required to have a State  
18 contract by 2013, but the contracts do not have to cover  
19 Medicaid benefits and can be limited to provisions such as  
20 data sharing. As a result, the majority of D-SNPs are  
21 either not integrated or are partially integrated with  
22 Medicaid benefits. There are a little over 300 of these

1 plans and they enroll about 1.16 million dual eligibles.

2 FIDE-SNPs are a subset of D-SNPs and they have  
3 State contracts to cover all Medicaid long-term care  
4 services. There are fewer than 20 FIDE-SNPs and together  
5 they enroll about two percent of all dual eligibles in D-  
6 SNPs.

7 Turning now to quality, the key question is  
8 whether D-SNPs and FIDE-SNPs offer better quality of care  
9 than beneficiaries can receive in fee-for-service. However,  
10 our ability to make this assessment is limited because we  
11 cannot compare SNPs' performance to fee-for-service for the  
12 majority of available measures. Also, we should note that  
13 the available measures are process and intermediate outcome  
14 measures and not direct measures of care coordination.

15 Working with the available measures, we find that  
16 D-SNPs' quality of care is generally mixed. We used a proxy  
17 method to identify D-SNPs so that we could evaluate them on  
18 the full set of HEDIS measures. We identify D-SNPs as plans  
19 with 75 percent or more of their enrollment in D-SNPs. We  
20 found that D-SNPs performed better than the non-SNPs on five  
21 HEDIS measures, but performed worse on the majority of  
22 measures. Although as a group D-SNPs' quality performance

1 is mixed, there are some D-SNPs that do perform better than  
2 non-SNPs on the HEDIS measures and that have high star  
3 ratings.

4 In addition to the analysis of HEDIS measures, we  
5 used CAHPs data to compare dual eligibles enrolled in D-SNPs  
6 and non-SNP MA plans to those in fee-for-service on the rate  
7 of influenza vaccination. We found that there was no  
8 difference between dual eligibles in fee-for-service, those  
9 in non-SNP MA plans, and those in D-SNPs on this measure.

10 To analyze the FIDE-SNPs' quality, we used a small  
11 subset of SNP-specific HEDIS measures. The results were  
12 more positive. We found that FIDE-SNPs performed better  
13 than other SNPs on the care for older adult measures. We  
14 also found that many FIDE-SNPs have very high scores on  
15 tracking the control of blood pressure among enrollees with  
16 hypertension.

17 Overall, however, we are not able to determine  
18 whether D-SNPs or FIDE-SNP improve quality of care relative  
19 to fee-for-service because of the limited measures available  
20 to us to make this assessment.

21 Now, I will turn to our analysis of Medicare  
22 payments. As you know, payments to MA plans in general are

1 higher than fee-for-service spending and, in some markets,  
2 MA spending always exceeds fee-for-service. Consistent with  
3 these general MA trends, we estimate that, on average,  
4 payments to D-SNPs and FIDE-SNPs will be between ten and 12  
5 percent higher than fee-for-service.

6 We also analyzed the bids for Part A and Part B  
7 services to see if D-SNPs and FIDE-SNPs expect to provide  
8 these services for less than the cost of fee-for-service.  
9 We found that the risk adjusted A-B bids for D-SNPs and  
10 FIDE-SNPs were between four and eight percent higher than  
11 fee-for-service. Based on these bids, it is not clear  
12 whether these plans can provide A-B services for less than  
13 the cost of fee-for-service.

14 As you remember, during the discussion of PACE  
15 program last fall, we discussed whether to extend PACE  
16 providers' flexibility to use Medicare funds to cover non-  
17 clinical services to FIDE-SNPs. PACE staff reported that  
18 this flexibility helps them provide enrollees with services  
19 that will maintain their health and allow them to live in  
20 the community.

21 One issue to address is if this flexibility should  
22 be extended, and if so, how. FIDE-SNPs could be given

1 flexibility to use their Medicare payments to cover non-  
2 clinical services. This is the flexibility that PACE  
3 providers have. Alternatively, FIDE-SNPs could be given  
4 flexibility to use the difference between the bids and the  
5 benchmark to cover non-clinical services. This approach was  
6 proposed by CMS but has not yet been finalized.

7 Another issue is which plan should receive this  
8 flexibility. CMS proposes to give this flexibility only to  
9 high-quality FIDE-SNPs. Another option is to also extend  
10 this flexibility to D-SNPs that are partially integrated  
11 with long-term care.

12 With respect to wider expansion of these programs,  
13 we find that it will be challenging for D-SNPs and FIDE-SNPs  
14 to expand to serve more dual eligibles under their current  
15 formats. Because we are not able to determine whether D-  
16 SNPs or FIDE-SNPs produce better quality of care than fee-  
17 for-service, we cannot conclude that these plans should be  
18 expanded based on quality of care alone. In addition, the  
19 higher Medicare spending on these plans raises questions  
20 about whether they should be expanded under their current  
21 payment system. It would also be challenging to increase  
22 the number of FIDE-SNPs because States have to contract with

1 these plans to cover all of their long-term care services  
2 and it is unlikely that a large number of States will  
3 establish these contracts in the near future.

4           However, there are elements of these plans that  
5 could be incorporated into larger-scale programs. For  
6 example, the key care management characteristics of  
7 integrated care programs that we reported in last year's  
8 June report were identified from D-SNPs and PACE providers.  
9 These characteristics are listed on this slide.

10           Another moving part is the CMS demonstrations.  
11 Last year, CMS established the financial alignment  
12 initiative to offer States the opportunity to test two  
13 models. Under the capitated model, CMS will sign a three-  
14 way contract with a State and a health plan. CMS will work  
15 with each State to develop the rates. Within a State, CMS  
16 will have a standard contract and rate setting methodology  
17 that it will apply to all health plans participating in that  
18 State's demonstration. CMS intends to develop the Medicare  
19 rates based on historical fee-for-service and MA spending  
20 within a State and to set the rates at a level where they  
21 provide for up-front savings to both CMS and the State.  
22 Proposals from the States interested in this model are

1 expected to be submitted over this spring and CMS expects to  
2 sign some of the contracts in September.

3 Under the managed fee-for-service model, States  
4 will finance care coordination programs for dual eligibles  
5 within fee-for-service. States will receive a retrospective  
6 performance payment if their programs meet certain quality  
7 thresholds and result in Medicare savings.

8 Over the next few slides, I will walk you through  
9 some possible directions to take this work. On this slide  
10 is a framework for you to keep in mind.

11 One direction is to improve the programs that we  
12 currently have. Another direction is to think about issues  
13 related to wider expansion of integrated care programs. A  
14 third direction is to assess the issue that dual eligibles'  
15 care is provided through a bifurcated payment system.

16 One option is for the Commission to explore  
17 outstanding issues with D-SNPs and FIDE-SNPs. It is  
18 important to note that this work would inform how to improve  
19 these programs and future integrated care programs. These  
20 issues that could be addressed include defining the criteria  
21 for a plan to be considered fully integrated, assessing  
22 which plans should be given flexibility to cover non-

1 clinical services, analyzing the appropriate payment system  
2 for integrated care programs, and identifying quality  
3 measures that the programs should report.

4 In analyzing the appropriate payment system, the  
5 Commission could consider refinements to the MA payment  
6 system and can also consider paying these plans through  
7 another payment system.

8 For the capitated model, the Commission could  
9 discuss how Medicare savings could be generated. One  
10 question is whether the rates should be adjusted to achieve  
11 savings. This would occur if the Medicare rates for the  
12 demonstration plans were set below current spending.  
13 However, it may be difficult to pay plans below current  
14 spending in markets where MA spending is higher than fee-  
15 for-service.

16 Another question is whether States should share in  
17 the Medicare savings. The argument for States sharing in  
18 savings is that the State makes an up-front investment to  
19 develop programs and Medicaid savings from reductions in  
20 nursing home use are realized over the long run while  
21 Medicare realizes more immediate savings from reductions in  
22 emergency department visits and hospitalizations. However,

1 programs like PACE that enroll the community-based long-term  
2 care population can produce immediate Medicaid savings by  
3 treating these beneficiaries in the community rather than in  
4 the nursing home. The policy for States to share in  
5 Medicare savings could also consider the more immediate  
6 Medicaid savings that States will realize.

7 Another question is whether beneficiaries should  
8 share in the Medicare savings or whether the beneficiaries  
9 should benefit in some way when savings are realized.

10 The Commission could also give guidance on which  
11 risk adjustment methodology should be used for the capitated  
12 model. It is not clear which methodology CMS intends to  
13 use.

14 Finally, CMS will have to consistent collect a  
15 sufficient amount of quality and cost data in order to  
16 evaluate and compare the demonstration programs. The  
17 Commission could explore which type of data should be  
18 collected.

19 Another option is for the Commission to explore  
20 additional issues related to the expansion of integrated  
21 care programs. One issue is the care management needs of  
22 disabled beneficiaries. We have not yet focused on this and

1 should understand these beneficiaries' needs before  
2 considering expansion of programs to this population.

3 The Commission could also explore a conceptual  
4 variation of the PACE model that does not rely as heavily on  
5 the day care center and could expand the PACE model to more  
6 beneficiaries.

7 Finally, as reported in your mailing materials,  
8 the Commission held an internal panel meeting on opt-out  
9 enrollment where participants identified standards for  
10 integrated care programs to be considered candidates for  
11 opt-out. The Commission could build on this work and  
12 develop a strategy for an opt-out enrollment policy.

13 The Commission could also explore the outstanding  
14 question of whether care coordination of all services for  
15 all dual eligibles can occur under the current Medicare and  
16 Medicaid payment systems or whether financial responsibility  
17 for all services should be assumed by either Medicare or  
18 Medicaid. There would be many issues to address if one  
19 program provided all dual eligibles' benefits, and the  
20 Commission could comment on these issues.

21 We would like for you to discuss during today's  
22 discussion the findings of our analysis. We would also like

1 for you to discuss which directions for moving forward you  
2 are interested in and to prioritize the order of the work.

3 This concludes the presentation and we're happy to  
4 answer your questions.

5 MR. HACKBARTH: Thank you, Christine.

6 Bob, do you want to go first on this one,  
7 clarifying?

8 DR. BERENSON: Yes. I'm trying to find -- can you  
9 go to the -- well, you don't have to go to the slide. I'm  
10 just going to ask this general question around the  
11 demonstrations. Typically, in Medicare -- this may be  
12 oversimplification, but I'll do it anyway -- in Medicare,  
13 demos are actually demos in the sense that the population is  
14 carefully defined, there's a control group ideally, it's got  
15 a time period, an evaluation, and a judgment about success.  
16 There's more of a tradition in Medicaid of sort of  
17 demonstration waivers in which authority is given to a State  
18 to basically put in across the whole system a fundamental  
19 change in how care is delivered and it's not subject to the  
20 same kind of evaluation. It's essentially a program change  
21 in the name of a demonstration.

22 Can we tell at this point, either from the RFP

1 that CMMI issued or some preliminary notions of what the  
2 States are proposing, whether it's more along the former  
3 lines, which is sort of a demonstration and a carefully  
4 controlled, or is it more like a waiver to allow the States  
5 to just change their care for the duals?

6 MS. AGUIAR: So the financial alignment initiative  
7 demonstrations that will be run through CMS, that's a joint  
8 effort between the -- what I keep referring to as the Office  
9 of the Duals, although they have a formal title, and the  
10 Innovation Center. So because it's being run through the  
11 Innovation Center, it has to follow some of the more  
12 traditional Medicare requirements. There will be about a  
13 three-year demonstration. There will be a robust evaluation  
14 to be done, as are all of the demonstrations that are being  
15 conducted through the Innovation Center.

16 Now, some of the States, and Oregon is a good  
17 example of this, they haven't submitted their final proposal  
18 to CMS yet. The way this works is that the States will have  
19 to post their proposals on their State websites for a 30-day  
20 comment period, incorporate those comments into the  
21 proposals, then send it to CMS, and then it will be up for  
22 another 30 days. But Oregon -- so from what we know what

1 Oregon is thinking through now, that's an example of where  
2 they are thinking of one of the financial alignment  
3 demonstrations that is related to the dual eligibles, but  
4 also aligning that with broader changes to the Medicaid  
5 system, the Innovation Center, that this demonstration  
6 through the Innovation Center wouldn't have authority over  
7 that. So they will also have to apply, I believe, for an  
8 1115 waiver at the same time.

9 DR. BERENSON: I see. One more, if I could. I've  
10 seen reference in a paper that some colleagues of mine at  
11 the Urban Institute wrote expressing concern about Medicaid  
12 taking the lead with care for the duals which references,  
13 actually, a MedPAC contractor report by Jim Verdier and  
14 colleagues and making the point that Medicaid managed care  
15 has typically focused on low-income children and moms and  
16 kids and really not the duals. Can you tell me any more  
17 about what we've learned from that contract in that area?

18 I guess, again, I'm going -- my concern about the  
19 demos is prematurely going away from what we're doing in  
20 Medicare with SNPs, et cetera, to sort of a broad expansion  
21 of Medicaid managed care within the States and I'm concerned  
22 about the capabilities of managing that kind of thing.

1 MS. AGUIAR: Right. And so that is an issue that  
2 has been raised in the past, and I believe that we put this  
3 in the June 2010 report, that one of just sort of the  
4 limitations to development of these integrated care programs  
5 is that some States tend to have much more experience with  
6 the mom and kids population and lesser with Medicaid managed  
7 care for all long-term care and behavioral health. So I  
8 would say that.

9 The report for us that Jim Verdier did for us,  
10 which I think you said that they had quoted, I haven't seen  
11 that paper so I'm not quite sure of the context that they  
12 pulled out of that. That report that we did with him was a  
13 site visit report to look at some integrated care programs  
14 and really to sort of go through how they were able to set  
15 up what are some of the -- you know, what made them work,  
16 how they were able to get things running, and then what are  
17 some of the limitations, again, to those types of programs  
18 expanding further.

19 DR. MARK MILLER: [Off microphone.] That's what I  
20 wanted to emphasize. The report was about looking at dual  
21 eligible programs --

22 MS. AGUIAR: Right.

1 DR. MARK MILLER: -- in the States, so that  
2 sentence might have just been something in the introduction.

3 MS. AGUIAR: Yes.

4 DR. MARK MILLER: You know, the States tend to do  
5 more of this. This report is about looking at these things.  
6 But the report was specifically about going out and looking  
7 at dual programs, which we did.

8 The other thing --

9 DR. BERENSON: So those were sort of prototype  
10 good programs that they went out and looked at. In other  
11 words, we weren't looking at sort of average programs. We  
12 were looking at sort of state-of-the-art programs that were  
13 in the States?

14 MS. AGUIAR: Right, exactly. And we didn't select  
15 those programs based on quality measures. I think as you  
16 could see from this presentation, there is a limitation. We  
17 have a limitation to be able to look at some quality data.  
18 The ones that we selected is because they were fully  
19 integrated and they were really somewhat State-run.

20 We went to New Mexico, for example, where they had  
21 decided to put their long-term care population into Medicaid  
22 managed care and then the plans that were running that had

1 the option to offer a companion SNP or MA plan. And so a  
2 beneficiary that was going to be possibly enrolled into the  
3 Medicaid managed care plan had the option to enroll with the  
4 same company into their Medicare Advantage plan.

5           So we selected -- we basically looked at the  
6 programs in the -- I'm sorry, June 2010, the report that we  
7 did the year before that, we had gone through a list of, no,  
8 here are the integrated programs as we understand it, the  
9 ones that States are working through with working with  
10 either MA or SNPs. And so we went to those. We also went  
11 to Massachusetts and then also to North Carolina, which is a  
12 fee-for-service overlay, which is much more like the managed  
13 fee-for-service model that is being -- one of the options  
14 under the CMS financial alignment demonstrations.

15           Again, so that report was really to look at these  
16 programs to figure out how they were able to get set up and  
17 what were the challenges and that sort of thing.

18           DR. BERENSON: And real quick, the last one would  
19 be in the three-way contracts that have to be established in  
20 the capitated demos, will Medicare require oversight at  
21 least as rigorous as what Medicare provides to SNPs at this  
22 point? Do you know?

1 MS. AGUIAR: I have to go back, actually, before I  
2 give you a definitive answer, and check their RFP that came  
3 out in a State Medicaid Director's level, because I know  
4 that they talk about oversight. It is my understanding that  
5 in some of the more oversight in some network requirements  
6 that they are looking at the MA program as an example. But,  
7 again, I have to go back and completely affirm that.

8 MR. HACKBARTH: In those projects where CMS has  
9 invited proposals, they do envision passive enrollment of  
10 duals?

11 MS. AGUIAR: Yes, they do. And that, again -- so  
12 passive enrollment with an opt-out. And again, so not very  
13 many of the proposals have actually come out yet. The one  
14 that is up on CMS's website for comment, that is from  
15 Massachusetts and they do propose -- they have identified  
16 who their target population is. That one will operate  
17 Statewide. Their intention is to notify those beneficiaries  
18 that they can enroll in one of these programs. They call  
19 them integrated care options, ICOs. They could be managed  
20 care-based or provider-based. So they will notify the  
21 beneficiaries, now you have a choice to have one of these  
22 programs. If the beneficiary does not choose a program,

1 then they will be assigned to one. So the beneficiary can  
2 opt out of the program.

3 MR. HACKBARTH: And how early can they opt out?

4 MS. AGUIAR: My understanding of it is that I  
5 think that they -- I think that they will be notified that  
6 they have to make a choice, and if they don't at that point  
7 decide, no, I don't want to participate in the program, they  
8 will be assigned to one. I'm not sure after that if there's  
9 a further sort of opt out.

10 MR. HACKBARTH: Sort of month to month or -

11 MS. AGUIAR: Right. Now, there's another proposal  
12 -- and I don't want to get them too confused in my mind -- I  
13 think it's actually Michigan. There is another one that  
14 says that they will be -- again, they have a choice. They  
15 will be auto-assigned into a program, and I think they have  
16 maybe a 30- to 60-day window to then opt out once they've  
17 been auto-assigned into the program.

18 MR. HACKBARTH: Okay. Bill, clarifying questions.

19 DR. HALL: I'm just trying to get kind of the big  
20 picture of this population. You mentioned PACE several  
21 times in there and PACE Without Walls as a potential.  
22 Strictly speaking, are these SNFs or SNPs?

1 MS. AGUIAR: You mean the PACE Without Walls?

2 DR. HALL: Well, any of the PACE programs.

3 MS. AGUIAR: No. So they're very-

4 DR. HALL: They're really kind of SNP-oid -

5 MS. AGUIAR: Exactly. They're different.

6 DR. HALL: Right.

7 MS. AGUIAR: They have their own authority, their

8 own --

9 DR. HALL: Yes. Some people just have Medicare  
10 and some just have Medicaid. Okay. So my real question,  
11 then, is what's the age distribution of the SNP population  
12 nationwide? I'd be particularly interested in how many are  
13 on the very low end, you know, below age 65, and then how  
14 many are in the sort of frail elder age, 75 and above.

15 MS. AGUIAR: We could get -- we'll get that for  
16 you.

17 DR. HALL: Do you have just a gestalt on that? I  
18 would guess it's a younger population.

19 MR. ZARABOZO: Well, typically in MA, you do have  
20 a younger population, but we don't know if that's true also  
21 of the SNPs and duals, and among duals, what is the  
22 distribution there.

1 DR. HALL: Okay.

2 MR. ZARABOZO: So we can do that, but we don't  
3 have it yet.

4 DR. HALL: Okay. Thank you.

5 DR. DEAN: Just on the quality of care issue. If  
6 I understood what you said, we can pretty well document that  
7 these programs are more expensive. We can't really document  
8 that the care is really better. How difficult is it --  
9 would it be -- to really kind of get the kind of data to  
10 know the quality or outcome issues? Is that something  
11 that's doable or is that out of our reach?

12 MR. ZARABOZO: Well, as we mentioned with the  
13 CAHPS data, we had the person-level data so that we could  
14 classify people by different categories. The HEDIS data,  
15 there is person-level data reported, so you could do a  
16 similar classification. CMS has the data. But for  
17 important measures like intermediate outcome measures, those  
18 are done by a sampling of medical records. So you would  
19 have to go through the whole process and say, well, you have  
20 given me a sample from your large group. Some of those  
21 people may be in SNPs. Some are maybe not. So what we want  
22 is a sample that is -- just do a sample of your SNP members

1 so that we can compare it to other MA plans on a similar  
2 sampling basis.

3 And then the other issue is how do you compare  
4 this to fee-for-service? We're not quite able to do the  
5 comparisons to fee-for-service. So --

6 DR. DEAN: So it would be difficult --

7 MR. ZARABOZO: -- something can be done, but not  
8 what you would really fully want to have done.

9 DR. NAYLOR: So Slide 14, first bullet, I just  
10 wanted to make sure that I understood. I thought I  
11 understood one thing from the paper, but this notion of  
12 exploring whether Medicare or Medicaid should assume full  
13 responsibility for duals, and that is full sets of services,  
14 long-term and health, medical -- I mean, is that -- it seems  
15 to me a movement and a different principle. Even on PACE,  
16 it's funding stream. So I just wanted to make sure --

17 MS. AGUIAR: Yes, exactly. We were -- and again,  
18 I think there was, you're right, a little bit more detail in  
19 the mailing materials about this. Here, we're sort of  
20 talking about merging the funding of the financial  
21 responsibility of the benefits to either the Medicare  
22 program or to the Medicaid program. So not working through

1 a third entity like you do in PACE.

2 DR. NAYLOR: Big change. Big implications.

3 MR. HACKBARTH: I was just going to say that --  
4 and some people think that, politically, that's probably not  
5 likely to happen. But conceptually, if one of the problems  
6 is that we've got separate streams of funding, one way to  
7 solve that is to join these streams of funding in a PACE  
8 program or in a fully integrated SNP, bring the two sets of  
9 dollars together and allow that private organization to  
10 manage the money. A fundamentally different approach is to  
11 say, well, let's merge the funding streams at the  
12 governmental level and say either Medicaid or Medicare has  
13 full financial responsibility for this population.

14 DR. NAYLOR: I really like that we're open to  
15 exploring that.

16 MR. HACKBARTH: Yes.

17 DR. NAYLOR: I mean, so the other -- one other,  
18 beneficiary savings as a potential outcome. Are there other  
19 examples in the Medicare program where beneficiaries'  
20 savings, shared savings has been a part of our thinking and  
21 --

22 [Pause.]

1 DR. MARK MILLER: In our conversations, a couple  
2 of -- just a couple things to your comments. One is that in  
3 trying to set the direction for the Commission to go, we're  
4 trying to obviously exhaust all the possibilities to make  
5 sure that you understand there's a lot of different  
6 directions. Number one.

7 Number two, to your point, a few times in these  
8 conversations, in talking about the shared savings between  
9 the states and all this, there have been these one-off  
10 comments about where's the beneficiary in this. If  
11 everybody is getting something out of this, why aren't we  
12 entertaining the beneficiary? Which is where that thought  
13 came from.

14 To your specific question, other examples, and I'm  
15 happy to take some help here, but you could kind of say, in  
16 MA, when there is reduction off of baseline -- I'm not going  
17 to save savings because we don't think it's actually a  
18 savings -- supposedly that goes back into benefits to the  
19 beneficiary. There's something there, but it's flawed by  
20 the fact that it's not real savings and it doesn't go into  
21 the beneficiary's pocket, per se.

22 MR. KUHN: The ACE demo?

1 DR. MARK MILLER: The what? Oh, the ACE demo.  
2 But actually in the ACE demo, I'm under the impression that  
3 they're abandoning it because -- I don't know who I'm  
4 looking at. I'm looking at Kelly. They're abandoning it  
5 and apparently this was kind of interesting, so the  
6 beneficiary got some money back, and Kelly, if you need to  
7 get to a microphone you should do that before I do any  
8 damage here.

9 But the beneficiary was getting confused by the  
10 fact that they were getting money back.

11 MS. MILLER: By the time the beneficiary got the  
12 money back, they had sort of forgotten what it was for, that  
13 they were part of the demonstration. So it didn't seem like  
14 it was really driving their choices about where they were  
15 getting the care.

16 MR. HACKBARTH: And it might be a little bit more  
17 readily understood if it's an enrollment level sort of  
18 decision that, Okay, I'm enrolling in this organization and  
19 I get some benefit from that, as opposed to just a set of  
20 services, which is a little tougher for people to grasp.  
21 And I'm the person who usually makes the one-off comment  
22 about --

1 DR. MARK MILLER: I was waiting for you to say  
2 that.

3 MR. HACKBARTH: -- about how we're talking about  
4 how the Federal Government shares in the savings and the  
5 state government shares in the savings and the provider  
6 shares in the savings and the person, you know, almost never  
7 here mentioned is the patient, which is also, as people well  
8 know, one of my concerns about the whole ACO thing. Again,  
9 it's we're going to divide up all these savings and forget  
10 the patient in the process. So that's why I'm raising that  
11 flag from time to time.

12 MR. ZARABOZO: Also within MA, there is -- one of  
13 the uses of the difference between the benchmark and the bid  
14 is return -- a reduction of the Part B premium. So there is  
15 a cash option, also, within MA, not frequently used, though.

16 MR. BUTLER: So my --

17 MR. HACKBARTH: How frequently is that used? Just  
18 say a little bit more.

19 MR. ZARABOZO: It's not frequently used, except in  
20 Puerto Rico, because of the special circumstances in Puerto  
21 Rico. So some plans offered it, but typically what it is,  
22 it's they're offering reduction in the Part B premium, but

1 at the same time you have higher cost-sharing or not as many  
2 extra benefits. So it's a trade-off.

3 MR. BUTLER: I have two questions. One relates to  
4 how important is this to a state, and the second is, how  
5 ready are they to be a participant? With respect to how  
6 important it is, you say there are 10 million dual  
7 eligibles, 18 percent of Medicare enrollees and 31 percent  
8 of the spending.

9 Now flip it to the state side. How much of the  
10 Medicaid spending in the state is in dual eligibles?

11 MS. AGUIAR: I don't have that off the top of my  
12 head. I believe, and I'm looking at Carol Carter because  
13 she was here, but I know that she took the lead on doing a  
14 data analysis where we had combined Medicare and Medicaid  
15 spending. And so, I'll have to go back and check to see if  
16 we have that statistic.

17 MR. ZARABOZO: But it is significant because, of  
18 course, the large expense is the long-term care.

19 MS. AGUIAR: Yeah.

20 MR. ZARABOZO: Custodial care and home and  
21 community-based services. So there's a significant expense  
22 associated for the states with this population.

1           MR. BUTLER: Okay. So you're likely to be high --  
2   it's likely to be high on their list as an opportunity?

3           MS. AGUIAR: Yes.

4           MR. BUTLER: Looking at states that are in bad  
5   fiscal shape tend to also have a fairly unprogressive  
6   Medicaid system in place and are getting ready for an  
7   expanded number of enrollees and they're hardly equipped to  
8   even do that.

9           MS. AGUIAR: Yeah.

10          MR. BUTLER: And so I'm trying to get a sense, how  
11   great a partner -- it's a little related to Bob's question -  
12   - how are they going to do all this stuff on top of just  
13   kind of running the basic business? So if you give -- is  
14   there any way you can give some subjective answer to the  
15   range of readiness at states? Because I could see maybe a  
16   very uneven roll-out of this kind of thing depending on how  
17   progressive the state is, who's in the leadership position.  
18   It would impact a little bit about how I would feel about  
19   which way to go.

20          MS. AGUIAR: Right. So again, our previous  
21   research, when we were looking at the integrated care  
22   programs that really had been up and run by the state, we

1 got more of a sense of some of the barriers on the state  
2 side, and they were very frank and honest with us, and some  
3 of it was that they just don't have the resources. It  
4 requires just a lot of up-front work to develop these  
5 programs.

6           However, there is an advantage to them to do so  
7 because if you could have a program -- and, you know, we  
8 have seen this evidenced with the PACE program that they do  
9 this -- that they can sort of successfully manage the  
10 community-based long-term care of the nursing home  
11 certifiable population and keep them in the community as  
12 opposed to the nursing home, there is the potential for  
13 Medicaid savings. So that is the incentive for them to do  
14 so.

15           I mean, that said, we have heard just sort of very  
16 anecdotally that some of the states that expressed initial  
17 interest in some of these demonstrations may have to delay  
18 implementation of it, you know, just because there's a lot  
19 of things to figure out and they have a lot of other things  
20 going on, a lot of other pressures.

21           So even though in some states I do feel it does  
22 appear to be that this is a priority to go through these

1 demonstrations, some of them just may not be able to -- at  
2 the official time line, which CMS has set up the time line  
3 to sign the contracts, the three-way contracts by September.  
4 And so for some states, it seems like they won't be able to  
5 do that.

6           So I think originally there was about like 38  
7 states, I think, that had submitted letters of intent to do  
8 other, the capitated model or the managed fee-for-service  
9 model, and it seems like what we're hearing is that there  
10 will be less than that that are able to do it.

11           MR. HACKBARTH: Christine, so one reason why a  
12 financially strapped state is interested is that they see an  
13 opportunity, perhaps, to reap some Medicaid savings by  
14 moving people out of institutions into lower cost settings.  
15 But also, aren't they motivated by an interest in sharing in  
16 Medicare savings?

17           MS. AGUIAR: Right. So the managed -- under the  
18 managed fee-for-service model, they will be able to save in  
19 some of the Medicare savings, to the extent that there are  
20 Medicare savings generated from that program, and they meet  
21 certain performance measures.

22           What is less clear, and I don't feel like I've

1 seen this explicitly stated in some of what's come out about  
2 the capitated model, is when CMS talks about forming these  
3 three-way contracts between the state and the health plan  
4 and CMS, and they say that the capitated rates will provide  
5 for up-front savings to both programs, but then some of the  
6 states in their applications say that they don't think that  
7 the Medicare money will only go to cover -- only go towards  
8 the Medicare services, that they will be able to cover some  
9 Medicaid services.

10           It's not clear whether or not in that negotiation  
11 of the capped rate and what Medicare spending could be used  
12 on, if there will be an opportunity for the states to  
13 capture some of that Medicare savings, which is why we  
14 wanted to raise the issue of while we understand the  
15 rationale, the rationale for why some of the states felt  
16 they should be sharing in the Medicare savings, we did want  
17 to address the issue of, you know, to the extent that these  
18 states are realizing more immediate long-term care savings,  
19 you know, if they will be going into these negotiations with  
20 CMS expecting to receive some of the Medicare savings, you  
21 know, one of the things that could be considered by the  
22 Commission is whether or not the potential for the states to

1 share in their own Medicare savings should be taken into  
2 account and, you know, whether they should share in the  
3 Medicare savings at all.

4 MR. BUTLER: So I won't comment on Round 2, but I  
5 think that in this case, I mean, our client is Congress. I  
6 think we can provide some important guidance and thoughts to  
7 states as a client on this and saying, Hey, this is how you  
8 might engage and solve some of your own problems. So I  
9 would think about them as a reader of this report as well.

10 DR. CHERNEW: So I have two quick questions. The  
11 first one is, who determines the state's share of the  
12 capitated payment portion? Is that just done through  
13 negotiation or is there a -

14 MS. AGUIAR: Yes, that's done through the  
15 negotiation. And again, the way that it reads so far -- our  
16 understanding to date, is what I want to caveat it with that  
17 -- is that in this negotiation there will be an opportunity  
18 for both Medicare and Medicaid to save, and it's not clear  
19 yet whether or not the states will share in some of that  
20 Medicare savings, but it will be done on a state-by-state  
21 basis.

22 DR. CHERNEW: And on a negotiated basis.

1 MS. AGUIAR: Right.

2 DR. CHERNEW: My second question is --

3 DR. MARK MILLER: And you mean in the  
4 demonstration.

5 MS. AGUIAR: In the demonstrations.

6 DR. MARK MILLER: Right.

7 DR. CHERNEW: It will, but I assume a he  
8 demonstration is going to set the groundwork for how you  
9 might go forward, particularly if you're doing it on a  
10 state-by-state basis.

11 The second question I have is, I find the idea of  
12 moving to this sort of capitated, single stream payment very  
13 appealing as a general rule. Have there been attempts to  
14 then simplify other regulations? Or do, in fact,  
15 regulations, when you do that, become more complicated  
16 because now you have to account for more things?

17 So I want to know what other barriers there are  
18 besides just the financial separation that prevents  
19 integration and whether or not those barriers rise or fall  
20 when you integrate the finances. Do you find everyone  
21 requiring a more detailed accounting of every penny, or are  
22 they more willing to accept the capitated rates and have

1 less detailed accounting of every penny?

2 MS. AGUIAR: I'll just say, we don't know that  
3 offhand, but we'll look into that for you.

4 MR. ZARABOZO: One of the purposes of the Duals  
5 Office in CMS was to address the other issues of why is it  
6 so hard to integrate, to have Medicare and Medicaid  
7 together, including, for example, appeals processes,  
8 enrollments and so on.

9 DR. CHERNEW: And I can see they have different  
10 utilization procedures and then you get into a big fight  
11 about whose takes prominence.

12 MR. ZARABOZO: Yeah. So I assume that would be  
13 part of the negotiation, is what rules apply, essentially.  
14 I'll put it that way.

15 MR. HACKBARTH: So there are differences within  
16 the fee-for-service programs at Medicare and Medicaid, but I  
17 think Carlos has pointed out that even at the plan level,  
18 there are very different rules that need to be reconciled  
19 and perhaps streamlined.

20 DR. CHERNEW: Understood your answer. The answers  
21 to whatever that is could differ by state. So it could be  
22 different in New Mexico and Ohio.

1 MR. ZARABOZO: That appears to be the case, yeah.

2 MS. AGUIAR: And I do think, though, there is some  
3 -- when CMS put out the -- it was in a state Medicaid  
4 director's level letter. I keep referring to it as an RFP,  
5 but it wasn't. But when they put that out, they sort of had  
6 laid out what some of the opportunities that they wanted to  
7 be able to align, do some of the financial alignment  
8 opportunities within that. So I think they are sort of,  
9 because it happened.

10 As Carlos said, they have been doing this back  
11 work to see what some of the barriers in the current system  
12 are. So I think they are trying to fix some of those under  
13 these demonstrations.

14 MR. GEORGE MILLER: Just a quick one. I'm  
15 intrigued by the PACE Without Walls and wondering if you  
16 have more information to share about how that may look, or  
17 is that something that we would allow the organization or  
18 the state to define for us. Have we looked at that?

19 And then possibly a second part of the question,  
20 what potential savings could there be if they're not limited  
21 by fiscal being and providing better benefits for their  
22 beneficiaries?

1 MS. AGUIAR: I can address the first one a little  
2 bit more. The savings piece, that would really have to -- I  
3 think the first step is sort of to define what it is, and  
4 the second thing to be, how would we pay for it. And so, we  
5 have thought about this. Just in our interviews, just with  
6 PACE providers and just all around, this keeps coming up as  
7 a possibility.

8 Interestingly, Oregon is sort of -- has asked  
9 permission to try to test a little bit of this. And so,  
10 what it really means is, the PACE model, which again there  
11 is evidence that shows that it does reduce hospitalizations  
12 and nursing home use, it's very focused on this day care  
13 center. And you have an IDT and multi-disciplinary -- you  
14 know, IDT team that really is closely monitoring.

15 And so, the idea of the PACE Without Walls is  
16 that, do you need that day care center? Can you have this  
17 multi-disciplinary team that somehow is maybe using  
18 telephonic management, maybe it's mobile, that could maybe  
19 perhaps -- and maybe it's perhaps for a less frail  
20 population that that could work. So it could expand to  
21 serve more beneficiaries. That's sort of the idea.

22 When we reported on our PACE site visits that we

1 had done in the fall, our hypothesis really going into that,  
2 the reason why we wanted to go see the rural PACE sites was  
3 because we thought that they might have had to have relaxed  
4 their model a little bit, and then maybe they would sort of  
5 see the challenges of operating in that environment.

6           You know, they would be, perhaps, a little bit  
7 more supportive of this. And so we didn't actually find  
8 that to be the case just amongst the people that we had  
9 interviewed, but we know that there is still interest in it.

10           And so, you know, the reason we put this as a  
11 future step is, could you think a little bit about it more?  
12 What would it look like? And then, you know, if it is so  
13 much altered from PACE, at what point does it become a care  
14 model that perhaps a managed care plan could offer? You  
15 know, is it sort of a stand-alone thing? Is it a piece of a  
16 larger program? And then that gets into how you pay for it,  
17 how would you pay for it.

18           MS. BEHROOZI: So just on the spending, so we  
19 don't see savings on the Medicare side with the sort of  
20 intensive programs, and I guess we don't have access to all  
21 the data on Medicaid spending, but is there anywhere, I  
22 mean, anyone, CMS, MACPAC, anybody looking at total Federal

1 spending on these programs, you know, the Federal share of  
2 Medicaid added to Medicare spending and seeing whether  
3 that's impacted?

4 MS. AGUIAR: You mean --

5 MR. HACKBARTH: Any SNPs in particular.

6 MS. BEHROOZI: Yeah, the PACE, PACE and these  
7 intensive SNPs, the dual SNPs.

8 MS. AGUIAR: To my knowledge, no, but we would  
9 have to go back and ask them, because I don't remember  
10 specifically asking them if they were considering -- if like  
11 MACPAC, for example, is considering to look at that now.

12 You know, one of the things that we did propose  
13 that we could look into further really are, when analyzing  
14 the payment system for the five SNPs, you know, one of the  
15 things we proposed -- this was more in the mailing  
16 materials, not in the presentation -- was to really look at  
17 their cost structure.

18 And if we were, you know, both through data that  
19 we have and then through interviews, and if we could do  
20 that, we're hopeful to try to get a sense of what's going on  
21 on the Medicaid side from them. But we could check with  
22 MACPAC to see if they have plans about that.

1           MR. HACKBARTH: So, let's see, in mid-February,  
2 Mark and I met with MACPAC on the issue of duals, and just  
3 wanted to raise a couple things that came up there. The  
4 first point is sort of a contextual one and it relates to  
5 Bob's initial question and that's, how fast is this  
6 particular train moving.

7           And it relates to this question, are we going to  
8 be seeing statewide programs under this CMS initiative where  
9 all of the duals in a given state are moved into new models,  
10 or are we just seeing what we would consider traditional  
11 Medicare demonstration projects?

12           And I don't know the answer to that question. One  
13 of the MACPAC Commissioners was saying he thinks it's  
14 definitely in at least some of the big states. They're  
15 talking about moving statewide, Massachusetts, California, I  
16 think are among them. So we're talking about potentially a  
17 lot of people and a fast-moving train here, which has  
18 implications both for MedPAC and MACPAC participating in  
19 this discussion.

20           Then much of the rest of the conversation focused  
21 on this issue of passive enrollment. Frankly, to my  
22 surprise, there were a number of MACPAC Commissioners, some

1 of which I wouldn't have expected, who were strong vocal  
2 supporters of passive enrollment, believing that the care  
3 that the patients are receiving in the current arrangement  
4 is so un-coordinated, in some cases poor, that the  
5 opportunities, just from a patient perspective and a quality  
6 of care perspective, were quite large, and the only way to  
7 move quickly in that direction was through a passive  
8 enrollment process.

9 I must say that I continue to have some  
10 reservations about passive enrollment based on the fact that  
11 the dual population is so heterogeneous, the needs are so  
12 diverse. You know, there's a segment of the dual population  
13 that's dually eligible, principally because they have low  
14 income and low assets.

15 On the other hand, we've got people with  
16 significant cognitive impairments and physical impairments  
17 and very different sorts of challenging clinical needs to  
18 deal with. You know, the typical managed care plan may be  
19 just fine for dealing with people who are just low-income,  
20 but it may not be well matched to the needs of a patient  
21 with significant cognitive impairments or significant  
22 physical disabilities.

1           And those organizations that can care well for  
2 those sub-populations have very particular clinical set-ups  
3 that allow them to be effective. And those clinical  
4 organizations are not, you know, just everywhere, statewide  
5 in Massachusetts or California.

6           And so, you know, quickly moving duals on a  
7 statewide basis, the whole population, given these diverse  
8 needs and the scarcity of the clinical organizations, I  
9 worry about, frankly.

10           The other part of the conversation, very related,  
11 is if you have passive enrollment, what does the patient  
12 need to do to opt out and how quickly can they opt out? Say  
13 it's a patient with significant physical disabilities and  
14 they find themselves enrolled in a private plan that really  
15 doesn't have the care delivery system that can meet their  
16 needs, how quickly can they get out?

17           My concern about passive enrollment would be, the  
18 least, if they could get out immediately and had month-to-  
19 month dis-enrollment. But again, somewhat to my surprise,  
20 there were a number of people at the MACPAC session saying  
21 that month-to-month dis-enrollment doesn't work, and that,  
22 in fact, the providers who might lose money because of the

1 effective management of the care, say a nursing home, they  
2 get the patients to quick dis-enroll because they see it as  
3 potential lost revenue as a result of better management.

4           And so, they want not only passive enrollment, but  
5 lock-insurance for fairly significant periods of time. And  
6 that combination of passive enrollment with lock-in, given  
7 the diversity of the population, causes me a significant  
8 amount of anxiety and if, in fact, this is a fast-moving  
9 train where we're going to see large states go statewide  
10 with this, I'm a little uneasy.

11           DR. BERENSON: Well, first let me associate myself  
12 with all those remarks and go -- up you a little more, if I  
13 could. I looked at the discussion about performance  
14 measures and I don't think we have good performance quality  
15 measures in this area.

16           I mean, I think the HEDIS measures are mostly  
17 irrelevant, even for an elderly medical population. They  
18 don't address those with physical disabilities. They don't  
19 address those with serious mental disability. So I don't  
20 think we can rely for good -- I mean, I just don't think the  
21 HEDIS measures are going to help us very much.

22           And outcome measures in this area are sort of

1 challenging as well. So I think we, at least for the  
2 foreseeable future, are going to have to rely more on  
3 oversight and requirements, structural requirements, and it  
4 makes me nervous that we don't necessarily have those in  
5 place, although obviously we'll see what the states propose,  
6 but I would be very concerned.

7           On the passive enrollment side, I have no problems  
8 with the concept of passive enrollment into a high quality  
9 accountable organization. I have great problems with  
10 passive enrollment into an organization that has no  
11 experience in this area and is being selected partly because  
12 of budget predictability.

13           So in terms of your questions about what we should  
14 be focusing on, so far the discussion hasn't been very much  
15 about SNPs, per se. I do think because there's a  
16 reauthorization -- when is the reauthorization for the SNP  
17 program?

18           MR. ZARABOZO: The duals have to have -- the  
19 contract requirement is beginning 1/1/2013, so in other  
20 words, if you don't have one now, essentially, you know, in  
21 the next few months.

22           DR. BERENSON: I thought the program had to be

1 reauthorized.

2 MR. ZARABOZO: The program also, in general, for  
3 2013.

4 DR. BERENSON: That's what I wanted to know. I  
5 think to be relevant to our sort of customers, who are the  
6 Congress, I think we probably do want to look at the SNP  
7 program specifically over coming months and see if we want  
8 to make any recommendations about that reauthorization.

9 But short term, it seems to me the opportunity to  
10 develop -- and this would be challenging, but I'll throw it  
11 out -- develop some basic principles or criteria under which  
12 we think these demos should go forward related to protecting  
13 beneficiaries as well as protecting Medicare trust fund  
14 dollars, I think would be a useful early activity.

15 What you've done is listed a whole bunch of  
16 activities which I all think should be done. We've actually  
17 started in this area last year -- well, two years in 2010.  
18 I mean, I think we are proceeding in a very logical step-  
19 wise fashion, and I would hope we could ultimately get to  
20 the big Kahuna here which is who should take financial  
21 responsibility.

22 But I think we can't do it all at once and so, if

1 I were giving a priority for the immediate future, it would  
2 be being able to comment on those demos, so developing a  
3 basis for commenting on those demos and getting into more  
4 detail in the SNP program so we can provide some guidance on  
5 the reauthorization.

6 MR. HACKBARTH: Can I just say one other thing? I  
7 just want to make sure that I don't leave any inaccurate  
8 perceptions about my conversations of MACPAC. I did mention  
9 that because I wanted to make it clear to the Commissioners  
10 that we have engaged with MACPAC on an issue of mutual  
11 importance, and, you know, I took care to say with some  
12 MACPAC Commissioners, I have no idea what the overall point  
13 of view is within the Commission. You know, we didn't take  
14 a straw vote, and as in any conversation, there are some  
15 people who are more vocal and participating more accurately.  
16 And so I focused on just some things that I heard from some  
17 of the MACPAC Commissioners that caught my ear and raised  
18 some issues in my mind that may or may not be an overall  
19 reflection of the point of view in MACPAC. I just want to  
20 emphasize that.

21 DR. HALL: I think this is really, really  
22 important. You know, there's something about the use of the

1 term "duals" that it tends to sanitize what this population  
2 is really like, socially and medically. I occasionally  
3 think about Hubert Humphrey's quote that's carved into the  
4 marble at HHS that says, "You judge the character of a  
5 country by how it cares for its youth, disadvantaged people,  
6 and old."

7           These are people who are the most vulnerable group  
8 of individuals in our society, and by the by, they're  
9 consuming 33 percent of Medicare resources right now.  
10 They're vulnerable -- I think this is a time where they are  
11 particularly vulnerable because of differences of political  
12 opinion on the role of Medicaid, the role of Federal  
13 supports, and they're a group that can't really advocate for  
14 themselves. You don't see them lined up on the steps of any  
15 Capitol protesting very much.

16           Also, I think 20 years from now duals will include  
17 a very, very large proportion of older adults, I mean, a  
18 huge -- not a huge number, but a very large number who will  
19 be, by definition, dually eligible for Medicare and  
20 Medicaid. And there's a hint that there might be better  
21 programs available for them if we could figure out some of  
22 the intricacies of managing both of these payment streams.

1           So I think we need to emphasize kind of the human  
2 aspects of this as we go through this, that this is a very  
3 important population that is probably a growing population.  
4 So I agree entirely with what both Glenn and Bob have said.  
5 Also, I think we then need to take a look at some other  
6 quality measures. While influenza vaccination is a good  
7 metric and I applaud any group that gets good compliance  
8 with that, it really doesn't measure the things that are  
9 important to this group of people, who really, as you  
10 mentioned, can't make decisions very well for themselves  
11 often, who have very complex problems that transcend just  
12 what we pay for medical services.

13           So I don't think we should drop this. I think  
14 that we should try and find if there are better ways of  
15 expressing the merit of the program other than what we've  
16 looked at. I don't know what those are off the top of my  
17 head.

18           DR. DEAN: I would just echo what Bill said.

19           DR. MARK MILLER: I would just say this: Peter,  
20 you asked the question earlier. About 18 percent of the  
21 people, 30-some-odd percent of dollars on Medicare, 15/40-  
22 ish on Medicaid. So I think that's what you were asking,

1 what were the comparable portions.

2 MR. BUTLER: So, what, 15 percent of the Medicaid  
3 members and 40 percent of the Medicaid expenditures of the  
4 state.

5 DR. MARK MILLER: Right, so it is serious business  
6 for the state, and then to these comments, you know, that  
7 were being made up here as to why there's so much interest.

8 MR. BUTLER: That's bigger than I would have  
9 thought.

10 DR. CHERNEW: So I think based on past stuff that  
11 I've seen here, it's pretty clear to say that we have --  
12 it's a very important population, and we have a lot of  
13 problems in the seams and a lot of things happen like  
14 churning between sites and gamings across programs and  
15 regulatory things that don't work. So I think there are  
16 probably a lot of aspects of inefficiency here, and a lot of  
17 room for improvement. And I think the challenge, in the  
18 spirit of the other comments, is that in the best cases you  
19 could see where this works wonderfully and where you can do  
20 a lot better. And in the worst cases, you could see where  
21 things could really go bad.

22 And so the challenge is we don't want to let the

1 sort of bad be the enemy of the good, so I think we have to  
2 figure out a way of going forward with this, and I'm very  
3 supportive of many of the models that were discussed. But I  
4 guess we have to make sure that we can do so in a way that  
5 the inevitable protections we put into place don't make the  
6 entire exercise worthless.

7           And I have to believe that there are ways to go  
8 forward, and in terms of focusing our energy, I think  
9 illuminating what those are, the places where we can get  
10 important improvements, I think that's where I would focus.  
11 And for me, what I'd like to understand is how prevalent are  
12 what I would call basically high-performing places in these  
13 states that really could do a good job and we could limit it  
14 to those places and we could have a program with some sort  
15 of entry -- in order to be eligible, you have to meet the  
16 following criteria. Is that a lot of groups? And so we  
17 really could think going forward -- are there really only a  
18 few organizations that are kind of the exception rather than  
19 the rule? I'd like to think that the former is true, that  
20 there's a lot of organizations. I've spoken to many that  
21 would say their lives would be much simpler if they could  
22 take dual stream funding with appropriate regulatory

1 simplification, and that they would do a great job for this  
2 population. And I actually believe that that's true. And I  
3 always feel somewhat sheepish when they note all the  
4 incredible barriers to doing that. And I think finding a  
5 way to remove those barriers without letting in a whole  
6 bunch of bad stuff should be the top priority.

7 MR. ARMSTRONG: I just would affirm I really  
8 support the way you're talking about going forward with  
9 this, and I really appreciate and agree with many of the  
10 comments that you all have made.

11 The one thing I would add would simply be I'm not  
12 sure we've really identified and we should think about how  
13 we could advise Congress or whoever on how is it that this  
14 is an issue that everyone agrees is so significantly  
15 important, and admittedly complex, but there are a lot of  
16 other complex issues, but why is it so hard for us to move  
17 this forward? Are we really asking that question and  
18 answering it in a way that allows us to be a little bit  
19 smarter about trying to get some acceleration moving forward  
20 with some of this work? I just don't know.

21 MR. GRADISON: This is a learning experience for  
22 me, and I certainly congratulate you for the work that

1 you've done.

2           My sense of it is that the states, somewhat in  
3 desperation, probably in desperation, are rushing to change  
4 their model of care not -- for all their Medicaid  
5 beneficiaries by moving whole blocs of people, sometimes  
6 trying to move the whole state into managed care in a very  
7 short period of time. What I'm going to say is not  
8 particularly logical, but just so you know what I'm thinking  
9 about, I think it's going to be important to try to monitor  
10 what's happening state by state with this migration of total  
11 population, not just the ones we have an interest in because  
12 they're duals, but what's happening at the state level in  
13 terms of quality of care and in terms of cost and in terms  
14 of the administrative capability of the managed care plans  
15 so quickly to take up such large numbers of people with such  
16 diverse needs.

17           Again, this may seem to be broadening it in a way  
18 that gets beyond what we're directly involved in, but  
19 somehow I have a feeling, at least for myself, that watching  
20 more carefully than I have in the past what's happening at  
21 the state level for their whole populations may help to  
22 inform us better what might be appropriate for this very

1 large segment, but not the whole Medicaid population.

2 DR. CASTELLANOS: It's just my experience in  
3 dealing in this group of patients, both the dual eligibles  
4 and the Medicaid patients, that there are -- like Bill said,  
5 these people are really critically in need of care. My  
6 observation, however, is that there isn't always good access  
7 to their care, and under the law they're supposed to have  
8 equal access. I would really like us to kind of look at  
9 that because I really don't think that's happening today.

10 MS. BEHROOZI: Just to share some of my  
11 colleagues' concern, among this population there are a lot  
12 of sicker, older people, but there are also people who have  
13 recently aged into Medicare, and they're, you know, just  
14 below the line. I mean, we have people, unfortunately, who  
15 work for a living who qualify for Medicaid, and then when  
16 they become 65 years old, they are eligible for Medicare,  
17 and, you know, they're sort of -- they're, you know, on the  
18 margin, but they're not necessarily old and sick. And, of  
19 course, they need care coordination just like all the rest  
20 of us do. We all benefit from that when we need health care  
21 services.

22 But to see them as a part of a monolith that can

1 be moved around by fiat I fear their commodification. And I  
2 love the way we started this conversation about looking at -  
3 - I don't mean today's conversation. I mean in general the  
4 work that you have been doing, looking at the programs that  
5 can really deliver high value for those in high need. But  
6 then to sort of move the conversation along, which I think  
7 we need to do, but I do think it's a little bit different,  
8 to what to do about duals and we encounter the challenges  
9 that states are facing and the sort of dramatic actions  
10 they're taking in response to their budgetary crises with  
11 this whole bloc of people and moving them around. And in my  
12 own state, which shall remain nameless -- you know what it  
13 is -- we're right in the middle of this transition of long-  
14 term care into first Medicaid managed care -- this is just  
15 for, you know, the disabled people who are not yet eligible  
16 for Medicare -- and soon-to-be Medicare eligibles who will  
17 at least have to receive their long-term care through  
18 managed long-term care companies, not necessarily SNPs.

19           The wrenching transition, the lack of preparation  
20 of the carriers -- and I'm experiencing it just from a  
21 little window where we pay for the health care of the people  
22 who provide these services, and I try to talk to the people

1 running these Medicaid managed care companies about, okay,  
2 so, you know, you're supposed to be helping us track the  
3 hours that people work to see if they're eligible for health  
4 care coverage based on the services that they're providing  
5 that you're paying for, and they're like, "What are you  
6 talking about? Really? I don't know anything about long-  
7 term care. We'll deal with it when we get to it."

8           And that's not even the care of the people they  
9 are now responsible for a benefit that they've never been  
10 responsible for. So that's not to criticize them. They  
11 will get there. They're smart people. They're caring and  
12 concerned and whatever. But, anyway, I'm just adding you  
13 voice to the cautions about taking this bloc of people and  
14 doing stuff with them that may or may not make sense,  
15 especially to do it abruptly.

16           DR. BAICKER: I think all of the cautions that  
17 have been raised are really well taken, and it highlights in  
18 some ways that this group amplifies all the things that  
19 we've been talking about throughout the last day and a half,  
20 that risk adjustment is particularly important in this group  
21 because of the heterogeneity of the group and the complexity  
22 that they disproportionately represent. And care

1 coordination is particularly important with this group  
2 because of them moving not only across providers but across  
3 insurance silos.

4           So all of that makes things hard, but on the other  
5 hand, it makes the returns to getting it right that much  
6 greater, that there are a lot of dollars at stake and  
7 there's a lot of health to be produced in this group so that  
8 it's worth investing in getting those coordination items  
9 right, especially in this group. And the fact that the  
10 state plays such a prominent role in some ways offers more  
11 opportunities to experiment with different delivery  
12 mechanisms.

13           So I think states moving whole-scale their  
14 populations is not necessarily the best model for that,  
15 although sometimes it might be if they're trying to do big  
16 coordinated entities. But we should be working with them to  
17 promote that kind of experimentation because the returns  
18 might be really great in this group and then would let us  
19 draw some of those lessons to the broader population.

20           MR. HACKBARTH: Any other comments? Mark,  
21 anything you want to add to this or ask in order to get  
22 direction for the next phase?

1 DR. MARK MILLER: I was going to have that  
2 conversation with the two of you and sort through what we  
3 think we heard here. So that's how I was going to deal with  
4 it.

5 MR. HACKBARTH: Okay. Thank you very much. Well  
6 done, Christine and Carlos.

7 We'll now have our public comment period.

8 Up here is the slide with our ground rules for the  
9 public comment period, so please do begin with your name and  
10 your organization. And when this red light comes back on,  
11 that will signify the end of your time.

12 MS. CARLSON: My name is Eileen Carlson with the  
13 American Nurses Association. I just wanted to comment with  
14 respect to care coordination for dual eligibles. I think  
15 one of the major barriers to achieving this with respect to  
16 the disabled population -- who I'm not sure what percentage  
17 they account for as beneficiaries, but I imagine that their  
18 expenditures are way out of line with the percentage of the  
19 population they account for -- is that what has happened  
20 over the past few decades, people with especially congenital  
21 disabilities are surviving to a much greater age than they  
22 used to. And, unfortunately, the health care system hasn't

1 really kept up with that.

2           For example, for particular disabilities there are  
3 multidisciplinary clinics in children's hospitals, and yet  
4 as that population ages, those clinics are often closed to  
5 them, and they go out to the community, and their care is  
6 much more fragmented.

7           So that's just something I wanted to raise to your  
8 attention, and I would be interested to see what you all  
9 have to say about that.

10           MS. WILBUR: I'm Valerie Wilbur. I'm with the SNP  
11 Alliance. We represent about half of the SNP enrollees in  
12 the country. We have about 31 organizations that provide  
13 services to about 250 plans, so we have a pretty good cross-  
14 section of that population. I wanted to make several  
15 comments.

16           First of all, I wanted to say in moving forward,  
17 instead of looking at just D-SNPs and FIDE-SNPs, I suggest  
18 that you also take into account institutional SNPs and  
19 institutional equivalent SNPs because, at least on the  
20 facility-based side, over 90 percent of their beneficiaries  
21 are dual eligible, so they have real relevance. And those  
22 SNPs have done phenomenally well in terms of producing good

1 outcomes like reducing hospitalization and emergency room  
2 rates.

3 I wanted to second Dr. Berenson's suggestion that  
4 we think about the kind of measures that are being used to  
5 look at SNPs. I wouldn't say that HEDIS, HOS, and CAHPS  
6 measures are all bad for the populations. I think you need  
7 to look at which measures you're considering in relation to  
8 which special needs populations are being targeted by  
9 different SNPs. But I would say that they might not be the  
10 most meaningful in looking at whether SNPs are really doing  
11 anything different than what they should be doing to achieve  
12 effective outcomes for high-risk populations.

13 I can't remember whether Christine mentioned this,  
14 but you probably know that NQF and NCQA are doing a lot of  
15 work on appropriate measurement for the dual populations  
16 right now, and they're very bullish on more population-based  
17 approaches.

18 Also, SNPs have to report on structure and process  
19 and model of care -- excuse me. They have to report on  
20 structure and process, and they have a series of model of  
21 care-related elements that they have to do, and neither of  
22 those two pieces are currently included in plan ratings.

1 That's something that we'd like to see, although they did  
2 just add a new HEDIS measure for care of older adults, which  
3 we're really happy about.

4           The SNP Alliance has said really since the  
5 beginning that we really think we need to focus on outcomes,  
6 things like inpatient hospitalization, readmissions,  
7 emergency room, and long-term placement in nursing homes.  
8 And the SNP Alliance has just gotten results back from our  
9 fourth annual survey of just our members -- not all SNPs but  
10 just our members. And one of the questions raised was, you  
11 know, whether the FIDE-SNPs, for example, and some of the  
12 other SNPs are doing better than others. And what we find  
13 is that for the FIDE-SNPs, their inpatient utilization per  
14 thousand beneficiaries is significantly lower than fee-for-  
15 service duals. So 2,509 days per hundred -- or excuse me,  
16 per thousand versus 3,327 days for the fee-for-service  
17 duals. And each year in the last three years, they've  
18 reduced that number by 10 percent.

19           They also have 72 percent of the FIDE-SNPs didn't  
20 have any hospitalizations in the 2010 data, and the  
21 percentage of people -- the percentage of duals in fee-for-  
22 service had five times as many hospitalizations in one year

1 relative to the FIDE-SNPs. So they're doing quite well  
2 there. They also have much lower ER rates. And the  
3 statistics for the I-SNPs are even more impressive. They  
4 had 1,820 days per thousand compared to 7,497 days per  
5 thousand in fee-for-service, and their emergency rates were  
6 351 per thousand versus 714 visits compared to fee-for-  
7 service. So that's one of the reasons why I really  
8 encourage you to look at what are I-SNPs doing to help keep  
9 those rates down.

10 I haven't seen -- is the red light on?

11 MR. HACKBARTH: Yes.

12 MS. WILBUR: Okay. I'm sorry. I wanted to echo  
13 what the other person said about the disabled. We have  
14 three members in Minnesota that were part of the Minnesota  
15 Disability Health Options Program that had to close because  
16 of the rates, problems with the rates when the frailty  
17 adjuster was taken away.

18 Thank you very much.

19 MR. HACKBARTH: Thank you.

20 MS. SHEEHAN: Hello. Kathleen Sheehan with the  
21 Visiting Nurse Association representing nonprofit home  
22 health and hospice. I just wanted to echo what the

1 Commissioners were talking about today in terms of the  
2 differences between the benefits and how that works for  
3 duals.

4           For example, in the Medicare home health benefit,  
5 you have to be homebound, a skilled service. For Medicaid  
6 that's different. We find that Medicaid directors sometimes  
7 get mixed up on whether or not they can require homebound  
8 status. We've been working with CMS to be sure that  
9 Medicaid directors understand the differences as they do all  
10 these different kinds of things. We have recommended that  
11 HHS consider sending a "Dear Medicaid Director" letter. We  
12 think that would be very helpful.

13           One of the difficulties for patients, of course,  
14 when you come into this if you're a dual, you come out of  
15 the hospital and you're on Medicare. You get the home  
16 health benefit. Then you get off the benefit. You get put  
17 on Medicaid. Then you have some sort of a crisis. You go  
18 back into the hospital. Then you're on Medicaid. So how is  
19 the patient notified? How does that happen for the patient?  
20 I think there's a lot of concern about what sort of notices  
21 the patients get and how that works in terms of the patient  
22 experience?

1           Last, but not least, the billing process has been  
2 a nightmare in Region 1 and 2. CMS did hold a very  
3 interesting listening session. They basically had a  
4 Medicaid director get on, state associations get on, and  
5 they had all of the people within CMS who were involved in  
6 the appeal process largely saying that CMS is spending an  
7 incredible amount of time dealing with appeals, and that has  
8 been I think because we have some Medicaid directors that  
9 have said to providers, "You must submit the bill to  
10 Medicare first, whether or not they meet Medicare standards,  
11 and bring us back a rejected bill before we'll deal with  
12 this."

13           Actually one of our members told us the other day  
14 that they were actually told to send a note to the physician  
15 saying, "You need to declare this patient to be homebound so  
16 we can submit it to" -- this was a Medicaid office telling  
17 this to a provider. "You need to submit it so they can be  
18 homebound."

19           So the billing situation is a nightmare, and I  
20 think that HHS is spending a lot of time trying to deal with  
21 this. So we appreciate any thought and attention that you  
22 all give to how do you blend these two diverse benefits, how

1 does it affect patients, and then how do we straighten out  
2 the billing process so that it doesn't take up a lot of  
3 provider time and a lot of CMS' resources.

4 Thank you.

5 MR. HACKBARTH: Okay. Thank you. We're  
6 adjourned.

7 [Whereupon, at 11:46 p.m., the Commission meeting  
8 was adjourned.]

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