

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, September 6, 2012
9:28 a.m.

COMMISSIONERS PRESENT:
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SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
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WILLIAM J. HALL, MD
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DAVID NERENZ, PhD
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1 P R O C E E D I N G S [9:28 a.m.]

2 MR. HACKBARTH: Okay. It's time to begin.

3 Welcome to our guests in the audience. This is, as you
4 know, our first session of a new MedPAC cycle with new
5 Commissioners.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 Potential structural factors explaining the

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

6 Even if the changes are structural, there is still
7 the potential for a reacceleration of health care spending
8 growth. For example, during the late 1990s, low medical
9 inflation and managed care kept health care spending at very
10 low levels, but then it rapidly reaccelerated in the early
11 2000s. And whether that pattern will be repeated here is
12 still an open question.

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

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

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

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

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

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

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

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

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

1 is projected to grow to about 50 percent in 2040.

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

9 So what is that financial outlook or that budget
10 outlook? By the end of this fiscal year, debt as a share of
11 GDP is projected to be 73 percent -- the highest level since
12 1950 and about twice what it was at the end of 2007, before
13 the financial crisis and recent recession. Medicare,
14 Medicaid, and Social Security are projected to grow
15 significantly over the next quarter century -- totaling 16
16 percent of GDP by 2040. In contrast, the entire federal
17 government over the past 40 years has amounted to around
18 18.5 percent of GDP.

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

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

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

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

1 under the Budget Control Act of 2011.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 In this table, you can see that chronic kidney

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

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

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

16 Second, many experts question the value of health
17 care spending. Researchers believe that while the aggregate
18 increase in health spending has produced value, the marginal
19 value of health spending is decreasing over time.

20 Utilization of improper or improperly applied services also
21 puts beneficiaries at health and financial risk and results
22 in inefficient spending.

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

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

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

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

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

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

11 DR. SAMITT: Thank you.

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

22 MS. BLONJARZ: So it is key that this is not

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

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

6 [Laughter.]

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

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

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

21 MS. BLONJARZ: They are not.

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

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

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

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

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

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

19 [Laughter.]

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

1 excess spending growth, which is relative to GDP growth.

2 And I just wanted to make --

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

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

16 DR. CHERNEW: Real [off microphone].

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

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

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

3 MR. HACKBARTH: Yeah.

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

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

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

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

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

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

10 DR. HALL: Okay. Thank you.

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

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

19 DR. NAYLOR: Okay.

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

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

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

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

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

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

1 recent slowdown could be permanent? How would that look?

2 MS. BLONJARZ: So this chart is based on what the
3 Medicare trustees assume.

4 MR. GEORGE MILLER: Oh.

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

10 MR. GEORGE MILLER: So this is --

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

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

15 MR. GEORGE MILLER: Okay.

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

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

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

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

8 MR. GEORGE MILLER: Okay. Thank you.

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

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

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

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

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

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

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

9 MR. HACKBARTH: Yes. I have another clarifying
10 question. This one pertains to the paper as opposed to the
11 slides. On page 21 in the paper, there's a heading,
12 "Medicaid Dominates Many States' Fiscal Outlooks." In the
13 first sentence there, it says Medicaid accounts for almost
14 24 percent of all State spending. And my question is, is
15 that just the States' share alone, or does that include the
16 Federal match?

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

19 MR. HACKBARTH: Okay. Can we check that?

20 MS. BLONIARZ: Absolutely.

21 MR. HACKBARTH: Thank you. I appreciate that.

22 Okay. Round two comments, beginning with Scott.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 the Medicare system.

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

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

17 [Laughter.]

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

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

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

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

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

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

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

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

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

1 therefore, we've got to increase the value.

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

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

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

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

1 trigger that kind of an action.

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

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

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

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

12 Yet for me, at least, 25 years is way out there in
13 the distance and tends to have that effect that Scott
14 alludes to, that, well, a lot of stuff is going to happen in
15 25 years. We'll probably have all new elected officials by
16 that time and let's not worry too much about this. We have
17 good news in the short term. The rate of increase is
18 slowing.

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

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

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

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

22 Okay. Thank you very much, Kate and Kahlie.

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

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

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

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

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

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

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

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

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

1 professionals pay for that type of insurance.

2 The GPCIs scale payments up or down depending on
3 whether an area's input prices are higher or lower than the
4 national average. So, in this example, the work GPCI of
5 1.04 scales the relative value unit for work of 0.97 up to
6 an adjusted relative value unit of 1.00.

7 Note also that in the example the work GPCI
8 adjusts just under half of the payment for the service. So,
9 0.97 represents 47 percent of that total unadjusted RVU for
10 this service.

11 And, that's characteristic of the fee schedule
12 overall -- that work payments represent, on average, about
13 48 percent of fee schedule payments.

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

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

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

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

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

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

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

1 the floor, the GPCI for Puerto Rico would be lowest, at
2 0.908. The locality with the next lowest work GPCI is
3 Montana, at 0.945. At the other end of the scale, Alaska
4 has a work GPCI of 1.50, a value specified in the statute
5 and not shown on the slide. Otherwise, Santa Clara,
6 California has the highest work GPCI, at 1.077.

7 Given the value of the work GPCI in each locality
8 and the locality's volume of services measured in RVUs, we
9 can estimate the effect that the GPCI has on spending for
10 fee schedule services. A GPCI generally has effects on
11 locality spending that are in a range from -2.9 percent to
12 3.8 percent. The exceptions are Puerto Rico and Alaska.
13 Puerto Rico's work GPCI impact is -5.4 percent. For Alaska,
14 not shown on the chart, the legislated work GPCI increases
15 the state's fee schedule spending by 25.6 percent.

16 The work GPCI has a temporary floor. It was
17 established initially with the Medicare Modernization Act of
18 2003 and continued with a series of temporary extensions
19 since then. The floor suspends the GPCI in localities with
20 costs below the national average. In other words, if a
21 locality's GPCI would be less than 1.00 without the floor --
22 say, it's 0.95 -- with the floor, the locality's GPCI

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

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

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

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

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

1 hospital wage index.

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

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

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

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

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

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

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

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

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

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

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

1 offset the cost of living.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 At the October meeting, we will present our

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

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

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

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

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

1 index.

2 So, that concludes the presentation for today.

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

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

11 MR. HACKBARTH: Okay. Thank you, Kevin.

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

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

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

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

1 in opposite directions.

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

8 DR. DEAN: Right.

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

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

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

1 on that?

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

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

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

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

1 there would be access problems?

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

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

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

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

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

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

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

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

7 MR. GRADISON: Okay.

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

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

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

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

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

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

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

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

6 DR. HAYES: Certainly.

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

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

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

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

18 MR. HACKBARTH: Exactly.

19 MR. GRADISON: Thank you.

20 MR. GEORGE MILLER: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 MR. GEORGE MILLER: Right, okay.

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

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

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

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

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

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

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

8 Then the report this year was partly, you know,
9 some simulation analysis of what would happen if you go to
10 the 441 localities, and I had a little summary of that in
11 the paper about how well, you know, the -- it would be plus
12 5 to minus 5 percent change in payments, depending on -- for
13 96 percent of -- the areas where 96 percent of the RVUs are
14 generated. So that was one thing that they did.

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

1 So, for example, we have, as you know, currently a
2 10 percent bonus is paid for fee schedule services billed
3 from a health professional shortage area. And so their
4 recommendation in that regard was that, you know,
5 concentrate on those types of policies.

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

21 There may be others, but that's --

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

1 helpful.

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

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

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

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

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

13 DR. HALL: Yeah, slides, sorry.

14 DR. HAYES: 7 and 8.

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

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

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

1 percent range.

2 DR. HAYES: No, no.

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

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

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

22 DR. HAYES: Yes.

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

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

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

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

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

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

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

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

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

9 DR. MARK MILLER: State medical societies decided.

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

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

13 DR. HAYES: Absolutely.

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

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

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

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

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

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

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

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

12 DR. NERENZ: Fine.

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

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

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

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

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

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

19 That's a question.

20 [Laughter.]

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

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

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

22 DR. BAICKER: [off microphone].

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

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

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

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

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

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

21 [Laughter.]

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

1 --

2 [Laughter.]

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

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

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

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

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

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

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

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

9 MR. BUTLER: Million, "M"?

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

11 MR. HACKBARTH: Per year.

12 DR. HAYES: Per year.

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

15 MR. BUTLER: Okay.

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

19 MR. BUTLER: I know you don't.

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

21 [Laughter.]

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

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

5 MR. BUTLER: Okay.

6 DR. MARK MILLER: You personally write a check.

7 [Laughter.]

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

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

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

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

18 DR. COOMBS: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

14 Last year, when we spent a lot of time talking
15 about the issue of provider based, a lot of presentations on
16 the CPT code 99213, you know, the general office code. And
17 if I remember right from those conversations, it was \$60,
18 \$70, or somewhere in that range about what that code paid.
19 So if we didn't have a work GPCI, how much would that impact
20 that code? \$5? \$2.50? What's kind of the sense of the
21 space we'd have on something like that?

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

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

9 MR. KUHN: Thank you.

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

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

18 Scott, clarifying questions?

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

21 [Laughter.]

22 MR. ARMSTRONG: -- with all due respect to

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

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

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

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

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

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

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

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

1 DR. MARK MILLER: Can I just ask you this about
2 that, Bill? Would you still make a cost-of-living
3 adjustment? Or it's just the amenities piece that kind of -
4 -

5 MR. GRADISON: Yes. Yes, precisely.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 DR. HAYES: This is the locality boundaries.

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

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

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

9 DR. HALL: That's what I thought.

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

14 DR. HALL: Okay.

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

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

1 outreach programs that would justify it.

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

12 DR. HALL: Okay.

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

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

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

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

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

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

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

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

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

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

20 DR. BAICKER: And the answer --

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

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

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

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

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

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

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

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

6 MR. HACKBARTH: Right.

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

11 MR. HACKBARTH: Right.

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

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

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

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

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

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

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

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

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

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

1 deleterious consequences if we don't make a recommendation.

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

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

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

9 DR. MARK MILLER: Correct.

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

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

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

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

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

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

4 MR. HACKBARTH: Yeah.

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

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

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

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

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

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

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

5 Craig.

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

12 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So I think you simplify the basic fee schedule.

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

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

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

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

1 either --

2 MR. KUHN: That's correct.

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

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

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

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

3 [Laughter.]

4 MR. HACKBARTH: There may be in time.

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

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

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

1 people up.

2 MR. KUHN: Right.

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

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

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

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

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

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

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

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

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

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

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

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

21 Tom, and then we'll move on.

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

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

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

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

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

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

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

10 DR. CHERNEW: Right.

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

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

18 And now we'll have our public comment period.

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

22 Seeing none, we will adjourn for lunch, and

1 reconvene at 1:15.

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

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

7 While the formal due date for this report is June
8 15 of next year, the temporary add-on payment policies will
9 expire under current law at the end of this year, which
10 means that the Congress will want to have the Commission's
11 advice as it makes a decision about whether to end, extend,
12 or amend these policies by the end of 2012.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 In addition, these policies are either temporary
2 or permanent and they are additive of one another where it
3 is applicable. The temporary add-ons, highlighted in
4 yellow, expire at the end of 2012, and the permanent add-ons
5 were implemented along with the ambulance fee schedule in
6 2002.

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

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

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

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

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

1 codes that were reclassified from rural to urban back in
2 2006.

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

11 In 2011, over 11,000 entities billed Medicare for
12 ambulance services. Overall, the number of these entities
13 increased by about 0.8 percent per year from 2008 to 2011.
14 Six percent of these entities were institution-based
15 providers, such as hospitals and skilled nursing facilities,
16 and the number of these providers decreased approximately
17 4.6 percent per year during this period. Ninety-four
18 percent of the ambulance entities billing Medicare were non-
19 institution-based suppliers, such as local fire departments,
20 public EMS agencies, or private for-profit and nonprofit
21 companies. The number of suppliers increased 1.3 percent
22 per year during this period.

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

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

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

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

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

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

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

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

1 ambulance user over the time period.

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

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

16 Now, further analysis into the BLS non-emergency
17 growth revealed two key additional facts. First, in 2011,
18 16 percent of suppliers and providers, or approximately
19 1,000 entities, devoted 90 to 100 percent of all their
20 transports to BLS non-emergency. This group of suppliers
21 and providers accounted for 27 percent of all BLS non-
22 emergency transports. And we also found that the

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

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

10 Ambulance transports to and from dialysis
11 facilities accounted for 15 percent of all transports in
12 2011 and 13 percent of all Medicare ambulance spending, or
13 \$700 million. Ninety-seven percent of these dialysis
14 transports were BLS non-emergency. In addition, from 2007
15 to 2011, the volume of claims going to and from a dialysis
16 facility increased 20 percent overall, more than twice the
17 rate of all other claims combined.

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

22 Just as with BLS non-emergency overall, a small

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

4 In 2009, using data from the United States Renal
5 Data Systems, we found dramatic variation in State-level
6 ambulance spending per dialysis beneficiary, that is,
7 spending on all ambulance services, not just transports to
8 and from dialysis facilities. For example, per dialysis
9 beneficiary spending on ambulance services was approximately
10 \$9,500, on average, in West Virginia, and approximately \$500
11 in North Dakota. The median State was Louisiana, with
12 \$1,900 in ambulance spending per beneficiary. Overall,
13 spending per beneficiary was significantly higher than
14 average in six States, marked in red above. States above
15 the median level of spending are labeled in orange. And
16 States at or below the median are labeled in green. But I
17 would like to note a more dramatic outlier here was Puerto
18 Rico, with spending of over \$25,000 per beneficiary in 2009.

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

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

10 And now, John will discuss our analysis of costs.

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

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

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

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

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

22 Now turning to fraud and abuse involving the

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

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

1 it up for your discussion.

2 MR. GLASS: Thank you, John.

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

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

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

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

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

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

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

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

20 Second, combine it with the permanent rural short
21 mileage add-on policy, which increases the mileage rate by
22 50 percent for all rural zip codes, and replace both add-ons

1 with a well-targeted low-volume isolated payment policy.

2 This could have some cost or be designed to be budget

3 neutral.

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

12 The temporary air ambulance add-on policy cost \$17
13 million and raised payments for only 8,000 air transports in
14 2011. It provides a 50 percent add-on to urban areas that
15 used to be designated as rural areas. It was justified as a
16 transitional policy following OMB's redesignation of rural
17 and urban counties. It has been in place for four years,
18 arguably long enough for providers to adjust to the new
19 designations.

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

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

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

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

3 Perhaps the first order question is should
4 Medicare pay for non-emergency transportation to or from
5 dialysis as part of the ambulance fee schedule at all.
6 Maybe it is a rare event and it should be covered in some
7 other way. However, as a first estimate, if spending per
8 dialysis beneficiaries could be brought to the level of
9 spending in the median State, the program could save about
10 \$460 million a year.

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

22 We invite your questions on any of the content of

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

4 MR. HACKBARTH: Okay. Thank you very much.

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

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

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

17 MR. HACKBARTH: Okay. Alice.

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

1 correlation with the availability of alternative or
2 substitute transportation?

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

5 DR. COOMBS: Yes.

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

10 DR. COOMBS: Right.

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

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

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

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

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

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

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

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

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

1 for the dialysis-specific ones.

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

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

8 MR. HACKBARTH: When is it due?

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

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

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

1 MR. HACKBARTH: Producing margin information in
2 particular?

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

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

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

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

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

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

5 Herb, clarifying questions?

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

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

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

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

9 MR. KUHN: Right.

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

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

19 MR. KUHN: Right, okay.

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

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

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

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

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

22 MR. KUHN: Right.

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

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

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

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

20 MR. RICHARDSON: That's right.

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

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

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

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

7 [Laughter.]

8 MR. GAUMER: Yes, that's right.

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

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

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

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

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

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

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

15 MR. RICHARDSON: Right, that --

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

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

20 MR. HACKBARTH: Okay.

21 MR. GLASS: And the bedridden or --

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

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

4 MR. HACKBARTH: Scott, clarifying question?

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

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

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

1 into that.

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

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

15 MR. ARMSTRONG: Okay. So for some --

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

18 MR. ARMSTRONG: Okay. Well --

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

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

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

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

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

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

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

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

11 MR. GAUMER: Yeah, I think, in fact, it grew about
12 14 percent.

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

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

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

8 DR. DEAN: Okay.

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

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

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

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

20 DR. DEAN: Yeah.

21 MR. GLASS: Right.

22 MR. GRADISON: I want to make sure I understand

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 MR. RICHARDSON: Right, that --

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

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

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

14 MR. RICHARDSON: There was up-coding.

15 MR. GLASS: There was up-coding.

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

20 MR. HACKBARTH: Okay.

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

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

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

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

16 MR. GAUMER: Correct.

17 DR. DEAN: [off microphone].

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

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

22 MR. GAUMER: That's right, yes.

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

4 MR. GAUMER: Yes.

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

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

22 MR. GEORGE MILLER: Or Stockton, Texas.

1 MR. GAUMER: Or Stockton, Texas.

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

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

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

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

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

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

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

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

13 DR. MARK MILLER: Is that --

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

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

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

4 MR. GAUMER: No, we don't.

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

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

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

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

9 DR. HALL: No.

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

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

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

16 DR. NAYLOR: Okay.

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

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

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

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

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

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

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

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

20 MR. HACKBARTH: Rita?

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

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

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

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

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

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

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

1 DR. REDBERG: For these non --

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

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

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

7 DR. REDBERG: 48 hours after the transport?

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

10 DR. REDBERG: And who certifies that that occurs
11 48 hours after?

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

15 DR. REDBERG: They certify it to the carrier?

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

18 MR. GLASS: The physician certification.

19 MR. GAUMER: The physician certification.

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

22 DR. REDBERG: Correct.

1 MR. RICHARDSON: That's a good question.

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

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

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

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

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

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

11 MR. RICHARDSON: No.

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

16 MR. GAUMER: That's correct.

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

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

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

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

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

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

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

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

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

11 MR. GLASS: Right.

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

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

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

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

19 DR. CHERNEW: I understand.

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

22 DR. CHERNEW: I understand. Just when we say

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

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

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

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

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

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

7 DR. NERENZ: Oh, sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 outside for ESRD patients where we might learn something.

2 But that probably -- what you just is true.

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

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

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

1 those, too.

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

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

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

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

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

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

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

1 namely, targeting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 think, is also an important component of this.

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

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

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

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

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

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

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

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

4 MR. GLASS: If people are getting transported
5 three times a week, round trip, that should be easy to pick
6 up pretty quickly.

7 DR. MARK MILLER: And we have gone over and talked
8 to the CMS program integrity folks. As you would predict
9 and as you would understand, they didn't want to tell us
10 what they were focused on. We did talk to them about OT and
11 ambulance, which OT we'll talk about tomorrow. But we can
12 still look into what exactly is going on here and how it
13 might help.

14 In the end, though, it will still be a pay-and-
15 chase proposition. Even though it may be faster pay-and-
16 chase, it's still that. The Secretary -- I want to say this
17 because several of you brought it up. The Secretary does
18 have a lot of new authorities to do things, you know, to say
19 there's no more providers needed in this area anymore, I
20 have plenty of utilization, I don't need any more to get
21 providers to re-up, you know, to sort of try and cull
22 through what might be fraudulent providers. The big problem

1 always is resources, and if the clarity on what basis you're
2 going after someone is not -- if the standards and
3 guidelines are not clear, it also gets hard to make the
4 cases.

5 And so, you know, it's always difficult to -- and
6 we should say this -- redirect and even say that the -- you
7 might want to say that the Congress should put resources
8 into it if they want to get control of this problem, but
9 there's even deficits there once you go that direction.

10 MR. KUHN: You know, part of the issue, too, is
11 they look at this that obviously they have now, what, 15
12 MACs, I think, you know, from the old days when they had 40
13 or 50 carriers and intermediaries. But certain ones have
14 edits, certain ones don't, and so there's no consistency
15 across the edits out there, so that, too, could be part of
16 the recommendation process, too.

17 MR. ARMSTRONG: I won't repeat but I just would
18 concur with the kind of direction that you've been hearing
19 from these guys about both the principles for evaluating the
20 policy options and then the approach that we would take to
21 looking at these.

22 Just one other point would be that there's post-

1 acute bundling, there's dialysis bundling, and, you know,
2 after awhile, chunks of these costs may end up getting
3 folded into some of these bundling ideas, and it just might
4 be interesting to kind of pay attention to where are the --
5 how much of this overall cost for ambulance services could
6 be candidates for getting folded into some other payment
7 structures.

8 DR. DEAN: I would just echo what Craig said. You
9 know, it occurred to me too that if we're bundling dialysis
10 services and the effectiveness of the service is clearly
11 going to be affected by whether the patient is there or not,
12 it fits well. They're the ones that both would have the
13 incentive to do it in an economical way and the incentive to
14 see that it happens, and it seems to me that it would just
15 fit.

16 Secondly, I guess the whole issue of physician
17 certification, this is the thing that drives especially
18 primary care docs just nuts, and I would say that we -- it's
19 probably the bane of our existence because we're asked to
20 certify things that very often we don't have any of the
21 information about and do they need this particular piece of
22 durable medical equipment or, you know, are they truly

1 homebound or stuff like that. It's kind of been an
2 automatic knee-jerk response that if we have to have some
3 kind of verification, we'll get the doc to certify it. And
4 I would argue that, first of all, it's a very ineffective
5 mechanism, and also it's a thing that is very
6 disillusioning, as one of the things that I think you will
7 hear negative responses almost uniformly from primary care
8 docs, and it has gotten much worse over the last five to ten
9 years.

10 So I would say that's a very undesirable
11 mechanism, plus it's ineffective and it disillusion people.

12 MR. GLASS: That's what we were wondering what
13 about if the nephrologist, or whoever was overseeing the
14 ESRD, because there's supposed to be a physician for any
15 ESRD patient who's overseeing --

16 DR. DEAN: Perhaps, but they're not going to be in
17 any better position -- I mean, first of all, what are we
18 certifying? Are we certifying that they need the service or
19 that they need -- I mean, that they need the dialysis or are
20 we certifying that they need the ambulance?

21 MR. GLASS: That they cannot get there -- that
22 they can't sit up in a wheelchair.

1 DR. DEAN: And --

2 MR. GLASS: Which I think they would know.

3 DR. DEAN: How would the nephrologist know that?

4 I mean, I --

5 MR. GLASS: Well, they're supposed to be seeing
6 the patient every 30 days.

7 DR. DEAN: Yeah, well --

8 DR. REDBERG: Tom, who would you suggest should do
9 that?

10 DR. DEAN: I'm sorry. What?

11 DR. REDBERG: Who would you suggest should be the
12 person to certify that?

13 DR. DEAN: Well, it needs to be somebody that has
14 access to the information and to know -- I mean, I would say
15 it needs to be social service, it needs to be somebody that
16 actually knows what the living conditions of that person
17 actually are.

18 MR. HACKBARTH: Tom, go back to David's point,
19 though. Dialysis is in some ways, I won't say unique but
20 different in that as part of getting the payment, there is a
21 specific requirement that the physician see the patient at
22 certain intervals, and, for example, the ability to sit up

1 in a chair is something that could be readily observed
2 during those required visits, those required face-to-face
3 contacts. And I say that understanding and agreeing with
4 your basic point that, you know, a primary care physician
5 who may not have a relationship where they're regularly
6 interacting being asked to certify things beyond his or her
7 personal knowledge is a problem. It's a waste of resources
8 and the like. But this may be different because of the
9 nature of the interaction.

10 DR. CHERNEW: But if you get the incentives right,
11 no one may have to certify.

12 DR. DEAN: Yeah, I --

13 DR. CHERNEW: You might be able to get around any
14 certification.

15 DR. DEAN: I think that makes the most sense. I
16 mean, let's get the incentives right about what does it take
17 to get the person there rather than, you know -- because I
18 think, you know, even the nephrologists, who are probably
19 seeing, you know, a large number of patients -- I don't
20 know. I'm not so sure that they would have as much
21 familiarity as we're assuming. But I could be wrong.

22 DR. REDBERG: I agree to get the incentives right,

1 but it seems like someone has made a decision that the
2 person needs an ambulance; otherwise, why are we calling an
3 ambulance? So there should be a certification.

4 MR. GRADISON: I just want to say a little bit in
5 addition to the excellent comment by some of the others
6 about dialysis. It would seem to me that what we ought to
7 do is to address the specific questions that have been
8 addressed to us by the Congress, and with regard to
9 dialysis, indicate there are issues, maybe even outline some
10 of the things that we think ought to be looked into, but I
11 truly believe there is gold in them thar hills and that
12 we're not going to be in a position to identify a plan of
13 action in a timely manner on dialysis.

14 With regard to bundling, there are some
15 complications in that. I'm not speaking against it, but
16 I've sensed that in some respects the discussion suggests,
17 well, that may be the answer, and maybe it is. But one of
18 them is that the nephrologists are often the medical
19 directors of the dialysis centers and may have a financial
20 interest in the P&L of the center. I don't think that's
21 uncommon at all. And their role is certifying and also --
22 there could be some conflicts of interest that at least need

1 to be thought through. Let me say it as nicely as possible.

2 Another thing is that if this is bundled, you get
3 some situations where people -- nobody's reimbursing them,
4 their spouse drives them or a neighbor drives them or
5 somebody from their church drives them back and forth three
6 days a week. That's not uncommon. But once the center is
7 in the act, they may have a financial interest in having
8 something set up for which money passes and which they get
9 to keep a piece of it. I just want to point out that
10 another thing about dialysis centers in urban areas, the
11 reason they're as small as they are -- 30 chairs is fairly
12 typical -- is the geography. They don't want people to have
13 to travel too far three times a week. I think that's the
14 fundamental reason for that geographical dispersion in large
15 urban areas. This may have a bearing on it, too, in terms
16 of the length of the trips.

17 In any event, I think you've done an outstanding
18 job, and I just think we ought to separate the more
19 immediate issue, as important as it is, and respond to it,
20 but also think about other things for another day.

21 MR. GEORGE MILLER: Yes, I would just like to add
22 to the argument for bundled payments, particularly on the

1 end-stage renal dialysis from the standpoint -- and I think
2 the legislation could be -- excuse me, the rules and
3 regulations could be structured so that it's just a payment
4 that is paid to the facility and not a co-pay, to Bill's
5 point.

6 I am troubled in the chapter by the increase in
7 the utilization, both there, the entry of for-profit
8 entities in that arena, and the increase in utilization that
9 there's a reason for that, and I think Cori may have alluded
10 to part of those reasons, and we need to get a handle on it
11 or raise that as an important issue.

12 As it deals with these issues, as long as we
13 identify and understand the rural issues where there may be
14 a single provider and appropriately compensate for the low
15 utilization, then I'm in favor of eliminating all the
16 temporary add-ons and then rebalancing the RVUs
17 appropriately.

18 DR. NAYLOR: Again, kudos for a fantastic piece.
19 I totally support the principles that you've outlined. The
20 recommendations related to add-ons, I am very much leaning
21 toward eliminating the add-ons and targeting the resources
22 to better address issues of access.

1 On the issue of dialysis, I would reinforce the
2 early recommendation that this is really worthy of study.
3 Looking at the variation by state by dialysis beneficiaries
4 for all services really suggests an opportunity not just to
5 look at ambulance but use of all services, and this I think
6 could be a great case to, on the one hand, make sure that
7 people who really need these services and are frail and meet
8 all the criteria have access to the highest-value services,
9 and maybe in some cases to make sure people who don't have
10 access get it, but certainly to understand how people --
11 we're seeing this variation in ambulance use, but it is
12 emblematic of use of many, many services and it represents a
13 great opportunity for study. So encouraging the Secretary
14 to study this based on the data that you've uncovered I
15 think is a great opportunity.

16 DR. HALL: I'm still on Figure 4, I guess, which
17 we've all talked about. A simple analysis, maybe simple for
18 me to say, maybe not so easy, would be to just take a couple
19 of the contiguous states, like New Jersey-New York, New
20 Jersey-Pennsylvania, North Carolina versus South Carolina, a
21 250-percent increase in charges and just take a look at it
22 and look at the frequency of dialysis in those two

1 comparable states that share the same geographic region,
2 same climate, and presumably the same kinds of people. And
3 if you see that this is related to increased frequency of
4 dialysis, that opens up a whole different scenario in terms
5 of who's ordering all this dialysis and what is the clinical
6 justification and outcomes.

7 DR. REDBERG: And also, maybe you've already done
8 it, but what's going on in Puerto Rico? It's so off the
9 charts.

10 DR. NAYLOR: [off microphone] Miami.

11 MR. GLASS: It seems to have dropped off in 2011,
12 so we think there may have been some enforcement activity.

13 DR. REDBERG: I see.

14 MR. GAUMER: In '11 it came down to about \$9,000
15 which is --

16 DR. REDBERG: Still at the upper end.

17 MR. GAUMER: -- still in the red, but -- yeah.

18 DR. REDBERG: And then, you know, I think the idea
19 of considering bundling for the ambulance for dialysis makes
20 a lot of sense, and eliminating the temporary add-ons.
21 That's all.

22 DR. BAICKER: Just agreeing with Mary that I think

1 the bundling with dialysis makes a lot of sense, but I'm
2 also interested in how much this is indicative of a broader
3 phenomenon of just higher intensity use across the board in
4 ambulance use and then across the board in other services in
5 some areas versus others where we'll focus on dialysis
6 because the example is so salient, but is this an ambulance-
7 specific problem or is this just an extra resources being
8 used in home health and all sorts of other things in the
9 same time?

10 DR. CHERNEW: I want to return to my theme before
11 about status quo confusion. The status quo now is that
12 current law gets rid of the add-ons. So I think the
13 question on the table is: Do we have compelling evidence to
14 put them back? And from what I hear around the table and
15 from sort of my program evaluation kind of view, would it be
16 bad if we didn't or good if we did or something like that, I
17 don't see the compelling evidence why we would put them
18 back. But the question on the table is should we eliminate
19 them. That's the status quo. The question is should we put
20 them back, and I don't see a particular compelling evidence.
21 So I think that's the first order of business.

22 The second order of business is whether or not we

1 should do something else, like bundle or do other empirical
2 investigations. That might work on a slightly different
3 time frame. I'm not sure. But I tend to think that, yes,
4 even if you were to revert back to the status quo, I do
5 think we might be able to both learn more and think of other
6 ways to deal with this issue in the context of broadly
7 moving the system forward. So I would be supportive of
8 doing that activity as well.

9 MR. HACKBARTH: Okay. Thank you very much, and
10 we'll look forward to our next discussion next month.

11 So our next item is approaches to bundling for
12 post-acute care services.

13 MR. CHRISTMAN: Good afternoon. Today Carol and I
14 will discuss bundling of post-acute care. This resumes
15 discussion of a topic we explored last spring.

16 The Commission is interested in bundling of post-
17 acute care because it has a potential to address many of the
18 current problems caused by having separate fee-for-service
19 payments for each provider in an episode of care.

20 First, bundling payments for PAC services could
21 create greater incentives for the coordination of care
22 longitudinally across an episode, which could be

1 particularly important for PAC patients as they make a
2 number of care transitions among different sites of care.

3 Secondly, bundling payments could provide an
4 incentive for the efficient use of PAC. Currently no entity
5 is responsible for ensuring that beneficiaries are referred
6 to PAC only when necessary or that beneficiaries are
7 referred to the site of care that is appropriate and least
8 costly.

9 Third, PAC spending varies widely among regions,
10 suggesting overuse or inefficient use. A bundled payment
11 could be set that would narrow the differences between high-
12 spending areas and the rest of the country.

13 Fourth we are also examining methods for the risk
14 adjustment of payment bundles that include PAC.

15 And, finally, PAC spending is also important
16 because of the size of the opportunity. Medicare paid over
17 \$50 billion to SNFs, IRFs, LTCHs, and home health for post-
18 acute care in 2012.

19 Bundling is a promising strategy because it is
20 complementary with other payment reforms underway. Bundling
21 could permit Medicare to address the separate PAC silos
22 without the complications of designing reforms that include

1 other Medicare services. The Commission has long been
2 concerned about the different PAC silos, and bundling would
3 be a way to create a more uniform approach to paying for
4 PAC.

5 Bundled payments could be a stepping stone to more
6 comprehensive models of care, letting providers gain
7 experience before they proceed to more sweeping models like
8 accountable care organizations. Successful ACOs will likely
9 have to establish bundle-line models of care to achieve the
10 desired efficiencies, and prior experience with bundling
11 could help smooth the transition from fee-for-service to an
12 ACO.

13 Another reason for MedPAC to examine bundling is
14 that it may be some time before other work in this area
15 leads to sweeping policy changes. Currently CMS is
16 exploring bundling in the bundled payment for care
17 improvement initiative, or the BPCI. However, it may be
18 difficult to draw conclusions for broader bundling policies
19 from this initiative because providers have been given
20 considerable latitude in designing the bundles. So the
21 results may not be unique to each provider organization and
22 not necessarily applicable to the broader program. Also,

1 this demonstration is voluntary, so only a limited number of
2 providers will be participating. By examining patterns in
3 PAC and acute-care use, the Commission may be able to
4 identify a national approach for implementing bundling on a
5 faster track than current efforts.

6 There are a number of ways to configure bundles.
7 Today we are asking for your input on three specific issues:

8 First, how should a PAC bundle be structured?

9 Second, should the bundle include readmissions?

10 And, third, what length of time should the PAC
11 portion of the bundle cover?

12 There are other design issues for PAC bundling.
13 We plan to return in the future to address at least one
14 other question, how to set the payments for the bundle.
15 Commissioners will also have to consider how to structure
16 the payment. More flexible approaches might be appropriate
17 for entities that are not ready for a highly integrated
18 model of care. For example, under a virtual bundling
19 approach, providers would continue to be paid under fee-for-
20 service up to a target amount. Given the numerous bundling
21 approaches possible, we wanted to get Commissioner input on
22 the three areas indicated on the slide before considering

1 different approaches to payment.

2 To provide some context for our discussions, we
3 worked with a contractor to construct a set of illustrative
4 bundles using Medicare data from 2008. 3M developed risk
5 adjustment models that used MS-DRGS and clinical risk
6 groups, or CRGs, to predict resource use under the different
7 bundling approaches. Resource use was measured using
8 Medicare payments for the services in a given bundle. Carol
9 will now take you through the three questions I mentioned
10 previously in more detail.

11 DR. CARTER: The first design decision is whether
12 the bundle should include both the hospital stay and PAC
13 services or be a PAC-only bundle. This slide illustrates
14 the two options: One would establish a payment to span all
15 PAC services within a specific time frame, and those are the
16 PAC services in red. Another would add to these to the
17 inpatient stay, which is in blue, for a combined bundle
18 that's in purple down below. For this work, we included
19 physician services furnished while the beneficiary received
20 post-acute care and during the inpatient stay.
21 Readmissions, which are in green, could be included in
22 either design, and we'll talk about those in a minute.

1 This slide compares the broad features of the two
2 options. The combined hospital-PAC bundles would create
3 greater incentives for care coordination. By including more
4 services in the bundle, this design would bring providers
5 one step closer to the broader payment reforms. However, a
6 combined bundle might influence whether providers refer
7 patients on to PAC as a way to lower their costs.

8 PAC-only bundles may not achieve the same level of
9 care coordination between the hospital and PAC because there
10 are fewer incentives to do so. In this bundle, the decision
11 to refer patients to PAC would be separate from payments,
12 just like in the current FFS, so that patients who require
13 PAC are more likely to receive them.

14 Under either design, providers would have an
15 incentive to furnish fewer PAC services as a way to lower
16 their costs. Because current patterns reflect payment
17 incentives and do not necessarily reflect care needs, some
18 reductions in service may not erode quality of care.
19 Putting providers at risk for quality measures would counter
20 incentives to lower reductions that harm patient care, and
21 these could be measures such as the use of the ER,
22 potentially preventable readmissions, and changes in

1 functional status.

2 A consideration in evaluating the designs is
3 whether one design does a better job of explaining spending
4 differences across episodes. Across all conditions, we
5 could explain 72 percent of the variation in spending for
6 the combined hospital-PAC bundles, including readmissions.
7 And for PAC-only bundles, we could explain 26 percent of the
8 variation in spending.

9 One thing these results underline is just how hard
10 it is to predict PAC spending. There are large differences
11 in who uses PAC, which setting gets used, and how much
12 service is furnished. MedPAC's previous work on the
13 variation in Medicare service use found that post-acute was
14 the most variable of all services. In addition, risk
15 adjustment methods have traditionally not focused on trying
16 to explain differences in PAC spending. We have work
17 underway to examine whether including functional status into
18 the risk adjustment will improve our ability to explain
19 differences across episodes that include post-acute care.

20 Selection of the services to include in the bundle
21 could hinge on factors other than explanatory power. The
22 combined inpatient hospital-PAC would require entities to

1 assume more financial risk than PAC-only bundles, which
2 might disadvantage small entities. An outlier policy would
3 help defray the impact of exceptionally high-cost bundles.
4 Yet combined bundles would encourage greater care
5 coordination and thus represent a larger step towards
6 broader payment reforms.

7 The second design decision is whether readmissions
8 are to be included or excluded from the bundle. Including
9 readmissions in the bundle would give providers a strong
10 incentive to coordinate care across all settings. However,
11 they are complex to design and to administer. For example,
12 we would need rules about attribution and financial
13 accountability for readmissions. If Medicare made a single
14 payment for a bundle, providers might have to pay other
15 providers for the readmission. Paying providers fee-for-
16 service up to a target amount, as proposed by CMS in its
17 bundling initiative, would sidestep some of these
18 complexities.

19 Alternatively, readmissions could be excluded from
20 the bundle. Hospitals would be paid for readmissions, and
21 the hospital readmission policy could be extended to PAC
22 providers. This past year, the Commission recommended that

1 SNFs be held accountable for readmissions that occur during
2 SNF stays. In either option, we will need to specify which
3 readmissions to consider. An all-cause measure holds
4 providers accountable for readmissions for any reason,
5 whereas a targeted measure, such as potentially preventable
6 readmissions, focuses on readmissions that could have been
7 avoided. In these slides, we're reporting potentially
8 preventable readmissions.

9 Readmissions are both infrequent and costly, and
10 that makes them hard to predict. Bundles that exclude them
11 are better able to predict episode spending than bundles
12 that include them. For example, our ability to predict
13 spending for the combined inpatient PAC bundle for 30 days
14 increases from 67 percent to 72 percent once readmissions
15 are excluded from the bundle and from 22 percent to 26
16 percent with the PAC-only bundles.

17 The third design decision is the length of the
18 bundle. The length establishes the number of days during
19 which service utilization would be included, such as 30 or
20 90 days after discharge from the hospital. And there are
21 advantages and disadvantages to each.

22 For short bundles, such as 30 days, these are more

1 likely to include services that are related to the initial
2 hospital stay. Short time frames may be fairer than long
3 bundles across providers of all sizes because small entities
4 may not be able to manage (or finance) the risk associated
5 with care furnished over longer periods of time. However, a
6 sizable share of PAC is furnished over more than 30 days.
7 For example, one-third of SNF stays are more than 30 days
8 long. On the other hand, short bundles may result in higher
9 overall utilization because providers would be paid
10 separately for services that are furnished after the bundle
11 is over. This may ensure access to services, but it could
12 also result in the provision of unnecessary services. And,
13 finally, short bundles will result in less care being
14 coordinated.

15 Here we're comparing the features of long bundles.
16 These are more likely to include almost all of post-acute
17 care, but they are also likely to include services that are
18 unrelated to the original hospital stay. Some providers may
19 resist being at risk for services that are either unrelated
20 to the care they furnished or the condition that they
21 originally treated. While long bundles would give providers
22 flexibility to consider the mix and timing of services they

1 furnish, they would put providers at greater risk because
2 costs and readmissions are more variable over longer periods
3 of time. Furthermore, providers may underfurnish care
4 because their risk is extended over a longer time period.
5 However, long bundles would be a natural stepping stone for
6 broader payment reforms.

7 One way to consider whether bundles should be
8 short or long is to look at whether short bundles capture a
9 large portion of the spending and readmissions that occur in
10 the longer bundles, and we found that the majority of
11 spending and readmissions included in 90-day bundles
12 occurred within the first 30 days and were, therefore,
13 captured by them.

14 Another factor to consider is whether our ability
15 to predict spending for the two bundle lengths is
16 comparable. Across all conditions, our ability to explain
17 variation in spending across stays is lower for 90-day
18 bundles than it is for 30-day bundles. We were able to
19 predict 72 percent of variation across 30-day combined
20 bundles compared to 58 percent of the variation across 90-
21 day bundles. And we see similar differences for PAC-only
22 bundles for short and long bundles. Here we show the

1 bundles without readmissions, but the patterns were
2 identical for bundles that included them.

3 Our results illustrate the tension between greater
4 payment accuracy and stronger incentives for care
5 coordination. Shorter bundles are more likely to result in
6 more accurate payments, but longer bundles will create more
7 incentives to coordinate care over a greater span of
8 services.

9 In terms of next steps, we'd like to narrow down
10 the bundle options that we continue to explore, selecting a
11 bundle type and length, and how we handle readmissions. We
12 will also continue to work with the contractor on a risk
13 adjustment method. At a later session, we plan to present
14 alternative ways to establish payments for the bundle. For
15 example, we will consider options based on the variation in
16 current PAC use. We will also look at private plan
17 experience and the practice patterns of efficient providers.
18 These analyses will not yield a "right" price but rather
19 will provide us with useful comparisons and benchmarks to
20 inform our discussions.

21 Given the array of payment comparisons, it would
22 be very helpful to narrow down the alternative designs to

1 those that reflect the direction the Commission would like
2 to take in the bundling policies. To recap, the basic
3 design decisions center on: the type of bundle: that is,
4 should it be a combined hospital-PAC or a PAC-only bundle;
5 whether to include or exclude readmissions; and whether to
6 focus on short or long bundles.

7 Identifying options that the Commissioners would
8 prefer will help us in our modeling of payments. And now we
9 look forward to your discussion.

10 MR. HACKBARTH: Okay. Thank you.

11 Kate, do you want to lead off with clarifying
12 questions?

13 DR. BAICKER: Yeah, I was really interested in the
14 analysis of what share of the variation you can explain
15 under different bundles and under different windows, and I
16 can imagine a couple of different stories that would produce
17 that. So as a first pass of questions, I wonder, which risk
18 adjuster are you using? Is it sort of the standard HCCs?
19 What are you trying to explain the variation with? And how
20 much of a difference do those make in explaining the
21 variation? In other words, is the variation just completely
22 idiosyncratic so we don't need to be worried so much about

1 selection going forward? Or are your limited set of risk
2 adjusters really moving things a lot, and so if you had even
3 better risk adjusters, you would expect them to move things
4 more and you would expect providers to be able to observe
5 that kind of nuance and, thus, capitalize on it?

6 DR. CARTER: Well, our risk adjustment method
7 right now has two pieces, as Evan mentioned. The first is
8 we use MS-DRGs and the severity levels that are included in
9 that. And then to look at the co-morbidities and sort of
10 the chronicity of the patient that they bring before the
11 hospital stay occurs, we're using 3M's risk adjustment that
12 looks at the clinical risk groups. And so that's helping to
13 -- because that looks at two years of claims experience
14 before the hospital stay. So it's looking at the chronic
15 conditions that a patient has.

16 And as I think I mentioned, or maybe Evan did
17 also, we're looking at folding in functional status for the
18 PAC users where we have assessment data. We are looking to
19 see if including that on top of those two helps.

20 DR. NERENZ: Three questions. I'll try to do them
21 quickly. First of all, if you could just clarify the goal
22 of these questions for us. I could see that they are either

1 to inform you about what you would focus on for additional
2 analysis or they could be recommendations to CMS about what
3 actually to pursue in terms of their bundling. Is it A or B
4 or both?

5 DR. CARTER: It might be both. But certainly at
6 least in terms of our modeling, to have this many
7 permutations in play is just -- I think we'll drown in data
8 and not have much information. So it would be really
9 helpful to narrow down sort of the focus or the things that
10 you feel are most promising. If the Commission was inclined
11 to make recommendations about a bundle type or length or,
12 you know, readmissions in or out, I sort of leave that up to
13 you.

14 DR. MARK MILLER: And probably further down the
15 road. I think this was about what would you like us to
16 focus on.

17 DR. CARTER: For today, certainly, just helping us
18 pare down what we're moving forward with.

19 DR. NERENZ: Good. Okay. Also, quickly, if you
20 can go to Slide 8, please? This is one the variance
21 explanation. The first question here is about the 72
22 percent. If I understand correctly, what you're doing is

1 looking at -- what was your phrase? -- across all
2 conditions, and then you're using MS-DRG. The question is:
3 Why should we care about that? Because, for example, in the
4 BPCI, people proposing bundled prices select specific MS-
5 DRGs or close groupings. And the question, therefore, might
6 be: What happens with the ability to predict costs within
7 one of those on the basis of then some other factors?

8 So what should we be thinking about in terms of
9 the 72 percent? I'm not sure why that matters, why it's
10 important.

11 DR. CARTER: Well, I think it matters in the sense
12 that you would like to know how well your risk adjustment is
13 doing across all conditions, not condition by condition.
14 I'm not sure you would want a different risk adjustment
15 method, depending on the condition. So this is sort of
16 looking across everything, how well can you do.

17 DR. NERENZ: Okay. I guess we'll hold that then
18 for round two.

19 DR. CARTER: Okay.

20 DR. NERENZ: Then finally the last one, just drop
21 down a bullet to the 26 percent. I presume it's here
22 because it's to catch our attention as a low number. Now

1 we're nearly, what, 30 years after the DRG system. It seems
2 to me the DRGs explain less variance than this. So is this
3 a remarkably low number, do you think? And if so, again,
4 how should we be thinking about that?

5 DR. MARK MILLER: I don't think it was intended to
6 sort of -- you know, you tell me. I don't think it was
7 intended to steer you away from that. I think probably part
8 of the reason you get such a big jump in the explained
9 variance is because you have -- or explained variation is
10 that you have the hospital in there, and the MS-DRGs, and so
11 you've got a big block of dollars where the risk adjuster is
12 working pretty well. And so I think that -- but I do think
13 we were just trying to point out that you have some
14 differences and some greater difficulty if you're focused
15 only on the post-acute care services, and part of that
16 reflects this state of risk adjustment, which you probably
17 are pretty --

18 DR. BAICKER: And the DRG is doing well not
19 because necessarily it captures true patient costs, but
20 because payment is based on the DRGs, so there is --

21 DR. CARTER: There is a little bit of -- although
22 we've looked at the --

1 DR. MARK MILLER: There is some of that going on
2 as well.

3 DR. CARTER: -- R squareds using charges as a
4 measure of resource use, and you still see the large
5 difference. And, again, it is because the MS-DRGs are
6 designed to explain differences in inpatient resource use.

7 I actually look at the 26 percent and am pretty
8 impressed by it, so I don't put it up there as a low number.
9 I think it's a good number.

10 DR. NERENZ: But that's exactly -- I just want to
11 make sure we're drawing the conclusions that you want us to
12 draw, and then we go from there. Okay.

13 MR. HACKBARTH: So I'm going to pick up on David's
14 question and ask a really stupid one as a lawyer who doesn't
15 really understand statistics very well. When I see these
16 numbers, I never quite know what to think. On the one hand,
17 I can see that if you've got a method that explains a lot of
18 variation, that might be a good thing and that you've got,
19 you know, a robust tool for describing, characterizing the
20 variation in patients. And so you've got a relatively --
21 you've got a tool that allows you to have relatively
22 homogeneous payment categories, and that might be a good

1 thing.

2 On the other hand, if there's no variation, it
3 also seems like there's no opportunity here -- no
4 opportunity for improvement. If everybody's doing the same
5 thing, you know, having a payment method based on this new
6 payment mechanism isn't going to improve things much because
7 there's already sort of a standard approach. Everybody's
8 incurring the same cost for treating the same patients.

9 DR. CARTER: Right, and actually I wanted to
10 mention that the variation in PAC is one of the reasons why
11 that R squared is lower. You have that same variation in
12 the combined bundles, but it almost gets swamped by the
13 inpatient stay dollars. But you're absolutely right, I
14 mean, there's a lot --

15 MR. HACKBARTH: Is the high number good or --

16 DR. BAICKER: We also want to distinguish between
17 the amount of variation that there is and the share of the
18 variation that you're explaining. So these are not telling
19 us -- it happens to be the case that PAC is more variable,
20 but the fact that we're explaining a different share of the
21 variation doesn't tell you that it's more variable. This is
22 telling us how predictable the variation is, not how much

1 variation there is overall. And it seems important in
2 understanding the source of the variation, understanding is
3 that something we want to build in. Do we want to correct
4 for that, or do we want to dampen it out?

5 MR. HACKBARTH: Right.

6 DR. BAICKER: Understanding that is going to
7 affect the policy, but those are two different things.

8 DR. CHERNEW: Plus you could have no variance
9 beforehand, change the marginal incentives, have no variance
10 afterwards, but it made a big change. Everyone was doing
11 the exact same wasteful stuff, change --

12 DR. COOMBS: That's the point I wanted to make
13 about cataract surgery and the cost of cataract surgery 10
14 years ago, 20 years ago, and that everyone would have been
15 in the same bar, no variations, but guess what? You're
16 right here now.

17 MR. HACKBARTH: Yeah. Okay. Well, I'm going to
18 have to work on this one some more, but we won't do it now.

19 DR. REDBERG: I'm just wondering, because there
20 are four different PAC settings, and did you see a lot of
21 differences between -- in the costs or the explanation of
22 variation between those four settings?

1 DR. CARTER: There are huge differences in the PAC
2 spending, and there's the table in the mailing that shows
3 that. But we did not look at the different R squared based
4 on sort of first site used, and I think that's one of the
5 reasons for the 26 percent, is depending on if somebody goes
6 to a NRF or a SNF or home health post hip surgery makes a
7 big difference on the spending, and yet we can't explain
8 those differences because the patient characteristics aren't
9 different enough.

10 MR. CHRISTMAN: As I recall, we didn't look at the
11 four silos, but we did compare institutional versus home
12 health, and the institutional was always -- the R squared --
13 the fit for that was always a little bit better than the
14 home health. Home health tends to be the hardest setting to
15 predict.

16 DR. MARK MILLER: And as you recall, that's one of
17 the most variable ones across the country.

18 DR. HALL: I just want to reinforce a comment I
19 think I made at our previous go-around here, that we
20 shouldn't think of SNF, home health, et cetera, as being
21 equal options in all these patients. And one of the things
22 we might want to look at would be to pick one of these, and

1 certainly SNF would be one where there would be higher
2 expenses involved and much more frequent use than the other
3 entities. This is a very, very complex area that we're
4 looking with an extraordinary number of confounding
5 variables in terms of clinical course. So I would think
6 very seriously about paring this down quite a bit from the
7 ten entities and four different options to maybe three or
8 four entities to really understand some of the
9 characteristics, I guess. I haven't --

10 DR. CARTER: When you say entities, do you mean
11 conditions?

12 DR. HALL: No, I meant the first PAC site used.

13 DR. NAYLOR: We've decided that we're reinforcing
14 each other, but I think that's a really huge opportunity in
15 the modeling to think about PAC as we describe it now but
16 also to think about how variation in spending under a
17 bundled payment model that would include acute and post-
18 acute might be different depending on whether first site is
19 home health or post-acute skilled facility. So I think
20 that's terrific.

21 I also wonder whether or not there's an
22 opportunity here with all the focus on readmissions, which

1 is where some of us have spent our life, is there an
2 opportunity to think about modeling that's a little bit more
3 robust in terms of acute service use that might include
4 emergency department, acute-care visits to physicians, and
5 readmissions rather than just readmissions? To me it's the
6 collection of acute-care resource and the path that I think
7 is really important going forward. And so to take it beyond
8 just hospital readmissions as -- I don't mean that you can't
9 look at that, but then to look more broadly at other acute-
10 care service use either in a 30-day period or 90-day period.
11 So it's just a thought. Or have you thought about that?

12 DR. CARTER: I'm actually a little confused by
13 what you're saying. Can you try that again?

14 DR. NAYLOR: On round two.

15 MR. GEORGE MILLER: Let me see if I can add to
16 your confusion. I guess I look at this and am a little bit
17 -- certainly impressed by the data and the information, but
18 I'm a little concerned from a rural hospital perspective
19 with the four different choices. I remember the
20 presentation that was made on the differences in the four
21 post-acute care sites and where they are scattered across
22 the United States. So as we try to figure this out and make

1 policies, there's some parts of the country that only have
2 one option and some part of the country only have two
3 options. But it seems to me we're trying to define -- or
4 you're asking us to give recommendations based on the entire
5 country, but the country is different, particularly in the
6 rural areas. That's one statement, not a question.

7 But I guess my question comes down to what is the
8 impact of the differences when one of the four -- only one
9 or only two of the post-acute care sites are available and
10 how will that impact that bundled payment?

11 And then the second part of my question, a little
12 bit different, dealing with the readmission, what happens if
13 that readmission, in fact, that can be documented the
14 results of -- I don't want to use the word "fault," but
15 results of the post-acute care stay and is being readmitted
16 back to the hospital? Then what happens? Who pays for
17 that? How is that going to be impacted? I'm not sure I
18 read that definitively in the chapter or understand it.
19 Maybe I don't understand it. That would be a factor also at
20 least in my mind. If you could help me understand those two
21 issues, that would be helpful for me.

22 end track 5a

1 DR. CARTER: Well, the paper talks about two
2 different ways and under -- if you thought about paying
3 providers what we've typically called virtuals, so you sort
4 of pay as you go up to a cap, up to a targeted amount, then
5 if a hospital incurred a readmission, then the hospital
6 would be paid for that readmission. But, of course, then
7 all of the entities that are related to that care still have
8 a bundled price that goes with all of the care.

9 So that would be in the version where readmissions
10 were included in the bundled price and the hospital would
11 get the payment, not get the payment from some place else.
12 But you could also imagine paying -- having readmissions
13 separate from a bundled payment and have readmissions be
14 paid the way they currently are, but extend the readmission
15 policies to PAC providers so they, just as well as
16 hospitals, have an incentive to minimize the readmissions.

17 MR. HACKBARTH: Let's stick with George's focus on
18 areas that may not have all of the different types of PAC
19 providers. The two most common are skilled nursing facility
20 and home health agency. The distribution of IRFs and LTCHs
21 are a little bit more uneven, especially the LTCHs. So one
22 empirical question that I would have, I'm thinking along

1 George's lines, is, what do we know about readmission rates
2 and how they vary depending on the type of PAC providers
3 available?

4 Are there higher or lower readmission rates in
5 those areas that have only home health agencies and SNFs for
6 post-acute care? One might hypothesize that the rates could
7 be higher because IRFs, and especially LTCHs, have more
8 robust hospital-like capabilities and that may, all other
9 things being equal, reduce the tendency to readmission. So
10 that would be a question that I think is amenable to
11 analysis and might be worth looking at, if you haven't
12 already. Perhaps you have.

13 DR. CARTER: We haven't looked at that. You'll
14 probably remember in the SNF readmission work that I did
15 last spring, we looked at the readmission -- the variation
16 in SNF readmission rates and it's considerable. But you're
17 asking a different question, which is for hospital
18 readmission rates, how much do those vary by the PAC
19 providers that are in their market.

20 MR. HACKBARTH: Yeah, the configuration.

21 DR. CARTER: And I assume we can do that. I don't
22 know if we can do it in what kind of time frame, but the

1 data are certainly all available.

2 DR. MARK MILLER: Could I also take a pass at a
3 couple of things he said? Just to make sure that the
4 audience understands, we're not up to recommendations yet.
5 I mean, eventually down the road, that might be the point,
6 but we're really talking about how to think about the
7 analysis and the structure. So I just wanted to make sure
8 that people didn't leave the room thinking that we were
9 anywhere near recommendations.

10 And on that point, George, the notion of how to
11 treat rural hospitals or, say, small or very low volume or,
12 you know, the location issues, that would be something that
13 would develop through our conversations.

14 And then just to reinforce the exchange you had
15 here, you were sort of asking, Well, how would it work?
16 Assuming that there was one payment that went to a hospital
17 and the hospital was responsible for the bundle, then that
18 hospital would be responsible for making arrangements with
19 providers, either in their area or out of their area, which
20 may implicate your rural problem, and then have to pay, in a
21 sense, some entity would receive the payment, let's just say
22 the hospital at this point, and then disburse it out to the

1 other providers.

2 The other alternative that Carol was speaking to
3 is virtual where you say, everybody continues to get their
4 fee-for-service. There's a set target. If a readmission
5 occurs, then everybody's bill is affected by that, you know,
6 downward by that readmission. So you take -- I'm making
7 this up -- 5 percent off of everybody's bill because they
8 were all involved, and they could either organize and try
9 and stop this problem or just continue to take the hit
10 whenever the readmission occurs.

11 I think that's the two models that she's saying.
12 And you were asking, well, what specifically would happen,
13 and that's the idea.

14 MR. GEORGE MILLER: Okay, thank you. That raises
15 more questions, I guess. But I'll wait until Round 2.
16 Particularly you now have EMS. If you're saying that I get
17 to pick up a provider, a post-acute care provider, and that
18 provider is a ways away, and they say, Yeah, I'll take them,
19 but you've got to pay for it, then I'm involved in the EMS,
20 the transport. And is that included in the bundled payment?

21 DR. MARK MILLER: That may be why you, as a
22 Commission, want to think about more virtual situations

1 where you let the fee-for-service run, but you cap out what
2 the bundle is going to pay and just put people at greater
3 risk. But that's a question.

4 MR. GRADISON: I have a number of Part 2s, but one
5 factual question with regard to the numbers. I'm trying to
6 understand -- let me just express this sort of as a
7 mathematical thing. I'm trying to understand the total
8 current cost, approximate total current cost for post-acute
9 care as a percentage of the hospital bill for those
10 particular patients who, after the hospital stay, require
11 post-acute care. I think that's probably something you can
12 get, I don't mean this minute, but --

13 DR. CARTER: We definitely have that.

14 MR. GRADISON: Okay. I'll speak more broadly
15 later. Thank you.

16 DR. DEAN: On the readmission issue, my assess is
17 that certainly there should be some responsibility for that,
18 some incentive to avoid those on the part of the post-acute
19 care facility. On the other hand, this will be a relatively
20 high-risk population and you certainly don't want to affect
21 the access because nobody wants to take these people if
22 they're going to be subject to penalties.

1 And I guess the question is, how well worked out
2 is the whole distinction between avoidable readmissions and
3 unavoidable readmissions? I mean, some of these people are
4 going to get sick and require readmission. I think that's
5 just a given. And I just wondered, do we have good
6 information on how to make that distinction? I mean, it's
7 going to be a judgment call in some cases, and I guess I'm
8 just not sure.

9 I mean, if somebody gets an infected pressure
10 ulcer, that's probably avoidable. If somebody gets
11 pneumonia, maybe, maybe not. And if somebody has an MI,
12 probably not avoidable. But, you know, I just wonder, how
13 clear are those distinctions worked out?

14 DR. CARTER: Well, in the methodology that we
15 used, and we ran all of our numbers using all cause
16 readmissions and potentially preventable readmissions, which
17 is a methodology that 3M has developed, and having looked
18 through that, it is a very transparent, explicit methodology
19 which they used a panel of clinicians to develop. And I can
20 share that with you to see what your reactions are to it.

21 MR. HACKBARTH: And, Tom, readmissions is also on
22 the agenda for tomorrow's meeting and I'm sure that there

1 will be some more talk about all cause versus avoidable.

2 Scott?

3 MR. ARMSTRONG: So I'm going to avoid the accuracy
4 analysis stuff and not get swallowed by that, but just step
5 back just a half a step and ask, just to clarify, so in the
6 2007 to 2008 work cycle for MedPAC, we made a series of
7 recommendations to CMS to advance bundling of post-acute
8 care service pilots. And so, did we do a similar analysis
9 to this back at that point in time or not?

10 DR. CARTER: So, Craig, yes, we did. We
11 developed, I think, 30-day bundles using a similar
12 methodology. I'm not sure that they used CRGs to do the
13 risk adjustment. It was just APRDRGs. And I think they
14 looked at 30-day bundles and it included post-acute care,
15 but I'm not sure, and physician services, but I don't think
16 sort of the post-discharge, you know, outpatient services or
17 after PAC. How am I doing?

18 MR. LISK: Pretty good.

19 MR. ARMSTRONG: Maybe the question a little more
20 specifically then would be, perhaps -- would there be merit
21 in understanding or bringing forward -- or maybe you've done
22 this already, some of the things we learned from the

1 analysis that we did back then into this analysis. And in
2 particular, my interest is in, so what was it about the
3 analysis that laid out a presentation and recommendations in
4 2008 that still has not resulted in anything actually being
5 implemented. And how can our recommendations now be built
6 in a way that much more likely results in actually piloting
7 happening and something being implemented.

8 It seems like a really significant criteria we
9 used to consider the different bundles and the way we bundle
10 this is the accuracy of our ability to predict costs.
11 Actually I guess it's a Round 2 point, but it just seems
12 like there's some other criteria that we would use to
13 evaluate, one of which would be, well, how can we package
14 this analysis so it's more likely to actually be implemented
15 in the next couple of years.

16 MR. HACKBARTH: So let me just say a word about
17 that and Mark and Carol and Evan and others can help me out.
18 So when we looked at this issue in 2007 and 2008, we stopped
19 short of making a bold-faced recommendation that Medicare
20 ought to move to bundling of all these services around a
21 hospital admission.

22 We thought, based on our analysis at that point,

1 that a reasonably compelling argument could be made that
2 there was a potential here for improving both the efficiency
3 and quality of care delivered for Medicare beneficiaries,
4 but there were a number of issues that needed to be
5 addressed to have a full-blown recommendation. What we did
6 recommend is that CMS do some pilots in this area. Congress
7 adopted that and it was included in, I guess it was, PPACA.
8 So now those demonstrations or pilots are being organized.

9 One of the issues that I have in this area is the
10 pace at which all of this stuff is happening. It was 2007-
11 2008 and we're just now in the process of beginning to
12 organize pilots, which by their nature, will take some years
13 to run and time to be evaluated. And the schedule is really
14 elongated.

15 Frankly, part of my personal interest in this area
16 was, is this something that we can do more quickly than
17 moving towards ACOs and organizational arrangements that
18 assume overall responsibility for all care for a defined
19 population. And we're sort of stuck. So one of the reasons
20 that we're taking this up again is, consistent with your
21 comments, are there ways that we can get this unstuck? Do
22 we want to get it unstuck and try to put this on a faster

1 path? So that's a little bit of historical context and it's
2 quite consistent with the issues you were raising. Mark,
3 anything you want to add to that?

4 DR. MARK MILLER: No. I mean, the pace was really
5 on point and that's what I would have said, and I think you
6 also hit it there at the end. I mean, you could, as a
7 Commission, say, no, just wait. Or you could say, no, we
8 should try and move the pace along. And what would fall out
9 of this research, at a minimum, are ideas about ways to do
10 bundles, improvements in risk adjustment, because, you know,
11 there's not -- we're one of the people who are trying to
12 move this process along.

13 And it could be, if we got far enough down the
14 road, to say, we think this is the most promising direction,
15 and then you could say to the Congress or to CMS, move that
16 other stuff aside and this is the way to go. Or, for these
17 sets of conditions, let's go with these now because this
18 seems to be ready. That would be the outcome.

19 But there is this basic question of, you know, do
20 you pursue this or not, or do you just let that run, and so,
21 there's some basic science that comes out of it, risk
22 adjustment, a bundle that looks like this, and possibly some

1 directions that come out of it.

2 MR. ARMSTRONG: And I'll express my opinion about
3 how far and how fast I think we should go in a minute, but
4 the question really was, our staff and our analysts and team
5 here are brilliant and we're doing this incredible work, but
6 is that really what's going to get this thing moving, was
7 kind of the question. You know, if there are some other
8 considerations for how we would do this analysis that might
9 actually accelerate our ability to actually get something
10 done. That's why I was asking that.

11 MR. KUHN: Two or three quick questions. One, you
12 talked about the predictive capability on home health and
13 that's pretty consistent with what we saw with the Care tool
14 as well. That tool also validated. That's very hard to
15 predict kind of resource utilization there as well. Is that
16 correct? Did I remember that right?

17 DR. CARTER: Yes.

18 MR. KUHN: Okay, thanks. And the second question
19 is the whole issue of readmissions, and I appreciate
20 George's question and Mark and others' follow-up because
21 that helped me think that one through a little bit more
22 because I was kind of quite confused on that. But let me

1 maybe go to a finer point here, and I might be off-base
2 here.

3 We're talking about readmissions, but in effect
4 we're talking about rehospitalizations. But what would
5 happen if, for example, you had someone that had an acute
6 care stay, they went to home health, they stayed home, and
7 then a couple weeks later they said, well, we might need
8 some more home health, we're coming back. So is that kind
9 of a readmission versus a rehospitalization? Am I think
10 that through incorrectly or what would happen in a situation
11 like that in a bundle?

12 DR. MARK MILLER: If I understand the scenario
13 he's saying, you're saying that they go to either post-acute
14 care setting or they go to home health?

15 MR. KUHN: Right.

16 DR. MARK MILLER: Then they go home.

17 MR. KUHN: And then they come back to post-acute
18 care.

19 DR. MARK MILLER: Then they come back to post-
20 acute care.

21 MR. KUHN: Not rehospitalized.

22 DR. MARK MILLER: Got it.

1 MR. KUHN: But they're readmitted to a PAC
2 provider.

3 DR. MARK MILLER: So what I think is, is if the
4 bundle is this time period and that event occurs within that
5 time period, then they're responsible for it. If the person
6 comes back in past the end of the bundle -- notice my
7 scientific graph here, end of the bundle -- then that would
8 be outside the payment. But if that little event that you
9 talked about, I'm in post-acute, I go home, then I come back
10 to post-acute all occurs between here, then whoever is
11 responsible for this bundle is responsible for that care.

12 MR. KUHN: Okay.

13 DR. MARK MILLER: You guys okay with that answer?

14 DR. CARTER: Yep, that's fine.

15 MR. KUHN: That's helpful, thanks. And one final
16 thing on the bundles. If we put together both inpatient and
17 post-acute care together and say a person presents
18 themselves for care and the care team says, Boy, this could
19 be an inpatient admission with maybe some PAC services, but
20 given kind of the care delivery of certain SNFs in the area,
21 we can bypass the acute care, go right to the SNF, and get
22 the care level that we need, but right now they're bound by

1 the three-day prior hospitalization.

2 Do you see PACs being able to kind of waive those
3 kind of systems so that you could get folks into the right
4 setting and get the most efficient care possible and get
5 some of those fee-for-service barriers out of the way that
6 exist now?

7 DR. CARTER: All of our work has centered around
8 an initial hospital stay, and so we haven't looked at
9 bundles developed around either observation days or not a
10 hospital stay at all. And I think that would be kind of a
11 different project, and I know it's something Evan is
12 particularly interested in because, you know, something like
13 a third of home health doesn't start with a hospital stay.
14 But our work so far hasn't focused on that.

15 DR. SAMITT: Just two clarifying questions. On
16 Slide 9, I wasn't sure whether this was an either/or, and
17 what I mean by that is, could we envision a scenario where
18 the readmission is included in the bundle and there are
19 policies that apply to the PAC regarding readmissions from a
20 PAC as well, or whether the vision is that it would be
21 separate and distinct.

22 DR. CARTER: We haven't really thought about kind

1 of the overlay. I think we were thinking more readmissions
2 in or out and if they're out we would certainly want
3 something in place. I guess I wouldn't rule out an overlay,
4 but we honestly haven't thought about that much.

5 DR. SAMITT: And my second question is on Slide
6 11, and this was also -- this was about the bundling and it
7 was also referenced in the meeting brief. It talked about
8 the concern of a shorter bundle resulting in providers
9 delaying services until the bundle expired. And I had a
10 hard time envisioning what that would look like. So what
11 does that mean, if a provider delays services before a new
12 bundle? I didn't quite understand whether there were
13 specific examples of what that could be, because I had a
14 hard time imagining that.

15 MR. CHRISTMAN: I guess maybe I'd grab Herb's
16 point about the patient that maybe is in home health and
17 needs to bounce back to a higher level of care. You know,
18 the bundled entity in that 30-day window, they're holding
19 them in home health. If they could push that start of that
20 SNF day outside of the 30-day window, the cost of that SNF
21 care would be paid under the regular fee-for-service. It
22 would not be the responsibility of the bundle because it

1 happened outside of the 30-day window.

2 So that's kind of one way. When the period is
3 relatively short, the amount of sort of time that you have
4 to serve a stint is shorter and perhaps easier to game. I
5 think that was the concern.

6 DR. SAMITT: But they're also risking additional
7 expense within the bundle by delaying nursing services for
8 that full duration of time.

9 MR. CHRISTMAN: It depends on whether they --
10 yeah, it does.

11 DR. COOMBS: Craig, just one issue with that. In
12 a lot of the SNFs, they may have patients with wounds and
13 they may treat them conservatively and they might want to
14 apply a VAC or they even may want to do a re-
15 vascularization. And it's one of those things that they can
16 treat conservatively until that window expires.

17 A question I had, had to do with how you resolve
18 diagnoses that are remotely connected to the primary
19 diagnosis for which they were hospitalized. A complication
20 ensues that is unrelated to the primary diagnosis just by
21 the mere fact of the co-morbid conditions. So that's one
22 issue. How do you resolve that piece?

1 And then leakage. A lot of hospitals or SNFs are
2 located within a small geographic area in terms of bounce-
3 backs, what they bounce back to. I would love to see this
4 and I don't know if you guys did this. If an on-site LTCH,
5 SNF within the confines of a hospital delivery system, does
6 it make a difference in terms of cost variations?

7 DR. CARTER: Okay. So the first question had to
8 do with risk adjustment, I think, right? And sort of how do
9 co-morbidities affect the assignment of the patient to an
10 MS-DRG? So the diagnoses that are related to the hospital
11 stay would affect the coding in the MS-DRG, and then we've
12 overlaid on top of that the co-morbidities that a patient
13 has had kind of prior to the hospital stay.

14 So you could think of it as for any MS-DRG, it
15 gets blown out into many different tiers, not just the
16 severity levels that MS-DRGs --

17 MR. HACKBARTH: So, Alice, I thought I heard you
18 ask a little bit different question --

19 DR. CARTER: Okay.

20 MR. HACKBARTH: -- not one about co-morbid
21 conditions and MS-DRG assignment, but responsibility,
22 clinical and financial, when a patient that's within the

1 bundle --

2 DR. COOMBS: That was part of it.

3 MR. HACKBARTH: -- has a separate condition, that
4 it wasn't the principal reason for the initial admission.
5 Are they responsible for the costs incurred?

6 DR. CARTER: Yes, they would be, yes. So they
7 would have a financial responsibility for the care within
8 the bundle that's triggered by a hospital stay. So that was
9 your first question.

10 DR. MARK MILLER: Wait just a second. Before we
11 leave that first question, but I thought your specific point
12 was, what if it's truly -- and I don't have a good clinical
13 example, but say unrelated. Okay? Right? That's what you
14 were asking? So let's just go back to this because I want
15 to connect this dot back over to Tom.

16 What the Commission has done on this issue up to
17 this point has taken a position that is potentially
18 preventable admissions, which is different than all cause,
19 as you guys know, and that's a question and you can revisit
20 it. And the attempt in these methodologies and in the
21 methodology we're using here is that there is a clinical
22 panel that says, These admissions shouldn't be counted in

1 this measure. So that's the concept.

2 Now, you could potentially take issue when she
3 shows you that list or shows you that list, whoever wants to
4 see it, you could say, Well, I don't agree with this. But
5 the point is, is the methodology tries to incorporate a
6 clinical judgment that -- when you get a car accident after,
7 you know, this, it's unrelated and that shouldn't be counted
8 in the readmission. And I think your first question was
9 about an unrelated readmission. Right?

10 DR. COOMBS: Right.

11 DR. CARTER: Oh, it was? Okay. I didn't hear the
12 readmission part. Yes. You could use potentially the way
13 the bundle would separate those out. And then your second
14 question --

15 DR. COOMBS: The second question was about
16 leakage. In some of the metropolitan areas, Boston, New
17 York, there are lots of hospitals with SNFs within each
18 other. There's a small geographic distance. How do you
19 accommodate that in the statistics? So that a patient might
20 go to one hospital SNF and then out and then back to another
21 facility.

22 DR. CARTER: Well, right now our bundle spending

1 includes the spending regardless of where it occurred. So
2 if there's leakage outside some market that just doesn't
3 matter. The spending is scooped up kind of in our bundles.

4 MR. BUTLER: So when you're at the end of Round 1,
5 I think you should be the first in Round 2 because I have no
6 questions, but I do have all the answers, but I don't know
7 if we'll get to them. I do have suggestions about how to
8 speed all of this up, but if we can get a round again, maybe
9 I'll get them on the table.

10 MR. HACKBARTH: And we're not going to wait.
11 You've got all the answers?

12 MR. BUTLER: He's going to take me up on it.
13 Okay.

14 DR. DEAN: Calling your bluff.

15 MR. BUTLER: Calling my bluff. The medical
16 spending per beneficiary we all have now, which shows
17 exactly our profiles for a 30-day bundle, three days prior,
18 30 days past. It is poised for value-based purchasing in
19 2015 or something like that.

20 It could be treated much like an ACO model, in a
21 sense, and you could tweak either -- well, say you could pay
22 out claims as we are now without paying out a fixed bundled

1 payment and you could tweak the hospital payment up or down,
2 or, you know, provide just improvement over your base using
3 the data we have now and you wouldn't have to change and fix
4 an exact price per-bundle. You could do it in the
5 aggregate, and I think fairly effectively and have a big
6 impact. So that's the way I would go.

7 We already have in our hands and is publicly
8 available how we're performing in the PAC world and it is
9 displayed by a major diagnostic category, not by MS-DRG. A
10 lot of the data is right there in the hospital's hands as we
11 speak. So it's kind of like a mini ACO within the broader
12 picture.

13 Now, this is an idea I haven't run by anybody
14 other than myself, so I can take all the credit and all the
15 blame for it being stupid or brilliant, but I think it is a
16 real possibility.

17 DR. MARK MILLER: So just to make sure I'm
18 following, you would say, I'm going to draw a circle around
19 all of the hospital and post-acute care that follows that
20 hospitalization, compute a per-beneficiary amount, and in a
21 sense have a global dollar amount that you're sort of
22 managing, too?

1 MR. BUTLER: Well, you could do it in a global
2 amount --

3 DR. MARK MILLER: I'm not making a payment. I'm
4 just letting fee-for-service run.

5 MR. BUTLER: Exactly.

6 DR. MARK MILLER: But what happens in your mind
7 when, okay, so your hospital, really good, it stays within
8 that global. My hospital, really bad, runs over that. What
9 would you do?

10 MR. BUTLER: We have a ratio around that right now
11 and you could apply that ratio to your inpatient payments,
12 in effect, up or down based on how you're performing
13 globally, or you could take -- because we have it now -- you
14 could say, You know what? I'm going to do it only for half
15 of the cases. Some of these things are not really things
16 you want to have apply to a bundle, so maybe it wouldn't be
17 the global amount.

18 But you'd pick out the ones that you think are,
19 you know, this 30 percent of the business would be focused
20 on it. But you wouldn't have to disrupt the current play.
21 You wouldn't have to hand out dollars by bundle. You would
22 be putting the financial penalty and benefits on the

1 hospital directly, I realize that, which is not the only
2 model to do.

3 MR. HACKBARTH: So in this model, Peter, there
4 would be no effect on payment to the skilled nursing
5 facility and home health agency?

6 MR. BUTLER: No, none would be required. You
7 would be managing the coordinated bundle, but you wouldn't
8 have to address any of the downstream unit payments. Just
9 like in ACOs. You're paying the claims out and you're
10 looking at, you know, how that's being managed, but --

11 MR. HACKBARTH: Okay. We've got that on the table
12 and people can react to it as we go around Round 2, ask
13 further questions about it. Mike, you have a Round 1?

14 DR. CHERNEW: I just wanted to go to the slide
15 that had the risk adjustment on it. It was Slide 8. And I
16 wanted to ask a question about the 72 and the 26. What
17 matters to me -- the quick question is, this is a percent of
18 the individual level variance. If you run an individual
19 level model, this is the percentage of the variance at the
20 individual level that's being explained. Is that how to
21 interpret these numbers?

22 DR. CARTER: Right.

1 DR. CHERNEW: And so the real question is, when
2 you group this up into larger organizations that might be
3 bundled, how much of the variation across those
4 organizations you were explaining as opposed -- because I
5 don't care if you get way off for a bunch of things. I care
6 about how much between organizations you're doing, and
7 that's going to depend on sample sizes and case mix
8 differences and a bunch of things like that.

9 DR. CARTER: Yes. I understand what you would
10 like. We haven't done that, but I understand what you're
11 interested in.

12 DR. MARK MILLER: Doesn't the R-squared have to go
13 up? If it's done at the episode level and then you
14 aggregate up to the entity, the facility or the hospital?

15 DR. CHERNEW: Yes. I would suspect that you're
16 going to do a lot better --

17 DR. MARK MILLER: That's what I --

18 DR. CHERNEW: -- because you care about the
19 systematic variation, not the random variation. And so you
20 just have a --

21 DR. MARK MILLER: All right. We'll figure it out.

22 DR. BAICKER: [Off microphone.]

1 DR. CHERNEW: Yes. But, in general, I think your
2 intuition is right, that you're going to do a lot better.

3 So I guess the only comment I would have is a
4 broad comment beyond this. The common evaluation of risk
5 adjustment tools is often -- has the same paradigm, which is
6 we're going to run a bunch of individual analyses and look
7 how bad the R-squared is, and it's never good because it
8 kind of hinges on variation. But that's not the test that a
9 predictive risk adjustment tool should have to meet. It's
10 how much systematic remaining residual variation is there,
11 and then, even more than that, how it relates to the sort of
12 incentive effects of what the thing is. Even if you
13 explained it good or poorly, you care about how the
14 incentives are going. And so you could tell a story where
15 there's a huge amount of variation that's not explained, but
16 it's all because some of the people are doing way hugely
17 wasteful stuff. I wouldn't feel so bad if I'm not
18 predicting all of that one way or another.

19 MR. HACKBARTH: Okay. So we're going to start
20 round two, and as always, any comment that you think is
21 important is invited, and we can talk more about the
22 technical aspects of this. Or I would invite, also, your

1 reactions to where this fits in sort of the grand scheme of
2 things and priorities for not just MedPAC, but for Medicare
3 improvement, and in particular are there ways that we can
4 improve the incentives around managing post-acute care,
5 which right now are quite problematic, in ways that are
6 relatively quick and easy to implement. And Peter has
7 offered one way to think about that and I invite reactions
8 to Peter's idea or any others that you might have.

9 DR. BAICKER: So I think the idea of the bigger
10 bundles across admissions, PAC, readmissions, and over a
11 longer time is great in that we think that a lot of those
12 handoffs are the opportunity for coordination to fail and
13 care to have lower quality and higher cost. So the fact
14 that you move the bundles across those transitions seems
15 like a great opportunity to improve the quality of care by
16 incentivizing the people at the beginning to follow the
17 whole stream.

18 I think the reason I'm focused on the risk
19 adjustors and I think Mike's interest is similar is that the
20 danger there is that you don't want to punish providers that
21 end up having particularly sick patients. You don't want to
22 disincentivize taking care of patients who are likely to

1 have worse downstream health episodes. But at the same
2 time, you don't need to explain 100 percent of the
3 variation. You need to explain enough that there's not that
4 residual selection left. And also, you don't want to
5 explain the variation that's driven by the choice of which
6 kind of PAC facility. And I think that's one of the reasons
7 not to -- to make the bundle independent of which PAC
8 facility because if there are ones that are more efficient,
9 we want people to be going to those if they're lower cost.
10 So that's a reason to incorporate that whole array in the
11 same bundle.

12 To the extent that we're able to adjust for
13 patient risk enough that there isn't -- first, the providers
14 aren't facing an undue amount of risk, and that's why I was
15 saying at the provider level when you aggregate out how much
16 of the risk can you explain, because, of course, you're
17 going to pay too much for some, too little for others, and
18 all of that evens out. That's okay as long as it evens out
19 over a reasonably small number of people, except you still
20 care about the individual level for the selection reason.
21 So you care about the provider level, explanatory power for
22 the risk smoothing for the provider. You care about the

1 individual level risk selection -- the individual level
2 adjusted predictability because you don't want them
3 selecting away from expensive individuals.

4 DR. CHERNEW: [Off microphone.] If they can
5 predict it better.

6 DR. BAICKER: If they can predict better. Right.
7 So you don't care about the absolute prediction. You care
8 about the power of our prediction relative to the power of
9 their prediction. So does that make sense to everyone?
10 We're all agreed on that.

11 DR. CHERNEW: Kate and I agree.

12 [Laughter.]

13 DR. BAICKER: That's right. So then you care
14 about that, and also one thing which has come up in our past
15 discussions that I know everyone is aware of but we haven't
16 mentioned here is that, of course, you care about the
17 patient outcomes, too. All of this is conditional on
18 patients getting sorted to the appropriate post-acute care
19 facility. You don't want to do disincentivize the expensive
20 one when it's the right one. You're trying to incentivize
21 the best care at the lowest price that you can get for that
22 care, and so that suggests that some people are probably

1 going to higher-cost facilities than they need to. But if
2 we're not adequately measuring either the patient risk going
3 in or the outcomes on the back end, you risk selection on
4 the front end or stinting on the back end. So, of course,
5 all of this is conditional on adequate quality measures.

6 DR. MARK MILLER: [Off microphone.] One really
7 minor point. Another way to kind of deal with the selection
8 issue is you could build an outlier policy into the --

9 DR. NERENZ: Okay. Three closely related things
10 I'll try to do quickly. First of all, in the written
11 chapter, there are several points where this whole approach
12 is described as a transitional step or a stepping stone to
13 capitation, and I would prefer actually that we just not
14 include that concept. It seems to me that this payment
15 model is a perfectly valid and good end state payment model
16 for many circumstances and we just -- we have effectively
17 the same discussion without making the inference that this
18 is going to move on to something else in the future. So
19 that's a quick thing.

20 Now, with that in mind, if we do think about it as
21 sort of an end state payment model, I go back here to my 72
22 percent and now make the observation, I'm still not

1 particularly interested in that sort of all conditions
2 analysis. The reason why is I think, as I imagine this
3 going forward, it will look like the BPCI demo, and that is
4 that the hospitals or other entities wishing to do this will
5 want to select specific sort of clinically tight episodes,
6 so heart surgery, joint replacement, and they will not be
7 particularly interested in kind of a big global bundle for
8 which then the DRGs become adjustment factors. We can talk
9 about that. We can challenge that. But I just -- I don't
10 see it.

11 With that in mind, then, I think the focus would
12 be on to select some likely tight, clinically tight bundles
13 and then focus the question on the issue of predicting costs
14 within those bundles on the basis of clinical and other
15 factors that would generally be outside the hospital or
16 other entity's control -- now, this is kind of this
17 territory again -- in order to come up with really good risk
18 adjustment models that would do the right things that we
19 want risk adjustment models to do. So I would focus the
20 analysis within selected clinically tight bundles like joint
21 replacement, like heart surgery, not across all.

22 And then, finally, the last thing is that -- back

1 to our point about social risk factors -- bundled things
2 right now, I think, don't do this. I know the folks working
3 on them with the Prometheus System have at least expressed
4 some interest in this. But this may be a time to get some
5 of these issues on the table to determine whether, example,
6 poverty, illiteracy, lack of social support, other things
7 actually have a place as risk variables in a bundled payment
8 model. I don't know that they do. I don't know that they
9 don't. But this might be the time to look. Because if they
10 matter, this then becomes a gaming problem because if
11 they're not included in models, organizations may then have
12 incentives to avoid cases that are difficult or expensive on
13 that basis and I don't think we want that to occur.

14 DR. MARK MILLER: This stepping stone thing, I'm
15 sure Mike will say something when it comes around to his
16 turn. But the thing I want to just draw your attention to
17 is you're saying that nobody will -- you're thinking about
18 this as a demonstration, that if you went through and --
19 okay, then let me put it this way. Let's say that the
20 Commission went through all of this work and came up with a
21 bundled model that was risk adjusted in such a way that
22 people felt comfortable it was to go forward. One way this

1 could all turn out is that becomes the way it's paid. It's
2 not a choice to the provider that they can say, well, I only
3 want to do this DRG or that DRG. It's this is how we pay
4 when you hit a DRG.

5 That's what I didn't follow in your comments. And
6 I was thinking you were thinking, well, this is all a demo
7 and people are volunteering, which is one way. It could
8 inform the demos. But the other way is if it became the way
9 it paid, this is how people would get paid.

10 DR. NERENZ: No, I understand that, and I did make
11 a different assumption, but I didn't assume that my
12 different assumption made it a demo, that there actually may
13 be the ability to select payment --

14 DR. MARK MILLER: Oh, I see --

15 DR. NERENZ: -- to be paid this way in real life
16 outside a demo.

17 DR. MARK MILLER: [Off microphone.] That's
18 against the selection --

19 DR. NERENZ: Well, maybe yes, maybe no. I think
20 that we could debate this at some length and we'll have to
21 see how we do this.

22 Just a point, though, that others may correct on.

1 It seems to me in the current BPCI demo that this "must do
2 all this" charge is as characteristic of the model one as it
3 was called in that demo, and if I'm correct, I think there
4 were very few takers on that.

5 DR. MARK MILLER: [Off microphone.] That's right.

6 DR. NERENZ: In models two and four, where you
7 could pick, I think there were a lot of takers on that.

8 DR. MARK MILLER: [Off microphone.] That's right.

9 DR. NERENZ: So, I mean, CMS may -- we may
10 recommend and CMS may come out and say, you, hospital, must
11 do this for all your DRGs. But I think there may be a lot
12 of push-back on that.

13 DR. MARK MILLER: [Off microphone.] I suspect
14 there would. I'm sorry. If these are all of the
15 conditions, it could be that we recommend you go with this
16 set of conditions, but that's how you get paid when you have
17 those conditions. But the provider isn't picking. And it
18 was kind of unspoken, but one of our concerns about the
19 demonstration is, is if it is completely within the control
20 of the provider to pick where they are, you could be getting
21 some demonstrations that are demonstrating places where
22 there's very little variance and sort of agreement on how

1 you approach it and the opportunity may lie, and I think
2 this was Glenn's point earlier, in conditions where there's
3 much more variance in how it's being treated.

4 DR. NERENZ: Right. Well, I guess maybe just for
5 me the last comment. I guess we just have to think, big
6 picture, do you want to essentially force hospitals to do
7 things that they cannot do or don't want to do or don't have
8 the tools to do, or are we better off if we invite hospitals
9 or ask hospitals to do things that they can do and are good
10 at and can produce savings. And I think that may
11 differentiate, do you have one big thing by which you pay
12 all discharges or do you select areas or offer hospitals the
13 opportunity to take up this model in areas where they think
14 they can do it effectively.

15 MR. HACKBARTH: So, Dave, in the approach that
16 Peter described, the financial responsibility and, I guess,
17 ultimately, the clinical responsibility for managing the
18 admission and associated post-acute care within a defined
19 category was borne by the hospital as opposed to allocated
20 across the hospital and the home health agency and the SNF.
21 Any reaction on that?

22 DR. NERENZ: Well, just that if you build a bundle

1 or an episode around a discharge and you include that cost,
2 you put the hospital in a central position almost
3 automatically. Now, you may find somewhere that there's
4 some different entity that actually could do that, but it
5 forces you, at least, to think primarily about hospital.

6 If we talk about post-acute care episodes only,
7 then I think it's a whole another story. It's not
8 necessarily the hospital now that would do that. Someone
9 else may do that. All sorts of different entities may do
10 that.

11 DR. REDBERG: I think the idea of bundling in the
12 bigger picture is good because it promotes the things we
13 want to -- I think we can use it to promote what we want to
14 promote, care coordination, you know, especially the
15 hospital PAC with including readmissions and a longer-term
16 window, because then I think we have more incentives to have
17 higher-quality care for the patient and have everyone
18 working together to achieve that goal. And so I think
19 there's the most potential for doing more with bundling in a
20 bigger picture.

21 DR. HALL: You know, there's a substantial
22 experience with bundling of some key medical and surgical

1 procedures in medical tourism, where people go to India or
2 South America or Mexico for major things like heart surgery,
3 elective orthopedic surgery. It's not just all plastics.
4 It's very major things. Well, they're bundled. Not only do
5 they do the acute surgery, provide post-surgery care, but
6 they even allow the families to come forward or come over,
7 as well. And I'm not suggesting that's what we should be
8 doing, but the idea that -- but what it points out is that
9 there are certain things that tend to lend themselves to
10 bundling much more than others, as I think many people have
11 said around here, and David just talked about so eloquently.

12 So I'm kind of wondering if in the bigger picture
13 of things we should kind of make life a little bit easier
14 for us to sort of say, are there certain bundles that we
15 could look at that would allow us to make some observations,
16 not only about what people might be doing wrong, but might
17 be doing right. And I would immediately focus on the
18 orthopedic procedures.

19 For instance, in Table 1 that's in our written
20 materials -- I'm not sure, is that in the slides or not? It
21 has the ten conditions. Three of the middle conditions are
22 all orthopedic -- major joint replacement, hip and femur

1 procedures, fractures. As near as makes no difference,
2 every one of those patients has some form of PAC. The
3 majority are SNF, but a substantial minority are home health
4 agencies.

5 I think concentrating on those areas and then look
6 at what kind of variance explains whether there's much
7 readmission, inappropriate first pass, putting people in the
8 wrong PAC environment, I think it's perhaps a quick and
9 dirty way but I think at least it gets us started. The idea
10 that we're going to bundle all of medical care, particularly
11 for unpredictable illness, just strikes me as almost
12 audacious that we would say that we could do that at this
13 point without understanding the mechanics a little bit
14 better.

15 DR. REDBERG: -- Geisinger are doing it now for
16 bypass surgery, kind of a bundle --

17 DR. HALL: It could.

18 DR. NAYLOR: So I think we should be audacious. I
19 think that the greatest opportunity we have right now to
20 improve care and reduce costs, get to affordable care for
21 Medicare beneficiaries, is to really figure out how to
22 better align the care with their needs. And this is an

1 area, in addition to having experience with bundled
2 payments, as Bill has suggested, we also have a tremendous
3 evidence base about how to do this. And I think it -- so I
4 like the frame that you've described. I think focusing on
5 hospital plus post-acute for all the reasons that Kate
6 talked about, we have a great evidence base on all the
7 things that go wrong in the connections between one and the
8 other. We have 50 percent of our people who are
9 hospitalized don't even get referrals for post-acute and
10 they are at risk for poor outcomes. So there is really good
11 reason to think about that.

12 I think including readmissions in the bundle is
13 something that we should seriously consider. My question
14 was whether or not we could not also include ED visits, and
15 I don't know if we can or can't, but it's -- and
16 observational visits -- because I think that they are
17 increasing and we need to think about ways that they are
18 part of what we look at. Acute care visits to physicians
19 are already there.

20 I really -- obviously, we need to have really good
21 metrics post-bundle that look at acute care resource for a
22 period of time, but the whole goal here is to create

1 alignments in these policies. We call them hospital and
2 post-acute. People call them what's happening to me here
3 and here. And so how you create alignment in the policies
4 that really are much more addressing and responsive to
5 people's needs.

6 And I do think all cause readmission is where we
7 need to be focused, both in looking -- including in the
8 bundle and looking at measuring its impact.

9 MR. GEORGE MILLER: One of the things I mentioned
10 earlier about disparities, I'm just wondering how we can
11 risk adjust for the current state of disparities in health
12 care, and adding a bundled payment, does that improve that
13 process? Does it not address it? Or does it make it worse?
14 I'd certainly like at least some research on that issue, and
15 particularly in people where service disparity is still
16 prevalent and has not improved, according to some of the
17 data we read in our package.

18 Just commenting on Mary's comment, looking at ED
19 visits, there's a growing body of, especially the uninsured,
20 that still use the ED for primary care and I'm not sure how
21 that would impact, being put in the bundle and if that's
22 appropriate. But I certainly would like to see that

1 information, but we're having, at least anecdotally, our
2 facility is seeing more and more patients using the ED for
3 primary care, and I suspect that is happening in other
4 places, as well. So I just would be curious to see how that
5 would impact a bundled payment.

6 MR. GRADISON: I haven't heard a word so far in
7 this discussion about the role of the patient, their family,
8 or their physician, and I think it's important to talk a
9 little bit about that before I talk about hospitals and
10 their ability to take this risk.

11 My understanding of this is that the hospital
12 would make the determination of where -- of which post-acute
13 care setting was appropriate and which particular facility.
14 If the patient has a preference, if the family wants the one
15 a mile from home instead of the one the hospital chooses ten
16 miles from home, they would not have this choice if I
17 understand the way this model is intended to operate. If
18 the physician has a nursing home, a SNF, where they
19 regularly make calls and have confidence themselves in the
20 quality of the care, that decision or recommendation of the
21 physician, I would suppose, would have to be overridden by
22 the hospital in order to make this plan work.

1 In other words, we're talking about managed care,
2 folks, in the sense that the options for the beneficiary are
3 reduced from what they are under traditional fee-for-service
4 medicine. Now, that may be a good idea or a bad idea, but I
5 think it's important to recognize it straight up.

6 Let me use this analogy of the ACOs. One of the
7 ironies about the ACO is the patient doesn't even know at
8 the outset what group they're assigned to. And furthermore,
9 once they find out or any time later, they can move to some
10 -- they can drop right out of the group. They have total
11 flexibility under that particular model, which makes me
12 wonder whether the folks who wrote that provision in would
13 even conceive of taking away that degree of flexibility when
14 it comes to the range of post-acute care services which
15 we're talking about right now.

16 But let me talk a little bit about this from the
17 hospital's point of view. I'm not sure the hospitals --
18 there are exceptions, I'm sure -- but I'm not sure hospitals
19 in general are in a position to take the financial, or
20 potential financial risks that may be involved here, nor am
21 I convinced that in many instances they have the
22 experiential basis for making the management decision with

1 regard to which post-acute care facility the patient should
2 go to.

3 With regard to financial risk, keep in mind what
4 we're doing, to a small extent, I acknowledge, is making the
5 hospitals into insurers because they, in effect, are at risk
6 for some portion of the expenses that are incurred for the
7 whole package, not just the part which is under their direct
8 control.

9 Now, that opens up a whole other way of thinking
10 about this, which I think we should put on the table at some
11 appropriate time, and that is whether to limit this to
12 hospitals. If a hospital wants to take the risk, I wouldn't
13 stand in their way. But there are other entities, such as
14 health plans, which are accustomed to making these
15 determinations and have a whole lot more experience,
16 especially the larger ones, in knowing about the clinical
17 capabilities and the costs of the post-acute care settings
18 than most hospitals that I know about with the current state
19 of knowledge.

20 So I do want to raise the -- I know we've talked
21 just, in effect, let's do it through the hospitals. I'm not
22 at all convinced that it should only be through hospitals

1 that this type of bundling should take place. Strong letter
2 to follow.

3 MR. HACKBARTH: So, Bill, those are really
4 important points. I would emphasize that there is no
5 proposal on the table about who has control over where the
6 patient goes, but those are issues that certainly need to be
7 thought through. And there is this tension that exists that
8 within the confines of traditional Medicare, we've got all
9 these ideas for trying to change the fee-for-service
10 incentives and give not just clinical, but also some
11 financial responsibility and risk to various types of care
12 delivery organizations, a role that is unfamiliar for many
13 of them. And there is this corollary question of, well,
14 what does that mean for the patient and do they have
15 constrained options as a result.

16 Now, I've felt -- in fact, the Commission as a
17 whole felt in our comments on the ACO rules that they struck
18 a balance that probably doesn't make a lot of sense. You
19 know, they're trying to create organizations with financial
20 and clinical accountability, but the patients are not buying
21 into the choice. They're not making any election. They're
22 retaining their free choice. And I, for one, wonder

1 whether, in fact, that's a sustainable combination of
2 arrangements.

3 Now, let me just push you. You know, one approach
4 would be to say, look, trying to do -- change these
5 financial responsibilities in the traditional Medicare
6 program is problematic for all these reasons, the
7 unfamiliarity of providers in bearing risk and the
8 implications for beneficiary choice. The alternative way to
9 accomplish these things is through Medicare Advantage.
10 Patients have the option of electing a private plan that, on
11 its face, may limit their freedom of choice and they get to
12 say, that's what I'm willing to do in exchange for a lower
13 premium or enhanced benefits. Are you suggesting that we
14 really ought to leave these new payment arrangements to
15 Medicare Advantage and not try to introduce them into fee-
16 for-service? Talk about that for a second. I'm not sure
17 where your comments lead.

18 MR. GRADISON: I'm fine. If the hospitals want to
19 take this risk, I'm -- more power to them. I think that the
20 more competitors we have, the better. But I would not say
21 that a health plan could not participate and take this risk.
22 With regard to the existing Medicare Advantage plans, they

1 might find this attractive, too, but I could envision a
2 health plan that would not necessarily be in Medicare
3 Advantage but might wish to examine this particular type of
4 risk to see if they have enough know how to feel that they
5 could manage it.

6 I can't overstate that -- but I'm going to repeat
7 myself to make sure you understand -- we're talking about
8 making hospitals, to a degree, into an insurer, and that's
9 not what they're -- that's not what their competitive
10 advantage, their knowledge basis is in most cases. Now, if
11 they want to take that chance, I'm not against it, but I
12 look at what's going on in the hospital field, the risks
13 that they're going to bear under current law with regard to
14 readmissions, and I ask myself, are they going to get dinged
15 for things that are totally beyond their control? I don't
16 know the answer to that, but I think there's a fair risk
17 that they will.

18 I look at the ACOs. My sense is that for an ACO
19 to be successful, at least initially, the low-hanging fruit
20 is going to be to take money, that is admissions, away from
21 hospitals or reduce the length of stay or do something in
22 the hospital area, which I think may not be such a far-

1 fetched comment. It may help to explain why there aren't
2 more hospitals, at least in the initial rounds, that are --
3 I don't say there aren't any, but why there aren't more that
4 are participating, because they're being asked in some cases
5 to come up with the management for the ACO and the money for
6 the capital, and if it's successful, it more than likely
7 comes out of their pocket. I don't quite see that business
8 model working very well.

9 So that's all. I'm not trying to say it's one or
10 the other at all.

11 MR. ARMSTRONG: So I'll just be fairly brief.
12 First, I think we've studied this long enough. It's time to
13 push hard. In terms of the design options, I think we
14 should combine hospital and PAC, include readmissions and
15 include the longer period of time for many of the reasons
16 expressed already.

17 I also just want to say that I think that this is
18 an important policy issue for MedPAC, not just because it
19 solves issues we've been trying to deal with for a long
20 time, but because it does accelerate in our industry the
21 kind of changes that we are trying to accelerate. And to a
22 lot of the points that you all have been making about, well,

1 how hard this is going to be for the hospitals or for
2 skilled nursing facilities or whoever, yes, that's exactly
3 the point, because the way they're working together is the
4 way that won't work in the future and that this is our
5 vehicle, through payment policy, to force these
6 organizations to work differently.

7 I don't necessarily believe hospitals are the only
8 organizations capable of owning responsibility for creating
9 the kind of integration and alignment and coordination. I
10 think there are a lot of well organized medical groups and I
11 think there are all sorts of other organizations, not just
12 health plans, that are very capable of stepping up and have
13 been demonstrating their ability to step up to this kind of
14 a role.

15 I also -- Bill, I think your point was an
16 excellent one. Let's not forget that this is actually less
17 about getting the payment right and more about using payment
18 to start forcing change in care delivery, that will deliver
19 on different outcomes. And it's not actually just about
20 care delivery. It's forcing changes in care delivery so
21 they can engage patients and their families in a different
22 relationship, as well. Patients and their families play an

1 incredibly vital role, particularly in this post-acute
2 period of care, in advancing better, distinctively better,
3 outcomes. But care delivery systems are woefully ill
4 prepared to engage them productively and I think that's
5 another example of the kind of change that we're trying to
6 force.

7 And I think the last point I would make would be
8 that -- someone said this already -- this really begs not
9 only an attentiveness to what kind of care system changes
10 are being forced, but quality reporting and other
11 complementary kinds of information. And I realize we need
12 to feel like we're nailing the payment policy and the
13 analysis behind that and so forth, but I think our report
14 really needs to speak to a lot of these other issues, as
15 well. And I'll stop there.

16 MR. KUHN: A couple of quick thoughts.

17 First is, on Peter's proposal, I don't know if I
18 completely understand it all together, but I'd like to hear
19 more about it as maybe he develops it or develops it more
20 with, Mark, you and your team.

21 But if I think about how this would impact the
22 post-acute care providers, I can see a real distinction of

1 how folks would operate. I think, under his proposal, if
2 the locus of control is at the hospital level then I would
3 see the PAC providers actually really marketing themselves
4 to the hospital and saying we can be the partner of choice
5 because here's what we can do in terms of reducing
6 readmissions or all the things that we can do as part of the
7 process versus an alternative, if they're part of the PAC
8 bundle, more of a partnership where you're kind of working
9 together to spread the risk overall and payment.

10 So really two different looks at that. And I
11 don't know which one is preferable, quite frankly. But I am
12 intrigued, the fact that you would be in a position where
13 they would actually be bidding or marketing themselves as
14 hard as they can, that we're the folks that can deliver this
15 service and give you these guarantees, et cetera.

16 Just that I think it creates two different kinds
17 of incentives that would be interesting to kind of look at
18 and explore a little bit more as we go forward.

19 In terms of the issues as we go forward, and kind
20 of the three questions you put forward, I still would be
21 interested in looking both at hospital-PAC as well as PAC-
22 only. I'm intrigued by both of those, so I think further

1 exploration on both of those.

2 In terms of readmissions, I'm kind of in the
3 mindset right now of probably excluding the readmissions.
4 My main notion for that is the fact that last year we put
5 forward a proposal for SNF readmission policy. Hopefully
6 this year we're going to be thinking about a home health
7 specific readmission policy.

8 So I just don't want the readmissions to be just
9 in the bundle section only. I really want it to be broader
10 thinking of organizations overall. So if hospitals have one
11 that begin on October 1, who knows what Congress will do
12 with SNF. But if they think future about SNF and home
13 health, it's part of the overall culture of the
14 organizations. It's just not for these particular payment
15 streams. And so that's why I'm thinking about exclusion.

16 And then on length of 30 versus 90 days, probably
17 the short one, a little bit what Bill and others were
18 saying. A lot of unknown here, a lot of risk. I think if
19 you put it in a more manageable time frame it gets at the
20 question that we had of how we make it simple, but also it
21 makes probably easier to integrate into the overall system.
22 So just a couple of thoughts.

1 MS. UCCELLO: Unlike Herb, I know I didn't quite
2 understand what Peter was saying, so I'll defer comments on
3 that until I understand that better.

4 In terms of the questions laid out, I prefer to
5 err on the side of more encouragement of coordination of
6 care. So longer and more inclusive bundles makes sense to
7 me.

8 And to the extent that the risk adjustment has
9 some shortcomings or smaller providers or others may not be
10 in the greatest position to handle that risk, if we can
11 handle those issues throughout outliers or some other kinds
12 of risk-sharing mechanisms, I think those should be examined
13 more.

14 DR. SAMITT: A couple of quick points. I live in
15 the world of bundled payments so you won't be surprised that
16 I would be in favor of a more inclusive bundle. In our
17 experience, bundled payments unveil poor quality and
18 inefficiency and drive system integration. And so I
19 certainly would go that way.

20 As I thought about the questions, I couldn't help
21 myself but to think of at least the first two in a two-by-
22 two matrix. I think we have to be careful to not think of

1 those two questions, the hospital-PAC and PAC alone as well
2 as readmissions in isolation. Because I think there are
3 unintended consequences if we combine the two wrong things
4 together.

5 So for example, if we go with a hospital-PAC
6 bundle and readmissions are not included, well as a hospital
7 I probably would want to send as many people home as
8 possible which is probably not a good outcome. Whereas if
9 readmissions are included, I would think very carefully
10 about -- I'd want to send the patient to the exact right
11 destination.

12 Likewise, if we think about it today, there
13 already is an impending readmission implication. If we
14 think of that, in the absence of a hospital-PAC bundle -- if
15 there were only a PAC bundle alone, for example -- well, as
16 a hospital, I would probably want to refer all my patients
17 to IRFs or LTCHs because there is a risk of readmission. I
18 don't want them to be readmitted. But I'm not responsible
19 for the bundle about where I send patients to PAC. So I'm
20 going to want to go to the highest cost setting in terms of
21 my referral pattern.

22 So I think as we think about these we have to

1 think about them together in terms of evaluating next steps.

2 DR. COOMBS: I agree with Craig in terms of the
3 comprehensive global budget for post-acute care admissions
4 in the sense that if the hospital has some investment into
5 the post-acute setting then they have some control over the
6 quality of that institution. But where there is no agency
7 for those post-acute care settings, then you have less
8 control.

9 And the things that really plague Medicare
10 patients, such as *c. difficile*, VRE, if they're on the
11 ventilator then ventilator-associated pneumonia. You lost
12 your cost savings from the acute hospital in the post-acute
13 care setting. You've lost it. In a week's time whatever
14 you save on the hospital end, you can lose in the rehab
15 hospital or the LTCHs.

16 So I think that without that you lose the control
17 over quality and cost.

18 MR. BUTLER: So quickly, I would do the hospital
19 plus the post-acute. I would include readmissions. And I
20 would do 30-day, not 90-day. I think the analytics and the
21 adjustments and exclusions you need to make for 90 day get a
22 little tricky.

1 And then I wouldn't lose the risk adjustment and
2 the attentiveness to the socioeconomic issues that David had
3 just as a -- think about that.

4 DR. MARK MILLER: [off microphone] Did you say no
5 PAC?

6 MR. BUTLER: You want the hospital and the PAC
7 together. That would be my vote.

8 MR. HACKBARTH: Peter, under your proposal, do you
9 envision a virtual capitation, sort of payments fee-for-
10 service against the target?

11 MR. BUTLER: Yes.

12 MR. HACKBARTH: Mike?

13 DR. CHERNEW: So first, I think one of the big
14 motivators here is speed. And so I think whereas
15 philosophically I might be in the do more thought, in the
16 purpose of speed that pushes me into the do more targeted
17 places where you really know it can work camp. And that's
18 where I am regarding this.

19 But more importantly, I don't actually see this as
20 a good end-state because of all of these complications. And
21 I see the end state as being a much broader, more global
22 budget for caring for the person and making all of these

1 things sort of work. I don't think it would -- I think we
2 would end up with a lot of complexities if our end-state was
3 a series of complicated post-acute bundles with things
4 ending at a particular point in time and then new things
5 happening right after that time. So I view that as more
6 complicated.

7 So I think we do have to begin to push the system
8 to organize better, like Scott said. But here I think we
9 should grab as much low-hanging fruit as we can and move as
10 quickly as we can and begin to push forward to the broader
11 set of changes. And I see these types of episode-based
12 bundling things as not where we would end up way down the
13 road.

14 DR. NERENZ: If I could just quickly respond, I
15 think we just have to clarify end-state for whom? Because
16 my statement was presumed on the idea that there may be
17 organizations or sets of organizations that are really good
18 at doing bundled episodes. They are not going, for example,
19 at doing ACO-type full capitation.

20 And maybe an end-state is some combination in
21 which CMS would pay ACOs on a capitation basis, the ACOs
22 would turn around and subcontract for bundles. And so you

1 have an end-state that includes both components.

2 I was just saying that what I was reading in the
3 text was the idea that this bundle would be around for a
4 while and then it would go away. I don't know if it will
5 ever go away.

6 DR. CHERNEW: I understand, although I guess what
7 I would say in that case -- and I agree with you, I see that
8 exactly happening. And I guess my view would be but then
9 all these complicated things that we struggle with would
10 have to be dealt with by those two organizations as opposed
11 to us sorting through all of the nuances of telling them how
12 they need to risk adjust, how they need to set their dates,
13 when they can do it.

14 I could not agree more with Bill's comment about
15 how to engage the beneficiaries and think about how to
16 maintain that in the context of the overall Medicare program
17 is really hard and very hard to do in this context.

18 MR. HACKBARTH: Okay. There's lots of food for
19 thought here. I hear some important areas of agreement,
20 some areas of disagreement, and some just frank questions
21 that need to be thought through in more detail. So we'll
22 process this conversation and then come back, hopefully,

1 with a proposed direction to get your reactions to.

2 Thank you, Carol and Evan. I appreciate your work
3 on this.

4 So our final session today is on competitively
5 determined plan contributions. In the audience, could I get
6 you to move in and out quickly and quietly, please?

7 Unfortunately, we have run over. I didn't want to
8 cut short the preceding conversation because we just need to
9 figure out a path. We need to make some progress on this
10 one way or the other, so we have run over. And as a result,
11 we have only 45 minutes for this last conversation. And
12 since it's our very first one on this topic, I think that's
13 fine. And what we will do is limit the discussion to just
14 one round of clarifying questions.

15 Before I turn over the presentation to Julie and
16 Scott, I just want to say a little bit about the context for
17 this, including why this name, competitively determined plan
18 contributions. And I think the best way for me to approach
19 that is by talking a little bit about recent MedPAC history
20 on the Medicare Advantage program, which at various points
21 in time we've invested a lot of time and effort in.

22 This history that I'll very quickly summarize

1 really goes back over the full 12 years that I have served
2 on MedPAC and several different periods of intense
3 examination of the Medicare Advantage program.

4 Over the course of that 12 years, there have been
5 a couple themes that have been consistent and constant, even
6 while the membership of the Commission has turned over
7 several times. One of those themes is that it is a good
8 thing for Medicare beneficiaries to have the option -- and I
9 emphasize, the option -- of enrolling in a private health
10 plan as an alternative to staying in the traditional
11 Medicare program. It may not be good for all beneficiaries.
12 It may not be what every beneficiary wants for herself or
13 himself. But it's an option that could suit the needs and
14 preferences of individual patients. Some private plans, in
15 fact, are proven performers at doing some things that
16 traditional Medicare has found difficult to do, including
17 effective care coordination. So consistent theme one is
18 having choices for Medicare beneficiaries is a good thing to
19 do.

20 The second theme that has been consistent is that
21 how we structure that choice is very, very important, and an
22 important part of structuring it properly is to give

1 Medicare beneficiaries a financially neutral choice between
2 staying in traditional Medicare or enrolling in private
3 health plans.

4 To put that a little bit differently, the
5 government ought to pay the same amount on a risk-adjusted
6 basis whether the beneficiary elects to enroll in a private
7 health plan or stay in traditional Medicare. So the
8 importance of options and financial neutrality have been
9 very, very consistent themes.

10 Because of these views, what we've found is that
11 while the Commission has been very supportive of Medicare
12 Advantage because it does offer that choice, we have
13 expressed concerns over the years about the payment
14 mechanisms used in Medicare Advantage, and particularly the
15 system of benchmarks that were often set well above the
16 Medicare expenditure levels in the same area, and as a
17 result of that, resulted in Medicare expenditures being
18 higher on behalf of beneficiaries who exercise the option to
19 enroll in a private plan as compared to those that stayed in
20 traditional Medicare. And that had been a point that we
21 repeatedly in recommendations urged Congress to eliminate
22 that gap and restore financial neutrality. As you know,

1 PPACA took significant steps in that direction of moving
2 towards neutrality, although not all the way there.

3 As we have worked through these issues over the
4 course of years now -- and I testified before Congress a
5 number of times on the issue -- I've tried to make the point
6 that financial neutrality is a key principle, but there are
7 various ways that you could get to financial neutrality.
8 The way that historically we have emphasized is using a
9 system of administered prices, namely, use the projected
10 Medicare expenditure per beneficiary as the peg and say
11 that's the amount we're willing to contribute, either on
12 behalf of the beneficiary if they stay in traditional
13 Medicare or the same amount if they elect to enroll in a
14 private health plan -- of course, with risk adjustment.

15 An alternative approach to financial neutrality,
16 however, would be to say let's not peg the contribution to
17 traditional Medicare expenditures, but let's peg it to
18 competitively determined rates, so have a competition with
19 traditional Medicare as one of the options but also private
20 plans, have them submit bids, and then link the contribution
21 to that competitively determined approach, and obviously
22 different formulas that you could use, the low bid, the

1 second low bid, the average bid. In fact, there are
2 programs that exist around the country, including the
3 Federal Employees Health Benefits Program, that operate much
4 in this way.

5 So the topic for this discussion is to begin just
6 trying to understand what the implications might be of
7 moving to competitively determined contributions as a way of
8 establishing financial neutrality between traditional
9 Medicare and private health plans being offered to Medicare
10 beneficiaries.

11 Now, I imagine that there are people in the
12 audience who are saying, well, this sounds a lot like
13 premium support, vouchers, defined contribution. There are
14 a lot of different names out there being applied to some of
15 the same ideas. Why aren't they using those terms? And the
16 reason for that is that what I want the Commission to engage
17 in is a discussion of this principle of how we set financial
18 neutrality, which raises a host of other issues beyond just
19 the financial calculation, to be sure. And I want to do
20 that in a way that starts with a blank sheet of paper so
21 that we can structure the conversation in a way that we
22 think makes sense to us. All of the different proposals out

1 there, whether they're called premium support or something
2 else, they are already ideas that have content attached to
3 them. There are various proposals that have answered
4 questions in different ways, and what I want to do is free
5 us from those already existing ideas to talk about this as a
6 matter of principle and how we would approach it, what
7 issues we would think are important to resolve, whether we
8 even think they're resolvable at all, without trying to
9 evaluate one or another competing proposal that already
10 exists in the environment.

11 So that's the reason for what some may say is a
12 very awkward title of competitively determined
13 contributions. I am not trying to cast a new label that the
14 world is going to latch onto. Actually, I'm trying to do
15 the opposite. I'm trying to distance our conversation from
16 all of the existing ideas out there, proposals out there, so
17 that we can focus on some first principles, again, starting
18 with a clean sheet of paper as it were.

19 Where will this take us? Frankly, I don't know at
20 this point. It could be just an examination of the issues,
21 identification of the issues that should be addressed. We
22 may find that there's a sufficiently broad consensus within

1 the Commission that on some of those issues we have a real
2 clear point of view about how they should be addressed, or
3 we may find that we have very different answers to the
4 critical questions and it leads to no particular set of
5 recommendations or conclusions. We'll have to see where the
6 path leads us.

7 So that's my preface to this conversation, and let
8 me ask, Mike or Mark, anything you want to add to that?

9 [No response.]

10 MR. HACKBARTH: So with that, Julie, are you
11 leading the way?

12 DR. LEE: Good afternoon. The Commission has been
13 considering reforming the traditional Medicare benefit to
14 complement our ongoing work on improving the payment system.

15 In the last June report, the Commission
16 recommended a redesign of the fee-for-service benefit
17 package as shorter-term improvements to the Medicare
18 benefit. Continuing our discussion of the benefit redesign,
19 we present an overview of the concept we call "competitively
20 determined plan contributions" and discuss some of the key
21 policy issues that the Commission would need to consider.

22 Today's presentation is in four parts. First,

1 we'll begin by defining the term "competitively determined
2 plan contributions." Then we'll look at Part D as an
3 example of the concept in current Medicare. Next, we'll go
4 over some key design issues. And we'll conclude with
5 additional policy issues that have significant implications
6 for Medicare beneficiaries and the program.

7 "Competitively determined plan contribution," or
8 CPC, refers to a federal contribution toward the coverage of
9 the Medicare benefit based on the cost of competing options
10 for the coverage.

11 Specifically, CPC has two defining principles:
12 First, beneficiaries receive a federal contribution to buy
13 Medicare coverage, and the contribution amount would be
14 competitively determined. And, second, their individual
15 premiums would vary depending on their choice of coverage
16 and the level of the federal contribution.

17 CPC is not a totally new concept. In fact, we
18 have an example of CPC in the current Medicare drug benefit,
19 or Part D. Under Part D, plans submit bids to provide a
20 standard drug benefit. Then CMS calculates the national
21 average bid based on plan bids, weighted by enrollment.
22 Then the national average bid is divided into two parts:

1 base premium and direct subsidy. The base premium is what
2 an enrollee pays, on average, to the plan, and the direct
3 subsidy is what Medicare pays to plans for each of the
4 plan's enrollees.

5 This slide illustrates the process just described.
6 We have three plans who each submit a bid. In this slide,
7 Plan 1 has the lowest bid and Plan 3 has the highest. Their
8 bids feed into the calculation of the weighted national
9 average bid, which gets divided into the base premium and
10 direct subsidy.

11 Now let's look at how enrollee premiums get
12 calculated under Part D. What each enrollee pays
13 individually for his or her drug benefit depends on how the
14 plan bid compares with the national average bid.

15 Picking up where we left off in the previous
16 slide, and moving left to right on this slide, let's start
17 with the national average bid, consisting of the base
18 premium and direct subsidy.

19 Plan 1 had a bid less than the average bid, and in
20 this case, the subsidy amount is sufficient to pay for Plan
21 1's benefit, and the enrollee pays no monthly premium.

22 In the case of Plan 2, whose bid is equal to the

1 national average bid, an enrollee pays the base premium.

2 In contrast, Plan 3's bid is higher than the
3 national average bid, and if the enrollee chooses Plan 3,
4 then he or she pays the base premium plus the entire
5 additional cost of the bid.

6 To sum up, this slide illustrates how enrollee
7 premiums under Part D can vary depending on which plan they
8 choose.

9 As noted previously, Part D represents one version
10 of CPC and provides a useful reference point for how CPC
11 could work in Medicare. But in some important ways, the
12 Part D example might not translate so easily to Part A and
13 Part B.

14 For example, there's more variance in the cost of
15 providing medical benefits compared with drug benefits. And
16 the cost of providing medical benefits might be more local
17 than national. These differences have important
18 implications for the design of CPC models for Part A and
19 Part B services.

20 As the Part D example suggests, there are
21 different ways to apply the principles of CPC. On this
22 slide, we focus on two key design questions: One, should

1 the benefit package be standardized? And, two, how should
2 the federal contribution be determined? We'll examine this
3 question in three dimensions, which we'll come back to after
4 the standardization question.

5 The CPC model would require some form of a
6 standardized benefit package. The idea is to encourage
7 plans to compete on the same or similar enough package of
8 benefits. But standardization can be interpreted in
9 different ways, with a varying degree of restrictions on
10 what plans can do with the benefit design. In this slide,
11 we illustrate three such examples.

12 The first version is most restrictive in that
13 plans are required to cover the same services at the same
14 level of cost sharing. For instance, Medigap plans are
15 regulated in such a manner. There are 10 standard Medigap
16 plans, and each specifies how it can fill in Medicare's cost
17 sharing. Such strict standardization means that plans are
18 easy to compare and more likely to result in price
19 competition. And because there's not much room to
20 differentiate plans, there's very low potential for risk
21 selection. However, there's no flexibility in plan design,
22 and beneficiaries who want something other than what's

1 offered would not be able to buy it.

2 Under the second version, plans cover the same
3 services, but can vary cost sharing. This is the approach
4 used in Medicare Advantage. MA plans have to cover the same
5 services covered under the Medicare fee-for-service benefit,
6 but they can change cost sharing, such as having different
7 levels of out-of-pocket maximums or a set of co-payments, as
8 long as the value of the benefit package as a whole meets
9 the benchmark value. This approach allows for some but
10 limited flexibility in benefit design, catering to different
11 beneficiary preferences.

12 In contrast, Part D requires an actuarially
13 equivalent package of services and cost sharing, which
14 allows for much flexibility in the design of benefits. But
15 in practice, there are more restrictions on Part D plans
16 because they're required to do certain things. For
17 instance, they must cover all drugs in certain classes, and
18 at least one drug in all classes.

19 In general, as we move left to right in this
20 table, from more to less restrictive standardization, we get
21 increasing flexibility in plan design, increasing
22 beneficiary choice, and increasing potential for risk

1 selection.

2 Under the CPC approach, how the federal
3 contribution is calculated has significant consequences for
4 beneficiaries and the Medicare program. We want to examine
5 three dimensions of this question.

6 First, should the federal contribution be based on
7 plan bids or set to a predetermined amount independent of
8 plan bids? For example, we can set the federal contribution
9 equal to a predetermined level -- let's say \$8,000 in the
10 base year -- and simply index it to grow at the rate of GDP,
11 inflation, or anything else. Under this approach, Medicare
12 program spending is predictable, whereas beneficiary
13 premiums are at risk for Medicare costs increasing at a
14 faster rate than the growth factor.

15 In contrast, a formula based on plan bids can
16 result in contribution amounts that vary over time and
17 across markets and are less predictable for both the program
18 and beneficiaries.

19 Next, should the contribution amount be set
20 nationally versus locally? To illustrate this question, we
21 provide two examples. In both examples, we have three areas
22 with different average cost for Part A and Part B benefit,

1 as shown in the first column of the tables. The national
2 average cost of the benefit is \$800 per month, and the
3 federal contribution rate is 87.5 percent.

4 So let's start with the first table on the top,
5 corresponding to a nationally set federal contribution. The
6 national contribution amount is \$700, which is 87.5 percent
7 of \$800, or the national average cost.

8 As shown in the second column of the table, all
9 three areas receive the same \$700. That means beneficiary
10 premiums in each area equal the area-level average cost
11 minus \$700. Or Column 3 equals Column 1 minus Column 2.

12 In Area 1 -- that corresponds to the first row of
13 the table -- the average cost is below the national average
14 at \$680, and even lower than the federal contribution amount
15 of \$700, and, therefore, the difference is minus \$20. The
16 simplest way to think about the minus \$20 is that
17 beneficiaries get \$20 in rebates. Alternatively,
18 beneficiaries could get \$20 in additional benefits or simply
19 pay no premiums.

20 In Area 2, the average cost is the national
21 average, so its beneficiaries pay \$100 in premiums and
22 receive \$700 in the federal contribution.

1 In contrast, in Area 3, beneficiaries pay \$220 in
2 premiums.

3 Now, let's look at the second table at the bottom
4 corresponding to a locally set federal contribution. In
5 contrast to the first example, the federal contribution is
6 87.5 percent of the local average cost of Medicare benefit.
7 Therefore, the contribution amount now varies across areas.

8 Looking at the second column, it is lower in Area
9 1 at \$595 and higher in Area 3 at \$805. As a result,
10 beneficiary premiums are now \$85 in Area 1 versus \$115 in
11 Area 3.

12 Contrasting the national versus local, you can see
13 that beneficiary premiums in Area 1 go up from minus \$20 to
14 \$85, and those in Area 3 go down from \$220 to \$115.

15 As this simplified example points out, what the
16 federal government pays and what beneficiaries pay in their
17 premiums very much depend on the exact formula of the
18 federal contribution.

19 The third and final question related to the
20 federal contribution is: Should fee-for-service Medicare be
21 included as a bid or not? For example, let's consider two
22 areas, one with low Medicare service use and one with high

1 Medicare service use. Each area has two plans bids, and the
2 average plan bid is illustrated by the red line.

3 I want to point out that these are for
4 illustration only and are not drawn to scale.

5 In our example, including fee-for-service Medicare
6 would lower the average bid in the low Medicare service use
7 area on the left, while raising the average bid in the high
8 Medicare service use area on the right, as illustrated by
9 the yellow dotted lines.

10 In other words, when fee-for-service Medicare
11 coexists with private plans, beneficiary premiums for fee-
12 for-service will now depend on how it compares to private
13 plans. In low Medicare service use areas, plan bids are
14 likely to be higher than fee-for-service. Because fee-for-
15 service is lower than plan bids, beneficiaries are going to
16 pay more to be in private plans.

17 The opposite is true in high service use areas.
18 Because plan bids are likely to be lower than fee-for-
19 service, beneficiaries would pay more to be in fee-for-
20 service Medicare.

21 These design issues have implications for
22 beneficiaries and plans. Under the CPC approach,

1 beneficiaries would pay different amounts for fee-for-
2 service Medicare across areas, depending on how the cost of
3 fee-for-service Medicare compares with the cost of available
4 private plans.

5 Moreover, how many plans would participate in a
6 CPC model and which plans would be available to
7 beneficiaries would also vary across areas.

8 Shifting gears a bit, we now turn to a couple of
9 additional questions that are broader in nature. The design
10 questions we've discussed so far are focused on creating the
11 mechanism of a CPC model. They're complicated, but at least
12 conceptually straightforward. You can see how those
13 questions can turn into design parameters or specs.

14 The two questions on this slide are broader: What
15 is the role of fee-for-service Medicare in a CPC model? And
16 what provisions should be made with respect to low-income
17 beneficiaries?

18 So let's first consider the role of fee-for-
19 service Medicare. Should traditional fee-for-service
20 Medicare still exist in a CPC model?

21 There are at least three possible roles it can
22 play. One, beneficiaries can have fee-for-service as an

1 option everywhere. This would be especially relevant if
2 there are areas where private plans do not bid. Two, as we
3 discussed previously in the presentation, fee-for-service
4 can be included as a bid in calculating the federal
5 contribution amount. And, three, independent of how fee-
6 for-service affects the contribution calculation, it might
7 be important to have Medicare payment rates available
8 because they can exert downward pressure on plan bids.

9 There's evidence from the literature that private
10 sector payment rates are higher than Medicare payment rates
11 in certain areas, and those differences in part reflect the
12 market dynamics in the area, such as provider or insurer
13 concentration. Therefore, lower Medicare payment rates may
14 constrain how much higher private sector payment rates can
15 go.

16 The CPC approach presents an additional set of
17 challenging policy issues with respect to low-income
18 beneficiaries who will need extra help paying for the
19 beneficiary share of the cost of Medicare coverage.

20 On this slide, we want to briefly mention some of
21 the questions any policies related to low-income
22 beneficiaries will need to address, such as: who will get

1 the additional subsidy, and how much; how will they choose
2 among available plans; how will benefits be coordinated
3 between Medicare and Medicaid services; and finally, who's
4 going to pay the additional subsidy and how will the federal
5 and state governments divide up the financing.

6 Depending on the answers to these questions, some
7 states could pay more compared to current law, and some
8 states pay less.

9 As we continue our work on this topic in the next
10 several months, here are some possible next steps:
11 Exploring the effects of Fee-for-Service in Medicare on
12 private plan bids, the importance and adequacy of risk
13 adjustment in a CPC model, empirical analysis of design
14 elements from today's presentation and the issues related to
15 low income beneficiaries.

16 We welcome your input and guidance on these items.

17 That concludes our presentation, and we look
18 forward to your discussion.

19 MR. HACKBARTH: Okay. Thank you, Julie.

20 So, we have only about 15 or 20 minutes left.

21 As I said at the outset, what I'd like to do is
22 focus on questions that commissioners have about the concept

1 and just try to clarify the concept, plus any analytic
2 issues you think would be good for the staff to begin
3 working on. So, those are my limited objectives for this
4 brief discussion, and Mike, I'll start with you.

5 DR. CHERNEW: Yeah, I'll be very quick. First, on
6 slide 3, I just want to make sure that I'm clear. The first
7 bullet point says the contribution is competitively
8 determined, but then later you have a big discussion about
9 predetermined contribution.

10 So, the question is you wouldn't -- would you
11 include in the CPC umbrella, models that have federal
12 contributions that are neutral, the way Glenn described it
13 in the beginning, but not necessarily the outcome of a
14 bidding process? It seems in the end that you would.

15 MR. HACKBARTH: So, let me address that, Julie.

16 I think that we can look at it either way, and
17 each approach has merits and demerits, but I don't --

18 DR. CHERNEW: I just wanted to be clear as to what
19 was in there.

20 MR. HACKBARTH: Did you have another one?

21 DR. CHERNEW: Yeah, just very quickly.

22 So, the second issue is there's a lot of analogy

1 in here to existing programs, like Medicare Advantage and
2 Part D, which I think is fine. In those programs, there's
3 an issue about what the plan can do with the money between
4 the bid and whatever the federal contribution is, and I
5 might add that to my list of things to think about
6 analytically as to what restriction.

7 What happens when plans, for whatever reason when
8 you set it up, when they're under whatever the contribution
9 is, thinking about what the rules are about -- that might be
10 another analytic thing that I would put on my list of
11 differences.

12 DR. BAICKER: Yeah, that was actually one of my
13 questions just to further clarify is there potential for
14 rebates to enrollees if they choose a plan that's below
15 whatever the benchmark or bid is, even below what any
16 premium contribution would be, but you know, in-pocket money
17 is one question.

18 And then, a second question -- I thought it was
19 very helpful to lay out how Medicare Part D and Medicare
20 Part C, or Medicare Advantage, array on these dimensions.
21 We have an interesting example of free-standing Medicare
22 Advantage and Medicare Advantage Part D plans, but combine

1 these things, and it would be interesting to see what the
2 evidence from the bids that those plans have made and what
3 beneficiaries elect and then the cost of care that they
4 receive to the extent that we have that data, how that maps
5 in those three different types of plans to give us some
6 sense of what outcomes you might expect on those different
7 dimensions.

8 DR. NERENZ: Yeah, quickly, slide 10, please.

9 Could you just remind me, or remind us, why we
10 think the plan bids are higher than Fee-for-Service on the
11 left and lower than Fee-for-Service on the right. What's
12 going on there?

13 DR. LEE: Just generally speaking, I think were
14 the plans to have an opportunity to manage utilization and
15 to do the things that the plans are supposed to do, there's
16 more opportunity for them to alter the utilization or do
17 more management in high use areas. So, I think those -- in
18 very broad brush strokes, that was kind of the thing that we
19 were trying to indicate.

20 DR. NERENZ: It doesn't explain the left though.

21 DR. LEE: Oh.

22 MR. HACKBARTH: Well, I'm not sure I'm going to

1 explain the left. Just to build on what Julie said, so as
2 you well know, there are very large variations in service
3 use across the country, and in areas where Medicare Fee-for-
4 Service/traditional Medicare service use is quite low it is
5 more difficult for plans to underbid traditional Medicare
6 because the way they usually do that is by cutting service
7 use, hospitalizations, et cetera.

8 A related issue is pricing in different markets
9 and different market dynamics. In some parts of the country
10 -- urban areas, typically -- there are lots of providers
11 competing, and because there's a generous supply of
12 providers there's greater opportunity for plans to get lower
13 rates because they're actively bidding against one another.
14 And so, in those areas, the gap between the Medicare Fee-
15 for-Service payment rates and plan rates may be relatively
16 small.

17 In areas, though, where there are fewer providers
18 and plans have much more market power, it's difficult for
19 private plans to negotiate and get effective rates. And so,
20 Medicare payment rates may be significantly lower.

21 And so, it's a combination of those factors.

22 DR. MARK MILLER: And, the only other thing I

1 would say is it's not just -- this is just an illustration,
2 but if you look at current bids in MA, this is what happens.

3 And then, the \$64,000 question is: Does that
4 change under a different paradigm?

5 DR. REDBERG: Just curious; what's the take-up in
6 Part D now? Do you know?

7 DR. LEE: For the overall?

8 MR. HACKBARTH: [Off microphone.] So, your
9 question is what percentage of beneficiaries -- [inaudible]?

10 DR. REDBERG: Take Part D, which obviously is
11 different because it was nothing versus Part D and now it's
12 Fee-for-Service, but I'm just -- because to me the challenge
13 is for people to be able to compare different plans and how
14 it gets fairly complicated.

15 DR. CHERNEW: Sixty percent of folks are in Part
16 D, but remember, most people have broad coverage through
17 some other ways. So, there's only 10 percent who have no
18 drug coverage, or less. I think that's right.

19 So, it's -- MAPD, for example, does that take up a
20 Part D?

21 If you have employer-provided drug coverage, does
22 that take up a Part D?

1 So, I think the right answer to your question is
2 90-some percent of people, I think --

3 DR. REDBERG: Have some.

4 DR. CHERNEW: -- have some drug coverage, one way
5 or another.

6 DR. REDBERG: And then, would you foresee that
7 people could go in and out of these different plans, like go
8 from Fee-for-Service to a CPC and then back to Fee-for-
9 Service?

10 DR. LEE: Presumably, there will be -- like as in
11 Part D, there's an enrollment because you are relying on
12 beneficiaries to make choices, and as the relative bids
13 change you want them to have things to make choices that are
14 better for them.

15 MR. HACKBARTH: But, that is a design issue. So,
16 over the course of Medicare Advantage and its predecessors -
17 - Medicare Plus Choice and various other names -- that has
18 evolved.

19 So, originally, it was month-to-month enrollment.
20 Every month, a Medicare beneficiary had the opportunity to
21 either go back to traditional Medicare or change plans.
22 Now, the format is different, and beneficiaries make

1 elections for a year-long period.

2 So, that is a design question.

3 DR. HALL: I'll pass.

4 Thanks so much.

5 DR. NAYLOR: I'm trying to envision the
6 standardized package. Can you talk about what might be some
7 of the opportunities to create a standardized package under
8 CPC, what it might look like?

9 I think it's one of the design elements.

10 MR. HACKBARTH: Are you referring to that early
11 table?

12 DR. NAYLOR: Standardized.

13 MR. HACKBARTH: Yes.

14 DR. NAYLOR: I'm sorry. Standardized benefit.
15 Sorry. Yes.

16 MR. HACKBARTH: So, if the -- question is: If a
17 plan was to do more than Medigap a model --

18 DR. NAYLOR: Yes.

19 MR. HACKBARTH: -- and have more stylized choices,
20 how might that look?

21 DR. NAYLOR: Exactly. I'm just -- I'm trying to
22 figure out what opportunities exist to really take advantage

1 of a standardized benefit here.

2 DR. MARK MILLER: Since we're getting a cold start
3 here --

4 DR. NAYLOR: It's probably -- I'm sure it's the
5 question.

6 DR. MARK MILLER: No. I'm not exactly sure, but I
7 mean, one way to start thinking about it is in MA -- and if
8 I mischaracterize this, guys.

9 In MA, sort of the way it works is there's an
10 expectation that the managed care plan provides certain
11 benefits -- hospitals, physicians, whatever the case may be.
12 And, the plan is given latitude on the cost-sharing. It has
13 to be an actuarial equivalent, but it can modify the cost-
14 sharing.

15 There are some ground rules within that, but it
16 can modify the cost-sharing. And then, the beneficiary is
17 getting a set of benefits and also may be able to go to a
18 different plan and get a different cost-sharing arrangement.

19 So, starting from that point, do you go more in
20 the direction of putting more of the benefit in an actuarial
21 equivalent box and saying let people define things?

22 Or, do you go stay at that midpoint or go further

1 in the sense of saying, well, no, I want to specify the
2 benefit and then say specify the cost-sharing, or that type
3 of thing?

4 I think that's sort of what the toggle is.

5 I don't know exactly how to answer your question
6 beyond that. It would be --

7 DR. NAYLOR: Actually, what you're describing,
8 though, is a range of choices in the design that we have.

9 DR. MARK MILLER: Right.

10 DR. NAYLOR: And, I wasn't -- I actually was
11 looking at the column across and not down.

12 MR. HACKBARTH: Keep -- I'm sorry, Julie. Go
13 ahead.

14 DR. LEE: I think the way to think about the three
15 different columns is that the value of the benefit package
16 is fixed. Now, to what degree or which levers do you have
17 in the benefit package that you can change to meet the value
18 of the package -- I think that's, as you go from left to
19 right, that flexibility. You have more levers that you can
20 go. I think that's the way to kind of think about it as a
21 continuum.

22 MR. HACKBARTH: Yeah. And, as Julie indicated in

1 her initial presentation, there are trade-offs.

2 On the one hand, allowing more flexibility allows
3 plans more opportunity to develop benefit packages that are,
4 you know, customized to meet the needs of particular groups
5 of patients; there's more choice for beneficiaries. On the
6 other hand, there's the concern that as you move towards the
7 right on that continuum the potential for those benefit
8 structures to be used to select better risk and avoid high
9 risk increases. And so, there are trade-offs in that
10 decision.

11 MR. GEORGE MILLER: My question has to do with
12 quality evidence-based medicine. Would we be able to use
13 this as a lever to drive quality for things we think, or the
14 evidence says, has benefit versus something that someone
15 wants to select.

16 And, then would we have the flexibility to say:
17 You can have it, but you pay more. This is going to be in
18 the package. This is evidence-based medicine. We think
19 that the majority of the Medicare beneficiaries would have
20 better outcomes if they choose this methodology.

21 Then so you could have a price tier and then
22 another lever if they want to go off on their own or try

1 some other things. Would we have the flexibility to do
2 those types of things?

3 Especially, what I've read and learned from this
4 Commission -- we can really drive quality and this may be a
5 lever to drive quality based on, as Mary said earlier, all
6 the body of evidence, that it's evidence-based medicine.

7 MR. HACKBARTH: The way I think of it, George, is
8 that this format allows us to pursue different potential
9 approaches to increasing the use of evidence-based medicine,
10 improving value for Medicare beneficiaries. You can try to
11 continue to do that through the traditional Medicare
12 program.

13 None of this would preclude all of the payment
14 reforms that we spend so much time talking about, where we
15 try to restructure the program to create both stronger
16 incentives and greater opportunities for providers to
17 identify what's high-value care and get it to Medicare
18 beneficiaries.

19 All of that work will continue, but it also
20 creates the avenue of private plans using a somewhat
21 different tool set to also drive towards that goal of high-
22 value, evidence-based medicine.

1 So, traditional Medicare offers a free choice of a
2 provider. Private plans often use selected networks. And,
3 each of those approaches has pluses and minuses in terms of
4 advancing the cause of high value.

5 This would basically make both approaches
6 available to beneficiaries and give them choices. In that
7 sense, it's really no different from Medicare Advantage, and
8 that's what Medicare Advantage does as well.

9 MR. GEORGE MILLER: Just one quick -- my second
10 question is how often would we adjust these bids or rates.
11 Would this be done annually? A fiscal year? A longer
12 period of time?

13 Do we have thinking on that yet?

14 MR. HACKBARTH: Well, typically, we think about
15 doing this on an annual basis --

16 MR. GEORGE MILLER: Annual basis, right.

17 MR. HACKBARTH: -- much as is done with Part D or
18 the bidding process under Medicare Advantage.

19 MR. GEORGE MILLER: Annual.

20 MR. GRADISON: Looking into your next round, just
21 two questions.

22 First, I'd like you to give some thought to how

1 this premium structure would work if the premiums were
2 income-related. Granted, the lowest income is zero. I
3 understand that. So, the premiums would rise in some manner
4 related to the income of the beneficiary.

5 I would just like to see how that would work or
6 whether in some way it could be integrated into this plan or
7 not.

8 And, the second thing, which is not unrelated, is
9 how this concept of premium payments would relate to the
10 options that are expected to develop through the exchanges,
11 where you've got -- I understand with the exchanges there's
12 bronze and gold and platinum, or whatever, but I think they
13 have a lot to do not with the benefits so much as they have
14 to do with the size of the deductibles. But, I'm not an
15 expert on that, but I think it's generally what I just said.

16 And so, I'd just like to see how those two
17 concepts -- income relations and how it would relate to some
18 -- to the premium structure conceptually under the exchanges
19 as they develop. Next round, you know another time, but I'd
20 like you to give some thought to that, please.

21 DR. DEAN: I know that introducing these kinds of
22 options certainly gives the opportunity to look at different

1 ways to deliver the care and hopefully come up with things
2 that are more efficient and more effective.

3 I guess my question is, do we know from the
4 experience, both with MA plans and especially Part D, what
5 happens -- what the beneficiaries' approach that is?

6 I mean, it seems to me that the value of choice
7 and shopping around and so forth is much more appealing to a
8 younger population whereas the older population -- and I can
9 identify with that now -- are more interested in security
10 and stability and are less interested in shopping around.
11 And, I know when Part D first came around we went through a
12 lot of turmoil, trying to help people figure out, you know,
13 what would fit.

14 And, I think there are some data about how often
15 do people actually change Part D plans as they're -- and my
16 understanding was it's pretty small even though if they were
17 shopping -- it isn't really -- it doesn't really directly
18 relate to this, but I think it might be relevant to, you
19 know, how the uptake of these ideas by a beneficiary
20 population.

21 MR. ARMSTRONG: Not really a technical question so
22 much as I would just ask -- the format for the analysis is,

1 I think, brilliant. I think it's great.

2 But, I would just ask; I'm thinking about our last
3 conversation that we get into a lot of analysis of
4 alternatives and so forth and that we should -- I would ask
5 that we make sure also as we look at the different choices
6 we've framed that we consider, well, what would you have to
7 believe about the changes in the care delivery system in
8 order for some of those assumptions to really be realized?

9 So, my request would be that as we go forward with
10 this analysis, it's really giving us the opportunity to talk
11 about what are the kind of changes or capabilities in the
12 care system and the industry that we're really trying to
13 drive through some of these policy alternatives.

14 MS. UCCELLO: I'm interested in understanding
15 better the national versus local issues. And, Glenn brought
16 up -- mentioned that the Commission has looked at local
17 market dynamics in terms of price and also regional
18 variations in utilization.

19 And so, what are the implications of national
20 versus local on variations in utilization and/or kind of the
21 price, local market dynamics?

22 DR. SAMITT: You've talked about MA and Part D as

1 sort of a comparative example of how this could work.

2 My question is whether there are any lessons to be
3 learned from the commercial marketplace or employers who may
4 already in many respects have experience and live within the
5 world of competitively determined plan contributions, and
6 whether there's anything that we can look at from a
7 benchmark perspective and an employee perspective in that
8 world that would signal a response to this world.

9 MR. HACKBARTH: So, even within the federal
10 government, the Federal Employees Health Benefits Plan uses
11 a structure at least somewhat like this. Some of the states
12 do. California's employee system does. And, I think there
13 actually is some literature on how those systems have worked
14 and what the rate of increase has been in their costs as
15 compared to other places. So, we can mine that a bit.

16 Peter?

17 MR. BUTLER: Slide 10. Just a little worried if
18 this has a life of its own, just to be absolutely clear.
19 We're neutral at this point in whether Medicare Fee-for-
20 Service as we know it is an option, or not, to pick. This
21 just is about whether or not it should be included in a
22 calculation of a federal contribution.

1 So, you might -- but, if you just read the slide
2 by itself, it might say should you include Medicare or not.

3 And, maybe it should say include Fee-for-Service
4 Medicare spending as a bid versus not, or something, because
5 as I read this by itself somebody may suggest that Medicare
6 is going to actually bid, and that's not the intent of this.
7 I think it's to include Medicare Fee-for-Service spending as
8 a part of the calculation.

9 MR. HACKBARTH: Okay. Let me just to be clear.

10 MR. BUTLER: And, maybe I'm not sure.

11 MR. HACKBARTH: Well, at my request, the way this
12 was arranged, it does assume that Medicare Fee-for-Service
13 is an option as I described at the outset.

14 And then, there would be the question of, well,
15 how do you factor that into the calculation of the
16 competitively determined plan contribution?

17 And, one way to do that is take the projected Fee-
18 for-Service expenditure and treat that as a bid, and then,
19 you know, do the calculation with the relevant plan bids.

20 MR. BUTLER: Okay, but later we do raise the
21 policy issue, and you articulated should Medicare Fee-for-
22 Service be an option or not.

1 MR. HACKBARTH: Yeah.

2 MR. BUTLER: But, again, this is just including
3 their expenses. It's not that they are going to, per see,
4 bid, and that's the way it might read: Include Fee-for-
5 Service Medicare as a bid.

6 It's just semantics on words.

7 MR. HACKBARTH: Yeah. So, you know, as I said at
8 the outset, my goal at this point is really not to preclude
9 any policy options. In fact, the whole purpose here is to,
10 as I said, start with a plain sheet of paper and consider
11 whatever issues you folks think are important.

12 But, I was just trying to explain why the
13 presentation was arrayed this way. I did ask for it to be a
14 system that included traditional Medicare.

15 And, maybe the term, bid, is what's hanging you
16 up. Really, it's just a calculation of the projected
17 Medicare per capita cost.

18 MR. BUTLER: It's not hanging me up. I
19 understand.

20 MR. HACKBARTH: Yeah.

21 MR. BUTLER: Somebody else may just read something
22 else into that.

1 DR. MARK MILLER: Right. Just to make sure I
2 understand, you're saying it's whether it's passive. You
3 know, it's just a calculation of the Fee-for-Service
4 spending in that area, or whether Medicare is actively
5 bidding. That's your point.

6 Just one thing; we'll have to ask everybody to
7 hand in their handouts. We'll catch it in the future, but
8 this batch is out.

9 MR. HACKBARTH: Any other final questions?

10 We are actually 10 minutes over at this point.

11 Hearing none, thank you, Julie and Scott, and more
12 on this later.

13 We'll now have our public comment period. And
14 since I see somebody rising to the microphone, let me just
15 briefly say what the ground rules are for this.

16 Please begin by identifying yourself and your
17 organization and I ask that you limit yourself to no more
18 than two minutes. When this red light comes back on, that
19 will signify the end of the two minutes.

20 MS. MIHALICH-LEVIN: Great. Thank you, I'll be
21 very brief.

22 My name is Lori Mihalich-Levin and I'm with the

1 Association of Medical Colleges.

2 As you consider your next steps with the
3 competitively determined contributions, the AAMC would
4 encourage you to consider, if this model becomes an option,
5 what would happen to the traditional policy payments that
6 are made to providers like direct graduate medical
7 education, indirect graduate medical education, and
8 disproportionate share hospital payments.

9 If these payments no longer exist in their
10 traditional form, at least with respect to the beneficiaries
11 who choose this option, we would urge you to consider how
12 teaching hospitals will continue to serve their traditional
13 missions of teaching residents or training residents and
14 caring for their vulnerable populations that they currently
15 care for.

16 One option that we would urge you to consider is
17 the current model under the Medicare Advantage plan as it
18 exists right now, where GME payments are made directly to
19 hospitals for the patients who select the Medicare Advantage
20 plans.

21 With that, I'd say that we are very open to the
22 opportunity to discuss this further with the Commission and

1 the MedPAC staff.

2 Thank you.

3 MR. WILLIAMSON: Good afternoon.

4 My name is Stephen Williamson. I'm president of
5 the American Ambulance Association.

6 I'd like to take this time also to thank staff for
7 listening to our concerns and recommendations.

8 We noted in the discussion today that it is
9 possibly impossible to get costing information. We would
10 suggest that we have shared ways with the staff, and would
11 be happy to share it with the full Commission, a model for
12 collecting the data. We think these will address the
13 concerns with the historic surveys.

14 Also, we encourage you to keep an open mind about
15 the two companies that have had two equity firms purchase
16 them. That's a very small portion of the industry and
17 doesn't reflect the issue as it pertained to the discussion
18 today.

19 We also would ask that you consider the GAO report
20 which will be out October 1st, and its reflection on local
21 subsidies and local and state regulations on the EMS
22 industry.

1 And finally, we understand that this area of
2 dialysis needs further review and we are very much open to
3 help in clearing up the misconceptions and conceptions of
4 what is going on in that particular dynamic.

5 Thank you.

6 MR. HACKBARTH: Okay, I'm seeing no others going
7 to the microphone.

8 We are adjourned for today and we reconvene at
9 8:30 tomorrow morning.

10 [Whereupon, at 5:42 p.m., the meeting was
11 recessed, to reconvene at 8:30 a.m. on Friday, September 7.]

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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, September 7, 2012
8:31 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
ALICE COOMBS, MD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA

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Mandated report: Improving Medicare's payment
system for outpatient therapy services
- Adaeze Akamigbo, Ariel Winter

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Refining the hospital readmissions reduction program
- David Glass, Craig Lisk, Jeff Stensland

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Public comment

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1 P R O C E E D I N G S [8:31 a.m.]

2 MR. HACKBARTH: Okay. Good morning. Our first
3 session this morning is on another congressionally requested
4 report, this one on improving Medicare's payment system for
5 outpatient therapy services.

6 Who has the lead? Adaeze?

7 DR. AKAMIGBO: Good morning. The Middle Class Tax
8 Relief and Job Creation Act of 2012 requires MedPAC to study
9 the payment system for outpatient therapy services and to
10 address how it can be reformed to better reflect the therapy
11 needs of the patient. I want to acknowledge Ariel Winter,
12 who is sitting next to me, Kevin Hayes, Carol Carter, and
13 Lauren Metayer.

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

20 Today I will begin with an overview of outpatient
21 therapy services in Medicare. I will briefly describe the
22 Medicare benefit, including therapy types and providers;

1 present findings on spending across the different therapy
2 types and the growth in spending over time; discuss therapy
3 caps; exceptions to those caps, which will expire at the end
4 of this year unless Congress acts to renew them.

5 I will also present some policy options the
6 Commission may consider to address our mandate which can be
7 grouped into three categories: options to improve
8 Medicare's ability to manage the benefit in the short term,
9 and in the long term the collection functional status data
10 and ways to reform the payment system for outpatient therapy
11 services.

12 MedPAC staff took a broad approach to gather data
13 and information on outpatient therapy services to address
14 our mandate. In addition to claims analysis and literature
15 review, we held numerous meetings with rehabilitation
16 professional societies that represent all therapy types and
17 providers, and several conference calls with CMS staff. We
18 also hosted a panel rehab researchers and practitioners to
19 discuss how the payment system could be reformed and
20 conducted an extensive set of interviews with different
21 health plans and private benefit managers to learn how
22 therapy services are managed in the private sector.

1 As a quick overview, outpatient therapy services
2 as defined by Medicare include three types of services:

3 Physical therapy focuses on treatments to restore
4 or improve function;

5 Occupational therapy focuses on independence in
6 performing activities of daily living;

7 And speech language pathology focuses on assisting
8 patients with communication and swallowing.

9 Under the Medicare benefit, conditions for
10 services to be provided must include:

11 A verifiable need for outpatient therapy services;

12 A treatment plan which must include at a minimum
13 diagnosis; long-term treatment goals; the type, amount,
14 duration, and frequency of therapy services;

15 The beneficiary must also be under the care of a
16 physician or a non-physician practitioner who certifies the
17 plan of care;

18 Outpatient therapy services are identified by
19 designated HCPC codes and paid the same physician fee
20 schedule rate across all sites of care.

21 You may recall that this is unlike other
22 ambulatory services where payment rates often differ by site

1 of care such as E&M visits, and we will present more on that
2 topic next month.

3 Therapy services may be furnished by the providers
4 listed on this slide. There are two main settings where
5 therapy services are delivered, and they are listed on this
6 slide -- generally in private practices and in outpatient
7 facilities.

8 The Medicare outpatient therapy benefit includes
9 annual caps on per beneficiary spending. The caps reflect
10 an effort to control spending on therapy services given the
11 absence of functional status and clear diagnosis
12 information. The adoption of therapy caps raised concerns
13 about restricted access to care, and this led to an
14 exceptions process around the caps which I will discuss in a
15 moment.

16 There are two cap limits: one for physical
17 therapy and speech pathology combined, and another for
18 occupational therapy.

19 Therapy caps are adjusted annually for inflation,
20 and for the 2012 spending year, the cap is \$1,880.

21 Until later this year, therapy caps have not
22 applied to services received in hospital outpatient

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

6 Now, a different threshold, unrelated to the caps
7 I just described, will trigger manual medical reviews of
8 therapy services. So starting in October this year,
9 combined spending on PT and speech that reaches \$3700 and
10 spending on occupational therapy that reaches \$3,700 --
11 separate -- will trigger manual medical reviews.

12 As I just mentioned, given the concern that caps
13 could impede access to therapy services, an exceptions
14 process was adopted to allow Medicare beneficiaries to
15 receive services above those limits. A KX modifier is
16 included on the claim to indicate that services incurred
17 above the limits are necessary and are documented in the
18 medical record. The list of conditions beneficiaries could
19 have to qualify for an exception is broad, and the
20 exceptions process has made therapy caps an ineffective tool
21 to control costs. As I mentioned earlier, the exceptions
22 process expires every year and requires legislative action

1 to be extended every year. The exceptions to the caps will
2 expire December 31, 2012.

3 Now, Medicare spent a total of \$5.7 billion on
4 outpatient therapy in 2011; 71 percent of total spending was
5 on physical therapy, while 19 percent and 10 percent were
6 for occupational and speech language pathology respectively.
7 Almost 4.9 million beneficiaries used outpatient therapy
8 services. Overall, per user spending was \$1,173. Since
9 beneficiaries used more than one therapy type, the average
10 therapy visits was about 16 per user.

11 This chart shows the breakout of spending from the
12 larger billing sites in 2011. Nursing facilities accounted
13 for about 37 percent of total spending; physical therapists
14 in private practice accounted for 30 percent. Hospital
15 outpatient departments and outpatient rehab facilities
16 accounted for 16 percent and 11 percent respectively.

17 Medicare has experienced significant growth in
18 outpatient therapy services. Across all settings, total
19 spending has grown by 33 percent, or by an average annual
20 rate of 4 percent over seven years, as you see in the last
21 cell at the bottom of this table.

22 While the overall average annual growth rates

1 appear modest, growth in some settings are more stark. For
2 example, from 2004 to 2009 -- that's the second to the last
3 column -- spending in nursing facilities grew by an average
4 annual rate of 8 percent and by 7 percent in the last two
5 years. And as we discussed in March of this year, the one-
6 year growth rate from 2008 to 2009 in nursing facilities was
7 21 percent.

8 Similarly, spending on physical therapists in
9 private practice has grown by 10 percent annually from 2004
10 to 2009.

11 Physical therapists were able to bill Medicare
12 independently starting in 2003, and that policy change might
13 explain some of the growth we see in that sector. But
14 without good data on the functional status of therapy
15 patients, it remains difficult to determine what explains
16 the growth in therapy spending in settings such as nursing
17 facilities.

18 Per user spending has been growing rapidly since
19 1999 despite policy changes to the caps, which are indicated
20 at the top of the chart, and the exceptions process
21 indicated at the bottom of the chart. Caps first took
22 effect in 1999, and as we see, per user spending dropped

1 that year. But from 2000 through 2005 when there were no
2 caps except for a three-month period in 2003, per user
3 spending increased dramatically -- according to the years
4 for which we have data. Caps were reintroduced in 2006, and
5 the exceptions process was introduced that year, although it
6 was a manual process at first. Per user spending dropped
7 that year relative to 2004, but after the exceptions process
8 became automatic with the KX modifier, per user spending has
9 increased every year since.

10 This chart shows a similar trend in total
11 spending. Caps without an exceptions process leads to lower
12 spending as we see 1999, and with a manual process, another
13 drop in 2006. But the absence of caps or the implementation
14 of caps with an automatic exceptions process has resulted in
15 increases in total spending on outpatient therapy.

16 The growth in total and per user spending leads to
17 questions about potential overuse, which is heightened by
18 our findings on geographic variation, which I'll discuss
19 next.

20 This slide shows spending per beneficiary among
21 high and low spending counties.

22 Adjusting for health status, mean per user

1 spending among the top ten counties is over \$2,800, while it
2 is \$477 among the ten lowest spending counties. Counties in
3 the southeast region, like Louisiana, Texas, Mississippi,
4 are among the highest spending areas in the country.

5 But Kings and Queens counties in New York are also
6 among the highest spending counties and with very large
7 numbers of beneficiaries using therapy services. Queens is
8 ranked 19th highest spending county, so it's not on this
9 list here.

10 You may recall that in our March presentation,
11 Miami-Dade County was the highest spending county in the
12 country with per user spending of \$4,500 in 2009. But in
13 2011, per user spending dropped to about \$1,900 in Miami-
14 Dade County after additional reviews and claims edits were
15 implemented to address overuse and fraud.

16 The lowest spending counties are concentrated in
17 Midwestern states of Iowa, Minnesota, and North Dakota.

18 As I mentioned earlier, there are spending caps on
19 therapy services, but there is an exceptions process. In
20 2011 about one-fifth of therapy users exceeded the caps
21 through the exceptions process, and this has grown over
22 time. The mean spending for users who exceeded the caps was

1 slightly over \$3,000, about three times higher than the
2 national average of \$1,173, and much higher than spending
3 among beneficiaries who did not exceed the caps.

4 I will now switch to some of the concerns about
5 diagnosis and functional status data in the outpatient
6 therapy payment system.

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

15 There are no commonly used patient assessments
16 among therapists, as we'll get to in a moment. Poor
17 diagnosis codes make it difficult to determine the
18 conditions and the acuity of the beneficiaries and poses
19 challenges for Medicare's ability to clearly define the
20 benefit.

21 In addition to poor diagnosis codes, there are no
22 functional status measures for outpatient therapy

1 beneficiaries at baseline, at discharge, or at any time
2 during the course of therapy. There are some instruments
3 available as we described in your mailing materials, but
4 they are not widely used. Providers have not been required
5 to report standardized data on functional status to be
6 reimbursed. This makes it difficult to determine the
7 progress patients make, that is, their outcomes once therapy
8 is initiated.

9 In sum, we have presented a lot of data that show
10 that the outpatient therapy payment system is fraught with
11 spending growth and wide geographic variation in spending,
12 with therapy caps that are ineffective in restraining
13 spending due to a wide-open exceptions process and little
14 information on the patient's condition or outcomes. As I
15 mentioned earlier, the Commission is required to make a
16 recommendation on how to improve this benefit under
17 Medicare.

18 Some policy options the Commission could consider
19 would include: improved ability to manage the benefit in
20 the short term; and in the long term, the collection of
21 functional status data; and reforming the payment system to
22 pay appropriately for services provided.

1 I will now walk through each option briefly.

2 To improve management of the benefit, the
3 Commission could consider requiring services from HOPDs to
4 be included under the cap. Until this year, HOPDs have not
5 been included under the cap due to concerns about access.
6 But the broad exceptions process makes this unnecessary.
7 Services in HOPDs will be included under the caps starting
8 in October through December this year. The Commission could
9 discuss making this permanent.

10 The Commission could also discuss an option to
11 introduce focused reviews of therapy claims with specific
12 focus on high-use geographic areas such as Kings County or
13 Brooklyn, New York, and counties in Louisiana, as well as
14 reviews of providers who deliver substantially more services
15 than the average provider. This option could involve
16 medical record reviews, payment edits, and site visits to
17 verify addresses and actual physical location of therapy
18 providers.

19 PPACA granted the Secretary new authority to
20 address fraud and abuse in geographic areas and among
21 providers who exhibit aberrant patterns that suggest
22 fraudulent billing. Under this new authority, the Secretary

1 could place a temporary moratorium on enrollment of new
2 providers, require providers to re-enroll, implement payment
3 edits, or suspend payments for services that show a high
4 risk of fraud. The Commission could urge the Secretary to
5 exercise this authority for outpatient therapy services.

6 The Commission could also discuss the option to
7 reduce the certification period from 90 days to 45 days.
8 Our analysis has shown that the average episode lasts for
9 about 32 days. A therapy plan of care for 45 days would
10 accommodate the majority of outpatient therapy users and
11 would increase physician engagement and oversight of the
12 plan of care. But while this option may increase oversight,
13 requiring recertification after 45 days could lead to more
14 physician visits associated with a therapy episode of care.

15 The Commission could also discuss potentially
16 requiring that all submitted claims have clear and specific
17 diagnosis codes and prohibit the use of V codes as a primary
18 diagnosis in order to be reimbursed. Finally on this slide,
19 the Congress could give the Secretary the authority to
20 adjust beneficiary cost sharing. This is consistent with
21 the Commission's June 2012 recommendation on cost sharing.
22 Making beneficiaries more sensitive to the cost of therapy

1 services could encourage them to carefully assess the value
2 of those services.

3 To collect information on functional status, the
4 Commission could discuss the development of a standard tool
5 to capture key information on functional status and therapy
6 needs. The goal for such a tool is that it would facilitate
7 categorizing the majority of therapy users by severity and
8 functional status during an episode. As outlined in your
9 mailing materials, there are currently many tools that exist
10 to develop clinical plans of care, and they are specific to
11 therapy types such as PT and speech pathology.

12 But a new tool that would capture demographic
13 information, therapy specific diagnosis, such as
14 osteoarthritis, affected body structures, such as the
15 shoulder, and affected activities or limitations in
16 activities, such as walking or communication, would provide
17 the basic information necessary to group patients into
18 defined levels of acuity and enable CMS to prospectively
19 determine how much therapy a given patient may need. This
20 new tool would not prevent the use of other assessment
21 instruments currently used for care planning, but it would
22 collect information necessary for payment purposes.

1 There is a prototype for such a tool that was part
2 of a CMS study, and as we discussed with researchers and
3 practitioners, additional data elements to that prototype is
4 a good start towards developing an instrument for payment
5 purposes.

6 And finally, the Commission could discuss long-
7 term options to redesign the payment system. It could take
8 two forms.

9 First, a payment system that pays per episode.
10 This would be based on extensive data that has been
11 collected using the instrument I just described. This
12 option would take some time because of the data collection
13 that would need to occur in order to construct severity
14 groups and payment categories, as well as expected episodes.
15 This option could reward providers who achieve better
16 outcomes in the expected amount of time.

17 For some patients however, the predicted amount
18 may not be enough. On the high end, an unrelated injury or
19 illness could delay progress from therapy services, and in
20 those cases there would be outlier payments to pay providers
21 for their costs above a certain threshold. Similarly, an
22 episode could be truncated for several reasons. Therapy

1 patients often do not complete a prescribed number of
2 therapy sessions. In those cases, Medicare could pay for
3 the completed visits rather than an entire episode.

4 Another option could be to implement a similar
5 method to the private sector's approach to managing the
6 outpatient therapy benefit. From the series of interviews
7 we conducted with private plans along with our contractor,
8 we learned they often impose a per beneficiary visit limit
9 and require pre-authorization for any additional visits
10 above that threshold. Under this approach, we may not need
11 information collected using the standardized tool described
12 earlier.

13 To wrap up, we would like your reactions and
14 guidance on these policy options. Some of the policies
15 we've discussed expire at the end of the year. Congress has
16 required MedPAC to make recommendations in this report. For
17 those recommendations to be useful to the Congress, they
18 need to be produced before the provisions expire.

19 And with that, I will turn it back over to Glenn.

20 MR. HACKBARTH: Okay. Thank you, Adaeze. Well
21 done.

22 Could I kick off the round one clarifying

1 questions? Over the years, we have spent a lot of time
2 talking about therapy and home health agencies and skilled
3 nursing facilities. And I think it would be useful to make
4 sure that everybody understands how this outpatient therapy
5 service benefit relates to that. Let's focus in particular
6 on home health agencies for a second.

7 You have a Medicare beneficiary who is receiving
8 home health services. Medicare is paying for a home health
9 episode, and one of the services the beneficiary is
10 receiving is therapy services. How is Medicare paying for
11 those therapy services? Is it all under the home health
12 payment system, or is there also a payment under the
13 outpatient therapy benefit? Would you just clarify that and
14 make sure everybody understands how that works?

15 DR. AKAMIGBO: Yeah. So it's a similar situation
16 with nursing facilities, SNF. So you can get therapy as
17 part of the SNF bundle or part of the home health bundle
18 payment. In skilled nursing facilities or home health, for
19 the patients -- the beneficiaries who reside there, say
20 skilled nursing, who are not getting therapy under Part A or
21 the SNF bundle, they can get therapy services covered under
22 Part B.

1 MR. HACKBARTH: Right.

2 DR. AKAMIGBO: So they're not skilled patients
3 necessarily. They're nursing home residents getting Part B
4 therapy.

5 In home health, it's less clear there, but
6 basically if they're homebound, getting other services --
7 not getting therapy services under the home health benefit,
8 Part B -- therapy services can still be billed to Part B to
9 cover physical, speech, and occupational therapy. I don't
10 know if that's clear.

11 DR. MARK MILLER: Just let me go through this for
12 a second. If somebody is homebound and they're getting a
13 skilled service during the home health episode, that would
14 be covered there.

15 MR. HACKBARTH: Under the home health payments.

16 DR. MARK MILLER: Under home health. I'm sorry.
17 I'm not being clear. In theory, that person is homebound
18 and then wouldn't be able to travel for outpatient therapy.
19 They would be getting their therapy there. So I'm not
20 saying there is no billing that occurs. I'm always
21 surprised by what happens.

22 MR. HACKBARTH: And so --

1 DR. MARK MILLER: But in theory, that should be
2 two different events.

3 MR. HACKBARTH: So let me just play it back. If
4 the patient is homebound receiving care under the home
5 health benefit and payment system, then the dollars for the
6 therapy flow only under the home health payment system.

7 If, however, the patient is not homebound,
8 therefore ineligible for home health payment, and is
9 traveling to a different location for therapy services, then
10 it's paid under this outpatient therapy benefit.

11 DR. CHERNEW: When they get the therapy in the
12 home care setting, is it a higher case mix adjuster? In
13 other words, I thought home care had different levels of
14 payment for home --

15 MR. HACKBARTH: Oh, yeah --

16 DR. CHERNEW: I want to know if the receipt of
17 outpatient therapy changes the severity and payment level in
18 the home care payment system.

19 DR. MARK MILLER: Within home health, there are
20 different -- like hospital DRGs and that type of thing --

21 DR. CHERNEW: Yeah, like a RUG.

22 DR. MARK MILLER: -- there are different

1 categories.

2 MR. HACKBARTH: It is a RUG, in fact.

3 DR. MARK MILLER: No. That's SNF. That's SNF.

4 MR. HACKBARTH: Oh, that's right.

5 DR. CHERNEW: So we're close.

6 DR. MARK MILLER: But it's the same idea, and so

7 you can have high-intensity patients and low-intensity

8 patients.

9 DR. CHERNEW: And so my question is: The receipt
10 of physical therapy or any of these therapies, is that a
11 cause for moving from one of the home health categories to a
12 higher one? And I say that mostly so we can see what the
13 payment rate is in the --

14 DR. MARK MILLER: Yeah, so, for example, if you
15 had more complex needs and needed, you know, more skilled
16 therapy services, that would move you up in the home health
17 payment system.

18 MR. HACKBARTH: Yeah, and then just to complete
19 it, on the SNF side, if the patient is in a skilled nursing
20 facility receiving services, that's a clear-cut case. The
21 payment is through the skilled nursing facility payment
22 system.

1 If the patient is not actually residing in the
2 SNF, they can receive services at a SNF on an outpatient
3 basis under this outpatient therapy benefit system. So when
4 we see statistics here on the rate of growth in SNF-based
5 payment, these are patients who are not living in the SNF
6 that are going to a SNF on an outpatient basis?

7 DR. AKAMIGBO: Let me -- yeah. So most of these
8 are patients who live in the nursing facility.

9 MR. HACKBARTH: Yeah.

10 DR. AKAMIGBO: They're not the SNF Part A.

11 MR. HACKBARTH: Yeah. They're not SNF patients.

12 DR. AKAMIGBO: They're not SNFs. That's why I'm
13 trying to be consistent in saying nursing facility as
14 opposed to skilled nursing facility.

15 MR. HACKBARTH: Right.

16 DR. MARK MILLER: Right, so think of the scenario
17 of a dual eligible who is living in a nursing home, so
18 they're getting their nursing home services from Medicaid,
19 but they may be, you know, going to the clinic that's part
20 of the nursing home and getting Part B outpatient therapy.

21 DR. AKAMIGBO: Therapy, yeah.

22 DR. MARK MILLER: Again, in theory, or, you know,

1 the way it's supposed to work, if they're actually in the
2 skilled stay, the SNF stay, then they shouldn't be getting
3 it.

4 DR. AKAMIGBO: They could get it, but it would be
5 billed under --

6 DR. MARK MILLER: They should not be getting the
7 Part B outpatient therapy

8 DR. AKAMIGBO: Yeah.

9 DR. MARK MILLER: You okay?

10 MR. HACKBARTH: Okay. Let's see. Whose turn is
11 it to start? It's George. George looks like he's ready to
12 go here.

13 [Laughter.]

14 MR. GEORGE MILLER: Well, let me see if I can add
15 to your confusion. What about a patient in a swing-bed, in
16 a hospital swing-bed who may need therapy? Which -- how is
17 that billed?

18 You think I would know, but --

19 MS. KELLEY: [Inaudible.]

20 MR. GEORGE MILLER: Still Part A?

21 DR. MARK MILLER: So -- yeah.

22 MR. GEORGE MILLER: Okay.

1 DR. MARK MILLER: So that the transcriptionist
2 gets it, SNF Part A benefit. Okay?

3 MR. GEORGE MILLER: Okay. I've got other
4 questions, but I'll wait until round two.

5 MR. HACKBARTH: Clarifying question?

6 DR. NAYLOR: Just, if a patient's plan of care is
7 for -- I'm trying to figure it out in terms of the
8 alternative payment opportunities, episode versus private.

9 If a patient's plan of care is elongated, meaning
10 over time, how would either one of these -- is it the
11 private sector approach that would allow for that
12 flexibility, meaning I want to prevent functional decline in
13 someone and it's not someone who is going to benefit
14 necessary by lots of therapy visits right up front but
15 rather over time?

16 How would either of these alternatives -- which of
17 these might be the better to address that kind of person's
18 need?

19 DR. MARK MILLER: I'll give you a couple thoughts,
20 and if you guys -- so, if you start with the episode option,
21 so the idea here is you should have much more detail on the
22 needs of the patient, including functional limitations,

1 which is really -- there are other important factors that we
2 can cull from our conversations but functional limitation
3 being really important.

4 So, you know what limitations they come in. You
5 can see if those improve, which is the idea anyway. And
6 then, you would build episodes on the base of those
7 characteristics and have blocks of spending. Say, for these
8 types of characteristics, here's the block of spending.
9 Then, you have two safety valves.

10 One is the patient stops coming, and maybe the
11 program says, well, I'm not going to pay you the whole
12 episode; I'll pay you for a few visits because the patient
13 opted out.

14 On the other hand, it would be like an outlier
15 payment which you often see in our other payment systems.
16 Somebody exceeds the episode for some period of time, and
17 then the program comes back in behind that and sort of
18 begins to pick that up. And, what that threshold is and how
19 much they pick that up would be a matter of design.

20 Now, one thing I want to say is that it still
21 doesn't necessarily put a cap on total episodes. So, people
22 could just generate episodes, and we may still have, you

1 know, the issue we have now.

2 In the private sector, the way a lot of private
3 sector plans work, not exclusively, but they say: Our
4 benefit is 14 visits. If you want more, your physical
5 therapist calls our physical therapist and discusses whether
6 there is, you know, a need to go beyond that.

7 And, the guidelines there -- fairly hazy.

8 DR. HALL: So, on the V codes, there's -- just to
9 make sure I understand this. There's virtually no way to
10 backtrack how V codes correspond to clinical diagnosis. Is
11 that correct?

12 DR. AKAMIGBO: That is the diagnosis code.

13 DR. HALL: Yes, that's the diagnosis code, but I
14 mean, abnormality of gait could be something as simple as a
15 bunion or it could be a stroke --

16 DR. AKAMIGBO: Yeah.

17 DR. HALL: -- or it could be horrible frailty.
18 And, there's no way at this point to put that kind of a
19 discriminator, at least.

20 DR. AKAMIGBO: For the V code, no. It's -- yeah,
21 when it says other physical therapy, that's all we've got

22 DR. HALL: Okay. Thank you.

1 And then, just one other question. The geographic
2 disparities and notably the Miami case, which got a lot of
3 publicity you mentioned in the write-up, has anything like
4 that been done in other areas of the country that are very
5 high, seem to have high utilization?

6 Some of the southern -- other southern economies -
7 - Louisiana.

8 DR. AKAMIGBO: We haven't heard of any in the
9 outpatient therapy space. Yeah, maybe others --

10 MR. WINTER: In the -- we did talk to carrier
11 medical director from a southern state that shows a high
12 level of utilization, and they -- he had said in the past
13 they had implemented various things which had an effect, but
14 they just don't -- they had to discontinue then because they
15 just don't have the resources to pursue all the services
16 that are risk.

17 DR. HALL: Right, right. So, I mean the Miami
18 experience was kind of a no-brainer, right?

19 A general physician billed no services and then a
20 year later billed a million, maybe two million dollars. I
21 mean, it doesn't take a rocket scientist to figure out
22 what's going on there.

1 Okay, that's all for round one for me.

2 DR. AKAMIGBO: Okay.

3 MR. HACKBARTH: So, on the Miami example, was that
4 an illustration of the effect of intense investigation of
5 fraud and abuse or application of utilization management
6 tools by a carrier?

7 DR. AKAMIGBO: Yeah, it was more the latter --
8 application of, you know, payment edits, things that are
9 implausible. An 80-year-old getting an average of 2 hours
10 of therapy a day, unlikely. And, that cut it down
11 significantly.

12 MR. HACKBARTH: Okay. Good.

13 Rita, clarifying questions?

14 DR. REDBERG: Do carriers routinely look at
15 changes in patterns, like ones not quite as flagrant as
16 going from zero to a million but just changes in patterns of
17 usage of providers and beneficiaries in their areas?

18 DR. AKAMIGBO: Depending on where they are.

19 DR. REDBERG: Like my credit card company would
20 call me, you know --

21 DR. AKAMIGBO: Yeah.

22 DR. REDBERG: -- if all of a sudden they saw

1 spending in a different area that I don't usually spend.

2 Does the carrier -

3 DR. AKAMIGBO: I think it depends on where they
4 are. We talked to a number of the groups that basically
5 cover, I would say, Florida, Texas would review, pay, you
6 know, edit. They would review claims a little bit more
7 often than carriers in others, say Iowa, that cover Iowa or
8 Minnesota. Just, it's not as prevalent a problem in some
9 other areas of the country.

10 On the private side, I think it also reflects a
11 similar pattern where depending on where they are, if
12 they've seen prior evidence of overuse or fraud, they're
13 more likely to review claims. But, if they're in some other
14 region of the country -- Oregon -- it's not something that
15 they have the resources to routinely do.

16 DR. MARK MILLER: If I could pick up for a second,
17 and Herb, you may need to help me out here.

18 So, my sense is that what -- the carriers have a
19 set of -- they have a contract with CMS. They have a set of
20 responsibilities that they're to execute. You know,
21 responding. You know, educating providers, processing
22 claims, doing a number of different activities.

1 And, this is often a function of the contract, but
2 as resources become limited, what happens in CMS is they
3 sort of prioritize what they're going to do with their
4 resources. Their top priority is making sure that claims
5 are paid, and there are legal requirements to pay claims
6 within certain time limits.

7 So, the difficulty here is that even those who --
8 and I think there is some variation, and I think that's what
9 you're saying, on how much attention gets paid to this type
10 of thing. But -- and, I think this goes to some of the
11 exchange here -- how sustained that can be and how
12 systematic it is, I think is something of a question.

13 You also raised yesterday, Herb, this new effort
14 where there's trying to be much more micro-examination of
15 the data, the kind of thing that credit card companies do,
16 like what's going on here, and have more of a real-time
17 response although we're not real deep on sort of how that's
18 going and where it's going to go.

19 MR. KUHN: That's right, Mark.

20 You know, the new predictive analytics program
21 that CMS has launched through their new fraud center helps
22 to deal with that. So, basically, what they've done a lot,

1 with a lot of the Medicare administrative contractors, is
2 they've got now other contractors -- known as ZPCs, RACs,
3 those other entities -- that when they start to spot these
4 activities they're going more to them.

5 Where a lot of the carrier medical directors are
6 spending more of their time lately, it seems to me, is
7 looking at their local coverage determinations and trying to
8 drive policy through those.

9 And, to give you an example of one, to kind of
10 show you a bit of the frustration I think some of these
11 CMDs, these carrier medical directors, are experience --
12 there's one MAC in the south right now that I understand has
13 an LCD that would prohibit entirely joint replacement
14 patients from going to an IRF for care. It would completely
15 draw a bright-line. And, that comment period on that one
16 closes next week, if I understand right. So, that's kind of
17 the extent where I think they're spending a lot of their
18 time right now.

19 DR. REDBERG: Just, maybe we can get more into in
20 round two. It seems to me the kind of things we would do --
21 one would do -- to prevent fraud is different clarifying.
22 It makes sense to clarify V codes because to have a V code

1 that doesn't tell you what you're doing, but that's more on
2 a clinical side.

3 And, I think, you know, because there is certainly
4 a suggestion that there's fraud and that currently the
5 carriers don't seem incented to really look for it and
6 because of this pervasive problem, that seems like a
7 different approach and problem and would have a different
8 solution than the kind of more clinical sides and refining
9 the codes, you know, and getting the episodes right and
10 looking at functional status because none of that is going
11 to get at fraud. And, fraud, you know, is serious enough
12 that I think we need to consider that separately.

13 DR. MARK MILLER: And, just to put this thought in
14 for you guys to discuss in your second round, there is a
15 different kind of auditor. The recovery audit contractors,
16 I think. Did I get that, right, Herb?

17 The RACs? Okay. And, there, they do have an
18 incentive to find it because part of their fee turns off of
19 what they recover.

20 And so, a question that you might consider in the
21 second round is: Is this some place for a focus for them?

22 I'm not sure what their focus is on this now. I

1 don't know if that's come up in any of our conversations.

2 So, I may be speaking out of turn, but it's something that
3 we can explore.

4 DR. NERENZ: I'm just curious if you -- if we know
5 anything about how the -- either the geographic variations
6 or the temporal changes relate to similar variations in
7 other payment streams.

8 For example, one might imagine that a lot of
9 physical therapy for back pain might be associated with
10 lower surgery expenses if the one reduces the need for the
11 other. So, you'd see an offset effect.

12 On the other hand, if you're in a region where
13 there's a lot of back surgery and the physical therapy
14 follows surgery, you'd actually see them positively
15 correlated because the one follows the other.

16 Is there a body of knowledge on this, and is --
17 should we know about this, or is there something to be
18 known?

19 DR. MARK MILLER: At least -- and not very
20 specifically on back surgery, out-patient therapy, that type
21 of thing, but there's been work done by others and by this
22 group that has looked at geographic variation and broke that

1 variation down into different categories of service and then
2 asked the question, well, if you see one go up, do you see
3 other stuff go down?

4 And, my general take from that -- I'm looking for
5 Dan -- is that you basically find positive correlations. If
6 you're higher, you're higher on everything. You don't see a
7 lot of substitution effect.

8 I don't know if other people have views on that.

9 Specifically, to your back surgery, OT - I don't
10 know if I could answer.

11 DR. NERENZ: And, that was just one example to
12 clarify the question. I assume you'd seen it in things like
13 occupational therapies and falls where the question is, does
14 one prevent, or does actually the occupational therapy
15 follow a fall that occurred with high prevalence for some
16 other reason?

17 I'm just curious how we should be thinking about
18 these things.

19 DR. BAICKER: I wasn't sure that I understood the
20 option within the episode-based payments to stop payment or
21 to pay less if patients prematurely end their therapy
22 sessions.

1 My understanding of the episode-based payments is
2 that you try ahead of time to figure out what the typical
3 number of visits would be. That bundle is based on patient
4 characteristics and all of that. And, some patients are
5 going to be higher, and some patients are going to be lower,
6 except if it's lower you're going to pay less and if they're
7 outliers you're going to pay more. And then, it stopped
8 sounding like an episode.

9 And, I wonder if I'm missing a subtle distinction
10 between the number of prescribed visits versus the visits
11 they actually consume, or if you're really saying we're
12 chopping off the top end for outliers and we're chopping off
13 the bottom end for low users.

14 MR. HACKBARTH: In the home health payment system,
15 in fact, you have -- what is it? The LUPA, the low use
16 payment adjustment. So, if there are only -- I forget what
17 the exact threshold is, but if there are only a few visits
18 the provider does not get paid on an episode basis but on a
19 per visit basis.

20 So, it would be analogous to that, and then at the
21 high end, there's additional payment.

22 DR. MARK MILLER: So, yeah, just to spell out the

1 high end, let's say, you know, this episode sort of assumes
2 a dollar amount and has an implicit number of visits. You
3 hit that visit. You run two, three, four, five, whatever it
4 is. And then, the outlier payment starts to kick in behind
5 it.

6 MR. BUTLER: On slide 13, one comment first on
7 these nursing facilities. I've seen a lot of this in
8 multiple settings.

9 I think just to further clarify; I think there are
10 a whole lot of patients that are sitting in SNF beds, are
11 not receiving Medicare Part A because there was no prior
12 hospitalization but are receiving physical, occupational,
13 other therapies, like we said, in a Part B. And then, it's
14 somebody that could be on a downward path and just needs
15 more activity of one kind or another, and it's just more
16 heavily utilized than ever before. And so, that, I think is
17 a decent part of what you're seeing in the nursing
18 facilities.

19 But, my question relates to the -- it's getting a
20 little bit at the fraud and abuse. The private practices
21 are primarily the majority of the use on the private
22 practice side.

1 So, I know that -- let's take a joint replacement
2 where the orthopedic practice may own the physical therapy
3 service themselves and can refer patients to their -- for
4 the use for their own patients. That's one kind of
5 scenario.

6 And, they do the joint replacement and then come
7 get your treatment. I understand that.

8 What I don't understand is like the family
9 medicine physician in Dade County who billed \$1.2 million.
10 Those can't be just their own patients, I wouldn't think.

11 So, this doesn't talk anything about these are
12 private practices of physical therapy practices. So, I
13 don't quite understand the billings of physicians versus
14 these separate private practices.

15 DR. AKAMIGBO: Yeah, well --

16 MR. BUTLER: Honestly, the physicians are just
17 billing outright fraud and --

18 DR. AKAMIGBO: Oh, no.

19 DR. MARK MILLER: [Inaudible.]

20 DR. AKAMIGBO: Yeah. So, I think -- let me try to
21 answer your question as I understand it.

22 Physicians can bill for therapy services.

1 So, we'll take physical therapy. Physicians can
2 bill for delivering physical therapy services. Private
3 practice physical therapists can also bill.

4 So, if a PT, or a physical therapist, is operating
5 in a physician's office and claims are submitted through the
6 physician, using the physician's number, that is -- that
7 will come up under the physician claim. You know, that will
8 come up under the physician stream.

9 A PT that owns his or her own practice and is
10 billing using their independent number, that will come up
11 under the physical therapists in private practice.

12 So, they would be separate, and this line here is
13 showing just physical therapists in private practice.

14 MR. BUTLER: So, would the majority of the 400 --
15 you know.

16 You've got total private practice as 1.4, and the
17 physical therapy practices are 1.0. Is the 0.4 a
18 difference, mostly physicians probably billing for physical
19 therapy services in their practice?

20 DR. AKAMIGBO: Yes.

21 MR. BUTLER: Supposedly, for just their patients?

22 DR. AKAMIGBO: Yeah.

1 MR. BUTLER: That's what they're permitted to do,
2 right?

3 DR. AKAMIGBO: Yeah.

4 MR. WINTER: It could also be occupational
5 therapy.

6 DR. AKAMIGBO: Yeah, so that subheading there is
7 private practices. The majority would be physician, but you
8 would also have occupational therapists in private practice,
9 speech pathologists starting in 2009 who have their own
10 private practices and then PT, and also nurse practitioners
11 or non-physician practitioners could also have their own
12 private practice, billing -- all billing outpatient therapy,
13 Part B services.

14 MR. BUTLER: But, the supposed fraud and abuse
15 would be occurring in that 0.4 sector primarily. It could
16 occur -- physical therapists then on their own could be
17 doing things, and there could be all kinds of other
18 payments, but that's where the overutilization from
19 physician practices will likely show up in these numbers.
20 Is that fair?

21 MR. WINTER: I don't think we know.

22 DR. MARK MILLER: Also, notice that the more

1 current numbers. The differential of 1.7 and 2.1 is getting
2 a little bigger. It's the same point. You're focused on
3 2004. That's the 2011 breakdown.

4 MR. BUTLER: Actually, the difference is exactly
5 the same between the two, but it has grown in both cases --
6 0.4.

7 DR. MARK MILLER: The -- if it's outright fraud,
8 I'm not sure that it's peculiar to one line or the other.
9 If you're talking outright fraud.

10 MR. BUTLER: Just crooked billing, under the table
11 pay -- all kinds of things that could -

12 MR. HACKBARTH: Billing for patients that they
13 don't see.

14 MR. BUTLER: Right, right.

15 DR. MARK MILLER: Then, you were sort of setting
16 up, I thought -- but maybe not. You were setting up the
17 potential for a self-referral type of situation where, you
18 know, the physician kind of has got a pool of physical
19 therapists and saying: Okay, now you need to go see the
20 physical therapist. I'm going to bill on that behalf, and
21 then I have a separate financial relationship with what I
22 pay the physical therapist.

1 And, I don't know that that's fraud, but that is a
2 self-referral type of [inaudible].

3 MR. HACKBARTH: And also, the inference I draw
4 from Adaeze's response is that that's actually a pretty
5 small amount of activity -- the physician self-referring to
6 his or her own physical therapist. In the private practices
7 group, it's just a fraction of the all-practices, the
8 subtotal line.

9 MR. BUTLER: That was my point.

10 MR. HACKBARTH: Yeah.

11 MR. BUTLER: That's what it looks like.

12 MR. HACKBARTH: So, there's the occupational
13 therapists and all of the others that are included in that
14 row. The physicians are just a piece of that.

15 DR. AKAMIGBO: I just want -- sorry.

16 I just want to be clear. We can't quite -- we
17 can't quantify how much -- and I'll let Ariel speak more to
18 this.

19 But, we can't quantify how much self-referral is
20 happening in physical therapy with physicians self-referring
21 to physical therapists or any therapist they employ. We
22 suspect some of that is going on, but it's very difficult,

1 given the data we have, to actually quantify that.

2 MR. HACKBARTH: But, the inference I'm drawing is
3 so if the all-practice number is 1.4 billion in 2004 and 1
4 billion of that is coming through the physical therapist
5 private practice. So, the physician is in the residual of
6 the 0.4 billion in 2004, but in that same item there's all
7 the occupational therapy and all of the other speech
8 pathology, all of the other items. And so, the physicians
9 are only a fraction of the 0.4, right?

10 MR. WINTER: It's a little bit more confusing than
11 that because physical therapists in private practice can
12 bill as a therapist in private practice, but that -- they
13 can be employed --

14 DR. MARK MILLER: They can still be --

15 MR. WINTER: -- where the practice can be owned by
16 a physician practice. I want to clarify that.

17 DR. MARK MILLER: That's right.

18 MR. WINTER: I think Peter was trying to get at
19 that.

20 So, many of -- we don't know. We can't tell what
21 share of those are truly independent private practices --

22 MR. HACKBARTH: I see.

1 MR. WINTER: -- versus private practices that have
2 some kind of financial affiliation --

3 MR. HACKBARTH: Got it.

4 MR. WINTER: -- or ownership relationship with a
5 physician practice. The claims data don't tell us that.
6 And, we've tried to use other data sources to get at that
7 and not been successful. So, that's why we can't quantify
8 the extent or what proportion of physical therapy is related
9 to physicians owning a therapy practice or employing a
10 therapist.

11 We've heard anecdotally this is an issue and a
12 growing issue, but we can't quantify it.

13 And, the last thing I'll say is GAO has been
14 tasked by Congress to investigate this specific question,
15 and we don't know -- we know that report is -- they're
16 working on the report. We don't know when it's going to
17 come out, but GAO is looking at this specific question.

18 MR. BUTLER: Can I ask one more then? Am I right
19 to say, though, that the bad behaviors are more likely to
20 occur in the private practice below the line than in the
21 nursing facilities?

22 There may be overutilization or utilization that

1 isn't particularly helpful in the nursing facilities, but
2 that's not as likely a place to go to look for the -- you
3 know, kind of the arrangements that just don't smell right
4 at all.

5 DR. AKAMIGBO: I don't think we know, but I would
6 be very hesitant to draw that conclusion.

7 I think anecdotally we've heard of overuse,
8 overbilling practices across all settings, and nursing
9 facilities have not been excluded from that. But, again,
10 without being able to quantify that, I would hedge a little
11 bit and not draw that conclusion.

12 DR. MARK MILLER: I would too, and I think it's
13 more a question of whether you're talking about outright
14 fraud or whether you're talking about I am -- you know. I
15 have a nursing home patient. They're failing. I'm putting
16 them into a Part B therapy.

17 And, rightly or wrongly, the Medicare benefit is
18 supposed to be about improvement. And, rightly or wrongly.
19 You know. I just want to be clear here.

20 And, if it's really not doing that, then I guess
21 there are questions about whether that should be going on,
22 at least from the Medicare benefit point of view. And

1 again, not rightly or wrongly.

2 That, I see as a much different question than sort
3 of fraud, or I'm just -- you know. I went from zero to a
4 million in sixty seconds.

5 DR. CHERNEW: I just want to -- can I follow up on
6 Mark just for one second?

7 In that dichotomy of sort of fraud-fraud versus
8 overuse, we're not sure if it was right or not, or maybe it
9 was more, how much of a problem would you put into the "We
10 should have our discussion thinking about this in terms of
11 fraud management detection" versus "We need to think about
12 this discussion in terms of there is a big gray area; we
13 need a policy to address that gray area?"

14 DR. AKAMIGBO: I think a good chunk of --

15 DR. MARK MILLER: I do not know the answer to that
16 question.

17 DR. AKAMIGBO: I think the discussion should be
18 focused on the latter, and I say that for a couple of
19 reasons.

20 When you have average spending per user in Miami-
21 Dade as we had in 2009, of \$4,500 per person, compared to
22 \$500 for the rest of the country, that's a clear case of

1 massive fraudulent activity.

2 DR. CHERNEW: [Off microphone.] It could just be
3 a different [inaudible].

4 DR. AKAMIGBO: Not when the differences are that
5 stark. I think if you're talking from 1,000 or 1,100 to
6 1,500, then we could discuss practice patterns or, you know,
7 some weird geographic variation that we don't know. But,
8 when you're talking 4,500 or even 3,000 compared to 500,
9 then I think we have some issues.

10 So, Louisiana; I think there's a clear case to be
11 made for talking about fraudulent activities and the same
12 thing with Brooklyn. You know, a couple counties in New
13 York.

14 But, a big -- a lot of this -- because outpatient
15 therapy, you have very few guidelines. There are no clear
16 guidelines when you talk to people who work in this area. A
17 lot of this is subject to interpretation. There's a lot of
18 autonomy. The therapists have to decide whether a patient
19 needs more therapy, and it's subject to very little
20 oversight. So, I think there we're talking about overuse in
21 a space where there are few guidelines to guide them as to
22 what the right amount of therapy would be.

1 MR. HACKBARTH: I think we're getting pretty round
2 two-ish here, and so I want to keep moving.

3 But, on this issue, you know, I don't think that
4 they're mutually exclusive, that we have to say, oh, we're
5 just going to have payment reforms that focus on overuse or
6 we're going to just have recommendations that relate to
7 potential fraud. We could do both.

8 Alice?

9 DR. COOMBS: Thank you for your excellent
10 presentation.

11 One of the questions -- the last alternative I
12 like a lot. But, in your evaluation and investigation into
13 the private sector, what percentage of private payers will
14 do preauthorization as a secondary for extension versus
15 preauthorization from the very start of physical therapy?

16 MR. WINTER: Yeah, so we talked to our -- me and
17 our contractors, NORC and Georgetown, talked to 11 plans and
18 3 benefit managers. So, this is not a national
19 representative sample. So, I want to start off with that
20 qualifier.

21 We did find cases where some plans were doing
22 prior authorization up front, before the episode even began.

1 DR. COOMBS: Right.

2 MR. WINTER: But, it was more common that they
3 would, you know, allow six to eight visits or even 25 visits
4 initially, and then the therapist or the physician wanted
5 the patient to get more visits, then they would go through a
6 prior authorization process.

7 So, we saw examples of both, but more commonly, it
8 was done after a set number of visits were reached.

9 DR. COOMBS: Do you have any idea of what the
10 market looks like based on any kind of data in terms of
11 prior authorization for extension?

12 MR. WINTER: Broader -- by that question, do you
13 mean broader than the 14 people we spoke --

14 DR. COOMBS: Yes.

15 MR. WINTER: Fourteen plans we spoke with?

16 We don't know, but we can try to do some more
17 looking around. But, I'm not sure if we're going to be able
18 to find that answer because I don't think there's a robust
19 literature on how plans are managing this particular
20 benefit.

21 But, we can look and see what else is out there.

22 DR. AKAMIGBO: So, let me just add. Prior to the

1 discussion, these interviews with the plans -- the health
2 plans and the private benefit managers -- we did do a
3 search, just a general search across the country, internet
4 search, to see what folks are doing, what's posted online,
5 and it looks like the majority authorize a certain number of
6 visits. Really, the outlier was at the lower end. It's
7 more like 25 to 35 visits per year. And then, you need to
8 get authorization to continue any additional therapy
9 services.

10 And by then, we're talking about your therapist
11 talking to therapist, or the nurse typically, to explain why
12 you need more services and maybe submit additional records
13 and things like that.

14 DR. MARK MILLER: But, Alice, I took your question
15 to be how often does an exception get granted.

16 DR. COOMBS: No. The reason why I asked this
17 question, if you were going to adopt a model that was
18 comparable to the private sector and you really wanted to
19 put some control over it, because the way I look at it is
20 that the slide that Peter referred to looks like a kid with
21 a great big giant cookie jar, and they could go into the jar
22 as much as they want without anyone having any kind of

1 surveillance or any kind of assessment as to the efficacy of
2 what they're doing. So if there were some boundaries and
3 some framework for which private practice, physical
4 therapists, or the relationships that exist between physical
5 therapy and not just primary care doctors but orthopedic
6 surgeons owning PT arrangements as well, I think that would
7 be something that would deal with any kind of factors,
8 whether it's overutilization or whatever.

9 DR. SAMITT: This was well done. Thank you very
10 much. I'm going to go where Mark was leading, which is the
11 exception process. That's the thing that's striking to me.
12 And I'm just curious about how the exception process works.
13 Who asks for the exception? Is it the physical therapist?
14 And who grants the exception?

15 DR. AKAMIGBO: No one asks, really. If when
16 you're getting therapy services, a beneficiary is getting
17 physical therapy -- first of all, I should say the
18 beneficiary should be under the care of a physician, so the
19 physician signs a plan of care. Therapy services are
20 initiated, say with a physical therapist, and after the
21 beneficiary has hit the cap, the therapist decides, along
22 with the patient, that they could use additional services.

1 And all that's required is a KX modifier on subsequent
2 claims after that cap has been reached. Actually, it's
3 around the time when you suspect you're reaching the cap --
4 because, remember, there's a lag -- to authorize additional
5 services, and that's an automatic process, so Medicare pays
6 those claims, assuming that the KX modifier is an
7 attestation that additional services are needed and that the
8 reason for those services are documented in the medical
9 record.

10 DR. SAMITT: So how does the doctor know to apply
11 the KX modifier?

12 DR. AKAMIGBO: The KX modifier is not necessarily
13 placed by the doctor. It's placed on the claim by the
14 provider who's delivering the therapy services. So if
15 that's the doctor, yes, then the doctor puts the KX
16 modifier. But in many cases it's the PT, the OT, the speech
17 pathologist, and they place the KX modifier on the claim.

18 DR. MARK MILLER: Even in the instance that it's
19 being billed under the doctor's ID, in all likelihood it's
20 the outpatient -- it's the therapist who is doing the work
21 and adding the modifier to the claim, and then it just goes
22 out under the physician's ID.

1 MR. HACKBARTH: And so it's automatically granted.

2 DR. AKAMIGBO: Yes.

3 MR. HACKBARTH: There is no mechanism for any
4 review of the exception.

5 DR. SAMITT: So I guess I would ask, why bother
6 having a cap if it's automatic?

7 [Laughter.]

8 DR. AKAMIGBO: And that's what we see.

9 DR. MARK MILLER: You're thinking of a cap as a
10 cap.

11 [Laughter.]

12 DR. SAMITT: I would think it would function as a
13 cap, but I guess it doesn't function as a cap.

14 MR. HACKBARTH: I just want to be clear. So there
15 is no mechanism in place for review of the exception,
16 asserted exception.

17 DR. AKAMIGBO: The MAC could come back to the
18 therapist -- in very rare circumstances they would do this,
19 but they could come back to the therapist to review the
20 medical record or, you know, to review additional
21 information, basically to make sure that there is
22 justification for the KX modifier. So there's a mechanism

1 in theory. How often it is exercised is a different matter.
2 And from talking to different medical directors, it's rare
3 that they do that.

4 DR. MARK MILLER: And just to have -- you know, I
5 didn't mean to be flip about the cap. You know, if you talk
6 to the providers, there's great concern that there are
7 patients who need and could benefit from more. And so when
8 the caps were put in place, there was a lot of pushback, as
9 you might imagine, and the attempts to deal with it are two:
10 one is they had a manual review, so it was sort of saying to
11 the carriers that you have to review these requests, and
12 there are many of these requests -- 15 percent, I guess, of
13 the activity is above the cap? And so this became
14 overwhelming, and they basically weren't doing it or saying
15 that they -- they were also saying that they couldn't keep
16 up with it. That's what led to this automatic process.

17 You know, if there's any drag on the system here,
18 it's sort of, well, somebody could come behind that and ask
19 you what documentation you have to justify the KX modifier.
20 But in practice, it just pretty much goes.

21 MS. UCCELLO: Yeah, so in terms of this private
22 sector approach of limit the number of visits plus pre-

1 authorization of additional visits, is there a sense that
2 the private sector finds this a satisfactory approach? Or
3 are they worried it's not doing enough?

4 DR. AKAMIGBO: I think it's an option that they
5 feel they must implement in the absence of better
6 alternatives. So in talking to the many people we spoke
7 with, they don't have clear guidelines to do some, you know,
8 pre-payment review to say, well, if you have this condition,
9 you ought to have -- it's very unclear. So prior auth is --
10 my sense, I would characterize it as some reluctance. It's
11 expensive to do a prior auth program. But it's the best
12 they've got.

13 MR. WINTER: Only one of the plans we spoke with
14 had no prior authorization requirements at all. They said
15 they got rid of it and replaced it with a \$50 per visit co-
16 payment, which they found to be very effective at managing
17 utilization.

18 MR. KUHN: Two questions. As you indicated, the
19 benefit is pretty ill-defined, so I guess -- I'm not aware
20 of but has CMS ever considered doing a national coverage
21 determination to better define the benefit? And,
22 furthermore, talking about the Medicare administrative

1 contractors and their medical directors, is there any
2 differentiation around the country, do we have any LCDs
3 around the country dealing with this particular benefit?

4 DR. AKAMIGBO: We do. I'd have to get back to you
5 on the national coverage determination. I want to say, yes,
6 I have one, that I have seen one, but I'm not certain. But
7 there are LCDs from across the different MACs -- a couple of
8 MACs, I should be more precise, that I've seen. There
9 aren't too many differences just from what I've read. But,
10 again, the LCDs that I've seen tend to focus around the same
11 geographic region.

12 MR. KUHN: Right.

13 DR. AKAMIGBO: I haven't seen one covering the
14 upper Midwest, for example. But I can get back to you on
15 that.

16 MR. KUHN: Thank you. And the second issue, in
17 terms of the functional status measurement tools, you talked
18 in the paper about the photo and the optimal tool and some
19 others that are out there. You also have had the
20 conversations with the private sector and their management.
21 But there are some other government entities that are
22 involved in this space, specifically the NIH and the VA.

1 Did we look at what they're doing, and is there anything to
2 be learned from them in terms of their management of the
3 benefit -- the benefits that they provide?

4 DR. AKAMIGBO: The short answer is no, I did not
5 look at the NIH or the VA's management of outpatient
6 therapy, and I was not -- I can look into this to see if
7 they're using any different -- if they have a standard tool,
8 I would imagine such a thing, if it would exist, would exist
9 with the VA. So, yeah, I can check into that also.

10 MR. KUHN: Thank you.

11 MR. ARMSTRONG: For me, the hard part about this
12 is that physical therapy, occupational therapy, these
13 services, they can be a very good investment in improving
14 the overall health of patients, and sometimes we're not
15 giving them enough of these services, but our payment
16 structure just doesn't allow us to really assess that very
17 well.

18 I think I know the answer to this question, but is
19 there a way to profile utilization and cost patterns in our
20 MA plans and compare that to this experience?

21 MR. HACKBARTH: [off microphone].

22 [Laughter.]

1 MR. ARMSTRONG: Right. Okay. Never mind.

2 MR. GRADISON: A quick follow-up to the question
3 about the private sector experience. Did any of the plans
4 you talked to quantify, give you any sense of the savings,
5 if they had savings, as compared with the way Medicare goes
6 about doing this?

7 MR. WINTER: No, they did not quantify -- they
8 were not able to quantify what kind of savings they achieved
9 from their different tools.

10 MR. GRADISON: This is my other comment. I can
11 understand the effectiveness of the \$50. I'm not so sure
12 about it in the case of Medicare. Wouldn't it be picked up
13 by Medigap for those who have Medigap coverage if there were
14 a required co-payment?

15 MR. WINTER: Yeah, depending on the structure of
16 their supplemental plan. If they covered all cost sharing
17 for Part B services, then yes.

18 MR. GRADISON: Which typically it is.

19 MR. WINTER: Yeah.

20 MR. GRADISON: Okay, thanks.

21 MR. WINTER: And just to back up to your first
22 question, they would sort of indicate that this approach had

1 worked better than others, but in terms of quantifying, you
2 know, what the savings were or how it related to a more
3 managed approach like Medicare, they didn't get into that.
4 We just didn't have time in our interviews.

5 MR. HACKBARTH: Okay. Before you go on round two,
6 George, I just want to ask the Commissioners in their round
7 two comments to really focus on the options on the table.
8 So if you would put up the overview, Slide 20, Adaeze, and
9 look at these options -- there's more detail in the ensuing
10 pages -- and give us your sense of which of these might make
11 sense. We are, as you know, operating on a very short
12 schedule, so we need to make some progress.

13 In that vein, let me just ask people in particular
14 to think about the episode-based payment idea. This is very
15 consistent with MedPAC traditional thinking about a problem
16 like this when we've got potential overuse, that gray area
17 use, under a fee-for-service system let's create some
18 boundaries, and episodes are potentially a tool.

19 Now, I would point out that there are some
20 similarities between the challenges here and those that we
21 have in home health, and there we tried to solve those
22 problems a decade ago using episode-based payment. I'm not

1 sure that it has worked all that well in home health. You
2 know, we ended up with a pattern of more users, more
3 episodes per user, and declining number of visits per
4 episode, and very high levels of profitability in the home
5 health business.

6 So reactions to the option framework overall, and
7 in particular, on the episode-based payment idea?

8 MR. GEORGE MILLER: Well, thank you, and, again, I
9 enjoyed reading this chapter. It was very well done. It
10 raised more questions in my mind than it answered, and along
11 with Peter's thinking, I think one of the things that I've
12 heard -- I have no proof of it, but I just heard that a
13 physician could own a practice, could bill, then send a
14 patient to the practice he owns, and because they're
15 different numbers could bill again. So I'm real concerned
16 about the potential for either misuse, mismanagement, fraud,
17 or whatever term we need to use, and then to try to address
18 that issue, as well as the options before the Commission.

19 Obviously, we want to have Medicare have the
20 ability to manage the system better in the short term. What
21 tool or mechanism that should take I'm not quite clear on,
22 but I believe we should move in that direction.

1 Like Herb, I would love to see what the VA is
2 doing and see if that would be applicable to here.
3 Obviously, they have a great deal of expertise in this
4 space, and I wonder if that's applicable and we could use
5 that approach and then use that as the basis for episodic-
6 based payments.

7 DR. NAYLOR: So before I get to what you've
8 requested, I wanted to reflect on what the Commission has
9 been asked to do, and the first thing is to say how to
10 improve the benefit so that it is better designed to reflect
11 functional limitations and severity. And I think it would
12 be appropriate to give some attention in this to the
13 question or comment that Mark made, which is, rightly or
14 wrongly, the benefit is now about improvement. And there
15 are many, and there's evidence to suggest that a benefit
16 moving forward should also pay attention to the great
17 opportunity to prevent further decline. And preventing
18 further decline for many enables us to prevent falls, to
19 really prevent acute resource, et cetera.

20 So I would, for one, want us, beyond thinking
21 about these three dimensions, which I think are spot on in
22 terms of how to improve it, say this is also an opportunity

1 for us to think about a whole population whom we could
2 better serve through these services to prevent more costly
3 use. I mean, it is the one thing Medicare beneficiaries
4 fear the most, limitations going to permanent disabilities,
5 and permanent disabilities cost us all.

6 So, that said, on the management I really do think
7 that many of the recommendations that you have to improve
8 management of the benefit, particularly on this idea of the
9 targeted or focused review of where we're seeing real high
10 use and where we're seeing real low use of services is
11 really important, along with all of the others that you
12 recommended, eliminating use of V codes and so on.

13 On the issue of functional status, I think that
14 this is critical as a path forward, that we get to
15 standardized measurement of functional status.

16 And to Herb's point, there is some work -- and
17 I'll share some of the contacts -- around this CMS, NIA, et
18 cetera, that are really trying to figure out what they are
19 and have some preliminary path forward, so it would be great
20 if we could align some -- if it makes sense, to align some
21 of those recommendations. And I do think changing the
22 payment system around episode, as I heard the response,

1 makes sense. But I also think we've got to get to
2 performance. And so I think this might be a short-term
3 path, but unless there's some accountability for when we
4 have a functional status measure in place to show that we
5 are improving or, if we could, prevent decline, I think that
6 would be important.

7 DR. HALL: I also wanted to compliment you on a
8 wonderful presentation.

9 So, in terms of the policy options, I guess we all
10 agree, number one, let's eliminate fraud. I mean, that goes
11 without saying, I suppose.

12 Now, in terms of the various kinds of caps, I
13 think there are kind of two issues that I'd like to talk
14 about briefly. One is caps on the individual maximum number
15 of services will inevitably disenfranchise some patients who
16 would really benefit from services, as Scott already
17 mentioned. So I'm a little bit worried about that.

18 The second thing, more importantly, if I wish to
19 sort of utilize physical therapy to the max for whatever
20 reason, I'll just do more patients. So we'll take each
21 individual patient up to their max, and then we'll just add
22 on another seven that they're also in SNFs. So it's a very

1 blunt instrument to try and get on top of that, so if I'm so
2 smart, what should we do?

3 Well, I would say the one thing is that the idea
4 of episodic payments but based on some concrete measure of
5 function, as many people have said -- and Mary talked about
6 it. I mean, this has been coming up over and over again as
7 we look at bundling and everywhere, we desperately need to
8 have the entire enterprise embrace functional assessment in
9 a way that can actually dictate payment but also outcomes,
10 which is so important.

11 The other thing we might want to suggest is that
12 in an average SNF, people sit around a lot. They don't do
13 very much just because of staffing or because of other
14 things. But basically what do the patients tell you when
15 you walk around? Well, they all have V codes. They're kind
16 of non-specifically not feeling well. They have some low
17 back pain. Their gait is a little bit abnormal. They might
18 have difficulty walking, and they always have a lot of
19 muscle weakness. This is baseline, and we have no
20 incentives put in the system for these organized SNFs to
21 develop other modalities that would be useful, such things
22 as group activities, training of lower-level personnel --

1 not lower level but people with different kinds of training.
2 And there must be some way to incentivize these SNF
3 facilities to -- you don't even have to think out of the
4 box. The techniques and modalities are there. They're just
5 not being utilized, because the candy box says you can just
6 continue to use these very highly skilled physical
7 therapists -- by the way, who are in very much demand,
8 they're very scarce, so the more we use them, the more
9 problems we're going to have.

10 So I think multi-pronged, let's get rid of fraud,
11 let's try and put some concrete functional assessment
12 instruments in place, and let's think out of the box about
13 what SNFs can do to accomplish what presumably these V codes
14 are telling us we need to do.

15 Thanks.

16 DR. REDBERG: So an excellent report. It was
17 very, very clear. And I do think, as Scott said and David
18 alluded to, physical therapy or the outpatient therapy
19 services are a really important service, and I wouldn't want
20 to, in trying to get rid of fraud, deny people that really
21 need the service. And that's the problem, and that's why I
22 want to just get back to making that a separate issue,

1 because physical therapy for people that need it is great,
2 and I think we should be doing more of it.

3 So I would, you know, like to look at the role of
4 the RACs and, you know, perhaps in another conversation
5 change -- because right now regional carriers are really
6 incented on paying quickly but not paying accurately claims,
7 and that's a big problem not just for outpatient therapy
8 services. But for the outpatient therapy, I mean, there is
9 potential to really increase quality of life and decrease
10 cost with increased use of outpatient therapy services.
11 Some of the examples you gave in the mailing, like, you
12 know, for rheumatoid arthritis patients, you know, we have
13 some very expensive and very toxic medications that we now
14 give our rheumatoid arthritis patients who might be better
15 off and feel better and, coincidentally, have less cost to
16 Medicare with increased use of outpatient therapy. And the
17 same with a low of back pain patients that are getting
18 surgeries that may not be helping them, causing a lot of
19 problems, and could be better with a more generous benefit.

20 And so for that reason, I would be concerned about
21 the cost sharing as an alternative because I'm sure it would
22 get rid of the fraud because if you really don't have

1 patients, you're not going to have \$50 for cost sharing and
2 so it gets rid of it. But it also gets rid of the people
3 that really need the services.

4 So I think focusing on functional status
5 assessments for physical therapy and then improvements in
6 functional status and actually making it more generous,
7 particularly if we're looking at it as an alternative to
8 more invasive and other procedures with the same kind of
9 problems, as I said, for rheumatoid arthritis or back pain,
10 but probably for lots of other services as well.

11 And I would have concern about episode-based
12 payment based on the home health experience, that it
13 wouldn't achieve the goal we're looking for. And certainly,
14 in terms of fraud, the focused reviews in the high-use
15 geographic areas I think makes sense.

16 DR. NERENZ: A couple things. I guess I would
17 appreciate just some continued clarity on exactly what
18 problem we're being asked to solve here. I notice that
19 we've discussed a lot about rising costs, geographic
20 variation costs, potential fraud and abuse. But those don't
21 seem to be directly in the charge we've been given. We're
22 asked to talk about linking functional status and we're

1 asked to evaluate private sector initiatives. So I just
2 want to make sure that when we talk about policy options,
3 we're focusing on policy options to accomplish what aims
4 specifically.

5 Then with that as preface, I would be basically
6 yes on the standardized instrument. In fact, it seems like
7 it must be automatically a yes given the first part of the
8 charge. If you're going to link management of this benefit
9 to functional status, you have to have some measure of
10 functional status.

11 That said, it strikes me as very difficult to
12 think of a standardized instrument, singular, that would
13 work across the whole domain of therapies that we're talking
14 about. The instrument that captures the essential features
15 of improvement for back pain would seem quite different from
16 the instrument that captures improvement for a swallowing
17 disorder.

18 I understand some of the same structural features
19 of an instrument might be there, but it would just seem that
20 we may end up in a domain of standardized instruments,
21 plural, as opposed to a single one. But there can be more
22 detailed discussion about that.

1 The episode-based payments would seem to be
2 positive, at least in a certain sense. If we link back to
3 our discussion yesterday about some of the bundled
4 approaches, there clearly are opportunities to bundle some
5 of these therapies into other procedure-defined or illness-
6 defined bundles, and so in some sense, some of that action
7 solves some of these problems. And whether those then
8 include a functional status component or not becomes perhaps
9 someone else's problem who's responsible for the cost and
10 the quality outcomes of a bundle.

11 I do understand, though, that there may be some
12 episode approaches that are only about these therapies
13 themselves, and in that case I defer to Glenn's comments
14 about previous experience that the group knows more about
15 than I do.

16 DR. MARK MILLER: If I could just follow up on two
17 things, the charge is what it is and what it says. The
18 issue that occurs with the Congress and why they brought it
19 to us and why they asked us for such a short turnaround time
20 is the exception expires every year, and this additional
21 cost of what occurs above the cap is the Congress is sort
22 of, well, how do I get control of this, I have this

1 exceptions process that I have to pay for every year, it
2 doesn't seem to be -- it seems to be fairly fluid, is there
3 another way to go at this, when you have conversations with
4 what the objective of -- in asking us to do this, that's the
5 problem that brings it to a head and brings it to a head
6 immediately. And, you know, some of the thought was this
7 mandate might help get at their overall problems and result
8 in a better benefit.

9 I do want to say something about the single
10 instrument because we spent a lot of time on this, and we
11 brought in a crew of clinicians, researchers, carrier
12 medical directors, and there may have been some other actors
13 in that. This is a very interesting and useful discussion.
14 I'm sorry to take the time, but I think there's some
15 important things here.

16 The last 20-plus years, this field has been
17 characterized by the different modalities and even groups
18 within the different modalities each having their own
19 instrument and arguing about this is the best way to do it.
20 And some of the gridlock in this area is there has never
21 been ability to kind of bring agreement on that.

22 What we found very interesting about this

1 conversation, when we got people in the room and were kind
2 of pushing them, there was the sense -- and I don't want to
3 say that anybody, you know, agreed or bought in because
4 those weren't the ground rules. But we walked away thinking
5 that there can be an instrument that actually cuts -- that
6 is common to all of these modalities, and there was some
7 level of agreement on this, and that the way this would work
8 is this is the instrument that Medicare collects to build
9 its payment system and make its payments. If the individual
10 modalities want to use their own instruments for plan care,
11 that is perfectly fine, and so this to us sort of felt like
12 a good way of kind of moderating this big fight against my
13 instrument and no one else's. Use that for your plan of
14 care. Use this to have the underlying structure of the
15 payments. My last comment. And, of course, the payments
16 are always a little off, and that's why you have things like
17 inliers and outliers and that type of thing, notwithstanding
18 the experience of the episodes not working in other areas,
19 which is yet a different problem.

20 DR. NERENZ: Again, you certainly have explored
21 this already in more depth with these groups. If the area
22 of common ground in a single instrument is something like an

1 SF36-type functional health status instrument, I guess I
2 would suggest that those instruments already exist. So I
3 would like to then learn more about what instrument that
4 kind of cut across these modalities and the needs within
5 modalities can be developed that does not already exist.
6 I'm just curious about what that looks like.

7 DR. MARK MILLER: And an instrument that we're
8 talking about building on does exist. It came out of one of
9 the demonstrations, and we were sort of saying you don't
10 have to build this out of scratch. You have to add to it,
11 but there is an instrument, and we can put that in your
12 hands.

13 DR. NERENZ: One quick thing. Whatever that
14 instrument is, or instruments, plural, I guess I'd be
15 interested in more discussion about that and the concept of
16 how it's used, meaning one could conceivably pay for
17 improvements specifically, and that's how it's use. Or one
18 could conceivably pay for evidence-based treatments that in
19 separate studies have been linked to improvement but are not
20 explicitly linked to improvement in an individual payment
21 for whom payment is made. So I would like some more
22 discussion about how the link is made then between the

1 functional status measure and the payment, and it seems like
2 there are some variations there that have to be discussed.

3 MR. HACKBARTH: Okay. Unfortunately, we're going
4 to have to pick up the pace a bit here. We've got about 18
5 minutes left in this session, and today we need to stay on
6 schedule because people have planes and trains to catch.
7 So, please, let's move along.

8 DR. BAICKER: So just two quick points. One, to
9 clarify on the common instrument, the instrument seems very
10 important to me to have a standardized instrument, although
11 whether you call it one or many for different conditions
12 seems more like a semantic question -- you know, if back
13 pain, go to this mode; if speech problem, go to this set of
14 questions. To me, the commonality was less about the
15 questions specific to the condition but, rather, the use in
16 different settings or by different types of providers, that
17 anybody who's going to get reimbursed for this type of
18 therapy has to have completed this instrument. And that
19 seems important to me, and then answering the second
20 question about episode-based versus other types of
21 management practices, that my natural inclination is towards
22 the episode-based payments, but then the caveats that you

1 raise and the failures of those payments in other settings
2 suggests -- or highlights the importance of a good
3 instrument so that you can both flag what type of therapy is
4 appropriate, but also the expectation of the amount of
5 therapy that is appropriate. And if we don't have a good
6 instrument for doing that, then I think the episode payments
7 are even more likely to fail on the dimensions you
8 mentioned.

9 So in the long run, I'd love to move toward the
10 episode-based payments, but maybe we won't be ready for that
11 until we've successfully implemented the standardized data
12 collection that would facilitate more specific payments.

13 DR. CHERNEW: I don't know ultimately what I will
14 prefer, but I do know that whatever I will prefer, I
15 actually won't like it.

16 [Laughter.]

17 DR. CHERNEW: So, that said, my concern is that
18 without guidelines of what to do, we can go after fraud.
19 But everything else we do, all the data gathering, all the
20 auditing, all the other many things are going to add an
21 enormous amount of administrative cost with virtually no
22 gain. So I'm extremely skeptical of a whole series of

1 things that sound like they make sense, but I think in the
2 end without guidelines about David's question, we're just
3 making a lot of people jump through a lot of hoops to get us
4 nowhere. And I'm worried about that, although I could be
5 convinced otherwise.

6 I do want to make this distinction between episode
7 and bundling. Bundling makes a lot of sense where someone's
8 responsible in some broad bundled way. But an episode just
9 within here I'm actually pretty strongly against because of
10 the home care example. And, again, I think the problem is
11 we're telling people we're going to pay you a fixed amount
12 for something, you don't know what it is, you just have to
13 tell us and then we'll pay you for a different thing, and
14 you can do more of them, or whatever you want, and it's just
15 not going to solve the problem, because the fundamental
16 problem is we don't have good guidelines, connect whatever
17 functional instrument we have to what then you should do,
18 and we're not sure that even if we had the right instrument,
19 that once we pay you based on an instrument, that the
20 information you put on an instrument is so objective that we
21 would trust that instrument when you actually had to pay on
22 it.

1 So, you know, I can understand the instrument
2 might work perfect in a research setting about what it
3 predicts and what you do. That's very different than
4 working in a payment setting where someone who might want to
5 push the boundaries just has to certify some particular
6 thing and you can't objectively measure all these functional
7 -- if we could objectively measure all that stuff well, then
8 I'm -- administratively, I'm for that. So that pushes me to
9 something that I don't like, which is going to involve
10 artificial limits or some other type of broad thing, which I
11 really don't like. I want to go on record as saying I
12 really don't like it. But I don't see a way around it, and
13 at least it gets rid of certain administrative costs of
14 something that I don't like, or some aspect of cost sharing
15 that I want to go on record as saying I really don't like
16 that, there's disparity issues that really worry me, but I
17 do think that you could structure something where you get a
18 certain -- instead of, I think, a cap, which says you only
19 get this amount, at a minimum I would say here's the cap for
20 what you get, and now you can get more but you have to pay,
21 instead of 100 percent for the service, we're going to
22 charge you less. That's better to me than a cap. So if a

1 cap was ten visits, instead of saying ten visits then zero,
2 I would say ten visits, then you pay 20 percent, and then
3 another ten visits, you pay 30 percent or some version of
4 that. It's not something I like, but it allows the person
5 to have to judge. And I don't know where the right caveats
6 should be and how we should make exceptions for some people
7 because of income. And maybe we just let the system be
8 inefficient and say if you don't like it and the system's so
9 expensive, go to a managed care plan which will do a lot
10 better anyway, or we'll have ACOs that will do a lot better
11 and not worry about it. But the only way I see around it
12 without huge amounts of administrative cost, as much as I
13 really hate to say it, is some cost sharing.

14 MR. HACKBARTH: I invite comments on cost sharing
15 as a potential tool as well. Just a reminder, though, about
16 the existing structure. So this is a Part B service subject
17 to the Part B deductible and Part B co-insurance, correct?
18 So there already is cost sharing, and in that sense this is
19 different than the home health case that we considered where
20 under the benefit structure there was no cost sharing.

21 DR. AKAMIGBO: Yes, and we have a slide up just to
22 guide -- yeah.

1 MR. BUTLER: If you could put back the policy
2 options slide, go back to the. I agree almost exactly with
3 what Mike was saying, but I could never say it the same way,
4 so I'll try to efficiently reaffirm the points, and I hope
5 I'm consistent.

6 So I definitely think -- of the importance on the
7 list, the first one, the short term is -- I'm most
8 supportive of, and on cost sharing, I do think -- maybe I'd
9 broaden the concept to shared decisionmaking even, because I
10 think a lot of people that -- so not just the financial. A
11 lot of people that are getting these therapies either are
12 not -- if you talk to them, they say, "I'm not ready for
13 them, I don't want them," or they're end-of-life issues, and
14 there's not the engagement of the beneficiary themselves,
15 financially or otherwise.

16 I'm supportive of the standardized instrument.
17 I'm supportive of alternative two, and I'm pretty strongly
18 opposed to one for the reasons articulated. I think you'll
19 get more bundles, and I think you'll get fewer units of
20 service provided. And I think this is particularly going to
21 occur in this area because of the lack of homogeneity of
22 definition. It just invites kind of underutilization pretty

1 easily. If it was a very clear service, you could then
2 define whether it's being underutilized as a result or not.
3 I'm just highly skeptical.

4 And, finally, I think about CMS, the logistics,
5 the administrative work to even create the definitions of
6 the episodes is probably not the best use of their time with
7 so many other things. It's not an insignificant series of
8 events to roll something like this. It's just not worth it.

9 DR. COOMBS: So I think with the discussion on
10 hand, the episode-based payments doesn't do anything for the
11 volume-driven care because you would ante it up to do more
12 patients. And so that's the main point with that. And then
13 the other issues that have already been discussed I think
14 are important.

15 I agree with a fixed amount of visits for physical
16 therapy, so a defined -- not necessarily time period but
17 encounter, number of encounters per beneficiary.

18 The piece on cost sharing after the extension I
19 disagree with only because I think there's some really
20 vulnerable populations within the Medicare population that
21 would be a disadvantage. If you have great scrutiny as to
22 the extension, whether it's an authorization or fitting a

1 long menu list and a check-off list at that secondary stage,
2 I think that might be enough to really drive some cost
3 savings. But I wouldn't want patients to really need the
4 therapy and not have access to it.

5 I think before you engage in a tool and an
6 instrument and management, I would like to know a little bit
7 more about the private sector before jumping off into a
8 complete privatization type of model within the Medicare
9 structure.

10 DR. SAMITT: Can we go back to Slide 21, just to
11 be specific about some of these things? I'm very much in
12 favor on a lot of these items, although permanently
13 including services under caps, while my sense is the caps
14 aren't really caps anyway, so why does this really matter,
15 sure, do it, although I'm more concerned about the exception
16 process, and that's really where the meat has to be.

17 Absolutely focused reviews. I think if we're
18 concerned about fraud or even managing the benefit, I think
19 we need these focused reviews. What I haven't heard a lot
20 of is we've talked about doing these reviews at the provider
21 level. I'd recommend we do these reviews at the referring
22 physician level as well. I would be interested in knowing

1 which physicians have so many beneficiaries that are using
2 physical therapy services. I'm a big fan of unblinding and
3 publicly reporting utilization data at the physician level,
4 and I think we need to understand this not just from the
5 providers, which may hide something, but on the referring
6 physician side as well.

7 I would reduce the certification period. I think
8 we need a more formal methodology at the end of the cap
9 before the exception as opposed to an automatic default. I
10 think there should be some formal gate or some formal method
11 that needs to be followed after a defined period of time.

12 And I am a believer in cost sharing. I think that
13 without it there's a risk of moral hazard, and at some point
14 in the future I'd be interested in discussing supplemental
15 insurance, because I wonder whether supplemental insurance
16 is creating a comfort level where a beneficiary should be
17 involved.

18 In terms of the long-term solutions, yes, an
19 instrument is likely to be necessary, and you may be
20 surprised that I'm against the bundle in this case, because
21 I'm afraid that we don't have a catch for the consequences
22 of underutilization here comparable to what we discussed

1 yesterday with PAC. I'm in favor of a more global bundle,
2 and that's why a bigger bundle solves this problem. If, in
3 essence, this was part of a global bundle where you were now
4 at risk for the consequences of poor physical therapy, then
5 I could understand how a bundle would be effective. But if
6 we bundle physical therapy services, I think there is a
7 great risk of underutilization of those services with
8 expansion of expenses elsewhere for the Medicare
9 beneficiary.

10 MS. UCCELLO: I agree with Craig's kind of short-
11 term thoughts of this. I agree with everybody on the need
12 for the functional assessment stuff. And I agree with Mike
13 and Peter on the concerns about the bundling. Conceptually,
14 I think we all like that approach, but I think there are
15 serious reservations about doing it in this area. So maybe
16 something more along the lines of private sector approach,
17 thinking about what Mike said almost in terms of tiering,
18 you know, your first X amount are paid in such-and-such a
19 way, and then after that -- but in terms of using cost
20 sharing as a lever here, what does that really even mean
21 when there's already cost sharing and a lot of that is
22 already being covered by supplemental coverage.

1 So, you know, we can think back to our
2 recommendations regarding the fee-for-service plan design
3 more generally and the impacts on the supplemental coverage,
4 but, you know, I just -- I don't know how effective that
5 would be.

6 MR. HACKBARTH: Assuming we get through these last
7 couple comments and have a few minutes, I'll come back to
8 this issue of cost sharing and the interaction with
9 supplemental coverage.

10 MR. KUHN: On the three areas that you have listed
11 up here -- improving Medicare's ability to manage the
12 benefit, obviously the focused reviews, we've all talked
13 about that. Suspicious billing and coding patterns need to
14 be identified, and it sounds like CMS is putting the
15 infrastructure in place to deal with that. Reducing the
16 certification period from 90 to 45 days, I am intrigued by
17 that. I think that's something that might be worth looking
18 at further. Obviously, the elimination of the V codes. And
19 then, finally, we've talked about it already a little bit
20 today, but I would like to understand a little bit more
21 about the option of an NCD and kind of the variation across
22 the country with current LCDs.

1 If we're talking about all this stuff in terms of
2 a standardized tool to classify patients and all this
3 activity, if we don't know what the heck we're trying to
4 classify, I mean, what does that bring value to us? So
5 let's really look at kind of what is this benefit and can we
6 do better with that.

7 On the issues of the alternatives one and two of
8 episode-based payments and private sector approach, I'm not
9 as fearful of predetermined rates of an episode versus the
10 per click arrangement that we have now with the piecework
11 that's in the system as it is now. We've got episode
12 payments throughout Medicare, whether it's DRGs or APCs or
13 RUGs, or whatever the case may be. The program has
14 wonderful experience with that, and they've developed it all
15 across the system. So I'm not as fearful as others are of
16 that. And I think it just beats, again, a per click system
17 that we have now. So I think it is worth looking at.

18 Then, finally, on the private sector approach, I
19 think there are some things that we can learn, that we can
20 look at. As I've shared in the past, I'm not a big fan in
21 the Medicare program of pre-authorization. I think it sets
22 up some real difficult issues in terms of beneficiaries and

1 their ability to appeal adverse determinations on access to
2 care. And I think it's a rigorous process to go through
3 that appeal process. But I do think that prior
4 authorization for providers that have been identified as
5 being problematic, 100 percent prior auth for those kind of
6 folks I think is just fine, and I fully support that kind of
7 activity.

8 MR. ARMSTRONG: I, too, just briefly, would affirm
9 -- I support the direction that's being described, both in
10 terms of the short-term ways of trying to control the
11 benefit or manage the benefit.

12 And with respect to these alternatives, not
13 surprisingly, I think the private sector approach works well
14 and that there's a lot to be gained from that. I don't
15 fully understand all the concerns about the episode-based
16 payments and our previous experience with it, so it might be
17 worthwhile for us just to continue to get really clear about
18 what the concerns there might be.

19 Glenn, you know, you just said we'll come back to
20 it in a minute, but I think that there is real value in
21 making sure that the out-of-pocket costs to the
22 beneficiaries is really thought about and that we make sure

1 that it's designed here in this case in a way to get to --
2 or contribute to some of the outcomes that we're trying to
3 get to.

4 MR. HACKBARTH: So on the issue of cost sharing,
5 Craig put his finger on a central issue, which is people
6 have supplemental coverage, that mutes or eliminates the
7 effect of whatever cost sharing Medicare might require at
8 the point of service.

9 So for the benefit of the new Commissioners, we
10 spent a fair amount of time looking at the benefit structure
11 over the last couple of years and in the spring made a
12 series of recommendations. First of all, we said that the
13 existing Medicare benefit package should be restructured
14 without in the aggregate any increase in any beneficiary
15 cost sharing. So we didn't think that overall the actuarial
16 value of the benefit should be reduced and beneficiaries
17 need to see higher costs at the point of service. But we
18 didn't think the existing structure of cost sharing made a
19 lot of sense, it was somewhat antiquated. And so we
20 recommended that the Congress give the Secretary the
21 authority to redesign the cost-sharing structure within the
22 confines of the existing actuarial value, no net increase in

1 overall beneficiary cost sharing, and suggested that the
2 Secretary be free to do that redesign using value-based
3 insurance design principles. So you may want to vary the
4 cost sharing, reducing it for service that are clearly of
5 high value and increase cost sharing for services that are
6 of more marginal value. And the Secretary can make those
7 adjustments without going back and getting congressional
8 authorization for every decision.

9 Then with regard to supplemental coverage, what we
10 concluded was beneficiaries should be free to purchase
11 supplemental coverage if they so desire. But when they make
12 that decision to purchase supplemental coverage, they should
13 face at least a portion of the additional cost that that
14 results in for the Medicare program, the higher utilization.
15 And so we thought that there should be an assessment on the
16 supplemental coverage.

17 Of course, that then leads to the question: Would
18 that alter the sort of supplemental coverage that people
19 buy? And we think in the long term probably it would. How
20 much it would change it in the short run is more difficult
21 to say. So that was where we stood on that issue.

22 Okay -- oh, I'm sorry. I forgot our last two.

1 Tom and Bill, I apologize. Whenever I do this, starting in
2 a new place, I always screw myself up.

3 DR. DEAN: I can agree with most of the comments
4 that have been made. The one thing that I would emphasize
5 is I really think it would be helpful to have the functional
6 measure some sort of formal -- I get these requests
7 frequently, and frequently the measurements I get, the forms
8 I get, are really hard to interpret, and I can't really tell
9 whether the person is improving or not. And it seems to me
10 that whether we talk about episodes or whether we talk about
11 a fixed number of visits or whatever, what's really
12 important is: Is that patient benefitting from the service?
13 And it's so variable, and that's why constructing these
14 other limits is difficult.

15 It seems to me that the underlying guideline
16 really ought to be that Medicare should continue to support
17 this as long as the person is showing some benefit. But
18 we've got to have a way to document and verify that. And
19 right now, even though I get reports of all the things that
20 are being done, I really have a hard time determining how
21 does that compare with where they were to begin with and are
22 we progressing.

1 If we could do that and make that the fundamental
2 determinant of whether additional visits are justified, I
3 think it would fit the clinical needs a lot better. Now,
4 whether it's possible to do that administratively and so
5 forth, I'm not sure. But from a clinician's point of view,
6 that's what I need to determine if I'm going to sign off on
7 that form.

8 MR. GRADISON: This is really to me a case of no
9 good option. An example of one of the realities of the
10 human experience is that every problem doesn't have an
11 answer.

12 With regard to episodic payments, I think unless
13 they're linked to an assessment of the functional status of
14 the individual, it doesn't make a whole lot of sense. And,
15 in particular, the notion that the same number of initial
16 visits should be allowed for everybody regardless of what
17 they're being treated for doesn't make much sense to me at
18 all.

19 I would certainly lean towards the private sector
20 experience because it seems to be working better than the
21 Medicare experience, but I'm at a total loss to see how
22 Medicare as it's currently organized can follow the private

1 sector experience. I think the sheer volume that would be
2 involved in prior authorizations would make that -- likely
3 make it unrealistic. So at the end of the day, I will
4 eventually, when we have a proposal before us, vote upon it,
5 but unless something new comes up, it's not going to be
6 done with any great enthusiasm that we will be contributing
7 to an improvement in the program or dealing particularly
8 effectively with the problems that you have so well
9 identified.

10 MR. HACKBARTH: Okay. Again, Tom and Bill, I
11 apologize for forgetting you at the end of the queue.

12 Just one question, and this came up in several
13 Commissioner comments. What do we know about the
14 effectiveness of the private sector tools? We went out and
15 we talked to people, and we have a sense of what they are
16 doing. Is there evidence of effectiveness, since that's an
17 explicit part of our charge?

18 DR. AKAMIGBO: As long as we're defining -- just
19 to be clear, effectiveness at controlling utilization and
20 costs, I would say the prior auth process is relatively
21 effective for the groups that saw significant growth prior
22 to implementing a prior auth, and there were several. This

1 was an effective tool in controlling utilization and
2 consequently costs.

3 MR. WINTER: Right, and that's what they reported
4 to us. Again, as we experienced, we looked at prior
5 authorization for imaging. There's a lack of literature
6 that examines the effectiveness of these approaches using a
7 control group. So, again, not independent confirmation.

8 MR. HACKBARTH: Well done. Thank you very much,
9 and more on this next time.

10 And our last item is refining the hospital
11 readmissions program.

12 [Pause.]

13 MR. GLASS: Good morning. The new hospital
14 readmission reduction program will start October 1st. Today
15 we'll review the Commission's position on readmissions, look
16 at recent trends in readmission rates, review the new
17 readmission policy, and discuss some issues that policy
18 raises and possible policy options for dealing with those
19 issues.

20 The Commission has been concerned with
21 readmissions for a number of years, and recommended the
22 hospital readmission policy in 2008. We have also

1 considered incentives targeted at SNFs and home health
2 agencies to discourage avoidable admissions from those
3 facilities, recognizing that responsibility for readmissions
4 are shared by other actors in the health care system.

5 It's important to reduce avoidable readmissions
6 because an avoidable readmission is a poor outcome for the
7 patient. Reducing readmissions could represent improved
8 care in the hospital, more help with transition, and better
9 care coordination outside the hospital, all of which are
10 better for the beneficiary.

11 Medicare spending on readmissions is substantial.
12 We estimate reducing readmissions by 20 percent, which is
13 CMS's current goal. It could save over \$2.5 billion in one
14 year. Although it is possible for hospitals to reduce
15 readmissions, as we'll discuss on the next slide, the fee-
16 for-service system creates a disincentive to do so because
17 hospitals see additional revenue for each readmission.

18 A successful readmission policy has to create an
19 incentive to reduce avoidable readmissions strong enough to
20 overcome the loss of revenue the hospital will see. We said
21 it's possible for hospitals to reduce avoidable
22 readmissions. We have visited high-performing hospitals,

1 talked with their representatives, reviewed the literature,
2 and found examples of hospitals that have reduced the rate
3 of avoidable readmissions.

4 At a broad level, techniques they have used
5 include -- they've identified the patients most at risk for
6 readmission and targeted their efforts on that population,
7 for example, patients who have been frequently readmitted.
8 They have reduced hospital complications by improving the
9 processes such as using check-listed surgery and to avoid
10 central line infections.

11 They have improved the transition at discharge,
12 Project RED and Project BOOST, for example. They can
13 provide patient education such as teach-back and self-
14 management. They can schedule follow-up visits and
15 medication reconciliation before discharge. And they can
16 make follow-up calls or visit the patient after discharge,
17 and they can communicate better with physicians and post-
18 acute care providers outside the hospital.

19 Now Craig will tell us if we can see evidence that
20 hospitals have successfully decreased readmissions at the
21 national level.

22 MR. LISK: In this slide, we are reporting how

1 readmission rates have changed since 2009. These are both
2 all condition measures; that is, they include all hospital
3 Medicare fee-for-service discharges. We've controlled for
4 changes in the mix of patients discharged.

5 Controlling for changes in the mix of patients is
6 important when looking at readmission rate trends over time
7 because readmissions vary substantially by DRG and the mix
8 of patients admitted to hospitals changes over time.

9 The first row shows an all-cause readmission major
10 which identifies cases with readmissions occurring within 30
11 days of discharge from a hospital. By this measure,
12 readmission rates have fallen about .3 percentage points
13 from 15.6 percent to 15.3 percent in 2011.

14 The second row shows a potentially preventable
15 readmission measure developed by 3M which includes an
16 algorithm to identify readmissions that are clinically
17 related to the prior hospitalization. It shows these
18 readmission rates dropped by .7 percentage points over the
19 same time period.

20 We note that the reduction in potential
21 preventable readmission rate of .7 percentage points is
22 greater than a reduction in the all-cause readmission rate.

1 This makes sense if hospitals are having greater success in
2 reducing potentially preventable readmissions than ones that
3 are not.

4 We also found that reduction for the three
5 conditions in the current policy have, in most cases in the
6 current readmission reduction program, have been greater
7 than the reductions on average. 2009 is when Hospital
8 Compare started reporting on hospital readmission rates, and
9 2010 was when PACA was passed. Thus, there appears to be
10 some evidence that hospitals are starting to preferentially
11 reduce readmissions for these three conditions. When the
12 penalty takes effect in 2013, there will be greater
13 incentive -- should be greater incentive to reduce
14 readmissions.

15 We do see some variation in readmission rates
16 across hospital groups and by beneficiary characteristics.
17 Looking across hospital groups, high characteristics such as
18 ownership and teaching status and add-ons such as DSH and
19 IME, we find some limited variation and the details of that
20 are in Table 3 of your mailing materials.

21 There is much more variation, though, within
22 hospital groups from which we conclude that other factors

1 such as hospitals' programs to reduce readmissions, have
2 more influence on these characteristics.

3 We also see differences in readmission rates by
4 certain beneficiary demographics. We see some very slight
5 differences by age and gender, and see larger differences by
6 race and income. We use Medicaid status as a proxy for
7 income in our analysis. African-Americans, Hispanics, and
8 low-income beneficiaries are shown to have higher rates of
9 readmissions.

10 Now I want to discuss the hospital readmission
11 reduction program that was part of the Patient Protection
12 and Affordable Care Act passed in 2010. The program starts
13 this October, in less than 30 days, with three conditions:
14 AMI, heart failure, and pneumonia, all conditions which
15 Hospital Compare has reported on publicly since 2009.

16 The policy will add at least four more conditions
17 in fiscal year 2015, in two years. These include COPD,
18 CABG, and PTCA, and other vascular procedures, and those are
19 DRG definitions there. The Secretary, however, can add more
20 conditions in 2015, or thereafter, if he or she wants.

21 Essentially, this policy uses the Hospital Compare
22 readmission measure. Hospitals that have had readmission

1 rates above average from July 2008 to June 2001 [sic] on any
2 of those measures, three readmission measures, will receive
3 a penalty starting in 2013. Non-IPPS hospitals are
4 excluded, including CHs, are not included in this program.

5 The penalty is applied to all cases that the
6 hospital has, but the size of the penalty is based on the
7 excess readmissions for which these three conditions as a
8 share of total hospital payments. We'll discuss the exact
9 payment formula in a few slides.

10 The penalty is capped at 1 percent in 2013, 2
11 percent in 2014, and 3 percent in 2015 and thereafter, and
12 the penalty is based on base operating payments and is not
13 applied to hospitals, IME, DSH, or special rural payment
14 add-ons or outlier payments.

15 Under the PPACA hospital readmission reduction
16 program, a third of hospitals will have no penalty; 6
17 percent will have no penalty because they have too few cases
18 for each of the three conditions. In other words, they have
19 fewer than 25 cases in each of those conditions over the
20 three-year period that is looked at.

21 Two-thirds of hospitals will have a penalty, and
22 the reason why more than half of hospitals are affected is

1 because the penalty is calculated for each of the three
2 conditions. So roughly half of all hospitals are affected
3 for each condition, and since half are affected for each
4 condition, we're doing three conditions, about two-thirds of
5 hospitals are affected in some way.

6 9 percent of hospitals are at the payment penalty
7 cap in 2013 of 1 percent of base operating payments. In
8 aggregate the readmission reduction program penalty will
9 equal about .24 percent of total payments to IPPS hospitals
10 in fiscal year 2013. The average penalty per hospital
11 receiving a penalty will be about \$125,000.

12 This slide shows how the policy affects different
13 groups of hospitals. The first column shows the share with
14 the penalty, and you can see that there is -- see that there
15 are some differences here. Major teaching hospitals have
16 the highest share with the penalty and hospitals that do not
17 receive IME or DSH payments are the least likely to receive
18 a penalty.

19 Moving to the second column, we do not see much
20 variation in the penalty as a share of total payments across
21 hospitals. In fact, the difference as a percent of total
22 inpatient payments is less than 5/100ths of 1 percent or

1 less across each of these groups. So there's very little
2 variation in what the average penalty is across hospital
3 groups.

4 Jeff will now discuss some long-term issues that
5 we wanted to discuss with you on the readmission reduction
6 program.

7 DR. STENSLAND: As David discussed, readmissions
8 are a poor outcome for the patients and they're a poor
9 outcome that's often avoidable. Craig explained how the
10 current readmission penalty creates an incentive to reduce
11 avoidable readmissions, and we find that following public
12 reporting of readmission rates, we've seen a small decline
13 in readmissions.

14 It appears from what we hear in the field that
15 hospitals are increasing their efforts to reduce
16 readmissions as we move closer to the start of the
17 readmission penalty. Therefore, it appears that the penalty
18 is serving its purpose of motivating hospitals to take
19 action.

20 While the current penalty is an important
21 improvement over the perverse incentives that existed prior
22 to the penalty, there is room for improvement, and I'm going

1 to talk about four possible refinements to the penalty that
2 can take place over the long term. The four concerns I'm
3 going to discuss are, first, the computation of the penalty
4 multiplier; second, random variation; third, unrelated and
5 planned readmissions; and fourth, socioeconomic status and
6 risk adjustment.

7 It should be noted that addressing these four
8 issues would require a change in law. Therefore, we'll have
9 to move carefully as we design ways to revise the current
10 payment formula.

11 When addressing these four concerns, we've tried
12 to keep four principles in mind. First, we want to maintain
13 the incentive for the average hospital to reduce
14 readmissions. The current incentive appears to be inducing
15 hospitals to ramp up efforts to reduce readmissions. We
16 want those efforts to continue.

17 Second, we want to increase the share of hospitals
18 that have an incentive to reduce readmissions. Currently,
19 some hospitals at the low end have no incentive because
20 they're not facing a penalty.

21 We want the penalty to be a consistent multiplier
22 of the cost of readmissions. Hospitals that have more

1 readmissions should face larger penalties. The current
2 penalty formula does not achieve this objective.

3 And fourth, we want the penalty to be at least
4 budget neutral to current policy with a preference for
5 achieving budget neutrality through lower readmission rates
6 rather than through higher penalties. Reducing avoidable
7 readmissions is the goal of the program and, in the end,
8 what the beneficiaries want.

9 The current readmission penalty formula can be
10 simplified into two basic parts. The first box is the
11 estimated cost of the excess readmissions. For example, if
12 you were expected to have ten readmissions and you had 12,
13 then you have two extra readmissions on a risk adjusted
14 basis. If the payment for the DRG at your hospital is
15 \$10,000, the cost of those two excess readmissions would be
16 \$20,000.

17 In the second box, we have the penalty multiplier.
18 Under current law, this is set equal to one divided by the
19 national readmission rate for the condition. For example,
20 if the readmission rate is 20 percent, the multiplier is
21 five. A multiplier greater than one makes the penalty
22 larger than the average revenue generated from the

1 readmission, creating a strong incentive to avoid the
2 readmission.

3 Some would argue that a strong incentive is needed
4 because the penalty only applies to three conditions, and to
5 get institutional change from a penalty that only applies to
6 three conditions, the incentive on those three conditions
7 will have to be large.

8 However, given any size of a multiplier, a key
9 question remains of how the multiplier should be computed.
10 Right now, the multiplier is set at the ratio of one over
11 the national readmission rate for a condition, and this
12 creates two problems.

13 The first problem is that the penalty increases as
14 the industry readmission rate improves. The decline in the
15 denominator in the formula causes the multiplier to
16 increase.

17 Second, the penalty multiplier differs for each
18 condition. If the national readmission rate for a condition
19 is 5 percent for one condition and 25 percent for another
20 condition, the penalty will be five times as large for the
21 condition with the 5 percent readmission rate.

22 And there are three steps we could take toward

1 addressing these concerns. The first step is to use a fixed
2 multiplier. For example, the penalty could be set at two
3 times the cost of excess readmissions. This is basically
4 two times the extra revenue the hospital gets from these
5 excess readmissions.

6 A second step is to use an all-condition
7 potentially preventable readmission measure. This increases
8 the incentive to reduce all types of readmissions, because
9 all readmissions are included in the penalty formula, and it
10 spreads the penalty over more conditions allowing for a
11 lower multiplier.

12 An alternative option is to eliminate the
13 multiplier entirely and set a lower target readmission rate
14 to maintain budget neutrality. For example, the readmission
15 target could be set at a fixed percentage of the historical
16 average for a condition, for example, 80 percent of the
17 historical average. And hospitals would then know in
18 advance that if they made this target they could avoid
19 penalties.

20 The target could be set so budget neutrality is
21 achieved. This is similar to the current system that's used
22 in New York for their Medicaid readmission penalty program.

1 Under this alternative, if the industry reduced its
2 readmissions penalties would be reduced across the industry.

3 The second problem I want to talk about is random
4 variation. The concern is that small hospitals may be
5 subject to more penalties due to have greater random
6 variation. Currently to address this problem, CMS shrinks
7 the reported values toward the national mean, as we
8 discussed in your mailing.

9 The problem with this solution is it reduces the
10 incentive to improve performance and can distort the values
11 that are presented to the public. One possible solution to
12 this problem is to use an all-condition measure. This would
13 expand the number of observations and reduce the random
14 variation.

15 A second option is to use more than three years of
16 data, as CMS currently does, with higher weights given to
17 more recent years. Some may feel that four or five years of
18 data would be looking too far back in time. However, others
19 may say that blending the hospital's current performance
20 with its past performance is better than what the current
21 situation is where they blend its current performance with a
22 simple national average.

1 Finally, we could allow hospitals to report their
2 performance individually, but then combine their performance
3 within a system for purposes of computing the penalty. This
4 would increase the number of observations used to compute
5 the penalty because you're using all the admissions in the
6 whole system, and that would reduce random variation. It
7 would also create peer pressure and create an incentive to
8 share best practices within the group of hospitals that are
9 in that system.

10 The third issue is unrelated and planned
11 readmissions. For example, a pneumonia patient may be in a
12 car accident following discharge. We may see that multiple
13 trauma admission as unrelated. The current law says that
14 CMS should eliminate unrelated readmissions, and it also
15 says it must use an NQF-endorsed measure. The problem is
16 that the current NQF-endorsed measures for the three
17 conditions that are currently in the policy have relatively
18 few exceptions.

19 However, there is a possible solution, and that's
20 there are two all-conditions measures, one that's developed
21 by Yale and one developed by 3M, and both these two all-
22 condition measures have expanded the list of exclusions for

1 unrelated and planned readmissions. We could move toward
2 one of those all-condition measures to help address this
3 issue.

4 And I want to note that moving toward an all-
5 condition potentially preventable readmission measure would
6 not only help address this issue, it would also help address
7 the other issues we just discussed about the computation of
8 the penalty and the multiplier as well as the issue of a
9 small number observations and random variation.

10 The fourth issue is that poorer Medicare patients
11 tend to have higher readmission rates, and this has been
12 commonly reported in the literature. This slide illustrates
13 this point with respect to patient income and readmission
14 rates.

15 First, hospitals with high shares of poor patients
16 have higher readmission rates using SSI as an indicator of
17 poverty. This is what you see in the first column. It
18 shows that hospitals with less than 2 percent of their
19 Medicare patients on SSI have an average heart failure
20 readmission rate that is 92 percent of the national average.

21 In contrast, if you look at the bottom of that
22 column, hospitals with over 19 percent of their patients on

1 SSI have an average heart failure rate that is 112 percent
2 of the national average. We see similar patterns for AMI
3 and pneumonia patients. The result is that hospitals
4 serving more poor patients are more likely to face
5 penalties, as we show in the second and third columns.

6 However, the second point I'd like to make in this
7 table is that some hospitals, even with the highest share of
8 poor patients, have a below average rate of readmissions.
9 If you go to the last column and at the very bottom, you'll
10 see that amongst those hospitals with over 19 percent of
11 their admissions being very poor patients on SSI, still
12 there are 25 percent of those hospitals that have no
13 penalty.

14 This suggests that it is possible to reduce
15 readmission rates for poor patients, but it may be more
16 difficult than for reducing readmissions for patients that
17 have more resources outside the hospital.

18 So we have four possible solutions with respect to
19 the SES issue. First, we could leave the strong incentive
20 in place for poor performers to continue to improve their
21 performance and reduce readmissions for poor patients. The
22 incentive would be for them to move toward the 25 percent of

1 hospitals that currently are able to achieve low readmission
2 rates despite having a large share of poor patients.

3 The second option is to add SSI status to the risk
4 adjuster to offset the higher readmission rate of poor
5 patients. However, there are two concerns with this.
6 First, it would vary differences based on socioeconomic
7 status, and this may prevent us from identifying disparities
8 that would exist, because these disparities would
9 essentially be risk adjusted out of the system and we'd no
10 longer be able to see them. In addition, we could be
11 accused of accepting worst performance at hospitals that
12 treat a greater share of poor patients.

13 A third option is to not include socioeconomic
14 status or income in the risk adjustment model, but compare
15 hospitals to ones with similar income level patients,
16 basically compare hospitals to their peers. This would
17 allow us to continue to monitor disparities because the
18 disparities amongst different income classes wouldn't be
19 buried in the risk adjuster, and also it would be prevent a
20 disproportionate amount of the penalties going to poor
21 hospitals because hospitals would be compared to like
22 hospitals.

1 Another option is to leave the penalties alone,
2 but provide financial assistance to hospitals with high
3 shares of low income patients. And this is similar to the
4 Commission's recommendation to redirect QIO resources, as we
5 discussed in our June 2011 report. These QIO resources
6 could be directed towards hospitals that have high
7 readmission rates or to hospitals that have high shares of
8 poor patients on SSI.

9 Now David will summarize for us.

10 MR. GLASS: In summary, we find that the hospital
11 readmission reduction program which will take effect in
12 October is moving in the right direction. It is creating
13 some incentive to reduce readmissions which is better for
14 beneficiaries and will save money for Medicare. As such, it
15 represents a major improvement over the current fee-for-
16 service program.

17 We find the magnitude of the penalty is reasonable
18 and is limited to 1 percent of payments to any hospital in
19 2013. However, we also find there are four major issues in
20 the current readmission policy that will need to be
21 addressed in the longer term, and we have presented some
22 options on how to address those issues.

1 Finally, we note that it's important to consider
2 the savings from reduced readmissions, as well as the size
3 of the penalty, when constructing policy options. Savings
4 from reducing readmissions to the program may be much larger
5 than any penalty if the incentives created are strong enough
6 to get real action to reduce readmissions from a large
7 number of hospitals.

8 We would like you to consider the following points
9 in your discussion. Almost all the policy refinements
10 discussed will require a change in law rather than
11 administrative actions by CMS. Therefore, we must proceed
12 carefully when recommending refinements.

13 To that end, we will be supplying you with more
14 detailed analysis in subsequent meetings such as modeling
15 all-condition readmission measures. Please let us know if
16 there are additional analyses that you would like us to
17 undertake.

18 Finally, are the principles we have proposed
19 appropriate given your experience in the field? We will put
20 these up now as a reminder. Now we look forward to your
21 discussion.

22 MR. HACKBARTH: Okay. Thank you for that. Lots

1 there to think about and discuss. Let me just say a word
2 about the context here. So as was discussed in the
3 presentation paper, MedPAC recommended that Congress
4 legislate a readmissions penalty a number of years ago.

5 The context in which we made that recommendation
6 was that we identified this issue with high rates of
7 readmissions and a lot of variation in the rates of
8 readmission, and we initially talked about addressing that
9 problem through bundling, bundling post-acute services with
10 the inpatient admission, and through that mechanism creating
11 an incentive for people to care about what happened after
12 the admission as over.

13 As we delved into bundling, it became clear to us
14 that it raised a lot of complicated issues, both complicated
15 issues about how to structure the payment system, as well as
16 issues about how providers would have to reorganize
17 themselves and create new relationships to work under a
18 bundled payment system.

19 It was clear to us that some of those questions
20 didn't have immediate answers, and in any event, would take
21 some time to develop a bundling approach. So we said,
22 another path to pursue might be -- it might be quicker to

1 adopt would be a readmissions penalty. And so, we made a
2 recommendation for the readmissions penalty and you know
3 what happened since there.

4 But we're still now, as our discussion yesterday
5 indicated, still working on these two related but separate
6 tracks, readmission penalty and bundling. And a recurring
7 question for us is, does it make sense to continue both
8 tracks or should we drop one track in favor of the other?
9 And so, as you think about the readmissions issue, I just
10 wanted to provide that additional context.

11 So let's see. Mary, would you like to begin with
12 Round 1?

13 DR. NAYLOR: So your interim comments were really
14 helpful, and this was a great report. I'm wondering, one
15 other piece that's going on simultaneously -- multiple
16 pieces are going on simultaneously, but the Partnership for
17 Patients effort, the Community-based Care Transitions
18 Program, and all the work that's going on to reduce
19 readmissions through better in-hospital care. I'm
20 wondering, in thinking about a readmission policy, the
21 balance between carrots and sticks and penalties and the
22 kind of motivation, so if you had thought about that.

1 And my second question, totally unrelated, is on
2 the SSI. As you look at that slide that describes
3 increasing share of people served in a hospital who are on
4 SSI, it's almost when you get to the 10 percent mark -- and
5 I'm wondering, can we learn anything from those hospitals
6 that are doing well, the 20 to 25 percent, you know, are
7 there characteristics of those places that could be helpful?

8 DR. HALL: Could you remind me --

9 DR. MARK MILLER: Wait, were we going to respond?
10 [off microphone]

11 DR. STENSLAND: Yeah, we can certainly add in --
12 look at the Partnership for Patients and what they're doing,
13 and I think one of the things we can think about is there
14 certainly would be ways to make it penalty -- a carrot and a
15 stick model that would still be budget neutral, and we could
16 bring up some of those opportunities.

17 In terms of the SSI, I think generally it's a
18 pretty clean movement from way at the bottom, 8 percent
19 below, to way at the top, 12 percent above. And so I think
20 that's pretty smooth, but there definitely are some
21 opportunities that we can go and find out what some places
22 are doing with some of their outreach activities outside the

1 hospital, like Denver Health has been noted at someone who
2 has lots of poor folks, but also low readmissions rates, and
3 that's another thing we can look into, so that's a good
4 idea.

5 DR. HALL: Can you remind me the definition of
6 readmission? Is it readmission to the same facility that --

7 MR. GLASS: Readmitted to any.

8 MR. LISK: It's readmission to any facility, and
9 what we measured here is actually -- we didn't measure
10 readmissions on our readmissions, so the person has an
11 initial admission and has a subsequent -- had a subsequent
12 readmission, is what we're measuring here. So that rate,
13 just to define that rate, might be a little bit different
14 from what you've seen from some other things because we're
15 not measuring readmissions on a readmission, for instance,
16 multiple readmissions.

17 DR. REDBERG: To any acute-care hospital, not any-

18 MR. LISK: To acute care, yes, it's only to acute-
19 care hospitals. And then the policy is readmissions to
20 critical access hospitals don't count under the current
21 policy because they're not considered a section -- I can't
22 remember what, 1886 D Hospital so -- because they're not

1 considered an 1886 D Hospital, a readmission to a CAH does
2 not count, which is different from what's been reported on
3 Hospital Compare. It's a slight technical issue, but I just
4 wanted to clarify that.

5 DR. HALL: Do you know what the order of magnitude
6 would be of patients being readmitted to another hospital?
7 Is it 1 percent or 50 percent?

8 MR. LISK: I mean, it's -- I'm not sure. I'd have
9 to check back. But it's probably 20 to 30 percent, from
10 what I recall from previous --

11 MR. GLASS: [off microphone].

12 MR. LISK: Of readmissions, yeah, or to a
13 different hospital.

14 DR. HALL: I think that might be a useful
15 statistic. I mean, not that I'm suggesting that there's
16 gaming going on, but it's conceivable; you shift the patient
17 to another hospital.

18 MR. LISK: The policy applies to discharge to any
19 hospital, though, so it's not going to help you.

20 DR. REDBERG: Thanks. Excellent report. I had
21 two questions, one on Slide 8, and I have to say I work at a
22 major teaching hospital, but I am curious why that had the

1 highest share with the penalty. It looked a lot higher than
2 all of the others.

3 My other question was on Slide 14, and I was just
4 wondering if you could say more about what the all-condition
5 measures were proposed by 3M and by Yale.

6 MR. LISK: The major teaching hospitals having the
7 higher share could be a combination of two things. It could
8 be that they tend to have a higher share of patients who are
9 poorer patients, who are more likely to be readmitted.
10 There could be some case mix issues about the types of
11 patients they're seeing are more likely to be readmitted.
12 It could be a performance issue on major teaching hospitals
13 as well. So we haven't done -- let's say we can do some
14 more analysis to look at that specifically in terms of other
15 factors contributing to that. We haven't done that.

16 In terms of the readmission measures, the 3M all-
17 condition measure is one where you have -- potentially
18 preventable readmission measure is one where you have
19 clinicians look at conditions and say what are the types of
20 things that may be related type of conditions versus not
21 related. A lot of medical conditions following a medical
22 condition -- initial admissions for medical, and if it's a

1 surgery afterwards, a lot of those will be considered not --
2 will not be considered potentially preventable readmission.
3 But a lot of medical conditions will be. But it's a
4 clinically based measure.

5 The all-condition measure is similar to the
6 measure currently used in Hospital Compare and using HCCs
7 and stuff to identify the risk, and then they do have some
8 exclusions that they also had made that was done by some
9 clinicians and stuff and thinking about exclusions.

10 So the 3M approach is more of a categorical model,
11 so if you're in a particular DRG, you have this -- with
12 these characteristics, you have a certain share, percentage
13 of cases you would expect to be readmitted, and that's how
14 that one is done. And the other one is a regression-based
15 model.

16 MR. HACKBARTH: So let me just pick up on Rita's
17 first question about teaching hospitals. Could you put that
18 back up?

19 So my understanding of this calculation, first of
20 all, is that this does not include any of the teaching
21 payments in the denominator. This is just --

22 MR. LISK: Correct. And that's why also, even

1 though 88 percent of teaching hospitals had a penalty, their
2 share of penalty is 0.29 percent, which is just 0.4 -- 0.04,
3 four one-hundredths of a percentage point higher than
4 average, is because the penalty is calculated as a share of
5 total payments, and IME and DSH payments are not part of the
6 calculation.

7 MR. HACKBARTH: And then the second point --

8 MR. LISK: No, not part of the readmission
9 penalty. They're in the denominator.

10 MR. HACKBARTH: Okay, yeah. So then in each of
11 these categories, I assume there's a fair amount of
12 variation.

13 MR. LISK: Yes.

14 MR. HACKBARTH: So there are teaching hospitals
15 that perform better than average, the overall average, and
16 some that are worse.

17 MR. LISK: Yes.

18 MR. HACKBARTH: And that's true for all of the
19 categories.

20 MR. LISK: Yes. There's more variation across --
21 within a group than across.

22 MR. HACKBARTH: Across the groups. That's what I

1 was struggling to say.

2 DR. NERENZ: Just quickly, on Rita's second
3 question, the all-condition, it's still not clear to me.
4 Does that phrase refer to all conditions in the index
5 admissions or all conditions in the readmissions?

6 MR. LISK: It's all conditions in the index
7 admission.

8 DR. NERENZ: Okay, thank you.

9 MR. LISK: We use the frame -- the terminology is
10 "all-condition, potentially preventable" or "all-condition,
11 all-cause." And so the current three measures that are used
12 are all-cause readmission rates for pneumonia, heart
13 failure, and AMI.

14 DR. NERENZ: Okay. But that, you just
15 reintroduced the confusion. Preventable refers to the
16 readmissions.

17 MR. LISK: Yes.

18 DR. NERENZ: All-cause, I just want to clarify,
19 that refers to the index admissions.

20 MR. LISK: Yes --

21 MR. GLASS: No, no.

22 MR. LISK: No, I'm sorry. All-cause is the

1 readmission. All-cause and potentially preventable is the
2 readmission. The index admission is either all-condition or
3 a specific condition. Think of all conditions and all
4 cause, are separate --

5 DR. MARK MILLER: Just a second [off microphone].
6 We've gone through this many times so if we could just
7 slowly --

8 MR. GLASS: So currently they're looking at three
9 specific conditions for the initial, and those are the
10 initial conditions.

11 DR. NERENZ: Yes, yes.

12 MR. GLASS: But their measure is an all-cause
13 readmission --

14 DR. NERENZ: Got it.

15 MR. GLASS: So any reason you come back to the
16 hospital for one of those three conditions counts.

17 DR. NERENZ: Okay. So just to be sure, so the
18 word "condition" refers to the index admission.

19 MR. GLASS: Correct.

20 DR. NERENZ: The word "cause" is the readmission.

21 MR. GLASS: Correct.

22 DR. NERENZ: As is prevent -- thank you. Just to

1 clarify.

2 MR. BUTLER: I'll make it a statement rather than
3 -- make it a question rather than a statement. I do think
4 that the major teaching hospital, if you look at your SSI
5 and how much that explains of it, it would be a good thing
6 to know, because I bet it does explain a lot of the
7 variation that's in the major teaching hospital. That would
8 be a good thing to know.

9 DR. COOMBS: So I was curious, being in the OR a
10 lot, what surgical readmissions look like relative. Has
11 anyone done any literature to look at surgical readmissions
12 compared to the three diagnoses? Because it's really
13 important, I feel, that you look at that as well, because
14 there's opportunities for improvement in quality. And if
15 that kind of parallels these three diagnoses, then that's
16 really neat because you can actually do some things with
17 surgical readmissions as well. So did you find anything in
18 the literature?

19 DR. STENSLAND: I think in the literature -- when
20 we look at the data, there certainly are various readmission
21 rates for surgical readmissions also that are usually a
22 little bit lower than the heart failure readmission rates,

1 but they're still material. And I think when we talk about
2 the three-condition readmissions versus the all-condition
3 readmissions, let's look at everything and try to improve
4 everything, I think there's a little bit of a philosophical
5 question there. And I think the movement from the three
6 conditions to the all conditions could be along the --
7 similar to what you said of saying there's a lot of things
8 that we can do to improve readmissions for all these
9 different conditions. A lot of the interventions we do,
10 like reconciling medications, improving hand-offs of post-
11 acute care, these are things that could help all different
12 types of readmissions, and maybe it's time to move to all
13 these deficit types of readmissions and create the incentive
14 for all of them.

15 DR. COOMBS: And then one other question I had
16 relates to the fact that a lot of hospitals have put in some
17 really robust follow-up programs, patient navigator
18 programs. Have you seen a lot of information in terms of
19 how the turnaround hospitals have been regarding
20 implementation of navigator programs?

21 MR. GLASS: We've looked at some examples of that,
22 and it does seem to work. Mary probably could tell us much

1 more in detail if you're interested.

2 DR. STENSLAND: We have gone to individual
3 facilities and said let's talk about your project. Or we
4 read about Project RED in Boston, or we go to another city
5 and we talk to them about their Project BOOST, what the
6 hospitals are doing, and lots of individual places are doing
7 stuff, and they have individual success. So that gives us a
8 lot of optimism. Probably what we haven't done yet is the
9 really analytical stuff of saying let's look at these
10 readmission rates or changes in readmission rates and relate
11 those to changes in programs on the national basis. And I
12 don't know if Mary knows of any ongoing studies that are
13 doing that right now, but we haven't taken that next step.

14 DR. COOMBS: I'm aware that Boston, BU, has a
15 program that's a navigator program, so that's an example.

16 MR. HACKBARTH: Mary, is there anything you want
17 to say here?

18 DR. NAYLOR: I'm happy to send you data. We've
19 done a review of the literature, and there's work ongoing to
20 try to keep in touch with how the Health Care Innovation and
21 the Community-based Care Transitions that CMS, the
22 Innovation Center, has launched are moving. And, yes, the

1 navigator program is among those that's demonstrating
2 positive outcomes early.

3 DR. SAMITT: I have two questions, one for the
4 team and one actually for Glenn. Great job. Thank you.

5 It wasn't clear to me from the meeting briefing --
6 it was referenced several times, but it wasn't clear what
7 the answer was, whether the penalty, currently or in the
8 future, is greater than the revenue loss from the
9 readmission. Have you done some modeling to see what the
10 impact would be either when it reaches a 3 percent level or
11 whether it would actually require all conditions to reach a
12 threshold to make it significant enough to really focus
13 intently on it?

14 DR. STENSLAND: For those three conditions, the
15 current penalty is greater than the revenue from the
16 readmissions, on the order -- excess readmissions, on the
17 order of four to six times the revenue from the excess
18 readmissions.

19 DR. SAMITT: Okay.

20 DR. STENSLAND: So there is a material incentive
21 to look at those individual conditions. You might argue
22 that maybe there isn't enough incentive to make

1 institutional change if the penalty in aggregate is only a
2 couple hundred thousand dollars and the institutional change
3 might -- the incentive might not be big enough to make an
4 institutional change that would go across the whole system,
5 go across all types of discharges. Does that make sense?

6 MR. GLASS: A little footnote on that. The way
7 the excess is computed in the current system kind of mutes
8 it somewhat because of the shrinkage for some hospitals
9 where they bring it down to the national average.

10 DR. SAMITT: And the question for Glenn is in
11 reference to your introductory remarks about how do we
12 reconcile the notion of changing a readmission penalty
13 process with the notion that yesterday we talked about
14 absorbing readmission risk essentially as part of an
15 inpatient post-acute care process. So it seems as if
16 they're a bit conflicting, if we're going to recommend
17 inclusion of readmissions in a bundle via our discussion
18 yesterday versus a modification and a penalty today, which
19 is it? Are we going to do both? Is one short term/long
20 term?

21 MR. HACKBARTH: You know, that's the question for
22 us collectively to answer, how we see these two. Are they

1 complementary or is one -- if we're able to make a bundling
2 approach work and practical, does that supplant readmissions
3 penalty? So that's not a question just for me. That's a
4 question for us collectively.

5 DR. MARK MILLER: And the only thing I would add
6 is, I mean, you have to be -- I think you have to be
7 conscious that you've probably got the penalty at least for
8 the nearer term, because if you pull it out, then there's a
9 whole set of savings that are lost, and a loss of focus on
10 this. And we have heard widespread responses to this that
11 people have are really taking it seriously, so that would be
12 something to keep in mind.

13 The other thing I would say is that you can
14 formulate bundling options in which you have bundled
15 everything and still leave the readmission as a penalty
16 function across the providers, or you could bundle with it
17 in. And I think even there you could imagine a penalty that
18 continued into a bundling world, or not, but that goes back
19 to the exchange you have.

20 MR. HACKBARTH: We touched on this yesterday, and
21 the way it was phrased by David, Is bundling an end state
22 that we may want to preserve in the long term, or is it just

1 a step towards, you know, broader bundling through ACOs or
2 some other mechanism? So, you know, one approach -- and I
3 don't want to put words in Mike's mouth --

4 DR. CHERNEW: You already have,

5 MR. HACKBARTH: -- but, you know, I think Mike was
6 leaning towards, well, you may want to do the -- continue
7 the readmission penalty, strengthen it, as we're discussing
8 today, and use that as the short-term vehicle for dealing
9 with the readmissions issue, not spend a lot of time and
10 resources trying to do the episode bundling around an
11 admission and focus instead on the big bundle of ACO, and
12 that might be one approach to thinking about these things.

13 But, again, I think that's a question, a strategic
14 question, for all of us to weigh in on.

15 MS. UCCELLO: Is there a reason that these three
16 conditions and the next four were chosen? Are they
17 particularly susceptible to high readmissions, or --

18 MR. LISK: Okay. So MedPAC had a report that had
19 a table in it that showed these seven conditions, and they
20 were conditions that were an example of conditions -- the
21 first three actually were ones that had the most
22 readmissions, but they were examples of readmissions and

1 those are what Congress to get set savings probably put in
2 place, but they specifically referenced our table in the
3 legislation.

4 MS. UCCELLO: Okay. So I assume that there are
5 certain conditions that are more likely to have planned
6 readmissions than others, so those are not evenly
7 distributed. And I'll also assume that those conditions
8 that are more likely to have planned or unplanned are not
9 distributed evenly across hospitals. Is that right?

10 MR. LISK: Yeah, that could be the case. And that
11 could be the case with surgeries, and that may be another
12 reason why the teaching hospitals' rate is higher is that
13 they may have more likelihood of patients who are going to
14 be getting follow-up surgery or something after something,
15 or something else is found. Or it could be someone with
16 subsequent -- you know, somebody who has cancer is treated
17 for pneumonia and is going to have some subsequent cancer
18 treatment. The risk adjustment has some effect for saying
19 those people are cancer, but they may be just more likely to
20 occur in teaching hospitals, and so that could be the other
21 factor that's going on, too.

22 So the planned readmission may not be related to

1 the initial diagnosis in some cases, too. Sometimes it's
2 going to be. So there's some planned readmissions for
3 people who have AMI that are excluded from the current
4 policy, but they're for people who go in for a CABG
5 subsequent for their AMI, as long as the initial -- the
6 readmission wasn't for AMI.

7 MR. KUHN: A couple quick questions. One is kind
8 of picking up where Rita asked the question about major
9 teaching. This has always been a concern of mine because of
10 the acuity levels that they have, and I noticed in the
11 written material -- by the way, it was a terrific paper.
12 But on page 8 in the second footnote, you talk a lot about
13 mortality, and kind of the issue of the inverse correlation,
14 you know, if you have higher readmissions, lower mortality
15 as part of the process.

16 So, you know, I guess some of the things I've been
17 talking to various folks around the country about is the
18 fact that for major teaching hospitals, they really get the
19 train wrecks. They get some of the really bad conditions,
20 and they're saving a lot of these people. But as a result,
21 those folks are so fragile, there is a high expectation
22 there's going to be a readmission as a result of that,

1 versus perhaps if that went to another facility, that person
2 might die, and then there's no readmission.

3 So is this going to be part of the continuing work
4 that we're going to look at that particular issue?

5 MR. GLASS: I'm glad you asked that question.

6 Jeff?

7 DR. STENSLAND: I have a prepared answer for this
8 one.

9 [Laughter.]

10 DR. STENSLAND: This is part of the continuing
11 work, and that's why we have a prepared answer. I think
12 there's two stories you hear; there's two hypotheses that
13 are brought up when you see this inverse relationship.

14 MR. KUHN: Right.

15 DR. STENSLAND: Sometimes you see it in two
16 different areas. One, you see some hospitals that tend to
17 have low readmissions -- lower mortality but high
18 readmissions. And you also see it when you do racial
19 breakdowns. You see African Americans tend to have lower
20 mortality in the hospital but higher readmissions. And
21 there's a couple different hypotheses that might explain
22 this.

1 I think the first hypothesis, we could call it the
2 low-mortality hospital. You know, you're really good. And
3 what I have here is maybe two hospitals have the same number
4 of patients that go into the system to be seen. They both
5 admit ten patients, but the one is really good, and so it
6 only has one mortality or 10 percent mortality; the other
7 one has two people die and they have 20 percent mortality.
8 But then the one that was really good, that person that they
9 kept alive was really frail and so they got readmitted.

10 MR. KUHN: Right.

11 DR. STENSLAND: So that's kind of the story that
12 some of these hospitals will tell you when they're maybe
13 writing op-ed pieces, well, the reason we have high
14 readmission is because we keep out people alive and then
15 they can get readmitted.

16 But there's another story that could also explain
17 the same phenomenon -- this would be hypothesis two -- and
18 this is that maybe you could just be in a high admitting
19 type system, or you could be in an area where people tend to
20 get their care at the emergency room rather than at their
21 doctor's office. So in this case, you're both seeing 100
22 patients, but the high admitting system admits 12 of them,

1 and the low admitting system admits 10. Now, the high
2 admitting system, because they admitted some people that
3 could be treated on an outpatient basis and maybe have some
4 lower level of severity than you would just get from the
5 risk adjuster we have, they only have two deaths, just like
6 in the low admitting system; but because they had 12
7 admissions because they admitted a couple other people that
8 maybe didn't really need to be admitted, maybe because of
9 the decision the hospital made or maybe because of the
10 patient's decision that they decided to seek care at the
11 emergency room and that affects whether you're admitted or
12 not, they have a lower mortality rate of 17 percent just
13 because they have a bigger denominator and they're admitting
14 more patients.

15 But then when you look at readmissions, maybe that
16 same place is also more likely to readmit patients, maybe
17 because when they're not feeling so well, maybe they can't
18 get into their doctor or they don't get into their doctor,
19 and they decide to go to the emergency room, and so they
20 have higher readmissions.

21 So these are just two hypotheses, but the high
22 readmitting story might fit more the African American story

1 of data, because if you do look at the data, you see a
2 disproportionate share of African Americans go the emergency
3 room, a disproportionate share of African Americans are
4 readmitted initially, a disproportionate share of African
5 Americans are readmitted, and there could be some system
6 issues there, neighborhood issues or primary care issues or
7 other things that cause them to be in this high admitting
8 system hypothesis.

9 I hope that wasn't too much.

10 MR. GLASS: And there was at least one study
11 showing a correlation between hospitals that admit a lot of
12 people and also hospitals -- high admission rates and high
13 readmissions.

14 MR. KUHN: Yeah, and I've seen some of that
15 information, so, one, I was absolutely thrilled when I read
16 the paper and I saw all of the information in that
17 particular footnote. I think there's a lot of powerful
18 conversation there that would give us some future research.

19 The other question I had was on Slide 15, and I'm
20 curious in that third column on the median penalty. The
21 data that was pulled together for that one, is that
22 basically the base payments or is that total payments? When

1 I say total payments, I mean does that include outlier, DSH,
2 other information. Because I think depending on how we
3 calculate it, we would get some different results here,
4 particularly since part of the DSH fraction is based on SSI.
5 So I'm curious how this was calculated.

6 DR. STENSLAND: I'll have to go back and check,
7 but I think that is the penalty as a share of just the base
8 payments. I'll have to check.

9 MR. KUHN: Okay. It would be interesting to look
10 at it if it had the supplemental payments on that.

11 And then the other question about this slide when
12 you presented it, and also in the paper, kind of the
13 supposition is there that since only 25 percent share no
14 penalty, it is possible for some of these hospitals that
15 have high SES to manage their readmissions. But I guess the
16 question is: What's the assumption that we're looking at
17 here in terms of the homogeneous nature of the attributes in
18 the community that we're talking about here? Because I
19 guess I'm curious about if those 25 percent have pretty good
20 vertical integration, they've got good transitional care,
21 they've got good coordination, that would be the
22 expectation. If the other 75 percent don't have those

1 community assets and then would have to expend capital to
2 build that capacity, that might be something for us to look
3 at. I think it would be an interesting series of questions
4 for us to look at.

5 MR. ARMSTRONG: Just, I don't think this is a
6 question, maybe more just a comment on our own experience,
7 but perhaps worth thinking about, and that is that a
8 readmission rate is a function of both, the overall
9 admissions and then those patients that are readmitted. Our
10 experience, and very intentionally focusing on -- our target
11 was actually to reduce the readmission rate by 50 percent.

12 At the same time, we're reducing the overall days
13 per thousand. And so, what we found was it was harder for
14 us to reduce the readmission rate while at the same time the
15 overall days per thousand, or admission rate, was also
16 coming down. And so, the overall -- in other words, there's
17 a certain percentage of patients in hospital beds that don't
18 belong there, and that will artificially lower the
19 readmission rate.

20 You take those out of those hospital beds and it
21 will put upward pressure on the readmission rate. And so,
22 you know, you're nodding and you're saying, Yeah, we're kind

1 of aware of that, and I guess that's the only point that I
2 wanted to make. You know, we focus on the readmission rate
3 and the second variable, but it's really the first variable,
4 also could have some bearing as we start getting traction on
5 avoidable admissions to begin with.

6 MR. LISK: You actually make a very good point,
7 and one of the things that we did in our analysis was
8 control for changes in the mix of the patients that's
9 happened over time. A lot of analysis and press reports
10 that said, There's been nothing happening on readmission
11 rates overall, and we do see actually, when we control for
12 it, we do actually see some improvement, and I think it is
13 because there are some cases fewer admissions that shouldn't
14 be there. They're less likely to be readmitted.

15 So the people who are left in the hospital
16 actually are more likely to be readmitted in some cases. So
17 it's hard to say because I think the policies probably
18 affect both sets of cases in terms of the programs that are
19 out there.

20 DR. MARK MILLER: And just a little commercial for
21 future work, and I can't remember where it's staged, but
22 we're going to be looking at some preventable admission and

1 preventable ER use data and trends in the future to try and
2 address some of this question. But your point on the
3 denominator is understood and well-taken here.

4 DR. DEAN: You commented that within each of these
5 groups there is a degree of variation within the groups.
6 What's the range of that variation in terms of some best,
7 worst? Is it roughly the same, compare one group with the
8 other? Is the range roughly the same? Is it worse? Are
9 there greater variations in some? Or what is the average
10 range?

11 MR. GLASS: Well, you're talking about the types
12 of characteristics of the hospital?

13 DR. DEAN: Yeah.

14 MR. GLASS: I think in every group there were
15 those with no penalty and those with the penalty cap. Is
16 that correct, Craig?

17 MR. LISK: Yes.

18 MR. GLASS: Yeah. So the range, in that sense, is
19 similar for all the groups.

20 MR. LISK: Yeah. I mean, it's a range where there
21 are some hospitals that have very few readmissions --

22 DR. DEAN: I just wanted --

1 MR. LISK: -- but the problem comes down, too, is
2 also an end one, that small end problem, too, that you have
3 just random variation in terms of who has readmissions and
4 that's hard to control for ultimately, too, in some ways.
5 So, you know, in any given year, some hospitals perform
6 better and sometimes they perform worse. But there is quite
7 a bit of variation now. And I can try to get you, next
8 time, we can get you and show you some more variation about
9 what that variation looks like.

10 DR. DEAN: Is that evenly distributed? Is it
11 geographically related? I'd be interested to see that. I
12 mean, I suspect that there might be, you know, since
13 admission patterns and utilization patterns vary so much, I
14 would suspect this might vary by geographic area. I'd just
15 be interested. I don't know.

16 MR. LISK: There is geographic variation. If we
17 look, the mountain region has the lowest average rate of
18 readmission and Middle Atlantic has the highest. There's
19 about a -- but it's about on an average basis about a 2
20 percentage point difference on both all-cause and
21 potentially preventable readmissions. So in terms of
22 average -- but within that group, again, there's a lot of

1 variation in terms of hospital performance.

2 And you can see that in terms of what's reported
3 if you go into the underlying data on Hospital Compare, too,
4 for the specific conditions.

5 DR. DEAN: And then you talked about excess
6 readmissions. And maybe you said this and maybe I missed
7 it. If I did, I apologize. How are the -- what is the base
8 line over which they're considered excess? I mean, how are
9 the expected level of readmissions -- is that an average for
10 a group?

11 DR. STENSLAND: Under current law, it would be the
12 national average for that type of person, risk adjusted. So
13 given how sick your people are and given whatever their
14 diagnosis is, the national average is this, and if you're
15 above the national average, you get some sort of penalty,
16 and the higher above the national average you are, the
17 bigger the penalty gets.

18 Of course, that is a policy decision and some of
19 the -- one of the options we discussed is maybe if you
20 wanted to get rid of that multiplier, you could set a lower
21 target. You could say, Let's don't have our target be the
22 national average. Let's have our target be what's the 30th

1 percentile right now and let's move people towards that
2 target. And that could allow some budgetary savings which
3 could offset some of the multiplier.

4 MR. GEORGE MILLER: Yes. This is a fascinating
5 report and I appreciate the information, particularly about
6 Slide 15, which is up. Can you help me or do you know which
7 of these hospitals would be safety net hospitals and where
8 they're located? I'm intrigued, and I think Herb hit the
9 point that those over the 19 -- like Denver Health, I think,
10 was in the report, but they have a large network of health
11 centers.

12 So while that's an excellent model, as Herb
13 pointed out, that's a lot of capital dollars in
14 infrastructure that may help them. So it would be
15 interesting, at least for me, to know how many of those are
16 safety net hospitals and who has that type of infrastructure
17 or not have that type of infrastructure.

18 Again, this was already mentioned. I'm concerned
19 about those folks who may get the care in ED. The slide you
20 had was a perfect indication of some of the concerns that
21 were expressed before, but that's a very good slide. But if
22 some of the safety net hospitals are taking care of

1 patients, especially minorities or other socioeconomic
2 status patients through the ED and get admitted through the
3 ED, it creates, in my mind at least, a problem of the
4 penalty.

5 And then finally, do you know the margins for
6 these hospitals that have a higher share of the SSI compared
7 to the rest of the hospitals, the operating margins now?

8 DR. STENSLAND: I can get back to you on the
9 operating margins. In general, they tend to do pretty well
10 under Medicare because they get DSH payments, but maybe not
11 so well under total. So we can get back to you on total and
12 Medicare because they tend to be hospitals that, Okay, I've
13 got a lot of poor patients so I get DSH payments, Medicare
14 and Medicaid looks good, but I have a lot of poor patients
15 and some of them don't pay me. So overall, I don't look so
16 good.

17 MR. GEORGE MILLER: Absolutely. And then I think
18 Herb asked the question, then in a medium penalty, you think
19 that's just base payment without DSH payments included?

20 DR. STENSLAND: We'll double check.

21 MR. GEORGE MILLER: Okay. Thank you.

22 MR. HACKBARTH: Okay. We're ready for Round 2.

1 Let me just invite comments on a couple things in
2 particular. So earlier, we had a brief discussion about the
3 relationship between the readmission penalty and bundling
4 around an episode.

5 As Mark indicated, our premise, and I invite
6 people to react to this, is that the readmissions program is
7 in place. It can be refined and we've just heard a
8 presentation on some of the issues and possible solutions.
9 And our premise is it makes sense to keep this in place,
10 keep it going, try to make it better.

11 Even though bundling, as an alternative approach,
12 may have some conceptual appeal, it is not as yet an up and
13 running live program, and so premise number one is this
14 makes sense to continue and work to refine readmissions.

15 Then the second thing I invite reaction to is
16 Slide 10, the principles for refining the policy. There's a
17 whole lot of material here and a lot of really complicated
18 issues, and people -- you're welcome to comment on any of
19 the specific issues raised in how to deal with SES or any of
20 the other issues.

21 But what I'd really like to accomplish today is to
22 make sure that people feel comfortable with the principles

1 as a guiding framework for what we do in subsequent meetings
2 about addressing specific issues. So if you can address
3 those two things, I'd appreciate it. Mary?

4 DR. NAYLOR: So on the principles, I really, first
5 of all, just like the overall direction where your proposed
6 efforts are going and have a suggested refinement about
7 collapsing one and two, to think about this as motivating
8 and increasing all hospitals incentives to reduce all
9 preventable rehospitalizations.

10 And I think that the language there is saying
11 that, you know, we started something, we're targeting people
12 or hospitals with excessive, but now we want to get
13 everybody in this movement. I think of the issue of
14 motivation increasing.

15 I do think that there is an absolute reason to do
16 this, because many think about how -- we're talking about
17 creating system change, so not just focused on a condition.
18 To get to better care and outcomes for AMI, pneumonia, and
19 heart failure, you have to better improve communication,
20 transfer of information, and it should apply to everybody.
21 So I think that this is a natural progression in terms of
22 these efforts.

1 The change in language, though, would also suggest
2 the opportunity to look at those carrots and sticks. I
3 mean, there's a lot of, in addition to what we described,
4 the emphasis on primary care and care coordination.
5 Targeting high risk people can contribute if we give it the
6 right incentives to motivating to help reduce readmissions,
7 et cetera.

8 In terms of alignment with bundle, I think that
9 this raises a big question, whether or not we need -- where
10 we started was to think about 30-day readmissions, but
11 whether or not performance in terms of getting to better
12 care and reducing avoidable preventable readmissions under a
13 bundled model could extend our thinking beyond that.

14 So if hospitals think about better partnerships
15 with community providers, bundled payment, could we be
16 thinking about readmissions that extend to 90 days or
17 beyond? So that, I would think, would be great. Anyway, I
18 love the focus. I love the orientation toward looking at
19 SES.

20 I don't know how it will fly in terms of whether
21 or not it's in the risk adjustment or not, I think, but I
22 think it's critically important that we look at who's doing

1 well here. Maybe it is that the characteristics of they
2 have a very well integrated community base care system, but
3 we need to know that.

4 MR. HACKBARTH: Before you go, could I just ask
5 one other question? I meant to ask this during the
6 clarifying round. So back when we initially recommended the
7 readmissions penalty, my recollection was that that was
8 coupled with a recommendation about authorizing gain
9 sharing, the idea being that this shouldn't all be about the
10 hospital and they need some tools to get others to align
11 with them in this effort. What is the status of gain
12 sharing at this point?

13 DR. STENSLAND: Ariel can correct me if I'm wrong,
14 but there is no law that says you can gain share. I think
15 there's a couple things going on. One is that people can
16 ask for exceptions, and the way I think the Government
17 usually then says, Okay, we don't have any plans to
18 prosecute you for doing any of this. So it's not a really
19 warm and fuzzy because there's no clear safe harbor.

20 And the other is there is a lot of demonstrations
21 going on and a lot of the bundling demonstrations say, you
22 know, You can gain share. So there's some opportunities to

1 do it through these different avenues, but there's no broad
2 law to do it.

3 MR. HACKBARTH: Programmatic.

4 MR. WINTER: And on the bundling program, it does
5 all include -- I mean, most of the options include
6 readmissions on some of those bundling.

7 MR. HACKBARTH: Okay. Bill?

8 DR. HALL: So I liked this report very much. I
9 think this is actually a very exciting report, and I guess
10 one principle is, if it ain't broke, don't fix it too much.
11 So since 2008, 2009, at least there seems to be some modest
12 improvement in terms of reduction of readmissions. So take
13 credit for it.

14 On the other hand, there are some things that have
15 been going on simultaneously in the health care industry
16 over this period of time which are worth noting. One is
17 that there's been enormous uptick in the introduction of and
18 utilization of electronic medical records since 2008.

19 One of the virtues of the medical record is that
20 it makes certain types of analyses and identification of
21 risk factors very much more evident, and that's going on in
22 most hospitals right now. One of those is an emphasis not

1 only on medication reconciliation, what is the post-hospital
2 care plan, but such things as literacy, for example, which
3 probably plays a huge role, or lack of same, whether it's
4 health care literacy or overall literacy, in terms of
5 readmissions.

6 So I think -- I don't think we need to ding people
7 more than this. I think we've gotten their attention and I
8 would say -- my only other thought was whether there was any
9 gain sharing opportunities there to consider in the future.

10 DR. REDBERG: I wanted to make a comment on the
11 point you were making about the relationship between
12 appropriate admissions and readmissions, because I think
13 particularly with regard to chest pain and AMI, it's a big
14 issue, and you do also mention in the footnotes about the
15 observation units.

16 I'm not sure how that plays into it, because I
17 certainly think currently there's a lot of evidence that
18 suggests there are a lot of inappropriate admissions for
19 chest pain for a lot of different reasons that not are all
20 related to avoiding readmissions, but concerns about
21 liability and just kind of -- a funny culture, but a lot of
22 people -- I mean, certainly in my own hospital a lot of our

1 very short inpatient stays are all these rule-out MIs that
2 really, I think, because they come in through cardiology so
3 I see them, shouldn't have been admitted.

4 I'm just wondering how we can account for that, or
5 perhaps also address that problem in the readmissions issue
6 because it's not necessarily in the patient's best interest
7 to be coming into the hospital besides the increased cost.

8 The other comment I just wanted to make was on
9 Slide 16 on addressing the effect of socioeconomic status on
10 readmissions. I would suggest that instead of providing
11 financial assistance, certainly directly to hospitals that
12 have high level income shares, considering a program where
13 hospitals, and I guess you could call it gain sharing, but
14 if they had that money, but that would be used to actually
15 award grants or programs that would help prevent
16 readmission, because I don't think it's in the hospitals.

17 It's what happening at home after discharge that
18 it's more likely to increase readmission rate in the low-
19 income communities. And so, if that money was actually
20 directed at either those patients themselves or at services
21 to help those patients rather than at the hospital.

22 MR. GLASS: Yeah. The observation stay thing cuts

1 both ways. It could decrease your number of initial
2 admissions or if it was used instead of a readmission, it
3 could reduce your readmission rate. So it is complicating.
4 It's a complicating factor and the use of observation days
5 has been increasing a lot.

6 DR. MARK MILLER: You couldn't know this because
7 it all happened before you got here, but when we went
8 through the reformulation of the QIO dollars, there was this
9 discussion of groups of providers coming together and trying
10 to create a community solution and that dollars could be
11 targeted to those types of things. It was kind of
12 contemplated in that recommendation.

13 DR. NERENZ: Definite support for the principles
14 here and just a couple areas of emphasis. One is in support
15 of what others have said. I think we should continue to
16 look very strongly at the SES risk factors, and I do like
17 Bill's mention of literacy specifically. I've tried to look
18 into this. The data are quite limited. But my daily
19 experience suggests to me that that matters, and so we just
20 ought to keep looking at that.

21 It's in the spirit of trying to not penalize
22 hospitals for things outside their control. And then with

1 that in mind, I'd encourage staff and all of us to try to
2 examine what's known about readmissions in order to try to
3 more clearly lay out the pathways or drivers to readmission,
4 and then try to categorize them as best we can in terms of
5 those that are truly under the hospital's control and those
6 that are perhaps, and then those that are likely not, and
7 then try to tailor policies as much as possible to focus on
8 those things that hospitals within their normal scope of
9 responsibility and activity can do.

10 I realize that there's a fuzzy area around that
11 boundary, but try to make it tight if we can.

12 DR. BAICKER: I like the principle a lot of
13 expanding the share of hospitals that have incentives, and I
14 think there's evidence from the pay-for-performance
15 literature that these thresholds are not so great because
16 anybody way above or way below has no incentive.

17 And it seems perhaps more important to expand the
18 group of hospitals where there's an incentive than
19 necessarily to get to an all-condition, all-cause measure.

20 To know the answer to how important that is, I'd
21 love to see a little more information about the correlation
22 between admissions for the conditions we're looking at --

1 readmissions for the conditions we're looking at versus
2 others, in that you could imagine that it's a good proxy and
3 highly correlated, or that it's actually harmful in that you
4 devote all of your resources to avoiding these readmissions
5 and readmissions elsewhere.

6 That doesn't seem so likely to me. But knowing
7 how good a proxy this subset is would be helpful in knowing
8 how important it is to expand the set of things we're
9 measuring versus expanding the number of hospitals who have
10 an incentive to improve on those things. Obviously those
11 aren't mutually exclusive strategies and we probably want to
12 pursue both.

13 MR. GLASS: And I think a two-sided strategy as
14 opposed to penalty only would increase the number of
15 hospitals.

16 DR. CHERNEW: I'm supportive of the principles
17 outlined and I would just add that with regards to the SES
18 adjustment, I think that reporting within groups of
19 hospitals, which was, I think, one of the ones on the other
20 slide, is probably where I would go in what is admittedly a
21 very difficult topic.

22 MR. BUTLER: So when this came up four years ago,

1 I was a big supporter of this being an important lens
2 through which to better understand Medicare spending, and
3 why not start with the hospital, even though they're not
4 accountable for all of this, and I'm still supportive of
5 this as a direction. I would make four points.

6 The first one with respect to the principles is I
7 support the principles. I think a fifth one, Glenn, might
8 be your very point that you made, and that is that this
9 remains a good area of focus, but it's a journey that has an
10 end to it that really wants to pass along more risk and get
11 more of the provider segment engaged in managing the health
12 of the population and the related expenses. So it might be
13 yet another principle. We don't want this to somehow slow
14 down that longer term vision.

15 Now, along those lines, I'd just point out that
16 when you sit here as a hospital, come October 1, now
17 suddenly we're in the pay-for-performance world, or maybe
18 paying for not performing, too. But we have the value-based
19 purchasing. Think about the scorecard in the sky for the
20 hospital right now. Starting October, you take away 1
21 percent of the DRG payments and you maybe you get some back
22 for your HCAHPS score and your core measures.

1 And then you've got three very narrow conditions
2 and readmission rates, and that's how we're moving money
3 around starting in October in a very kind of bizarre set of
4 limited measures.

5 And while it's good to get started, that's kind of
6 hardly the robust kind of attention. So there's a fair
7 amount of suboptimization of resources in institutions
8 around these that is not necessarily exactly right, but it's
9 as good as we can do. But it's something that's going to
10 have to be modified over time if you want to kind of look at
11 the bigger picture.

12 Second point is these adjustments that we've
13 talked about, particularly related to planned or unrelated
14 or SES, are kind of the devil in the details. I think we'll
15 find that in a value-based purchasing world, as well -- all
16 of the same institutions are going to kind of get negatively
17 impacted by these measures. And so you find a collective
18 impact that may be a little bit differently intended than
19 you think.

20 The low-scoring HCAHP people are going to be the
21 same ones with some of these high admission rates that have
22 socioeconomic populations that are different and kind of

1 snowball a little bit if we're not careful.

2 The third point is simply working with others, and
3 I would encourage those, whether you're in the audience or
4 not. This is an area that's getting a lot of good data and
5 a lot of good suggestions and it's an area where we really
6 can, I think, learn from some others that are working on
7 that, not just depend on our own staff.

8 And the final point is not something that maybe we
9 can do about, but some states like Illinois have suddenly
10 taken this readmission thing and just kind of run with it
11 and multiplied it into a penalty that is far in excess of
12 anything imagined in Medicare without much data, and whether
13 it takes hold or not, other payers, particularly Medicaid
14 and others, say, Well, I'll do that and I'll even do more of
15 it.

16 So what we're doing here does have implications
17 and is being grabbed on by other payers, and so I think we
18 need to kind of think about that. We want that to happen
19 where it's appropriately used, because we do want
20 synchronization across payers, but we should be a little bit
21 careful about what we're doing here and how it applies to
22 others.

1 DR. COOMBS: I agree with the principles as stated
2 and I agree with much of what has been said already around
3 the table. The bullets I would like to hit, first of all,
4 is the SES status, which I think it really is an important
5 issue. And as I think about it, I was wondering if it was
6 possible to consider it as an index with a calculation that
7 would actually correct so that penalties would not be
8 implemented based on the patient population of the various
9 hospitals.

10 And as you aggregate data over larger groups of
11 hospitals, I think it makes it a little safer, but at the
12 same time, it's possible to really kind of conceal some
13 areas that really need to be dealt with. So while we can
14 say that it's probably a little bit more reflective, and I
15 am one for not individual evaluations of hospitals in small
16 settings because I think, as demonstrated by the slide, it
17 only takes one or two patients rolling up at the wrong
18 place, because they've been cared for at another
19 institution, and that place not able to handle them in the
20 same capacity if they were to go back to their original
21 tertiary hospital, especially true in major interventional
22 cardiac surgical cases and vascular cases.

1 So I think we have to be sensitive to that. And
2 that being said, if there's a way to aggregate the data over
3 larger groups of providers. I think that's very true in
4 settings where you have a number of hospitals in a certain
5 geographic locale.

6 As for the data regarding African-American
7 patients, there's been a mixed bag on that data because
8 archives of surgery actually looked at surgical patients,
9 African-American, who were admitted to what we would call
10 the elite hospitals, and under the dome of those elite
11 hospitals, the African-American patients were actually taken
12 care of by what we call low-volume providers, and actually
13 had worse mortality and morbidity under that scenario.

14 So it may be that you look at a hospital that has
15 really good data. The subset of the patients within the
16 confines of that hospital may actually have issues that are
17 concealed by the larger numbers just statistically. It's a
18 statistical result. So those are a few of the things that I
19 have to say.

20 I think we're on the right path in terms of trying
21 to go to a system that -- I think this is a theme -- that
22 would incorporate us being able to transition to a form of

1 integrated health care delivery system, is where we want to
2 be. I think that we're going there.

3 DR. SAMITT: Just some quick thoughts. I think
4 the principles are spot on. I would have just a few
5 supplemental thoughts.

6 I would be in favor of expanding to additional
7 conditions. I think the opportunity here is vast, and all
8 conditions may be too far, but maybe it needs to be more
9 than the subset that we've got, because I think there's a
10 tremendous amount of low-hanging fruit here.

11 I'm not quite ready to give up on the notion of
12 bundling, and the reason I'm not is because readmissions are
13 not solely under the control of hospitals. We've done a lot
14 of work in our system to reduce readmissions, and a
15 tremendous amount of it is the receptivity on the physician
16 side in terms of follow-up visits after hospitalization. So
17 we can manage that easily in an integrated system. In less
18 integrated systems, how do the hospitals engage the
19 physicians if they're incented differently? And the
20 readmission penalties don't address this issue. So we may
21 want to think about the potential synergies of a bundling
22 relationship in addition to the penalties.

1 Then I just wanted to comment on the SES. We
2 haven't addressed it, but I really like the notion of
3 comparing hospitals with similar populations because there
4 may be high performers and maybe there's tremendous
5 opportunity for best practice sharing if we say, well, are
6 there examples of shining light with these types of
7 populations that would help those with higher readmission
8 rates. And so that comparison, I don't think we should be
9 afraid of that. I think there'd be opportunity to mine that
10 further.

11 MS. UCCELLO: I agree with the principles. I also
12 think that there is some synergy between the relationships
13 that hospitals need to develop with the non-hospital folks
14 to address these readmissions, and that relationship
15 building will help facilitate movement toward bundling or to
16 ACOs or something like that.

17 In terms of the SES, I think that our goals are to
18 move toward better quality regardless of who the patient is
19 or where they seek treatment. And so I think it's a good
20 idea to kind of look at some of these hospitals that are
21 doing a good job with lower-income patients and that kind of
22 thing to help give some more information. But I think then

1 what we can do with that is help target some payments to the
2 hospitals that aren't doing as well and help them get toward
3 better quality.

4 MR. KUHN: I'll speak to the principles in just a
5 moment, but if I could talk on just page 13 on the issue 2
6 of random variation in small numbers of observations, you
7 have three possible solutions. I might add a fourth that
8 might be worth looking at, and it could be to approach
9 readmissions with mortality as a combined adverse outcome.
10 I think that might help us look at -- deal with small
11 numbers, but also I think it might be a good indicator of
12 good quality care. So just something else to look at.

13 Going back then to the principles, I'm in pretty
14 good shape with those principles. I think they make sense,
15 and I think that's a good guidepost for us as we continue to
16 go forward. But just one observation on that, and that is,
17 if we go through with these principles -- and that's kind of
18 what we've been talking about here this whole process -- you
19 know, the community at large has to understand that there's
20 a sense of fairness here. So fairness in this regard is
21 either a more elegant or a better risk adjuster as we go
22 through the process. And we've talked a lot about SES here.

1 But let me put a little bit of a finer point on
2 that from what David was talking about, and my concern here
3 is that if we don't have a better adjustment and if we don't
4 look at the SES very seriously -- and I know we are -- is
5 that I think that could further serve to disenfranchise
6 through an inequitable penalty to a community of hospitals
7 that are working very hard to deal with a very difficult
8 population. So I think it's really key that everybody
9 understand that there's fairness in the system or else they
10 get very disenfranchised pretty fast. So I know we're
11 talking about it, we're going to do more research, but I
12 think it's pretty important on that part.

13 And I know I've shared this with some of you in
14 the past that we've done some work in Missouri, and we've
15 looked at poverty rates by zip code, and it produces a very,
16 very strong indicator in terms of which population are going
17 to be readmitted. So to me, I think the evidence -- there's
18 a growing body of evidence, and I hope we can continue to
19 look at it very seriously.

20 MR. HACKBARTH: Herb, any reaction at this point
21 on the idea of comparing hospitals to similar hospitals?

22 MR. KUHN: I've got some thoughts on that. I'm a

1 bit concerned about it, but maybe I can shoot you an e-mail
2 and think about that one a little bit more.

3 MR. HACKBARTH: Okay.

4 MR. ARMSTRONG: Just briefly, I agree. I think
5 the policies are appropriate. I think we've got enough
6 experience with this that we're very good at coming up with
7 all sorts of things to worry about. But I just think we
8 should expand it to more patients and move with this,
9 recognizing completely that we're dealing with near-term
10 fee-for-service payment structure constraints at the same
11 time we're trying to manage a broader payment for bundles or
12 for, you know, populations of patients, and that's just the
13 reality of the world we live in today.

14 DR. DEAN: I would echo what folks said. We
15 really appreciate this effort because I think this really --
16 I think maybe it was Peter that said, you know, it's kind of
17 a lens on the overall functioning of the system. It's much
18 more than just hospital function, and so I think it's really
19 fundamentally important. And I think the attention that it
20 has gotten already, you know, all indications are it's
21 making a difference, and we really need to support the
22 efforts that especially individual facilities and systems

1 are making.

2 I certainly support the overall principles. You
3 know, to get more specific, I was concerned about that
4 multiplier. That seems to me to be just absolutely --
5 what's the word I want? -- bad, for lack of a better word.
6 I mean, to have a higher penalty as you get better with your
7 performance, it's obviously something that doesn't make any
8 sense.

9 The issue of the hospital being the focus of these
10 activities, it certainly is a fair argument that hospitals
11 are being penalized for things that are oftentimes beyond
12 their control, and I think that as much as I admit that
13 that's not fair, it may still be just where we're at and we
14 may not have any other choice. It's a first step. But I
15 think we need to recognize that, and especially in relation
16 to -- I think Herb just mentioned those hospitals that are
17 dealing with more challenging populations. We know that
18 there are ways to provide good services to populations that
19 have a lot of special challenges, but the things that have
20 to be done are not things that anybody can do overnight, and
21 they're really major system changes. I mean, I think the
22 Denver example is a great example, but they didn't build

1 that overnight. That is a decade or several decades of
2 effort.

3 And so I think in terms of the socioeconomic
4 impacts, we need to consider it. I don't think it should be
5 built into the risk adjuster and say we accept higher
6 readmission rates. But at the same time, I would say that
7 we need to be looking at ways to look at, you know, what are
8 the best practices, what direction can we provide, what kind
9 of support can we provide to these, especially the safety
10 net hospitals. And basically we need to focus more on
11 carrots than sticks in this area because very often these
12 are facilities that are already stressed and yet are
13 providing vital services. And so we don't want to make it
14 any more difficult than it already is.

15 At the same time, just because they're dealing
16 with a difficult population is not an excuse for inadequate
17 care either.

18 So, anyway, keep up the good work.

19 MR. GRADISON: First off, my sense is that the
20 bundling issue isn't yet ready for prime time, and for that
21 reason alone, I would be inclined to separate the
22 readmission issue from the bundling issue.

1 I agree with the principles on page 19. I share
2 the concern expressed by so many about socioeconomic status.
3 I'm particularly interested in the part that may relate to
4 the health care system as it affects SES. In particular --
5 and I'm not sure if I'm right about this, but my hunch is
6 that folks in this part of our society are less likely to
7 have a regular physician relationship and, therefore, the
8 hospital may have a harder time even knowing who to be in
9 touch with to try to do appropriate follow-on, which is so
10 important, I think, in terms of readmission.

11 I would be interested in any data, if it's readily
12 available, on trends in observation status, which I perceive
13 to be one of the potential ways to game this thing.

14 MR. GEORGE MILLER: I agree with the principles,
15 and most all of my colleagues have said what I wanted to say
16 about the other issues. I think it is important that we are
17 concerned about SES and the impact it could have on those
18 patients, and a policy that reflects that I think is
19 important. But, again, I agree with the principles. Our
20 goal is for system change, and the fact that we're going
21 down this path helps to make the system change, which I
22 support. But at the same time, best practices that can be

1 used for education into how other hospitals are maybe
2 struggling with this issue is important to recognize.

3 Again, I just want to echo what others have said,
4 that hospitals are not in this alone. We seem to be taking
5 the penalty -- there are any number of factors for
6 readmissions, including patients we know are going to leave
7 the hospital that don't have the resources to take the
8 medicine to keeps them from being readmitted, and that's an
9 SES issue.

10 Thank you.

11 MR. HACKBARTH: Okay. Thank you all. Very well
12 done.

13 We'll now have our public comment period.

14 Before you begin, let me just see how many people
15 are going to be in the queue.

16 Okay, so we've got four, and we're going to cut it
17 off there because we are running late and we do have planes
18 and trains to catch.

19 MS. LLOYD: Can you make it five, Glenn?

20 Can you make it five? I can get up here fast.

21 MR. HACKBARTH: Okay, five, but that's it. And,
22 we'll have to manage this quite tightly. So, when this

1 light comes back on, I really need you to wind up. If you
2 don't, I'm going to have to interrupt, and that's awkward
3 for both of us.

4 So, please begin by introducing yourself and your
5 organization, and remember, both the five in line and
6 everybody else in the audience, this isn't your only or even
7 your best opportunity to provide input on the Commission's
8 work. The best opportunity, of course, is to interact with
9 the staff. But, in addition to that, there still is -- Jim,
10 am I correct -- a place in the web site for people to place
11 comments as well that relate top our particular meeting this
12 week, and please avail yourself of that.

13 Okay.

14 MS. FELDPUSH: Thanks. Hi. Beth Feldpush of the
15 National Association of Public Hospitals.

16 Thanks for this great work and the really
17 thoughtful discussion today. We were particularly pleased
18 to see so much of the discussion centered around the impact
19 of socioeconomic status on readmissions.

20 You've mentioned several of the innovative and
21 really effective programs that have come out of safety net
22 hospitals that have successfully reduced readmission rates,

1 such as those at Denver Health and Project RED, but safety
2 net hospitals really do struggle every day to support their
3 patients once they leave the hospital with education and
4 resources for them to successfully self-manage and receive
5 care in the community.

6 We know that these impacts are real. There is a
7 growing body of literature that supports the impact of
8 socioeconomic status on the risk of readmissions. And, you
9 know, we thank you for your attention to it but really feel
10 that the current Readmissions Reduction Program does not
11 account for those differences as well as it should, and in
12 fact that can lead to real inequities and unfairness in the
13 program that can be biased against certain hospitals,
14 particularly those that take care of vulnerable patients.

15 So, we would just encourage you to continue your
16 work in this area and to provide some strong recommendations
17 on how the current program could be improved so that those
18 inequities go away.

19 Thanks.

20 MR. NANOF: Hello. I'm Tim Nanof, Director of
21 Federal Affairs with the American Occupational Therapy
22 Association. Also, I'm a co-chair of the Consortium for

1 Citizens with Disabilities Health Care Task Force.

2 Thank you for your discussion of outpatient
3 therapy. I really appreciate that and MedPAC's willingness
4 to work with the associations.

5 I wanted to raise one particular concern about the
6 application of a permanent cap to hospital outpatient
7 departments. Very specifically, the issue there relates to
8 temporary versus permanent. The consequences of applying it
9 permanently to the hospital outpatient setting would
10 eliminate the access to care if the therapy cap were fully
11 in place. In 1997, Congress explicitly allowed hospital
12 outpatient settings to be exempted from the cap so that
13 patients would have a way to access care.

14 Currently, it was mentioned that the exceptions
15 process is that new pathway to care. The problem is the
16 exceptions process is temporary, and that would be real
17 concern if Congress was to fail to act because of budgetary
18 reasons or political reasons.

19 So, please take that into consideration. Thank
20 you.

21 MS. FAERBERG: Hi. Jennifer Faerberg from the
22 Association of American Medical Colleges.

1 I just want to, at first, echo comments from Beth
2 about a wonderful discussion that you've had this morning
3 and really appreciate your focus on SES and how that impacts
4 readmissions.

5 We've actually done a data analysis on this and
6 have found, as you know from the literature that SES factors
7 do have a statistically significant impact on readmissions.

8 We've done an analysis to use dual eligibles as a
9 proxy for SES and have found some similar data about very
10 high rates at our major teaching hospitals. We have, in
11 looking at this data analysis, have come up with a
12 recommendation in using a stratification approach based on
13 dual eligible status that allows you to calculate the
14 readmission rates based on the dual eligible patient
15 population and non-duals, coming up with a blended approach
16 which ultimately then tightens the curve on the payment
17 penalty, doesn't give a pass, applies broadly to all
18 hospitals and allows for some of that discussion being able
19 to compare like hospitals.

20 So, we ask that you maybe consider that in your
21 deliberations.

22 And, we're also in response to a prior comment

1 about working with others; we're happy to work with MedPAC
2 staff on what we have found and moving forward.

3 Thank you.

4 MS. SATTERFIELD: Hi. I'm Lisa Satterfield from
5 the American Speech-Language-Hearing Association, and I
6 wanted to thank the panel for their discussion on therapy
7 services.

8 I believe you have some information regarding the
9 use of the National Outcome Measurement System that speech-
10 language pathologists use in health care settings. About 15
11 to 20 percent of speech-language pathologists in health care
12 settings utilize our NOM System.

13 And, we also wanted to show our support regarding
14 the use and the discussions of the VA system in therapy
15 services, as NOMS is also used in the VA and has been used
16 for outcome reportings in that system.

17 We'd like to help the Commission with any of this
18 information.

19 Thank you.

20 MS. LLOYD: Hi. Danielle Lloyd with the Premier
21 Alliance.

22 We're an alliance of 2,500 hospitals around the

1 country, trying to improve quality and reduce costs. And,
2 we very much support, obviously, the goal of reducing
3 readmissions and holding hospitals accountable. We're a
4 Partnership for Patients Hospital Engagement Network. We
5 have over 400 hospitals working with us. We've had
6 readmissions in our QUEST program for at least two years
7 now.

8 So, I do want to make sure, as Mark said, everyone
9 is diligently working on these issues. I wanted to
10 underscore that.

11 We are a measure developer. We know that is very
12 hard. The science of risk adjustment is very hard, building
13 these robust measures. We work very much with Harlan
14 Krumholz who created the CMS measures.

15 But, these measures aren't always able to
16 accurately look at and rank hospitals. So, we're taking
17 measures that don't necessarily statistically differentiate
18 between hospitals, we're forcing a variation, and then we're
19 attributing a payment penalty.

20 So, this is where it becomes really hard to get us
21 out of this potential vicious cycle with the payment, of
22 taking potentially money away from those safety net

1 hospitals that very much need that money to invest it in
2 reducing the readmissions.

3 So, we want to make sure that we find some
4 policies. We support this dual eligible proxy that the AAMC
5 just mentioned, of segmenting those populations and using
6 that to dampen the effect on the safety net, initially.

7 Of course, all of these things can grow and change
8 as we move into these policies. But, right now, we're
9 throwing on VBP and readmissions and soon this new HAC.
10 And, there's going to be a lot of transitions, and we just
11 have to be very careful that there are not unintended
12 consequences.

13 The other thing I'll say is we very much support
14 this idea of setting a target and moving towards that
15 target, where everyone can potentially reach it. It's much
16 more like the value-based purchasing program. In fact, we
17 recommend that Congress put readmissions not as a standalone
18 program but actually into VBP where you can have balancing
19 measures like mortality and other things, and have a single
20 approach with more common incentives across those different
21 measures.

22 The last thing I'll say is I wouldn't be too quick

1 to jump to an all-conditions measure. One thing is that we
2 do need to be working on systems and across measures, but
3 there are a couple problems.

4 One is you kind of perceive it as boiling the
5 ocean. Sometimes hospitals really need to be looking in
6 particular areas. Just because you're good at -- you can be
7 good at cardiology, for instance; you can be bad at
8 pneumonia, at the same facility. So, unless they have sort
9 of actionable information, it's harder to really make that
10 change.

11 So, thanks.

12 MR. HACKBARTH: Okay. Thank you very much.

13 We're adjourned and see you in October.

14 [Whereupon, at 12:04 p.m., the meeting was
15 adjourned.]

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