

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 15, 2011
10:11 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [10:11 a.m.]

2 MR. HACKBARTH: Okay. We're going to start up in
3 just a minute here, if people would take their seats.

4 Okay. Good morning. Welcome to everybody in the
5 audience. We are beginning a new MedPAC annual cycle. This
6 is our first meeting of the new cycle, and the first item on
7 our agenda for today is Physician Payment and the
8 Sustainable Growth Rate System. Before we begin the staff
9 presentation, I want to just try to set the stage for this
10 and say how we came to be at this point.

11 MedPAC first recommended repeal of the SGR system
12 in 2001, and we recommended repeal at that point because we
13 thought the system would be ineffective at controlling
14 growth and volume and intensity of service; and that it
15 would be inequitable in that it treats all physicians the
16 same, even though they did not all contribute equally to
17 whatever volume and intensity problem we might have; and
18 that it was likely that there would be unintended
19 consequences from maintaining a formulaic link between
20 physician fees and the growth rate in expenditures. I think
21 we were right in 2001, and I think the subsequent record
22 shows that our concerns were valid concerns about SGR.

1 Of course, Congress decided not to repeal SGR.
2 Initially, SGR -- this is a long time ago, and many people
3 may have forgotten, but initially SGR actually increased
4 physician fees because target spending was below the SGR
5 line so there were, in effect, bonuses paid out to
6 physicians. And then, I think it was 2002 -- Cristina and
7 Kevin, correct me if I am wrong -- that there was actually
8 the first cut under SGR, a 5.4-percent cut in fees, as I
9 recall.

10 As the years went by, as everybody well knows,
11 Congress elected to, when necessary, override the SGR
12 formula to assure that there would not be substantial cuts
13 in physician fees, in some years freezing fees, in some
14 years offering modest updates. But as the years went by,
15 the cost, as scored by the Congressional Budget Office, of
16 repealing SGR grew and grew and grew, until today the most
17 recent CBO estimate that I have seen is that to repeal SGR
18 and replace it with a 10-year freeze on physician fees has a
19 10-year cost of about \$300 billion. If there is more than a
20 freeze, if fees are allowed to increase above a freeze,
21 obviously the cost goes up approaching \$400 billion,
22 depending on the precise policy.

1 In March of this year, the Commission, MedPAC,
2 talked about repeal of SGR and agreed to embark upon the
3 process that we are now continuing today of looking at
4 repeal and considering alternative mechanisms for
5 calculating physician payments.

6 Personally, I have a growing sense of urgency
7 about the need to repeal SGR. I think it is becoming an
8 increasingly urgent matter to once and for all deal with the
9 issue. Of course, the cost of repeal will continue to
10 mount. That is one thing that we can be sure of. Each year
11 that the decision is deferred, the cost of repeal grows
12 larger.

13 Beyond that, each year the decision is made to
14 just postpone cuts, the cost of even deferrals rises
15 inevitably and relentlessly as we go forward. In a period
16 of growing fiscal stringency -- and I don't think we're
17 talking about a year or two of tight budgets but really a
18 new era of austerity -- finding even offsets for deferrals
19 will become increasingly difficult, I fear.

20 With regard to repeal, the cost is already very
21 large. As I say, CBO estimates a 10-year cost of \$300
22 billion and up from there. That is a very big number, and

1 in particular, it is a very big number in the current policy
2 and fiscal context, and the opportunities for offsetting
3 such a large cost I fear will be diminishing.

4 Many changes have been made in Medicare recently
5 with an eye towards reducing Medicare outlays. PPACA, the
6 Patient Protection and Affordable Care Act, included large
7 Medicare savings, some based on MedPAC recommendations.
8 That large sum of money, roughly \$500 billion over 10 years,
9 was applied to the goal of expanding coverage for Americans
10 without insurance. A fix for SGR was not included in the
11 package.

12 Now, myriad organizations have made proposals for
13 reducing Medicare outlays with an eye towards reducing long-
14 term Federal deficits. Some have taken into account SGR in
15 their recommendations; others have not. In the Congress
16 itself, we have the special joint committee charged with
17 identifying a large amount of Federal budget reductions,
18 deficit reductions over the next 10 years. And, presumably,
19 one of the places they will be looking for those savings is
20 the Medicare program since it is not only a large portion of
21 federal spending, it is also one of the most important
22 drivers of long-term growth in federal spending.

1 My fear is this: that if large Medicare savings
2 are used for other purposes, however worthy those purposes
3 might be -- whether it is expansion of coverage for the
4 uninsured or to reduce long-term deficits -- and SGR is not
5 addressed, it is just pushed down the rate, we could end up
6 in a situation where all of the available Medicare savings
7 have been claimed for other purposes, and we will still have
8 this destabilizing element at the heart of the Medicare
9 program. And that could bode ill not just for the
10 physicians who serve Medicare beneficiaries but also for the
11 Medicare beneficiaries themselves.

12 So the premise of this effort is that it is in the
13 best interests of the Medicare program over the long term to
14 deal with the SGR issue once and for all. To accomplish
15 that will require difficult choices, not just by MedPAC but
16 much more importantly by the Congress itself.

17 What I have done based on input from the members
18 of the Commission is asked the staff to develop a proposal
19 for repeal, which will be presented today, that follows
20 certain guiding principles. One is to sever the formulaic
21 link between physician fees and total expenditures and
22 replace that with a specific schedule of physician

1 conversion factors that cover the next 10 years.

2 Second is to do everything that we can to protect
3 access to care for Medicare beneficiaries in the process.

4 Third is to use this as an opportunity to
5 encourage participation by physicians in new payment
6 methods. Ultimately, the path to improving the efficiency
7 of health care delivery, including improving the quality of
8 care, I believe, is to move away from our current structure
9 of fee-for-service payment to new payment methods, whether
10 it be ACOs or bundling or other mechanisms. And so this I
11 see as an opportunity to provide a boost for that movement
12 towards new payment systems.

13 Fourth, I asked the staff to develop a proposal
14 that would accelerate the revaluation of services within the
15 physician fee schedule. Those who have followed our work in
16 the past know that this has been a long-term concern of
17 MedPAC, that the current relative values are not accurate,
18 and as a result do not distribute the payments
19 appropriately.

20 And then the final guiding principle was that this
21 all be constructed so as to be budget neutral, a recognition
22 of the current fiscal challenges that the Congress faces.

1 So in just a minute, the staff will present that proposal.

2 Our schedule in broad terms -- and I will say a
3 little bit more in detail on this later, but our goal is to
4 have a proposal for a final vote of the MedPAC Commissioners
5 in October with communication of the results of that work to
6 the Congress as quickly as possible after that October
7 meeting, which is the week of October 3rd -- is that right,
8 Jim? So it is the 5th and 6th of October, something like
9 that.

10 So those are my introductory comments. Cristina,
11 are you leading the way?

12 MS. BOCCUTTI: Okay. So as Glenn was mentioning,
13 the Commission has spent several meetings discussing the
14 challenges facing policymakers regarding the sustainable
15 growth rate system, of course, as we all know it, the SGR.
16 So today Kevin, Kate, and I are going to summarize the
17 principles that you have discussed and present some draft
18 recommendations for your discussion.

19 We start on this slide with a very brief review of
20 MedPAC's assessment of the SGR. Much of this is what Glenn
21 was talking about, but for the audience and for everyone, it
22 is here very briefly on this slide. And it was also in our

1 last June report, much of this, too.

2 So, first, a fundamental flaw is that the SGR
3 creates this formulaic link between annual updates and
4 cumulative expenditures, and this automatic tie is strictly
5 budgetary. So it is completely void of incentives of
6 improving quality, efficiency, or even price accuracy.

7 The formula also doesn't differentiate by
8 provider, so it neither rewards providers whose clinical
9 practice tries to reduce unnecessary services nor penalize
10 those physicians and health professionals who contribute
11 most to unnecessary volume growth.

12 Then, of course, the SGR formula, which has been
13 overridden by Congress many times, currently calls for a 30-
14 percent cut in 2012, and that's often referred to as a
15 "cliff." Continuing on the course of over the last decade
16 as we have discussed of temporary overrides to avoid deeper
17 and deeper cuts is untenable. The stop-gap "fixes" have
18 created uncertainty, frustration, and financial problems for
19 medical practices, and additionally, they add significant
20 burden to CMS claims processing. So the work that they do
21 gets held up as well.

22 So given these flaws, the Commission is

1 considering policy options to repeal the SGR. A major issue
2 then becomes, of course, cost. Repealing the SGR and
3 replacing it with a 10-year freeze for example, across all
4 fee schedule services translates to a minimum budget score
5 of about \$300 billion. Accordingly, repealing the SGR could
6 require significant budget offsets.

7 So with that brief summary, we will introduce some
8 of the principles that the Commission has raised for
9 considering repeal of the SGR.

10 First, it's important to sever the formulaic link
11 between annual updates and cumulative expenditures for fee
12 schedule services. So repealing the SGR means that there
13 will no longer be a spending control mechanism specifically
14 attached to the fee schedule. Instead of the SGR formula,
15 it will be useful to establish a stable, predictable, 10-
16 year legislated fee schedule updates. This path of updates
17 would not include the 30 percent cut in 2012.

18 In repealing the SGR, it is crucial to strike a
19 balance between the total cost of repeal and the need to
20 ensure beneficiary access. That is a paramount concern that
21 the Commission has raised continually.

22 Kate here is going to discuss potential offset

1 opportunities in more detail later in this presentation, but
2 the main gist here on this slide of principles is that the
3 cost of repeal will need to be shared across physicians,
4 other health providers, providers in other sectors, and
5 beneficiaries. And in addressing access concerns, it is
6 also going to be important to ensure that the legislative
7 updates continue to result in positive growth in annual per
8 beneficiary revenue for practices that continue to see
9 Medicare patients.

10 So a body of literature continues to show that
11 good primary care which provides comprehensive, coordinated
12 patient care is essential for maximizing the quality and
13 effective of our health care delivery system. Yet given
14 current trends, the greatest threat to access over the next
15 decade is related to primary care services.

16 We see, for example, that in patient surveys, such
17 as the one that MedPAC conducts annually, beneficiaries and
18 privately insured individuals are more likely to report
19 problems finding a primary care physician than a specialist.
20 For instance, in last year's survey, 12 percent of Medicare
21 beneficiaries reported big problems finding a primary care
22 provider compared with 5 percent for specialists. We also

1 see a differential for privately insured individuals.
2 Compare here the 19 percent reporting big problems finding a
3 primary care provider to the 8 percent for specialists.

4 In physician surveys, primary care providers are
5 less likely to accept new patients than specialists. Again,
6 this holds true for Medicare and privately insured
7 individuals, as shown in the results on the slide here, more
8 on the bottom, and those were taken from the National
9 Ambulatory Care Survey. These access issues highlight the
10 importance of protecting primary care over the next decade.

11 Now I am going to turn it over to Kevin to tell us
12 how we can be productive.

13 DR. HAYES: So to implement the realignment
14 Cristina described, the legislated updates would follow a
15 path that includes:

16 First, reductions and then a freeze in the
17 physician fee schedule's conversion factor for services
18 other than primary care;

19 Second, payment rates for primary care would be
20 frozen at their current levels. Primary care could be
21 defined as it is for one of the primary care bonus
22 alternatives the Commission recommended in June of 2008. It

1 is the alternative for the bonus that was enacted as part of
2 PPACA. That is, the definition of primary care would have
3 two parts:

4 Part 1 is practitioner specialty designation. For
5 physicians the specialties would be geriatrics, internal
6 medicine, family medicine, and pediatrics. The list of
7 eligible practitioners also includes nurse practitioner,
8 clinical nurse specialist, and physician assistant.

9 Part 2 of the definition of primary care for the
10 bonus is whether the practitioner has a practice that is
11 focused on primary care, defined as primary care services
12 accounting for at least 60 percent of allowed charges in a
13 previous year. Primary care services themselves are office
14 visits, home visits, and visits to patients in nursing
15 facilities, domiciliaries, and rest homes.

16 The freeze on payment rates could be implemented
17 with a freeze on the fee schedule's conversion factor, or
18 the freeze could be implemented with a payment modifier or
19 payment adjustment. If the latter, the payment adjustment
20 would reverse the conversion factor reduction for services
21 other than primary care.

22 The intention here is to: one, allow continued

1 increases in the revenues physicians receive from Medicare;
2 two, ensure beneficiary access to care; and, three, control
3 the cost of repealing the SGR. Our next slide illustrates
4 how these implementation issues would play out.

5 Aiming for a policy with a 10-year budget score of
6 about \$200 billion and freezing primary care payment rates
7 at their current levels, the reductions in the conversion
8 factor for non-primary care services, shown here at the
9 orange line, would be 5.9 percent each year for 3 years. So
10 to illustrate, the current conversion factor is about \$34.
11 Over a period of 3 years, it would go down to about \$28 and
12 stay at that level for the remaining 7 years of the budget
13 window.

14 Considering now primary care, if the freeze for
15 primary care is implemented through the conversion factor,
16 the current conversion actor of \$34 would remain in effect
17 for all 10 years. On the other hand, if a payment
18 adjustment is used to freeze payments for primary care, the
19 adjustment would be set to maintain payment rates at their
20 current levels.

21 Despite the decrease in the conversion factor from
22 non-primary care services, practitioner revenues would

1 continue to increase. I am referring now to the top line
2 that you see on the slide. That line shows that taking into
3 account the increase in the number of Medicare beneficiaries
4 over the next 10 years, total practitioner revenues coming
5 from Medicare would go from \$64 billion to \$121 billion.
6 But even on a per beneficiary basis, practitioner revenues
7 would continue to rise because of increases in the volume of
8 services. The estimate is that the revenues per beneficiary
9 would go up at an average rate of about 2 percent per year.

10 Again, the balance that the policy would aim to
11 achieve is to repeal the SGR in a way that is affordable and
12 to maintain access to care.

13 Next we have the Chairman's draft recommendation
14 for you to consider on this. It reads as follows: The
15 Congress should repeal the SGR system and replace it with a
16 10-year path of statutory fee schedule updates. This path
17 is comprised of a freeze in current payment levels for
18 primary care and for all other services annual payment
19 reductions of 5.9 percent for 3 years, followed by a freeze.
20 The Commission is offering a list of proposals for the
21 Congress to consider in offsetting the budgetary cost of
22 repealing the SGR system.

1 On the spending impacts of this recommendation,
2 obviously you need to discuss them. As stated with the
3 previous slide, the path of statutory updates would increase
4 spending over 10 years by about \$200 billion. But then the
5 recommendation closes with the statement that the Commission
6 is offering a list of proposals to offset the cost of
7 repealing the SGR.

8 What are the potential offsets? The Commission in
9 its March 2011 report made a number of recommendations that
10 could help offset the cost of repeal. Those recommendations
11 together represent offsets of about \$50 billion. It is more
12 difficult to anticipate the rest, but in just a moment, Kate
13 will present a number of options for you to consider.

14 Whatever the offsets chosen, each would have
15 implications. Assessing those implications is complex,
16 however. With the change in payments for fee schedule
17 services, it would be a shared sacrifice. Striking a
18 balance between payment reductions that practitioners are
19 willing to accept while contributing to the cost of
20 repealing the SGR, on the one hand, and achieving a level of
21 payment that is higher than the steep cliff of a payment
22 reduction that would occur under current law.

1 Then there is a set of offsets with potential
2 implications for beneficiaries and providers. Each offset
3 would have direct effects that are quantifiable. However,
4 second-order effects are possible, too, and those are more
5 difficult to quantify. In the case of effects for
6 beneficiaries, the direct effects would change their
7 incentive structure through, say, changes in cost sharing.
8 For providers, there would be direct impacts on payments
9 depending upon whether they furnish primary care services or
10 other services.

11 This next slide addresses the issue of data needed
12 to improve payment accuracy. The Commission addressed this
13 issue in this year's June report. The concern is that the
14 Secretary lacks current objective data needed to set the fee
15 schedule's relative value units for practitioner work and
16 practice expense. Surveys might be an alternative, but they
17 are costly and response rates are likely to be low. Time
18 and motion studies would be costly, too. In addition, they
19 are subject to bias, the well-known Hawthorne effect. And
20 mandatory data reporting, analogous to the cost report
21 submitted by institutional providers, would raise concerns
22 about administrative burden.

1 Instead of these approaches, the Secretary could
2 collect data on a recurring basis from a cohort of
3 practitioner offices and other settings where practitioners
4 work. Such data collection would allow her to be RVUs on
5 services as they are furnished in efficient practices. In
6 addition, the Secretary could use the data to validate and
7 adjust RVUs, a PPACA requirement.

8 To address implementation issues, we are working
9 with contractors, but it appears that the necessary data are
10 available from electronic health record, patient scheduling,
11 and billing systems. When the Secretary adjusts RVUs with
12 the data collect, the RVU changes would be budget neutral.

13 Which brings us to the Chairman's draft
14 recommendation number 2: The Congress should direct the
15 Secretary to regularly collect data, including service
16 volume and work time, to establish more accurate work and
17 practice expense values. The data should be collected from
18 efficient practices rather than a sample of all practices.
19 The initial round of data collection should be completed
20 within 3 years.

21 The RVU changes resulting from this data
22 collection would be budget neutral, so the recommendation,

1 just from the standpoint of the RVU changes, would have no
2 impact on program spending. However, the budget
3 implications of this recommendation would include the
4 funding that Congress would have to provide for the data
5 collection activity.

6 Moving now to beneficiary and provider
7 implications, for beneficiaries access to care could improve
8 as data are collected and payments are distributed from
9 overpriced services to other services, including primary
10 care. For practitioners there would be reductions for those
11 who furnish overpriced services but increases for others.

12 Moving forward from the SGR could also include a
13 change in the process for identifying overpriced services in
14 the physician fee schedule. At previous meetings the
15 Commission has discussed evidence that some services are
16 overpriced. Some of that evidence has come from the
17 Commission's work and from research for CMS and the
18 Assistant Secretary for Planning and Evaluation. In
19 addition, Commissioners have reported on their own
20 experience with overpriced services, and recommendations
21 from the RUC in recent years have shown that a number of
22 services are overpriced.

1 There is a process in place now for review of
2 potentially misvalued services. However, it is time-
3 consuming and has inherent conflicts. The conflicts arise
4 because the process relies on surveys conducted by physician
5 specialty societies. Those societies and their members have
6 a financial stake in the RVUs assigned to services. To
7 accelerate and better target the process, the Secretary
8 could be directed to: one, analyze the data collected under
9 the previous recommendation; two, identify overpriced
10 services; and, three, adjust the RVUs of those services.

11 Further, to accelerate the current review process,
12 the Congress could direct the Secretary to achieve an annual
13 numeric goal equivalent to, say, 1 percent of fee schedule
14 spending. This would be a goal for reducing the RVUs of
15 overpriced services. As is the case now, the RVU changes
16 would be budget neutral and, therefore, would redistribute
17 payments to underpriced services.

18 For a recommendation on identifying overpriced
19 services and reducing their RVUs, we have the Chairman's
20 draft recommendation number 3, which reads as follow: The
21 Congress should direct the Secretary to use data specified
22 in the Chairman's draft recommendation number 2 to identify

1 overpriced fee schedule services and reduce their RVUs
2 accordingly. These reductions should be budget neutral
3 within the fee schedule. The Congress should specify that
4 the RVU reductions should achieve an annual numeric goal for
5 each of five consecutive years of at least 1 percent of fee
6 schedule spending.

7 As to the recommendation's spending implications,
8 the RVU changes would be budget neutral, so the
9 recommendation would have no impact on program spending. On
10 the issues of beneficiary and provider implications, the
11 implications of this recommendation would be the same as
12 those for the previous recommendation: for beneficiaries
13 improved access to care following redistribution of payments
14 from overpriced services to other services, including
15 primary care; and for practitioners there would be
16 reductions for those who furnish overpriced services but
17 increases for others.

18 Now we will shift gears, and Cristina will talk
19 about options for accelerating delivery system reform.

20 MS. BOCCUTTI: So the Commission has stated on many
21 occasions that Medicare must implement payment policies that
22 accelerate changes in our delivery system to improve quality

1 and efficiency. The current fee-for-service payment method
2 for fee schedule services is inherently flawed. It rewards
3 volume growth, it penalizes providers who constrain
4 unnecessary spending, and it provides no accountability for
5 care quality.

6 It is important, therefore, for delivery system
7 reforms to shift Medicare payment policies away from fee-
8 for-service. New payment models, such as ACOs and bundled
9 payments, for example, can potentially improve
10 accountability for efficient use of resources and care
11 quality.

12 Repealing the SGR may provide here an opportunity
13 for Medicare to strongly encourage providers towards these
14 models and make fee-for-service less attractive.
15 Additionally, to achieve widespread delivery system reform,
16 beneficiary incentives must also be aligned with these
17 objectives for greater accountability in our health care
18 delivery system.

19 So in thinking about policies to accelerate
20 delivery system reform, we next consider ways to align
21 payment policies for fee schedule services with incentives
22 for improved efficiency and quality. Looking at the ACO

1 program, for example, Medicare could create incentives for
2 physicians and other health professionals to join or lead
3 ACOs. One way would be to allow greater opportunity for
4 shared savings to those physicians and health professionals
5 who join or lead ACOs in two-sided risk models. The greater
6 opportunity for shared savings would come from calculating
7 the ACO's spending benchmark using higher overall fee
8 schedule growth rates. So under this policy, if overall fee
9 schedule rates are reduced, two-sided risk ACOs could be
10 measured against a freeze and would, therefore, have a
11 better change of coming under the benchmark and, thus,
12 enjoying a greater opportunity for shared savings. Again, I
13 stress this incentive would only apply to ACOs that are
14 subject to penalties or bonuses, of course, based on
15 performance.

16 So with that example, we have a recommendation,
17 and here we have Chairman's draft recommendation 4: Under
18 the tenure update path specified in Chairman's draft
19 recommendation 1, the Secretary should increase the shared
20 savings opportunity for physicians and health professionals
21 who join or lead ACOs with a two-sided risk model. The
22 Secretary should compute spending benchmarks for two-sided

1 risk ACOs using 2011 fee schedule rates. The spending
2 implications here are that that policy would increase
3 Medicare spending.

4 Under the beneficiary and provider implications,
5 first we have that it would increase willingness of
6 physicians and other health professionals to join or lead
7 two-sided risk ACOs. It would also increase provider
8 accountability for health care quality and spending. And,
9 finally, it would increase the likelihood that the
10 beneficiaries' providers are in these ACOs.

11 So we have covered all the draft recommendations,
12 but we have two more items that we are going to talk about.
13 First Kate is going to review some considerations for
14 potential offsets for repealing the SGR, and then I am going
15 to talk on one more slide about Medicare's balance billing
16 provisions.

17 MS. BLONJARZ: Repealing the SGR system carries a
18 very high budgetary cost, and in the current fiscal
19 environment, full offsets are essential. A package of
20 savings proposals within the Medicare program could offset
21 the budgetary cost of repealing the SGR system. Recall that
22 under our policy physicians are receiving reductions and

1 freezes in their fees. This could be coupled with offset
2 proposals to reduce current law spending across providers
3 and other sectors as well as beneficiaries. I want to
4 reiterate that these offsets are offered in the context of
5 repealing the strategy system.

6 The offset package totals approximately \$235
7 billion over 10 years. The first tier in this offset
8 package are MedPAC recommendations, which total
9 approximately \$50 billion over 10 years. The second tier
10 consists of proposals informed by analysis done by CBO, OIG,
11 and other groups, as well as the analysis done by the
12 Commission, and it totals approximately \$180 billion over 10
13 years.

14 I want to describe in a little more detail how the
15 proposal comes together. The first component of the
16 proposal is the update path for physicians and other health
17 professionals. This path freezes the update for primary
18 care and provides a reduction in the update for non-primary
19 care services followed by a freeze. This update path is
20 estimated to result in an increase of 2 percent per
21 beneficiary per year in total physician revenue. The cost
22 of this update proposal is approximately \$200 billion over

1 10.

2 This is the contribution the physicians make
3 towards the cost of repealing the SGR system. Then the
4 second component of the proposal is the list of offsets I
5 mentioned on the previous slide. This includes in the first
6 tier the MedPAC recommendations and in the second tier
7 proposals informed by outside groups as well as MedPAC
8 analysis.

9 I want to make very clear that this is a working
10 list and it is not finalized, and you have more detail on
11 this working list in your draft meeting materials.

12 The pie on the right-hand side of the slide shows
13 the effect of the proposals and the draft offset package by
14 sector or group, and going through the pie, starting at the
15 top, the beneficiary category totals about 14 percent; DME
16 totals 6 percent; drugs total 32 percent; labs, 9 percent;
17 MA, 5 percent; post-acute care is 21 percent; and proposals
18 affecting other areas total 2 percent. There are going to
19 be downstream and indirect effects as well, which could be
20 substantial.

21 You can see that the cost of our proposal is
22 estimated to be approximately \$200 billion, and the draft

1 savings package is approximately \$235 billion. I again want
2 to caution that these estimates are draft preliminary and
3 subject to change. They have not been scored by CBO, and
4 they are not official estimates. As such, the cost of the
5 update path could be higher and the savings could be lower.

6 I am going to turn it back to Cristina to talk
7 about balance billing.

8 MS. BOCCUTTI: Okay. So in this last slide, we're
9 going to talk about another policy issue that has been
10 raised with respect to fee schedule services, and it relates
11 to provisions on Medicare's policies for balance billing.

12 First I will say that the vast majority of billed
13 Medicare-covered fee schedule services are provided on
14 assignment, and that means that the provider accepts the
15 listed fee schedule rate as payment in full. But for the
16 remaining 0.5 percent physicians may charge a higher rate
17 and what is called balance bill their patients for the
18 remainder. However, there is a limit to how much higher the
19 physician may charge a beneficiary for Medicare-covered
20 services. This is what is known as the limiting charge, and
21 it comes to about a little more than 109 percent of the
22 standard charge. So when physicians balance bill their

1 patients, patients incur higher cost sharing, up to about 30
2 percent of their total charge.

3 I can go into a little bit more detail on how that
4 math is during the Q&A because it is a little contorted, but
5 I would be happy to but I'm not going to take the time here.
6 But I do want to mention a couple other things.

7 A physician may not balance bill patients that
8 have Medicaid, and Medicare only allows physicians to
9 balance bill, so health professionals, other health
10 professionals that are not physicians cannot balance bill.

11 Some policy discussions have considered raising
12 the limiting charge, so we have listed a few implications of
13 doing that here on the last three bullets. Speaking
14 economically, allowing physicians to charge higher Medicare
15 cost sharing could increase access and physician willingness
16 to supply services to some beneficiaries, thus increasing
17 beneficiary access. But this would probably be very market
18 specific and work vary by specialty. Raising the limiting
19 charge would also increase cost sharing, as we have
20 described, so it could worsen access for beneficiaries with
21 lower incomes who are ineligible for Medicaid.

22 And, finally, patients' ability to shop around in

1 emergency situations or if they are already in the hospital
2 if they wanted to find a physician that did not balance bill
3 is very limited. So if the proportion of physicians who
4 balance bill grows, it may be hard in those certain
5 circumstances.

6 So we are concluding our presentation now. You
7 have a lot to discuss.

8 MR. HACKBARTH: Thank you. Nice job. Let me just
9 make a few additional comments.

10 First, with regard to the process that the
11 Commission will use to consider the offsets, we have
12 developed a draft list for consideration by the
13 Commissioners, and we have just begun our discussion of that
14 list. We understand, of course, that there are various
15 people outside the Commission who would be interested in the
16 items on the list and plan to make it available next week.

17 Our final decisions about the recommendations and
18 on any offsets will occur at our October meeting, as I said
19 earlier.

20 The offsets that we are considering -- and I
21 underline "considering" at this point -- are in two broad
22 categories: The first category are items that MedPAC has

1 already recommended in the past and made formal
2 recommendations to the Congress, but those recommendations
3 have not yet been adopted. Then the second group of offsets
4 includes items on which we have not yet made formal
5 recommendations to the Congress.

6 I want to emphasize that the specific elements of
7 this proposal, including the conversion factor cuts and
8 perhaps some of the offsets that are ultimately included as
9 well, these are not necessarily items that we would endorse
10 independent of repeal of SGR. Let me focus as an example on
11 the conversion factor cuts.

12 Having talked to each Commissioner about this, I
13 think it is fair to say that there is no individual
14 Commissioner who, outside of the context of SGR repeal,
15 would recommend cuts in the physician conversion factor of
16 the magnitude that were presented a few minutes ago. That
17 is not considered to be an ideal policy. It is something
18 that we think is worth considering in the context of
19 achieving the very important goal of repealing the SGR
20 system.

21 Likewise with some of the offsets, Commissioners
22 may have more or less enthusiasm for some particular items,

1 but in the context of achieving the goal of SGR repeal, we
2 are more inclined -- we are inclined to reach -- take that
3 as an indicator of how important we think the objective is
4 of repealing the SGR and creating a more stable system of
5 payment for physicians serving Medicare beneficiaries.

6 I want to emphasize that our recommendations would
7 establish a new baseline for physician payment over the next
8 10 years. So what exactly does that mean, a new baseline?
9 What it means from a MedPAC perspective is that that would
10 be current law in the absence of new legislation, the
11 schedule of conversion factors that we recommend would go
12 into effect, assuming Congress embraces our recommendation.

13 However, we would continue our annual process of
14 reviewing payment adequacy for physician services just as we
15 do for all other services. If at any point in that 10-year
16 period we saw evidence that the level of payment was
17 inadequate and impairing access to care for Medicare
18 beneficiaries, we could recommend a change in the schedule
19 of conversion actors. In fact, we would recommend a change.
20 I would go so far as to say that.

21 The consequence, though, of recommending a change
22 in the legislated schedule of conversion factors is that it

1 would be scored as an increase in Medicare expenditures by
2 the Congressional Budget Office, and Congress would have to
3 enact new legislation to effect the increase. So the key
4 point here is that we would not be forswearing any annual
5 effort to consider the adequacy of Medicare payments to
6 physicians. However, agreeing to this recommendation does
7 have material consequences both in terms of the legislative
8 process and the budget scoring process.

9 So let me stop there and let's begin the
10 Commissioner questions. We will, as usual, have two rounds,
11 the first round being clarifying questions, and I urge
12 people to be really disciplined in terms of asking just
13 clarifying questions while reserving more complex questions
14 and comments for round two.

15 DR. BORMAN: I wonder if you could tell us what
16 the percentage change in the conversion factor would be if
17 it were inflation adjusted. You have given us a minus 5.9
18 percent for other than primary care. Do you have the number
19 for that inflation adjusted?

20 DR. HAYES: So, in other words, inflation -- what
21 would happen to the conversion factor if there was an MEI
22 increase?

1 DR. BORMAN: I mean, clearly, if I am correct,
2 this minus 5.9 does not have any inflation adjustment
3 embedded within it.

4 DR. HAYES: Right.

5 DR. BORMAN: Okay. So at some point I think we
6 need to know what that number would be, not necessarily
7 today. Then --

8 DR. HAYES: I can just comment. I will give you
9 some kind of preview of what the answer would be. If we
10 look at, say, the Trustees Report, it has a forecast of what
11 the MEI would be out 10 years or so. And so in the early
12 years, they're projecting continued low inflation in the
13 economy in general and including inflation in physician
14 practice costs. And so the increases are all very low, like
15 less than 1 percent, you know, for the initial 2, 3 years,
16 somewhere in there. And then it just goes on up from there
17 to be some level in the area of 1, 2, percent.

18 MR. HACKBARTH: And, Karen, I think your question
19 is an important one and a valid one. I can ask for help
20 from some of the economists here, but I think it is true to
21 say that --

22 DR. BORMAN: He answered--

1 MR. HACKBARTH: -- inflation projections beyond
2 the next couple years, there is just a huge amount of
3 uncertainty about what is going to happen in the general
4 economy as you go further and further out in the 10-year
5 window.

6 DR. BORMAN: Right.

7 MR. HACKBARTH: So long-term projections are
8 usually just sort of extrapolations of recent experience,
9 and you don't know --

10 DR. BORMAN: Right, but for the 3 years that these
11 cuts are in place, I think we should have that number.

12 MR. HACKBARTH: That's closer, yes.

13 DR. BORMAN: The second piece, my other question
14 would be: If we think about this as a principle of shared
15 sacrifice, do you happen to have the number that if the cuts
16 were distributed across all Part B providers, what that
17 number would be as opposed to zero versus minus 5.9?

18 DR. HAYES: So, in other words, if we were
19 continuing with a goal of a policy that would have a budget
20 cost of about \$200 billion --

21 DR. BORMAN: Right, changing no other assumptions.

22 DR. HAYES: Right. Then the change in the

1 conversion factor, the reduction in the conversion factor
2 would apply to everybody, to all services, and that would
3 be, our estimate is, about 5.4 percent.

4 DR. BORMAN: Okay. So that would somewhat suggest
5 that a lot of the underpinning of the fee schedule is
6 resting on volume and intensity of primary care services.
7 Anyway, asking for a conclusion may be too --

8 MR. HACKBARTH: Karen, maybe this helps. Kevin, I
9 think the estimate of the total payments that fit the
10 primary care definition that we're using is about 8 percent
11 of total payments, so 92 percent of payments are subject to
12 the conversion factor, but 8 percent of payments would be
13 protected from the conversion factor cut.

14 DR. BORMAN: Okay. And then I have just two more.
15 Help me to understand where, other than the attempt to save
16 roughly X million dollars, what are the data to support the
17 relativity that this induces? If I do the calculation --
18 because this is a separate relative value scale. If I do
19 the calculation of this, it is roughly saying there's
20 somewhere between a 25- to 30-percent premium you're placing
21 on primary care services, ballpark, in terms of the
22 relativity of the two conversion factors. So what leads us

1 to that being a number -- what are the data that support
2 that number? Are there any metrics or things we're using?
3 Or is it simply a budget savings calculation?

4 MR. HACKBARTH: Let me answer and then Kevin can
5 fill in behind me.

6 At year 10, after the completion of this schedule
7 conversion factor -- the schedule of conversion factors, the
8 primary care conversion factor will be about 20 percent
9 higher than the all other services, so that's the
10 differential at the end of the window. That difference
11 wasn't a normative judgment that, oh, we ought to hit 20
12 percent. Instead, it is the result of our saying that our
13 greatest fear for access is primary care; therefore, we want
14 to protect primary care using a narrow definition of what's
15 protected, and then the other numbers flow from that policy
16 judgment.

17 DR. BORMAN: But the 20-percent number as opposed
18 to, say, a 10-percent number is primarily a backwards budget
19 calculation to get to that.

20 MR. HACKBARTH: In the same sense that the
21 conversion factor cut is driven by having a package that we
22 can finance. As opposed to a normative judgment, oh, we

1 want to cut specialty services by 5.9 percent, it is driven
2 by the fact if we want repeal of SGR, we want a credible
3 proposal, we need to figure out how to finance, and this is
4 what we think we can finance, we want to protect access in
5 an area that we think is most vulnerable, primary care, so
6 we protect them and then you do the arithmetic from there.

7 DR. BORMAN: Okay. And then my final question
8 would be -- and maybe I just miss it, and we mean to imply
9 it in the text or whatever. This particular recommendation
10 does not introduce any volume or intensity constraints
11 similar to the SGR's effect on the fee-for-service system.

12 MR. HACKBARTH: Kate, help me out here. I assume
13 that in doing a final estimate, the CBO would do a volume
14 offset assessment, as is their norm, when they do physician
15 fee schedule calculations. Is that correct?

16 DR. MARK MILLER: Right, but just to Karen's
17 point, there's no link in the policy, which I think is what
18 you were driving at, right?

19 MS. BLONJARZ: [Nodding affirmatively.]

20 DR. MARK MILLER: Okay. And I know you know that.

21 MR. GRADISON: What would be the budget neutral
22 cut if it were made evenly over the 10-year period instead

1 of 3 years at 5.9 percent?

2 DR. HAYES: I will have to get back to you on
3 that. It is knowable, but I just don't have the number with
4 me.

5 MR. HACKBARTH: Sort of a rough magnitude would be
6 -- in an earlier iteration -- it is not exactly the same but
7 similar -- we were talking about 3 percent for each of 10
8 years.

9 DR. HAYES: Yes.

10 MR. GRADISON: Thank you.

11 MR. HACKBARTH: Or am I missing --

12 DR. HAYES: No, that's in the right ballpark. I
13 just don't have a precise number.

14 DR. MARK MILLER: And, again, that assumes that's
15 the only change, you are about --

16 DR. HAYES: Right.

17 DR. CASTELLANOS: Could I have Slide 6, please?
18 Try to help me understand these curves a little bit.

19 Now, the increase goes from \$60 to \$120 billion,
20 or about \$60 billion over a 10-year period, and that's
21 pretty well based on increased -- new people coming into
22 Medicare. Is that correct?

1 DR. HAYES: It's a mix of new people coming in and
2 an increase in the volume of services.

3 DR. CASTELLANOS: And volume of services, okay.
4 Now, we all recognize revenue doesn't mean income, so on the
5 physician side, you have to subtract costs. Now, there's no
6 way we can estimate cost, but we can look at it
7 retrospectively based on MGMA or CMS costs that have gone up
8 about anywhere from 20 to 40 percent over the past 10 years.
9 What is that going to do to physician income? Not revenue
10 but income.

11 DR. HAYES: It's really hard to say. I mean, it
12 could be a combination of factors. Once again, I mean, it
13 depends upon how much -- what happens on the private side.
14 It depends upon what happens with respect to increases in
15 the volume of services. As was indicated a moment ago, we
16 anticipate that there could be a volume response to
17 reductions in enrollees. It depends upon how much inflation
18 there is. It depends upon all the dynamics that are at work
19 in the health care system.

20 As we have argued in the case of misvalued
21 services, there are productivity gains that are underway
22 with respect to physician services due to factors such as,

1 you know, learning by doing, improving work processes within
2 a practice, substitution of personnel -- a whole range of
3 possibilities here.

4 DR. CASTELLANOS: A whole range of possibilities.

5 DR. HAYES: So it's really hard to say what the
6 impact would be, and the thought would be that there would
7 be that --

8 DR. CASTELLANOS: Not only that, but several
9 mandates for new procedures --

10 DR. HAYES: What's going to be the impact of IT,
11 you know, maybe in the short term it's going to cause an
12 increase, but --

13 DR. CASTELLANOS: So really --

14 DR. HAYES: -- over time it's going to improve
15 efficiency.

16 DR. CASTELLANOS: When we talk about revenue going
17 up, it does not mean income going up.

18 DR. HAYES: Not necessarily, no.

19 DR. CASTELLANOS: Maybe you could help me -- and I
20 apologize. I should be better prepared. Slide 4, please.
21 If I remember right, we saw the MedPAC data in the age group
22 55 to 64. Just refresh my memory, and I should have done

1 the homework on this, but I didn't. In the 55 to 64 group,
2 wasn't there a crack in the wall showing that the
3 specialists in that age group had harder access to care than
4 primary care? I know we're focusing on primary care and
5 access, but I'm saying it may also apply in the specialists.
6 And if I remember that data, it didn't show that.

7 MS. BOCCUTI: Well, first to clarify, you're right
8 that the MedPAC survey looked only at Medicare beneficiaries
9 that are 65 and older. And for the privately insured, it
10 looked at people age 50 to 64 to as close as possible
11 approximate a Medicare population or at least get closer to
12 a higher age.

13 Now, I'm not sure about the crack that you're
14 referring to. Maybe you could -- I have some of the 2010
15 survey results here, but I'm not sure I understand what --

16 DR. CASTELLANOS: Maybe I could look at that with
17 you and go over it.

18 MS. BOCCUTI: Sure. We can do that after.

19 DR. CASTELLANOS: Thank you.

20 MR. HACKBARTH: Ron, for sure what it showed was
21 that, in general, access for people in the 50 to 64 age
22 group was less than for Medicare beneficiaries.

1 MS. BOCCUTTI: Worse.

2 MR. HACKBARTH: Patient-reported access was lower
3 for the non-Medicare population than for the Medicare. What
4 I don't remember -- and we can check is --

5 DR. CASTELLANOS: [off microphone]

6 MR. HACKBARTH: -- the specialty differential.

7 MS. BOCCUTTI: Right, it's for both.

8 MR. HACKBARTH: Well, it is for both, but I think
9 what Ron is saying, the pattern for the non-Medicare is
10 different than for the Medicare.

11 DR. CASTELLANOS: Yes [off microphone].

12 MR. HACKBARTH: And for the non-Medicare, it shows
13 more problems in specialty access.

14 DR. CASTELLANOS: Slightly [off microphone].

15 MR. HACKBARTH: And so we'll check that.

16 MS. BOCCUTTI: Maybe that's why I don't understand.
17 Is it not what's on the slide for --

18 DR. CASTELLANOS: I apologize. I have to go back.
19 I should have done the homework. I didn't realize we were
20 going to be discussing this. But maybe we can look at it
21 together and not --

22 MS. BOCCUTTI: But here it says for privately

1 insured.

2 DR. MARK MILLER: We can take it offline [off
3 microphone].

4 DR. NAYLOR: Thank you for your report. Just one
5 clarifying question. On Slide 7, when you talk about the
6 impact on providers of the proposed freeze, for example, we
7 do know from a growing body of evidence that access to
8 primary care for Medicare beneficiaries will rely
9 increasingly on non-physician health professionals -- nurse
10 practitioners, physician assistants, and others. And the
11 current model, when there is direct payment to those
12 providers, it is 85 percent of physician fee schedule for
13 E&M services. Does the proposed payment freeze in the way
14 it was calculated build on that existing payment method?

15 DR. HAYES: Yes.

16 MR. GEORGE MILLER: A quick question on Slide 17,
17 and I apologize for not knowing this, but are there criteria
18 for physicians that may charge a higher rate and balance
19 bill? How do they get into this 0.5 percent category?

20 MS. BOCCUTI: They are not what's called a
21 participating provider, so they do not be considered, so
22 they are called non-participating providers, and non-

1 participating providers may balance bill on a patient-by-
2 patient basis -- service-by-service basis, really.

3 MR. HACKBARTH: And choosing to be a non-
4 participating provider has consequences, so you have to do
5 your own billing of the patient. It doesn't happen -- so
6 you're familiar with that.

7 MR. GEORGE MILLER: Yeah.

8 DR. STUART: If we could go back one slide, and
9 help me out here. The offset package on the right-hand side
10 does not include any offset from changing physician
11 reimbursement, and the reimbursement implications for
12 physicians are on the left-hand side. And would I read it
13 as follows: that if the estimated cost of the freeze plus
14 the reduction for specialty services would save \$100 billion
15 over a freeze that applied for all services? In other
16 words, is the net cost of this over a freeze \$100 billion?

17 DR. MARK MILLER: I think the way -- and, you
18 know, Kate, help me out here. I mean, part of the reason
19 that we parse this here is on the left-hand side, that is a
20 cost. You can view it as a lower cost than a freeze. A
21 freeze would cost \$300 billion. This policy has a lower
22 cost of \$200 billion. You are sort of characterizing that -

1 - I think you said the word "savings." From a scoring point
2 of view, everything on the left is going up. It's just
3 whether it's going up 300 or 200.

4 DR. STUART: Well, you see where I'm going here.
5 If you look at the right, it looks like you've got these
6 percentages based upon all non-physician revenue, and the
7 physicians, from my perspective, if they're contributing
8 \$100 million on a base of --

9 DR. MARK MILLER: Billion.

10 DR. STUART: -- a CBO estimate of \$300 billion, it
11 would help me to understand this if I knew what physicians
12 were contributing to this overall package compared to
13 everybody else, in which cases 100 of that 335 billion would
14 be physician contribution.

15 DR. MARK MILLER: Yeah, and if you want to
16 characterize it a relative to a freeze, then I think your
17 statement is correct. But the denominator between the two
18 sides of the slide -- right?

19 DR. STUART: My only point here is that this
20 fuzzes it in terms of what physicians are contributing
21 because the physician contribution here is huge.

22 MR. HACKBARTH: There certainly is no intent to

1 fuzz it. In fact, in talking about how to think about this
2 package with Commissioners, I've adopted often the approach
3 that you describe, which is, you know, one way to think
4 about this is if a freeze would cost \$300 billion over 10
5 years, we're developing a package that lowers that from 300
6 to 200. In effect, physicians are being asked to bear \$100
7 billion worth of this package. So all of that, I understand
8 your logic. But keep in mind what Mark says. You know,
9 strictly from an accounting standpoint, we would be mixing
10 things that should not be mixed. What is on the left from a
11 budgetary standpoint is still a cost. This is increased
12 spending above the baseline; whereas, what's on the right
13 are savings relative to the baseline.

14 And so mixing them in one graph -- I actually
15 asked the staff to mix them in one graph, and you're mixing
16 apples and oranges when you do that.

17 DR. STUART: Okay. I guess the only point I would
18 make here is that if it does not get all in one graph, at
19 least there should be some narrative that explains this from
20 the perspective of the CBO baseline.

21 DR. HALL: Could we go to Slide 5 again, please?
22 On the second major bullet, the two-part definition of

1 "primary care," I think the abbreviation in the slide may
2 have us looking at different definitions of primary care.
3 Let me make sure I understand it.

4 When we say specialty, it would be that there are
5 certain specialties that are associated with board
6 certification, like family medicine, internal medicine,
7 pediatrics, geriatrics, possibly OB. Is that what we mean
8 by specialty? Or is it pattern of actual performance in the
9 field?

10 DR. HAYES: No, it's pretty much the self-declared
11 specialty of a physician. Whenever they enroll to bill
12 Medicare, they identify on the enrollment form, okay, this
13 is my specialty.

14 DR. HALL: Well, that would mean that half of the
15 people who self-designate as cardiologists are not board-
16 certified cardiologists, for example. I think we really
17 need to understand this because I think this is a point that
18 is going to be debated among people who perceive that there
19 is some inequity in some of the recommendations we are
20 making. So it is specialty determined by some kind of
21 governing body? Is it the actual pattern of care and
22 billing over a period of time.

1 DR. MARK MILLER: It's also that, and [off
2 microphone] so there is a two-part field to the definition.
3 It is the declaration of the specialties, which you were
4 talking about with Kevin, and we do understand that there's
5 play in that, that a person could self-designate.

6 DR. HALL: Self designate.

7 DR. MARK MILLER: But then -- and I will get the
8 percentage wrong, Kevin -- 60 percent of the services for
9 this person has to be from a selected set of E&M services
10 which are designated as primary care -- home, nursing
11 facility, and one other place I've forgotten.

12 DR. HALL: Okay.

13 MR. HACKBARTH: So the points you're raising,
14 Bill, are good points, and these are things that we wrestled
15 with 2 of 3 years ago when we recommended the primary care
16 bonus that ultimately was incorporated in PPACA, and there
17 are issues I know Congress wrestled with when it was trying
18 to configure that. It is an imperfect definition for the
19 reasons that you mention. This is self-designation. It's
20 not board certification. And, you know, that raises some
21 potential issues. But we try to confirm, if you will, the
22 self-designation with the pattern of care as well, so some

1 protection.

2 DR. HALL: I think that's the best way to make
3 sure that people who have to look at this understand that
4 pattern of care is going to have an important determinant.
5 Thank you.

6 MR. KUHN: Christina, a quick question. Since we
7 don't have cost reports for physicians and so adequacy of
8 payments, you know, I guess the one tool that we use is this
9 survey, this Medicare beneficiary survey to look at access
10 of care. So I'm just curious.

11 On the timeliness of the data that we get on the
12 survey, so say this proposal went into place, we went onto
13 that glide path to take us down that 5.9 percent for those
14 subsequent years, what would be the tool that we would have
15 or could -- or would there be an enhanced tool to kind of
16 really monitor what was going on in the field as a result of
17 these changes?

18 MS. BOCCUTI: I've two things to say with that.
19 First, we do -- this survey that we use is part of a broad
20 look at access. We look at other surveys. But this survey
21 that we do is absolutely the most current, and that gets to
22 your point. In fact, we'll have more results in a couple

1 months I'll be able to bring you from a survey that's in the
2 field as we speak.

3 And so, we do this in order to get the most and
4 current data in order to inform the payment adequacy
5 analysis. And so, I think that goes to what Glenn was
6 saying about how we will continue to do that and then, if
7 the Commission, sees some issues that come up in the future,
8 we would re-examine what our payment recommendations are
9 going forward. But you'll be seeing 2011 data in the near
10 future.

11 MR. KUHN: Great. That's what I was curious about
12 and thank you. And the other question I had is just on the
13 balance building notion. I know we had this conversation 12
14 months ago or something about the issue of concierge care.
15 How would that be impacted by balanced billing? Can you
16 just do a quick refresh how that would factor into this, if
17 that was a new opportunity that physicians might want to
18 pursue more aggressively?

19 MS. BOCCUTTI: I can see the relationship there,
20 but a physician that has a concierge practice, and then for
21 just a quick summary, this is where they may change an
22 annual or monthly fee to patients and they usually have

1 smaller caseloads.

2 That physician doesn't necessarily have to become
3 a non-participating physician. So if you are participating,
4 balanced billing is not possible. It is likely that
5 concierge physicians are more likely to be non-
6 participating. So there is an association, but I wouldn't
7 say that there's an impact. Did you want to say something,
8 Mark?

9 DR. MARK MILLER: [Off microphone.]

10 MS. BOCCUTI: Forgive me. I thought --

11 DR. MARK MILLER: [Off microphone.]

12 DR. BERENSON: Cristina, my questions are also --
13 I have two quick questions about the balanced billing slide
14 17. 99.5 percent unassignment is pretty high and higher
15 than what I've been carrying around in my head, which was
16 around 90 percent. Has there been a trend towards
17 increasing?

18 MS. BOCCUTI: No. I think that that comes from
19 the -- I am guessing that the number you're carrying around
20 is the share of docs that are participating, and that's in
21 the 90s, the lower 90s.

22 DR. BERENSON: And so if --

1 MS. BOCCUTTI: If you recognize that non-
2 participating physicians don't always balance bill, then you
3 realize that those two numbers can't be the same. So what's
4 happening is that even though only -- that the participating
5 physicians are in the 90 percent, the actual charges -- so
6 these are dollars -- that are paid on assignment is higher.

7 DR. BERENSON: Okay. But that makes sense. My
8 second question is, what is happening with the number of
9 opt-out physicians? Do you know that? The number of docs
10 who simply opt out of the whole system?

11 MS. BOCCUTTI: We're going to be tracking that, and
12 I think we'll bring that issue up when we look at the
13 updates for now. It's a hard number to get a hold of. They
14 need to submit these affidavits and we'll talk with
15 COMPANIES about that.

16 MR. HACKBARTH: Could you, Cristina, just quickly
17 clarify for those who aren't familiar with the difference
18 between non-participating and opt-out physicians?

19 MS. BOCCUTTI: Sure. So you have those sort of
20 three levels. Right? We have the participating physician,
21 and when they get paid, Medicare pays them directly the 80
22 percent of the fee schedule rate.

1 DR. MARK MILLER: Can I say, the distinguishing
2 feature there is they have a signed agreement to accept
3 Medicare payment as payment in full.

4 MS. BOCCUTI: Right.

5 DR. MARK MILLER: Right? Okay.

6 MS. BOCCUTI: And then there's the non-
7 participating physician who then can balance bill, as we've
8 discussed. Yes, Mark?

9 DR. MARK MILLER: One more time. Taking Medicare
10 patients, they just haven't signed this agreement. And so
11 they are free to charge differently because they have not
12 signed this agreement. But they're still -- because to the
13 public, non-participating may sound like they're not in
14 Medicare. They're still in Medicare. They just don't have
15 this signed agreement, which brings you to your third
16 category.

17 MS. BOCCUTI: Right. So then the third option is
18 what's called opting out, and this is where physicians will
19 say, and other health professionals can do this as well, I'm
20 opting out of the Medicare program. That means that any
21 Medicare patient I see I will not get paid by Medicare and
22 Medicare will not reimburse that patient for my services.

1 They're entering into a private contract with the
2 patient and can charge whatever they have determined. But
3 Medicare will no longer reimburse services provided by an
4 opt-out physician. So there's no agreement that the
5 physician has with Medicare, and they sign an affidavit to
6 this effect.

7 MR. ARMSTRONG: Just briefly, among a lot of the
8 policy ideas in this proposal that I like is the reference
9 to changing the structure of payment for ACOs, certain ACOs,
10 and I'm just interested to know, have we done a lot of
11 analysis to understand how much real impact on the formation
12 of ACOs this particular idea would have? Or is this still
13 just another in a series of incremental policy adjustments
14 to try to promote the idea?

15 MR. HACKBARTH: The latter. In fact, as I think
16 Kate -- somebody mentioned earlier, or Cristina maybe, the
17 ACO provision would initially have a cost attached to it
18 because you're saying, Well, if you go into a different
19 arrangement, you're not subject to the fee schedule cuts.
20 It's not quite that, but let me state it simply that way.

21 So in theory, that would increase outlays. It's
22 hugely difficult to try to estimate the impact of that when

1 there's so much uncertainty about ACOs in general, the regs
2 are still pending, what the level of participation will be
3 in ACOs in general, let alone risk-based ACOs in particular.

4 So I would definitely characterize it as what you
5 said, the second, which is this is not a finely calibrated
6 policy, but something that directionally would reinforce a
7 direction that we think makes sense. Cori? Tom?

8 DR. DEAN: Kevin, just a quick question. If a
9 physician qualifies as primary care under the definitions
10 that we've set up, does that mean that all the payments to
11 that physician would be frozen, or just the ones that fall
12 under the primary care codes?

13 DR. HAYES: Yes, it would be just the latter.

14 DR. DEAN: So it really is code-based in a way?

15 DR. HAYES: Well, it's code-based, but it's code-
16 based for those practitioners who have focused their
17 practices on those codes, you know. So there's a
18 complementary there. I mean, it's going to be those
19 practitioners for whom those primary care services, the
20 visits and the, you know, total up to at least 60 percent of
21 their allowed charges.

22 And the view of the Commission, you know, a couple

1 of years ago when considering this was, that that
2 constituted someone who has indeed focused their practice on
3 primary care. And then it's a question, Okay, you meet that
4 threshold. Then which services qualify for --

5 DR. DEAN: That was the question.

6 DR. HAYES: Yes.

7 MR. HACKBARTH: It's not code-based in the sense
8 that two physicians providing the same code could get
9 different payment based on the one qualifies for the primary
10 care designation and the other does not. You know, a
11 cardiologist providing an E&M service with the same code
12 would be paid at a different level if they don't meet the
13 primary care test.

14 DR. DEAN: Right, okay. Thanks.

15 MR. HACKBARTH: Mitra?

16 MS. BEHROOZI: This is probably around zero
17 question or dumb question, or whatever, but that last page
18 on balanced billing which relates to half a percent of
19 Medicare-covered services, I'm not sure of the connection to
20 the sort of big issues that we're discussing. Can you
21 clarify that for me? That's --

22 [Overlapping speakers.]

1 MR. HACKBARTH: Well, you're asking just the right
2 person for that. It's there for two reasons, because it was
3 raised by some Commissioners, and the gentleman to your
4 immediate leap -- immediately to your left was one of those.
5 And it's a natural issue to raise.

6 When you're thinking about increasingly tighter
7 constraints on fees, I'm not an economist, but you might
8 worry about whether that's going to result in access
9 problems and an opportunity to balance bill could be seen as
10 a safety valve that might help ameliorate any problems with
11 access. So whether you agree with that or not, that's the
12 conversation that it's meant to trigger.

13 The other reason is that I know that this is an
14 issue for some people in the Congress, and if I am asked to
15 testify about this, I'm 100 percent positive I will be asked
16 about balanced billing and I want to know what to say. I
17 want to know what the Commission's view is. So that's why
18 it's there.

19 MS. BEHROOZI: Okay. So I'll save my view for the
20 second round.

21 MR. HACKBARTH: Yeah.

22 MS. BEHROOZI: But the other question is on the

1 Page 4 where you contrast problems finding a PCP or PCPs
2 accepting new patients versus specialists. You know, as was
3 noted earlier in the questions, Medicare still seems to be
4 doing better than private pay in terms of perceived access
5 problems or whatever, or doctors, I guess, reporting that
6 they're accepting new Medicare patients.

7 And I know we've talked about this when we've done
8 the physician update analysis in the past. Have you seen a
9 deterioration? Is that 83 percent of PCP still accepting
10 new Medicare patients worse over time than it has been in
11 the past? Or the other indicators, have they been getting
12 worse?

13 MS. BOCCUTI: Our chart has it over several years.
14 We saw bigger differentials in 2010. So I'll share with you
15 a review of the chart that has it over several years because
16 I don't want to misspeak on which year was up, which year
17 was down and that kind of thing.

18 MR. HACKBARTH: Are you asking about the patient
19 survey or the physician survey or both?

20 MS. BEHROOZI: Both. Because while you're showing
21 that Medicare looks like it's doing better than private
22 insurance, but you're saying that we fear a problem looming.

1 I think we need to, you know, also put the evidence in that
2 it's getting worse.

3 MR. HACKBARTH: Yeah. Well, we can, as Cristina
4 says, we can for next for sure have the actual series of
5 data. My recollection is on the patient survey, the numbers
6 have bounced around a little bit. There is no clear trend
7 towards it getting better or worse.

8 It's been looked at over the last four or five
9 years relatively stable. Again, some years it goes up a
10 little bit, some years it goes down a little bit. But
11 there's no a discernible trend.

12 MS. BOCCUTTI: But what is stable is that it's --
13 we always find that the rate of reported problems is higher
14 for primary care than for specialists.

15 MR. HACKBARTH: Correct.

16 MS. BOCCUTTI: Both in Medicare and in private
17 insurance.

18 MR. HACKBARTH: Correct. Good. Mike?

19 DR. CHERNEW: I have a question about Slide 16.
20 It builds on Bruce's question. The denominator here is the
21 percentage of the overall savings. It's actually the
22 percentage of the 235. It would be useful to know the

1 percentage relative to the total spending in the sector. So
2 drugs has 32 percent there, but drugs aren't --

3 MS. BLONJARZ: We could get that to you.

4 MR. HACKBARTH: Yeah. Pete?

5 MR. BUTLER: Slide 5 or 6. Sometimes there's a
6 good one and you have axes and sometimes it creates
7 confusion. But just to clarify, I'm talking about the top
8 line. So if you look at the right-hand side, this says the
9 total spending that goes through Medicare Part B subjected
10 to conversion factor would go from about double, \$60 billion
11 to \$120 billion over ten years.

12 DR. HAYES: Yes.

13 MR. BUTLER: And that that would, in that
14 calculation, include the 5.9 percent reduction for the first
15 three years. So all of the growth there is related to the
16 number of beneficiaries plus the volume of services used by
17 the beneficiaries? It is total practitioner revenue, right?
18 It doesn't mean per practitioner revenue, but that's the
19 total revenue that would go out?

20 DR. MARK MILLER: But your paper also has the per
21 beneficiary growth in it as well.

22 MR. BUTLER: Right. Beneficiaries, unit pricing,

1 volume are all the factors in that, and these numbers are in
2 the base -- these MedPAC estimates, are these are what are
3 in the baseline estimates by CBO or somebody else in terms
4 of the volume and the -- where does the line come from, the
5 data that supports it?

6 DR. HAYES: These are, you know, MedPAC analysis,
7 you know, subject to review and updating and whatever you
8 call it by CBO and others who do this for a living.

9 MR. HACKBARTH: So the major elements are three,
10 the conversion factor, the growth in beneficiaries, and the
11 growth and volume and intensity. The growth in
12 beneficiaries is a pretty predictable number. I would
13 assume that's drawn from CBO reports.

14 The volume and intensity increase is the recent
15 trend, but not a CBO number, but just our number based on
16 recent trend. And then the conversion factor is what our
17 proposal is.

18 DR. MARK MILLER: And in constructing this, he's
19 looked at things like CBO reports, looked at things like the
20 Trustee's reports, and looked at underlying elements, and
21 then tried to construct a line based on that.

22 MR. HACKBARTH: Okay, Round 2. Karen?

1 DR. BORMAN: I think first, it would be
2 appropriate to compliment the leadership of the Commission
3 and the staff on all the work that has gone into bringing
4 forward this conversation. It's typical of the good work
5 that staff does, and the thoughtfulness at the head table.

6 DR. MARK MILLER: [Off microphone.]

7 [Laughter.]

8 DR. BORMAN: Having said that, I think it's
9 reasonably apparent that I have great difficulty in
10 supporting -- yeah. So I want to make that point and
11 absolutely so.

12 I think philosophically, I'm somewhat bothered
13 here that we're asking for a fairly substantial contribution
14 from physicians that is primarily a budget-backed
15 calculation. I understand the practicality of the world,
16 but I think that the Commission has typically brought things
17 forward that have been subject to a lot of analytical rigor
18 and incredible level of thought.

19 And we've given advice that has not always been
20 popular, and Mark and Glenn in particular have been punished
21 for that, not me, in times of testimony and so forth. But
22 we have, in fact, taken those positions.

1 I fear that we are undertaking something that
2 we're starting to violate those principles. If we could go
3 to Slide 12, we talk about -- in the first bullet, we talked
4 about that the current system is inherently flawed by
5 rewarding volume growth and penalizing providers who
6 constrain unnecessary spending and provides no
7 accountability.

8 I don't see where this addresses those questions
9 at all. So, in fact, sort of perpetuates that, and I
10 understand there's a separate recommendation that follows
11 this, but the reality is that just simply manipulating the
12 fee schedule doesn't particularly do that and it, in fact,
13 creates an incentive for a certain -- even more of an
14 incentive for a particular subcategory of providers.

15 And I think that we become open in this to many of
16 the criticisms that we ourselves have made about relative
17 value scales in the SGR. I think we're dual eligible facto
18 introducing a second relative value scale for which we have
19 no data that really speak to the percentage adjustment that
20 that should be.

21 I'm not here to say there shouldn't be a
22 percentage adjustment. I need to see the data that are

1 driving it and I'm not seeing that. If you would go to the
2 access log, which I think is your one on Page 4, I'd just
3 like to remind everyone of some potential issues with this.

4 Number one, most specialists seldom, if ever, have
5 a closed panel and fail to accept new patients because other
6 than primary care specialists, I want to say we have just --
7 primary care physicians are specialists. They are other
8 than. We're talking about the other than primary care
9 specialists, and we owe that respect.

10 Other than primary care specialists, typically
11 we'll have some turn-over in their patients. You treat them
12 for something and you discharge them, and that enables you
13 to continue to deliver care. In ideal worlds, a primary
14 care practitioner maintains a very long-term relationship
15 with that practitioner [sic].

16 So I think it is some -- you would expect that
17 special, other than primary care specialists will, in fact,
18 be able to take on new patients longer and more often than
19 will primary care specialists, just by virtue of the turn-
20 over factors are different.

21 I think the other thing, and I've had discussions
22 before with some of the staff, is that the survey really

1 doesn't have a way to measure access to acute care, and in
2 fact, a number of the interventions that we're talking about
3 that will take substantial hits are, in fact, acute needs in
4 terms of acute interventions or myocardial infarctions,
5 stroke, acute surgical interventions.

6 And a patient is protected from seeing the trouble
7 that the emergency department doc has in finding a
8 specialist to respond. But there are other forms of data in
9 terms of the surveys of emergency department physicians that
10 speak to that, the response times.

11 I mean, we have patients in EDs waiting for 24
12 hours plus in order to access service. And so, this touches
13 a piece of the puzzle, but does not measure the acute care
14 service piece. And so, if this is the primary data piece on
15 which we're saying that this 20 percent differential is
16 appropriate, then I would ask you to maybe think about a
17 little bit of the proprietary of that.

18 So I think that there's a lot of laudable goals here
19 in the recommendations. This approach I'm personally having
20 great difficulty with.

21 MR. HACKBARTH: Karen, is there an alternative
22 approach that you would like us to consider? Actually, let

1 me be explicit about a premise of my question and make sure
2 I've got it right. And I think based on past conversations,
3 you agree with the objective of repealing SGR. So if I'm
4 correct in that, what alternative approach would you like us
5 to consider?

6 DR. BORMAN: I think that there are, in fact, cuts
7 in other things and savings that can be realized potentially
8 outside the Medicare program as well as things inside the
9 Medicare program that may not be historically viewed as the
10 purview of this Commission to comment on that could lead to
11 the savings to make up this difference.

12 MR. HACKBARTH: Yeah. I hope this doesn't feel
13 like I'm interrogating. I'm really just trying to
14 understand as clearly as I can what you're saying. So your
15 inclination would be to try to expand the pull of assets in
16 a way that would allow lower conversion factor cuts or
17 eliminate them, if possible.

18 And you would prefer that there not be any
19 differential treatment for a primary care versus other
20 services. Whatever conversion factor policy is adopted, it
21 applies evenly. Is that correct?

22 DR. BORMAN: Absent data to support what the

1 differential should be, then I would propose that there
2 should not be a differential purely for primary care
3 services as they're defined in this particular thing.

4 MR. HACKBARTH: Now, on the I think it's a non-
5 started for MedPAC to say, Well, the offsets ought to be
6 somewhere outside of Medicare. I don't think that we ought
7 to cut defense or, you know, increase taxes on high income
8 people. I don't think, in fact, I know that would not be
9 received well in the Congress.

10 So the constraint that I'm operating within, I ask
11 you to operate within, is we're talking about Medicare
12 offsets. And I just want to pick up on the language,
13 precise language that you used, that there might be other
14 Medicare cuts that could offset the need for a conversion
15 factor cut that may be outside of MedPAC's purview.

16 I'm interpreting that and I just want to check
17 with you, that you're talking about things like changing the
18 age of eligibility. Is that --

19 DR. BORMAN: That could be one that would be among
20 an example of a cut I think it might fall into.

21 MR. HACKBARTH: Are there others? Are there other
22 examples that --

1 DR. BORMAN: There's already existing some level
2 of tiering of premiums and that possibly --

3 MR. HACKBARTH: So income-relating benefits
4 further?

5 DR. BORMAN: Right. Under the category of benefit
6 redesign, I think there are a number of things that could be
7 addressed.

8 MR. HACKBARTH: Okay, thanks. Bill?

9 MR. GRADISON: I really don't have a question,
10 just a really short comment. The overall budgetary
11 situation and the focus on it these days creates an
12 opportunity to do something about an issue which has been
13 crying out for action for about ten years.

14 I'm not sure the window of opportunity is really
15 open. It's hard to say. Somebody could easily take our
16 suggestions for offsets and if they like them could use it
17 for something else. But I think that this is one of those
18 situations which really, I think, basically in my experience
19 happened quite often in the Medicare program and that is,
20 it's necessary to make decisions without all the data we
21 would like to have. I think that's sort of what the trade-
22 off is.

1 DR. CASTELLANOS: Thank you. And again, the
2 platitudes to the staff and to you, Glenn, for putting up
3 with my nonsense on my telephone calls.

4 You know, I think the SGR is just part of the
5 total deficit problem that we're all looking at, and I think
6 we all agree to that. You could have blame games, but we
7 don't get anywhere with the blame games. I think society
8 has a responsibility to deal with the debt, as Bill
9 mentioned. It's probably been kicked down the road too many
10 years.

11 I really believe that everybody is responsible for
12 that, and that includes Glenn, you, Bob, everyone, not just
13 certain segments of the population. I'm very concerned,
14 like Karen is, with this cut, the reason being is it is
15 going to divide the medical community at a time that we
16 really all need to come together and work together as a
17 team, rather than in separate silos like we've had.

18 Now, as you all know, I'm very supportive of
19 primary care. I don't see how this is really -- this is not
20 fixing the reimbursement for primary care. And certainly
21 they need that fixed. 30 to 40 percent of what primary care
22 does is unreimbursed. We're giving them some temporary

1 relief, but I don't see this as an answer to fixing the
2 primary care problem.

3 As Bill mentioned earlier, and Karen briefly, the
4 definition of primary care, and I mentioned this to Glenn
5 and I mentioned this last year at a meeting. I think this
6 is going to cause some unintended consequences, and again
7 I'll bring up psychiatry as a perfect example. They don't
8 qualify for primary care. And yet, they're the largest
9 group of doctors dropping out of Medicare and they're
10 dealing with a most vulnerable population.

11 So I don't know if we're really understanding all
12 what we call the unintended consequences. I hope that we
13 could all come together and recognize that we need to deal
14 with getting rid of the SGR, but how we do it in a fair
15 model is what -- I'm in the medical community. I'm somewhat
16 concerned.

17 I would just briefly like to talk a little bit
18 about the ACOs as you talked about. You know, nine months
19 ago, ten months ago, there was tremendous excitement and
20 enthusiasm for ACOs, but subsequently with all the onerous
21 regulations which are still pending, the cost of
22 implementation and that, I don't think ACOs are really going

1 to be a good answer for a long, long time. And I'm
2 concerned about that.

3 I'm also concerned about how these cuts that we're
4 proposing works on the conversion factor. I think there's
5 been examples in the cardiology community when COMPANIES
6 stopped paying for some of the procedures that were done in
7 the office. What happened?

8 Well, being a businessman, and I run a practice.
9 I'm a small businessman and you've heard that comment so
10 many times that I have to look at other avenues of
11 increasing my business. And I look at a different business
12 model. And what do the cardiologists do? They went into
13 the hospital. And what happened there? Increase of costs
14 of providing that care to the patient.

15 Yes, we're going to make some changes and
16 hopefully a recommendation, but I think working on the
17 conversion factor, we may have some unintended consequences.

18 Balanced billing. I agree with Mitra. I didn't
19 know where that came from, but you're right. There's a lot
20 of people in the medical community that have looked at that
21 as a possibility. I'm concerned about it because of the
22 significant workforce problem that we're going to be faced

1 with, with increased population changes and having people go
2 into balanced billing causing more of an access to care.

3 So I would like to see -- Karen used the words
4 shared sacrifice earlier. I would like to look at it with
5 these cuts or potential more of a shared responsibility. I
6 think we all have a responsibility. And certainly the
7 physician community has a responsibility with the SGR and I
8 would like it to be more of a shared responsibility.

9 MR. HACKBARTH: So, Ron, I have the same questions
10 for you that I had for Karen. I just want to be as clear as
11 I can about what you would like to see changed. No
12 differential on the conversion factor is one thing that I'm
13 hearing. Is the same conversion factor --

14 DR. CASTELLANOS: Perhaps no or maybe a blended
15 thing, but I think every doctor has a responsibility and I
16 think every doctor should help anticipate --

17 MR. HACKBARTH: So what do you mean by blended?

18 DR. MARK MILLER: Blended, yeah.

19 DR. CASTELLANOS: Well, you're 5.9 for the
20 specialists and zero for the primary care. I don't have a
21 figure and I can't do it, but I think the primary care also
22 has a responsibility, a social responsibility. It's a

1 societal responsibility. And to some degree, they should
2 participate in solving this problem.

3 MR. HACKBARTH: So not necessarily the same
4 conversion factor, but some reduction for --

5 DR. CASTELLANOS: I think we can look at that from
6 a lot of different angles.

7 MR. HACKBARTH: Yeah. Other specific proposals
8 that you have?

9 DR. CASTELLANOS: Well, a lot of them are what
10 Karen had said. Karen and, quite honestly, myself had
11 talked about this ahead of time. And some of the things
12 that she mentioned that were on the table and perhaps should
13 not be brought up at this meeting. But certainly there are
14 other ways of looking at solving more income coming in.

15 MR. HACKBARTH: I'm not following. Could you be
16 more specific?

17 DR. CASTELLANOS: Well, Karen mentioned a couple
18 of things.

19 THE COURT REPORTER: Your microphone?

20 DR. CASTELLANOS: Okay. Age of participation,
21 looking at some of the other buckets that you have talked
22 about, the third bucket specifically, things that we've

1 talked about but have not really discussed or made any
2 significant recommendations.

3 MR. HACKBARTH: Okay. Mary?

4 DR. NAYLOR: So first I want to say that I think
5 what I've learned in the last two years is that the
6 sustainable growth rate is an unsustainable path to getting
7 to the care system that Medicare beneficiaries in this
8 country deserve. And so, I really do support the Chairman's
9 recommendation for repeal and to achieve this, obviously, in
10 a budget-neutral fashion is critical.

11 I'm coming at looking at how, in the path to do
12 that, from the lens of someone who's worked with older
13 Americans, Medicare beneficiaries, coping and living with
14 multiple chronic conditions for the last 30 years, and our
15 team has been really attempting to think about how is it
16 that you get to a care system that is so much more aligned
17 with the changing needs of this population.

18 And it is from that perspective that I think
19 placing attention on primary care, which both from an access
20 and quality perspective, is going to be critically
21 important. Primary care in this context, not thinking about
22 it as office visits or service delivery, but really about

1 continuity, care coordination, integration of services,
2 making sure that we're on top of the people as they move
3 from, you know, whatever it is, they're in their trajectory,
4 into the acute care sector, post-acute, and back.

5 So all of those are the opportunities here, and
6 for that reason, I think not creating an emphasis on the
7 primary care role re-emphasis, re-igniting it is critically
8 important in addressing the SGR problem.

9 And I think the evidence really backs it up, and
10 certainly the evidence about primary care, especially of
11 chronically ill Medicare beneficiaries, really speaks to the
12 opportunity to get to better quality. So I don't think, you
13 know, if you look at it from the Medicare beneficiaries'
14 perspective, I think this represents both an opportunity to
15 fix a fatal flaw, a destabilizing flaw, for them and for the
16 people that serve them, as well as to get to a better care
17 system.

18 And as you think about it in the context of your
19 other recommendations, I'm thinking about, you know, how to
20 address over-pricing and getting to better data collection
21 to figure out how to measure value. And also to think about
22 systems that really recognize the contributions of all the

1 players in achieving higher value are, I think, important as
2 well.

3 MR. GEORGE MILLER: Thank you. I want to echo
4 some of the comments Mary made about primary care and
5 support them. I also support the Chairman's recommendation
6 along the lines of addressing the issue about SGR. If you
7 put Slide 16 up, I'm going to try to make my comments
8 succinct.

9 As I look at that chart, this comment is just
10 really part of observation versus a question, but I do want
11 clarity on this. On that chart, you've got the hospital 11
12 percent of that, and many hospitals employ, as has been said
13 before, physicians. So thinking about my colleagues, very
14 few, if any, sane CEOs are going to cut the physicians'
15 salaries.

16 But the hospitals are then going to take the brunt
17 of that and then have to find ways to make that up somewhere
18 else. So it seems to me that if you look at this chart, of
19 all those folks who will help solve this problem, is the
20 hospital is going to take a double whammy. They're going to
21 be looking at costs -- excuse me -- they'll be looking for
22 other cuts in the Medicare program. I've heard estimates of

1 \$155 billion. And then you add this on top of that.

2 So while others talk about shared burden, it seems
3 that at least that one sector is going to take a double
4 whammy and take the hit twice because they employ a lot of
5 physicians. Again, I don't think many CEOs are going to cut
6 the physicians' salary directly.

7 So it is a shared sacrifice with it all. So
8 that's more of a comment than an observation.

9 DR. STUART: If we could go to Slide 14, please?
10 And I guess part of the question is, why is this slide here?
11 There are two questions really. First of all, I thought
12 that ACOs were supposed to save money rather than to
13 increase spending. So that would be, you know, what is the
14 thinking here in terms of increasing. And if it does
15 increase spending, what is it doing in SGR reform?

16 And then the third question is, if this increases
17 spending within the context of SGR, doesn't that mean that
18 the offsets would have to be even greater?

19 MR. HACKBARTH: Let me take them in reverse order
20 and then I'll invite Kate and Mark to chime in. As the
21 bullet in the middle says, Logically, this would increase
22 spending. At this point, estimating the magnitude of that

1 increase is difficult because of all of the uncertainty
2 around the ACO rules and how many ACOs there will be in
3 which physicians can participate, how many of those ACOs
4 will be risk-based? These are all imponderables that I, for
5 one, wouldn't know how to estimate.

6 I suspect that if we ever got far enough in the
7 legislative process, CBO would have to attach a number here.
8 How they would do it I don't know. I don't think the staff
9 can predict that either. And so, there is an uncertainty
10 there, just as there's uncertainty in the ACO program.

11 The more fundamental question you raised is, Well,
12 why is this here if it increases spending? My reason for
13 including it is my belief that in the long-run, the way we
14 address not just the growth and the volume and intensity of
15 service, but also encourage the sort of things that Mary was
16 talking about in the reconfiguration of practice to better
17 meet the needs of Medicare beneficiaries.

18 The only path there is not through fee-for-service
19 payment, but through new payment mechanisms, of which ACOs
20 are one, and in particular risk-based ACOs are one.

21 And so, it seems to me appropriate -- and you may
22 disagree, others may disagree -- that when we're talking

1 about a mechanism, SGR was initially put in because of
2 concern about unconstrained growth and volume and intensity,
3 that we ought to try to do some things to point the way out.
4 And it seemed to me that this was a link. That's my answer.

5 DR. STUART: I share those views and I think what
6 you're really saying is that you believe that over a ten-
7 year horizon, if this was to be scored, that it would be
8 cost-saving.

9 MR. HACKBARTH: Right.

10 DR. STUART: And so, if that's the case, then I
11 guess I would say, Let's have the spending implication that
12 in the long-term, we anticipate this would be cost-saving.

13 MR. HACKBARTH: And maybe we can elaborate on that
14 bullet in a way that addresses your issue.

15 DR. MARK MILLER: And just the -- and we will and
16 we're trying to be cautious, you know, that if for some
17 reason CBO looked at it -- and here's the thing to put in
18 your mind, and I'm not speaking to why or anything, just the
19 scoring point. If CBO already assumes that there are a
20 certain ACO savings in the baseline and they assume if,
21 they're assuming that in calculating that, they assume, you
22 know, fee reductions, and we come along and say, For

1 purposes of the performance, assume a freeze, they might
2 view that as a cost off of their baseline.

3 And the other thing I'll say, not speaking for
4 them, is that I wouldn't anticipate this being a huge
5 number, but we wanted to at least accommodate that. But the
6 larger implications of what you're saying are not lost and
7 we can revisit the wording here.

8 DR. STUART: Just to finish up, if you had a curve
9 here that suggested, and again, I realize that CBO has to do
10 the scoring, that had an uptake at the beginning and then
11 coming down below the zero line, you know.

12 DR. HALL: Thank you. Well, there is a lot of
13 pain here. Anytime that we have constrained resources, we
14 realize that there is no way to -- what we really need here
15 is a pain specialist, talking about specialists and primary
16 care. I don't fit that category. But my thinking on this
17 has evolved a little bit over the weeks, and anytime we're
18 in a position, a situation where we have these constrained
19 resources, I think we all can agree on a couple of things.

20 One is, whatever we do, we want to achieve some
21 cost containment. We would like very much to maintain or
22 possibly even improve the quality of care that's distributed

1 to our Medicare recipients across the country. And as has
2 been mentioned by several people, we also want to deal with
3 issues of access and what type of a health system in the
4 future during this burgeoning growth of an elderly
5 population for the next 50 years, what's the best way to
6 achieve access.

7 We all agree that SGR is a very flawed payment
8 mechanism. We have some disagreements as to how that pain
9 should now be distributed around, and there's no way around
10 that. It's real.

11 So I guess the tipping point for me has become the
12 whole issue of which mechanism right now, given the
13 constraints, will have the least deleterious effect on
14 access to care for the next 30 to 50 years in this country.
15 So a couple of things have come to my mind.

16 First, there is not much question in terms of
17 primary care that a higher percentage of primary care
18 providers, whether they're labeled as physicians or, as Mary
19 has said, other primary care providers, that there is a
20 direct correlation with improved health quality, and this is
21 true for such things as infant mortality and true for
22 mortality from cancer, from stroke, for how people deal with

1 complex chronic illness.

2 It has been said that for every increment of one
3 primary care provider for 10,000 people in a community,
4 there will be a predictable 5-percent decrease in mortality
5 from chronic disease. The reason for this is that these
6 physicians are managing these patients in between
7 specialists. It's not that the specialists are -- the
8 specialists are still very necessary in the process, but
9 it's the overall management where the whole becomes greater
10 than the sum of the parts, and that's the future role of
11 primary care. And these same kinds of savings cannot be
12 correlated with the percentage of specialists within any one
13 community. I would like it not to be that way, but I think
14 that is the way it really is. And that's not even taking
15 into account, again, this huge bulge of the elderly
16 population and the expectations of this elderly population
17 to live with chronic illness.

18 At the same time, for the last 20 years we have
19 seen a tremendous attrition of interest in primary care as a
20 career choice for physicians. Dramatic changes. There is
21 an age factor in the current primary care physicians. There
22 will be a huge dropout, attrition just from natural

1 retirement. And the production line is very, very slim.

2 There are lots of reasons for that about
3 lifestyle, but fundamentally it really comes down to a sense
4 of worth, partially, I think, attributable to what society
5 rewards me for doing.

6 So to me, that becomes the tipping point that
7 says, while this is a painful decision, in many ways it's
8 probably the least painful in terms of permitting continuing
9 access to care. So I guess I speak in favor of this
10 proposal.

11 MR. KUHN: My compliments also to Glenn and all
12 the staff for all the hard work they have done. I would
13 agree with what Glenn and others have said, that this is a
14 very urgent matter. It is very destabilizing for not only
15 beneficiary but particularly for clinicians, physicians that
16 are out there, and it does serve to undermine the integrity
17 of the Medicare program in the eyes of a lot of
18 practitioners out there. And so dealing with this issue is
19 important.

20 Of all the goals we're trying to achieve here, I
21 think one that's very critical is to make sure that we have
22 predictability and stability in the system. Those that do

1 business with the Federal Government to serve those that are
2 on Medicare deserve predictability, and they also deserve a
3 very stable program. So I think one of the goals we're
4 trying to achieve here is definitely the predictability.
5 The stability, I think there is some varying degree around
6 people around this table whether the glide path we are
7 talking about will give us that stability we're after. But
8 I'm comforted by the answer Cristina gave to a question I
9 asked earlier, and that is that we are going to be
10 monitoring this ever so closely, and I think there is
11 opportunity for course corrections along the way if we think
12 stability is not there.

13 So in that regard, I am in support of repeal of
14 SGR, and I think it should be fully offset with the
15 recommendations we come forward with. And I think the
16 trajectory that we're on right now is probably the best
17 course we can continue to pursue. So I'm still with you,
18 Glenn, and want to continue to move in this direction.

19 The one thing that would be helpful, however, for
20 me as we come back to the October meeting -- and it's a
21 little bit what George was talking somewhat about -- and
22 that is, as we know right now, we have high employment of

1 physicians by hospitals across this country. In Missouri, I
2 think in the survey information we have, it's not as defined
3 as well as I would like it to be defined, but it's anywhere
4 between 18 to 30 percent of the physicians in our state are
5 currently employed by hospitals. If you take the term
6 "functional employment" -- that is, the payment for on-call
7 services, et cetera -- it goes well up over 50 percent. And
8 so maybe if we come back and look at this more, I would just
9 be interested in some baseline information that we could
10 gather in terms of physician employment right now. And I
11 know it's probably hard to predict what this policy would
12 mean, but, you know, would this hasten employment in the
13 future? Is there any way we could kind of project that or
14 think about it?

15 The reason I ask that is we know there are some
16 people that are concerned about the market concentration
17 aspects, and would this then lead to other unintended
18 consequences down the road? And this is something that we
19 ought to at least be aware of as we move forward.

20 DR. BERENSON: Yeah, I strongly support the
21 package that has been proposed. I only have time to comment
22 on a few points, and I will.

1 I want to first pick up on a point that Karen
2 raised about why specialists and primary care doctors might
3 have different willingness to see Medicare patients. And I
4 actually agree with her point but come to a different
5 conclusion.

6 It is clear that a number of specialists don't
7 have much of a practice if they're not seeing Medicare
8 patients. Prostates enlarge over time, and typically older
9 people have prostate problems, older people have heart
10 problems or macular degeneration. And so some specialists
11 simply can't really have a business if they're not seeing
12 Medicare patients. And the other practical reality is that
13 specialists have a much harder time telling their referral
14 physicians, "I just want your well-paying patients. I don't
15 want to see your Medicare patients," et cetera. Specialists
16 are not in the same position as currently primary care
17 physicians are in and are showing they are less dependent on
18 Medicare patients. There's a shortage of primary care
19 physicians in general, and other clinicians, and we are
20 seeing in the data, I think, an imminent threat which will
21 get much worse as my generation of primary care physicians
22 retires. And so I'm not persuaded by arguments of fairness

1 or equity or something like that. I think it is this
2 differential that we're recommending or the protection for
3 primary care is to deal with the access problem and the
4 potential threat to access.

5 I do agree with Bill that the data pretty much
6 shows you need a strong primary care base, but I just think
7 we also simply are going to not have doctors willing to see
8 -- primary care physicians willing to see Medicare patients.
9 In fact, the primary care docs are out there sort of
10 thinking they're going to -- they want a significant
11 increase in their payments, and we're recommending a flat
12 line essentially and a differential.

13 And I would observe that where we're starting from
14 based on the Urban Institute study to MedPAC a couple of
15 years ago where we simulated what physicians' incomes would
16 be, their compensation would be if Medicare's fee schedule
17 was used by everybody, shows that a number of specialists
18 are earning two to two and a half times more than primary
19 care, would have that times more compensation.
20 Interestingly, the surgeons generally are not at that higher
21 level, but cardiology, radiology, some of those specialties
22 actually have those kinds of differentials.

1 So I don't have a hard analytic basis for
2 justifying what we're basically saying, 5.9 percent for 3
3 years for everybody except primary care, but where we're
4 starting from is a major differential in the other
5 direction.

6 The second point I would want to make goes to the
7 issue that Bruce raised and others have commented on as sort
8 of the physicians' proportionate share of the cutting in
9 this package. And I guess I would simply say that, one, SGR
10 is a physician policy, so it would -- there's some logic to
11 having physicians as part, as a significant part of the
12 solution. But more importantly, I think, the fee-for-
13 service fee schedules generate volume. We all want to
14 replace volume generating payment systems with something
15 else, but over the last decade, until moderation is shown to
16 last about 2 years or so, there was substantial volume
17 increase and substantial revenue increases that went to
18 physicians serving Medicare patients.

19 One of the things I like about this policy is that
20 the revenue per enrollee continues to go up. So, yes, we
21 are taking what will be seen as a substantial hit on the
22 conversion factor, but, in fact, revenues continue to

1 increase, not just absolutely but per enrollee or per
2 beneficiary. That, unfortunately, penalizes the prudent
3 docs who aren't generating unnecessary services, but we
4 can't solve that in a fee-for-service system. What we can
5 do is accept the fact that this it -- I think this is sort
6 of a moderate middle ground between completely unacceptable
7 30-percent cuts from the SGR and continuing sort of a zero
8 or 1-percent increase, which would be dead on arrival if we
9 really thought we were going to have any impact on what
10 Congress was going to do. So I think perhaps not
11 analytically justified but politically it works, and I think
12 we can go to the physician community and say that your total
13 revenues are going to continue to go up.

14 The third point I want to make nobody has
15 commented on, and so I wanted to get it on the record, is
16 recommendation 3 with the recommendation that we achieve 1-
17 percent spending reductions for overpriced services.
18 Clearly, this has been a topic that I have been at the
19 center of. I am absolutely confident that we could achieve
20 that and that we need to have such thresholds stated to
21 actually get the work done, because the tendency is to
22 identify undervalued services and not overpriced services.

1 The RUC and CMS have both now taken this on. But what they
2 have not yet done is go to -- I mean, they're looking at
3 particular categories of services such as fast-growing
4 services, services that have changed their primary place of
5 service, et cetera. But there are a whole bunch of very
6 high cost services that have not been reviewed recently, and
7 I'll tell you the one that I would expect would be at the
8 top of the -- should be at the top of the line, and it's a
9 primary care service. It's interpretation of EKGs. Right
10 now the estimate of time that it takes in the RUC database
11 for an internist to interpret an EKG is 5 minutes or 7
12 minutes, depending on whether the office also runs the EKG.
13 With automation, that is now perhaps 5 seconds, the time it
14 takes to review the automated report. For those who don't
15 have automation, it still can't take more than a minute. It
16 represents half of 1 percent of fee schedule spending. I
17 think it's a perfect service. The work component should be
18 packaged in with the office visit. It's really not a
19 distinct service as far as a primary care physician is.
20 That should be reduced. And there's a whole bunch of other
21 ones that I think are there, and so I like the idea that we
22 are setting, I think, a very achievable threshold of

1 accomplishment for CMS, ideally with the RUC working with
2 them. So I endorse that as well.

3 DR. BAICKER: I'm strongly supportive of the idea
4 of fixing in a long-run way the SGR for all the reasons
5 people have outlined, and also the notion that we have to
6 come up with some offsets for this to be a viable policy
7 proposal. So I would just think broadly about
8 characteristics that I would like those offsets to have, and
9 one of the themes that we've hit on again and again in past
10 recommendations is using payment levers to move towards
11 higher-value care, and that means reducing payment for
12 overpriced services and increasing payments for undervalued
13 services. And we have a very hard time doing that in the
14 absence of good information, and a lot of the proposals
15 we're talking about endorsing going forward try to draw on
16 new ways like ACOs or other mechanisms to get the prices
17 right, because we have a very hard time just writing them
18 down.

19 So I'm very supportive of the flavor of offsets
20 that moves us towards higher-value care by drawing on all
21 the tools available to us to draw in outside signals of the
22 value of the care and line up our payment accordingly. And

1 I'm more nervous about a flavor of proposals that would push
2 Medicare prices out into the world in a way that's less
3 supported by lining up with higher-value care. And that's
4 important for getting high-value services for our
5 beneficiaries within a limited budget, but I think it's also
6 important for the well-being of the health care system that
7 Medicare is such a large player in the way that care is
8 delivered throughout the health care system that we have to
9 be cognizant of the effect of our policies on our
10 beneficiaries' non-Medicare costs and on other people's
11 health care costs and the value of care delivered throughout
12 the system. In the same way that policies that affect
13 private markets have spillover effects to Medicare, I'd love
14 to focus on promoting high-value care within our system in a
15 way that also promotes high-value care for everybody else
16 consuming health care.

17 MR. HACKBARTH: Please feel invited to offer
18 specific proposals that fit the specifications.

19 MR. ARMSTRONG: Thanks, Glenn. At this point much
20 of what I'd want to say feels a little redundant, but there
21 are a few points I do want to quickly make.

22 First, I think this proposal is a package that is

1 smart, that it represents this Commission taking
2 responsibility that it should be taking, and I think it
3 takes huge steps overall to strengthen the Medicare program
4 and the likelihood that our Medicare program will be around
5 for decades to serve people that it's supposed to serve.
6 And, frankly, in this environment, as we've said, we don't
7 have all the answers, and I'm concerned about a process that
8 moves proposals forward that haven't been vetted the way
9 that many of ours have in the past. But if we don't do
10 this, someone else will, and I trust us far more than the
11 others who would be making those decisions.

12 Let's not understate the value of addressing this
13 legacy issue that's been hanging on this program of SGR. It
14 is an enormous step forward. I also feel that we have to be
15 careful about describing the offsets that we're moving
16 forward and other aspects of this proposal as bitter pills
17 to swallow or painful measures. In fact, what this is doing
18 is allowing us to accelerate and to advance policies that we
19 have already said we believe are the right policies and/or
20 to accelerate the pace of moving forward with policies that
21 we think would be good policies.

22 And so I think that we talk a lot about the

1 unintended consequences and the concerns. I think we
2 understate the potential unintended value that could come
3 from, for example, investing in a payment schedule for
4 primary care, as this is proposing. I run a medical group
5 of 1,200 doctors, and we spend a lot of time wrestling with
6 the relative compensation for hundreds of specialists and
7 hundreds of primary care doctors. And I tell you, that
8 equation is influenced by the fact that investing in our
9 primary care providers and their practices reduces the
10 overall expenditure rates and improves the quality and
11 health of our population. And we haven't talked about that.

12 I also think we should remind ourselves that we
13 are concerned about equity and disparities. There are
14 inequities and disparities in our current system, and what
15 we are doing is, in my mind, reconciling some of those, and
16 at the same time giving a kind of predictability and
17 stability to a payment structure that today does not offer
18 that to our specialists.

19 My last point would be -- I think Bruce mentioned
20 this -- that I do wish there were ways that we could get
21 more clear about investments in different mechanisms by
22 which we get out of the perversities of a fee-for-service

1 payment structure. That's just the reality of what we're
2 in. I think our nod to ACOs is kind of light in this, but
3 I'm not convinced that this is the best place for us to get
4 that much traction on it, and it's hard to do that anyway.
5 But I just think let's be honest about that. This is just
6 kind of a nod to something that I think we underestimate
7 what the potential upside really will be.

8 MS. UCCELLO: Like Scott, I think a lot of what I
9 would say has been said, and much better than I can say it.
10 But I'm still going to kind of reiterate just the high-level
11 view. Kate has said it several times, and others have as
12 well, but we really need to get rid of the SGR and we really
13 need to pay for it.

14 I strongly support the way these recommendations
15 are going, and as Scott said, I agree that we need to not
16 sell ourselves short about these, hoping to move the system
17 in the right direction.

18 Kate has alluded to this and Mike said it earlier,
19 too, and as part of my day job, I'm kind of a broken record
20 on this, that we have to think about things as not just
21 shifting costs but reducing costs in the overall picture.
22 And so implementing things that help move us down that path

1 are the way to go. So the more we can stack the deck of
2 these recommendations toward a system, that just makes more
3 sense overall. Paying for value is a better care
4 coordinated kind of system is the right way to go.

5 DR. DEAN: Well, I would just echo what most of
6 the folks have said, that I really do appreciate, Glenn,
7 your identifying this as an urgent issue. I think it
8 absolutely is an urgent issue, and it is a destabilizing
9 factor already, and it's only going to get worse if we don't
10 deal with it. So I wholeheartedly support and appreciate
11 it.

12 I support the recommendations. I think that, you
13 know, the issue -- there's just no way to fix this without
14 paying. Bill's comments about pain specialists is apropos.
15 And I certainly support the concept that there needs to be
16 shared sacrifice. I guess I would make the point that I
17 believe the primary care specialties have already sacrificed
18 and have made their sacrifice. I mean, they've stayed in
19 here when they were being reimbursed at substantially lower
20 rates and are not being paid for a lot of what they do. So
21 at first, I struggled with that a little bit, but the more I
22 thought about it, I believe that they really -- there has

1 already been a lot of sacrifice made. And so there's no
2 easy way out of this. It's a mess. It's a very destructive
3 kind of situation that we're in now, and we need to get out
4 of it. But I support the approach.

5 I completely agree, though, with what Ron said
6 about it's not a fix for the primary care problem. It
7 doesn't even come close. It basically just keeps things
8 from getting worse. And so I think that we don't want to
9 mischaracterize this that this solves the primary care
10 problem. The fee-for-service structure is just not an
11 appropriate structure to reimburse primary care, and until
12 we can move to models that use other structures and really
13 recognize the value that primary care brings to the process,
14 which the fee-for-service system does not, we're not going
15 to solve that problem. So we have to, I think, realize that
16 and recognize it. I think Scott alluded to that, and I
17 think your system probably demonstrates that as well as
18 anything.

19 Having said all that, there's certainly my concern
20 -- well, I have one other thing. We really have to deal
21 with some of the distortions that exist. We looked at when
22 physicians are billed through hospital outpatients that

1 reimbursement is completely out of line. Those things have
2 to be dealt with so that we keep some balance in the system
3 between hospital-employed physicians and physicians in more
4 conventional care. I certainly support the movement. I
5 like the ACO idea, but it's obviously got a lot of struggles
6 before it really becomes ready for prime time.

7 So overall I really support the direction of
8 these. My concern is I wish it could be better focused, and
9 I'm afraid that doing it by specialty doesn't necessarily
10 achieve all that I would like to see it do. Now, maybe it's
11 the best we can do at this stage in time, because, for
12 instance, I'm afraid there are going to be some unintended
13 consequences. You know, when we looked at where has the
14 cost growth been, E&M services and major procedures have not
15 risen above the rates of inflation, and yet one of those
16 groups will be protected and one group is not. Ron
17 mentioned psychiatry, which is a real concern.

18 So I think that as important as it is for us to
19 move, maybe this is the best we can do. I guess I would
20 feel that it's a less than perfect response, and we just
21 don't want to lose sight of the fact that there are services
22 that are going to be penalized or hurt by these movements

1 that don't really deserve that. They have not been the
2 source of the problem.

3 So I don't have an answer, but like I say, I wish
4 ideally it could be a little better focused.

5 MR. HACKBARTH: It is, of course, imperfect. Part
6 of the challenge is arithmetic. The broader you define any
7 protected category, the deeper the cuts need to be in the
8 other services. We actually did some work looking at other
9 configurations. You know, if, for example, you protect all
10 of E&M and major procedures, you're talking about a large
11 proportion of total Medicare spending being in the protected
12 category. What that means is the cuts for the other
13 services to come up with a budget-neutral package are much,
14 much deeper than what we're talking about here. And so it
15 is imperfect, but arithmetic constrains our choices.

16 MS. BEHROOZI: Before addressing recommendation 1,
17 I just want to make a comment about -- I guess it applies
18 really to recommendations 2 and 3 and kind of runs
19 throughout. You have under beneficiary and provider
20 implications that this is all about enhancing or maintaining
21 access for beneficiaries. But the extent to which we
22 rebalance payments to providers also draws with it cost

1 implications for beneficiaries. So whether it's by
2 adjustment of the RVUs or the conversion factor
3 recommendation, we're going to be making primary care
4 relatively more expensive than it is now with respect to
5 specialties. And so I think we need to keep that in mind
6 when we are looking at benefit design issues because we
7 wouldn't want to end up, you know, deterring a few more
8 people from getting primary care that they need. As Scott
9 says, it's the best investment to get people to maintain
10 primary care. So that's just on the general point.

11 You know, from the beneficiaries' point of view --
12 we haven't been talking about that too much -- access is two
13 things. It's having a doctor available who will accept you
14 and being able to afford it. So the lifting of the cap on
15 balance billing, I get that Congress is interested in it and
16 they probably don't care too much what I think, but for me
17 it's a non-starter because I don't think that -- as far as
18 an access issues, I don't think that's going to enhance
19 access for anybody. And, you know, to break out of our
20 silos a little bit, Kate is sitting here, so that bridge is
21 over to her presentation to come. In her paper she talks a
22 lot about the changing economic face, the changing financial

1 picture for beneficiaries whose incomes have stagnated for a
2 decade, whose retirement assets were wiped out, whose
3 defined benefit pension plans are disappearing. They're not
4 going to be able to afford more. So this notion of them
5 sharing the sacrifice in some proportionate measure just
6 means they won't go to the doctor. Their access will be cut
7 off if we aren't careful with, like I say, what we do on the
8 other side with benefit design.

9 So I'm not saying that's not a reason to do this,
10 but I really think we need to list among the implications
11 the relative shift in cost burden to beneficiaries. Okay, I
12 recognize only 10 percent of people don't have other
13 coverage, but it also will make Medigap policies more
14 expensive and whatever.

15 Did you want to say something?

16 MR. HACKBARTH: Just to make sure I have grasped
17 your point, you're pointing out that if you have any policy
18 that increases the relative payment for primary care
19 compared to specialty services and you combine that with a
20 benefit structure that uses co-insurance as a mechanism for
21 determining the patient responsibility, you have a perhaps
22 unintended effect of increasing the out-of-pocket costs for

1 primary care services relative to specialty services.

2 MS. BEHROOZI: [off microphone] Right.

3 MR. HACKBARTH: And so the next step I think that
4 you're leading to -- and this is what I wanted to check on --
5 -- was that in thinking about redesigning the Medicare
6 benefit package, we may want to depart from a co-insurance-
7 based cost-sharing structure to defined co-payments, dollar
8 co-payments, for example.

9 MS. BEHROOZI: Or a waiver of co-payments, as in
10 PPACA, for preventive services for driving people to high-
11 value care.

12 DR. CHERNEW: Yeah.

13 MS. BEHROOZI: Yeah. And Mr. VVID over here is
14 whispering. I didn't want to give it too much of a, you
15 know, jargony kind of title, but, you know, value, we do
16 talk about value.

17 Then with respect to recommendation 1, leading
18 into it -- where is the statement? What does it say? It
19 says that the -- wow, that's weird, but I can't find it now.
20 Oh, yeah, full offsets are necessary in the context of the
21 current deficit picture.

22 MR. HACKBARTH: Which one are you looking at [off

1 microphone]?

2 MS. BEHROOZI: I'm sorry. This is Slide 15, I
3 guess it is, page 15. So it's the second bullet, first
4 indented bullet. Necessary in the context of the current
5 deficit picture. I would not agree that that's a correct
6 formulation. I think they are necessary in the context of
7 the current -- I don't know, picture a different word, like
8 practical picture, and the practical picture is comprised of
9 the deficit. But it's also comprised of the current
10 political environment, the things that are within MedPAC's
11 jurisdiction versus outside of our jurisdiction. There are
12 a number of factors. And I would not agree that the deficit
13 picture drives us to offer offsets. I think there are, you
14 know, other things that people have -- that you have
15 articulated on. So that was one thing that I wanted to make
16 clear.

17 And then with respect to the offsets, the
18 proposals that we're going to be sharing, I agree with a lot
19 of what Scott said, that there's a lot of good stuff that
20 we've been talking about and haven't explored fully, and we
21 could look at this as an opportunity to kind of push things
22 out there that are of high value, but we have not gone

1 through the fully process. I don't know that we necessarily
2 need to spend years on each of these things. But, frankly,
3 I don't even know what some of them really means, you know,
4 how they would play out or, you know, exactly what's
5 referred to in some of them. So I caution that the language
6 of recommendation 1 -- I don't know if you want to put it
7 back up there -- where the last sentence of the bold-faced
8 recommendation states that the Commission is offering this
9 list of proposals, I fear that that could be interpreted as
10 turning those proposals into recommendations. And I think
11 we need to be clearer that we are only doing this because of
12 this extraordinary confluence of practical circumstances,
13 and it's only -- and I understand the intent was to link it
14 to the repeal of SGR, but as I said, I really fear that then
15 the conversation is over about those proposals because we
16 have already recommended them, and it doesn't matter what
17 else we might say or think or what else the analysis might
18 show.

19 So I am not sure that I would vote for the
20 recommendation with that sentence in it as such as opposed
21 to perhaps under spending implications.

22 MR. HACKBARTH: You have a good sense of the

1 nuance in the writing, so I would invite you to think about
2 the specific words that you think would better capture what
3 we're trying to do. That would be appreciated.

4 DR. CHERNEW: So it's interesting because there's
5 a tremendous consensus here about fixing the SGR and then a
6 lot of concern, hand-wringing around everything else. So I
7 think the bottom line is that the fiscal pressure we're
8 generally under creates a potential for some really bad
9 policy, and our goal is to try and find the best in a bad
10 set of choices. And so I think every group that gets
11 touched could have a completely legitimate argument as to
12 why bad things might happen about their being cut, and my
13 general view is while I agree with many of those arguments,
14 you know, the world's just not a pretty place when you're
15 operating under some of the constraints that we're operating
16 under. So a few things.

17 The first one is I agree most strongly with the
18 basic point, besides fixing the SGR, that we have to get to
19 better payment alternatives. And so I very much like the
20 ACO stuff. I believe very strongly that you could design an
21 ACO set of policies that would not cost money, in part
22 because there's nuances about how you update the ACO payment

1 over time, what volumes you use when you apply the fee to
2 it. So I really do believe we could define an ACO policy
3 that would be better, and, frankly, I think that will be
4 crucial because it gives the medical community control in an
5 ACO world about how to apportion these cuts. And so all the
6 complaints that you hear could be done with much more
7 flexibility in different systems in an ACO world -- not ACOs
8 as regulated but more, you know, as conceptualized. And I
9 think getting there is important, and I think we can
10 encourage that without costing a lot more money.

11 I have some basic concerns about the
12 recommendation per se in part because it does two things:
13 it does something that we all, I think, basically support,
14 which is fixing the SGR, and then most of the text in the
15 recommendation is actually devoted towards specifying the
16 burden across the different sectors, physicians and non-
17 physicians and --

18 MR. HACKBARTH: You're talking about [off
19 microphone] --

20 DR. CHERNEW: Recommendation 1, right. And I just
21 want to say now -- and I think we can deal with this in the
22 text, but the second part was not really done in the way

1 that we normally do things. In other words, we didn't
2 figure out the appropriate cut for physicians. You alluded
3 to this in your intro. Instead, we sort of used other
4 criteria. Specifically, we imposed this budget neutrality,
5 which I agree is a reasonable thing for MedPAC to do, but I
6 am completely supportive of Mitra's comment, which was that
7 might not be the right thing to do for policy, it's just
8 outside of our purview. So we're operating in this world or
9 environment or whatever words Mitra used to say we're now
10 going to do an exercise of fixing the SGR, which must
11 happen, and talk about how we could do that in a way that
12 takes all of the money necessary to do that out of Medicare
13 as opposed to anything else. And what we did, if I
14 understand correctly, is our other criteria was largely we
15 looked at all the offsets we should loosely come up with,
16 and some of them I think we would support even without this
17 SGR pressure. As Scott noted, we've talked about a lot of
18 them. But others actually I think probably would be a lot
19 more controversial if we went through them, and some more
20 painful than others and some of which with an unknown amount
21 of pain.

22 I'm supportive of that general strategy that we

1 used. I will say I think this criteria of no decrease in
2 physician revenue or physician revenue per beneficiary isn't
3 that useful because I think Ron was correct, it's really
4 income. So if you get the same revenue but you have to see
5 50 percent more people to do it or something, you know,
6 physicians would view that differently.

7 So I think the basic idea of finding reasonable
8 offsets and then basically what we did is take the rest of
9 it out, you know, what was left is what came out of
10 physicians, yielded this 5.9-percent cut, and I don't -- I
11 personally don't believe and I don't know if anyone believes
12 that that's the best cut or that if we would have asked
13 ourselves in another direction what's the reasonable amount
14 of cut and then tried to build up the offsets after that,
15 that we would have come with 5.9 percent. We did it in a
16 certain analytic way. We were left with that number. It's
17 possible -- and I think many people could make a reasonable
18 case -- that there would be some deleterious consequences
19 for all the various reasons. So my general point is that
20 while I'm supportive of the general activity and basically
21 in support of the recommendation, you know, this notion of
22 continued monitoring is going to be crucial, thinking how

1 this is all going to be scored by CBO because they might
2 have other behavioral offsets in this I think will be
3 crucial. And I guess that's where it leaves us.

4 The last point I will make, which is related to a
5 very early point about inflation, I think we could word this
6 in a way that's relative to inflation in a particular sense.
7 So this may be a little nuanced, but there are some people
8 that believe inflation might soar under certain policies
9 that may or may not happen over the next 10 years. And our
10 recommendations are all done in an absolute value kind of
11 way, and you could conceive of wording these recommendations
12 in a way that yields the exact same trajectory but would
13 have an out that if inflation went from the currently
14 forecast, whatever it is, 2 or 3 percent up to some much
15 higher number, there would still be the same gap but
16 physicians wouldn't be hurt as much, because there's a
17 potential with rapid inflation for these to look a lot worse
18 than they're being projected.

19 MR. HACKBARTH: To be clear -- and I know you
20 understand this, Mike -- there is an out, to use your
21 phrase, and that's the annual review of payment adequacy.

22 DR. CHERNEW: Exactly. Under current law [off

1 microphone] -- I understand. Go on.

2 MR. HACKBARTH: There are lots of things that we
3 may not be able to anticipate, inflation being but one of
4 them. And rather than fall into the SGR trap of let's write
5 a formula that, you know, captures exactly what the rate of
6 increase could be, should be, I think a more prudent thing
7 is to accept this for what it is, a new baseline, and that
8 means two things: that this is what's going to happen
9 unless there's new legislation, and if you want to go above
10 this baseline, it's going to cost money. But you're not
11 locked in.

12 DR. CHERNEW: No, I understand, but there's a
13 default as to whether the default is you have to do
14 legislation or not. So certain things -- like the IPAB used
15 GDP plus 1, which gives some other flexibility. And going
16 out 10 years, it's just a question of who you're putting the
17 risk on.

18 MR. HACKBARTH: Yeah.

19 DR. CHERNEW: So I think it's worth over the next
20 several weeks to discuss some of the nuances of the
21 recommendation and how we portray it, but the general sense
22 that I have is we are going to have to do something like

1 this because the overall biggest priority is fixing the SGR
2 so we can have a sensible policy going forward.

3 The second priority -- I think I agree with Kate -
4 - is getting us towards a system that's better.

5 And I think the third priority is to, frankly,
6 illustrate to individuals that when we work in the
7 environment that Mitra outlined, how difficult these cuts
8 really are, because you end up having beneficiaries paying a
9 lot more or you have to get money from taxes or you have
10 physicians take really big cuts potentially in real terms
11 for long periods of time. And I think illustrating that
12 clearly and describing why it's important would be my third
13 priority, and I think you've done a pretty good job of
14 getting there.

15 MR. BUTLER: Okay. As an academic medical center
16 that employs hundreds of specialists, this is a tough thing
17 to kind of separate myself from, but I will. I think our
18 customers are Congress and beneficiaries, and as I try to
19 practically look at this, if Congress does nothing this
20 fall, you know, my understanding is we would have a 2-
21 percent across-the-board Medicare cut of about \$135 billion,
22 and then come January 1, we'd have a \$300 billion cut in the

1 physician fee side of things if they do nothing. So I look
2 at this as at least a \$335 billion issue in some ways, not
3 just, obviously, SGR by itself. And I do feel that we
4 should be quite responsible in terms of providing some
5 thought specifically around SGR, but also the offsets as
6 well. You wanted to say something?

7 Now, I can support the recommendations, if not as
8 they are, close to them. Something tells me that the 3
9 percent over 10 years is less toxic and achieves the same
10 savings as the 5.9 over 3 years. I don't think we should
11 weigh in with politics in terms of we'll give them a higher
12 number and then they're whittle it down or something. I
13 think we should offer up what we think is a reasonable
14 thing.

15 Having said that, I understand when we do our own
16 long-term financial plans, we go out 10 years, and we kind
17 of ignore the last 7 years because we really say when we get
18 to that, we may have adjustments. So I do understand the
19 value of taking the savings when you can immediately achieve
20 them. So I'm on the fence of what is the right way to go on
21 that one.

22 I think with respect to specialty and primary

1 care, I think there's fine-tuning of what really -- along
2 the lines that Ron says, you know, there are specialists and
3 -- it's not as black and white as it appears, and it needs
4 to be sensitive whether it's to psychiatry or other areas.
5 But, in general, believe me, the primary care, not only do
6 they have it tougher now, in our system where we have a lot
7 of pay-for-performance contracts, where we've gone to
8 electronic health record, they're disproportionately
9 impacting the time and effort of primary care over the
10 specialists. And it shouldn't go unnoticed. The workload
11 that is associated with coordinating care through these
12 things is going to even fall more on primary care, and we're
13 going to need them to be paid well to -- or better to make
14 sure we have the supply necessary.

15 As for the spreading of the offsets, I think if we
16 just look at what we put on the table and say it's
17 disproportionately on physicians, I really don't feel that.
18 You have to take the longer view, and Part B spending in the
19 aggregate, because there have been governors, for example,
20 that have worked in the hospital side. Imagine if we didn't
21 have DRG payments what the volumes would be in inpatient, or
22 if we didn't have readmission rates in the queue. There

1 still is no governor on a lot of the Part B spending. And
2 it should be difficult, it should be painful, because we're
3 trying to move a system -- if it's easy to remain in a very
4 independent small practice, say, that is dependent on the
5 fee-for-service system, it's going to continue. And it
6 should be hard to make that happen. And I don't think in
7 general, coming back to the second customers, the
8 beneficiaries, I don't think we're going to get that many
9 people dropping out of Medicare that are those kinds of
10 practices. What you're going to have is more employment,
11 maybe, and more going into bigger groups. But I think that
12 that's a positive thing. I think that's a positive
13 consequence, and there will be less emphasis on the RVU
14 generation of an individual doctor and more emphasis on such
15 systems of care that are going to be required to improve
16 health overall.

17 So with all that in mind, I think that this is a
18 good job, and we've gone some fine-tuning, but I am
19 supportive of the direction we're headed.

20 MR. HACKBARTH: Thanks, Peter.

21 Let me just pick up on the point Peter raised
22 about there being alternative approaches to any conversion

1 factor cut. The one that we've offered here is a relatively
2 steep cut the first 3 years and then freeze at that level
3 for the remaining 7 years of the budget window. An
4 alternative approach, which I discussed with each of you,
5 was to have a smaller cut in each of the 10 years.

6 When I talked to Commissioners about those two
7 alternatives, it was remarkable the division -- the first
8 time I talked to you all back in sort of early/mid August
9 was almost exactly right down the middle, although generally
10 people did not have strong feelings one way or the other,
11 but their initial impulses were sort of half on one side,
12 half on the other side.

13 The reason that I came to recommend the steeper
14 approach for 3 years, the steeper cut for 3 years and then
15 leveling is I looked at the conversion factors that result
16 from the two different approaches, and the price you pay for
17 less steep cuts spread over 10 years is that the ending
18 conversion factor is quite a bit lower. So if you look at
19 it year 7, 8, 9, 10, the gap between the primary care
20 conversion factor and the specialty services factor gets
21 really large. I'm not sure if this is -- we've done several
22 iterations since, but one of the early iterations was that

1 if you had a 6.6-percent cut in 3 years versus 3.1 percent
2 over 10 years, at year 10 the primary care conversion factor
3 was 37 percent higher than the specialty services conversion
4 factor. And I was worried that that gap was getting too big
5 out of control. And so more front-loading of the cuts than
6 leveling was a method of looking down the road and making
7 sure that gap did not get too big.

8 So, you know, people -- we don't have time right
9 now, but people can think about that and react to it when we
10 talk some more about it. But that was how I came down on
11 this side, Peter.

12 Okay. We are well behind schedule, not
13 surprisingly, I guess, almost 50 minutes behind schedule.
14 We will have a 15-minute public comment period before we
15 break for lunch.

16 Could I see the hands of people who want to make
17 comments? Just so I have a sense of where we stand on time.
18 I'm just seeing two hands -- three. Why don't you stand up
19 so I can see you better. I just want to be able to -- so
20 we've got three people.

21 The ground rules for this is I'll give you, say, 3
22 or 4 minutes each for three commenters, since we only have

1 three. Please begin by identifying yourself and your
2 organization, and then when this light comes back on, that
3 will be the end of your time.

4 MS. McILRATH: Sharon McIlrath, AMA. I'm not
5 going to spend a lot of time telling you why we don't like
6 this and why we think a lot of physicians will think that a
7 15-percent cut is not a whole lot better than a 30-percent
8 cut, that access problems are likely to develop. But what I
9 would like to say is that I think it is important that if
10 you're going to go down this route, that you increase your
11 ability to monitor and that you also increase your ability
12 to be looking at very recent data.

13 If you are looking at specialty, the problems
14 within the non-primary care groups, I think you need to be
15 able to look at individual specialties, not just the group
16 as a whole.

17 If you look at the retirement data -- it was cited
18 several times here today about the retirement data for the
19 primary care physicians -- it's actually worse for a number
20 of the other specialties. It is particularly bad, more than
21 -- about 54 percent of psychiatrists are over 55. The
22 number is also very high for pathologists. It's also very

1 high for urologists. There are many, many of the surgical
2 specialties and some of the other specialties that have a
3 bigger retirement problem than primary care. So I think you
4 would need to be able to look at those individually.

5 The other thing is that you need to be able to
6 look at the combined impact of what you are proposing with a
7 number of other things that are on the table. This would
8 include potentially the sequester cut, which could be 2
9 percent or higher. It would also include a number of
10 penalties that are coming down the pike. I mean the PQRS,
11 the ERX, all of these things that have been incentives and
12 pluses for a while that are suddenly going to turn negative.
13 And many of them are being implemented essentially at least
14 a year earlier than what the law said because of CMS'
15 contention that they can't -- that that's what their data
16 requires them to do. So you have starting this year, based
17 on this year's performance, a 1-percent reduction that's
18 attributable to if you didn't do the electronic prescribing.
19 That eventually gets up to 9 percent within the window that
20 you're talking about, and that does not include the value-
21 based modified that's also coming down the pike. And there
22 are number of geographical changes that are coming along as

1 well: the practice expense, GPCIs that were changed and
2 potentially other changes in the GPCIs. So you need to be
3 able to look at even geographically, and you need to have
4 the most recent data on what the prices are, what people are
5 paying today. Because one of the things that -- I think the
6 Commission has frequently landed on imaging as a place where
7 they want to cut, and there continues to be this discussion
8 about rapid growth where it actually decreased last year.
9 It was a negative growth. So I think you need to be able to
10 look at that and, you know, get more recent data from CMS.

11 I also think that you need to be able to be
12 looking at what has happened most recently to the prices,
13 because since 2006, which some of the discussion is based
14 on, there have been a lot of cuts in a lot of the imaging
15 procedures, and there have been increases in primary care.
16 So your ratio doesn't look at the same, and you need to be
17 able to look at the most recent ratios when you're making
18 those decisions.

19 MS. CARLSON: Hi, my name is Eileen Carlson, and
20 I'm from the American Nurses Association. We also support
21 repeal of the SGR. To me there is an inherent unfairness in
22 balancing costs of Medicare on the backs of physicians and

1 other non-physician practitioners. There's no SGR for
2 hospitals. There's no SGR for DME. There's no SGR for
3 other facilities. So one of the things I'd like to see
4 consideration of is not perpetuating the siloing of costs
5 for SGR within the physician and non-physician practitioner
6 community.

7 Another thing, I wanted to just echo Commissioner
8 Naylor's comments about the importance of care coordination.
9 There's a little bit of concern that there needs to be an
10 emphasis on valuing and increasing value and rewarding care
11 coordination and primary care that actually does help lower
12 costs, and if there's an assumption that it all is going to
13 that may not be correct.

14 The other thing I'd like to talk about which has
15 been mentioned before, too, is that we'd like to see you
16 consider some flexibility in the definition of primary care.
17 Several Commissioners have mentioned psychiatry, for
18 example, as an example of an area where Medicare physicians
19 and physicians in particular are decreasing at a higher rate
20 than primary care. I think a lot of psychiatrists would be
21 very happy to get what primary care providers are being paid
22 right now, and the most prevalent mental health provider is

1 social workers, and I think there's a report that recently
2 showed they're paid less than people who work at McDonald's.
3 And there is a recognized crisis in mental health.

4 Also, for dual eligibles, Medicaid/Medicare
5 patients, their primary care provider might actually be an
6 orthopedic surgeon.

7 MR. CONNOLLY: Greetings. I'm Jerry Connolly with
8 the American Academy of Family Physicians, and I'll just
9 make three points.

10 One, one of the Commissioners made the point
11 earlier today that you were kind of struggling with what
12 your charter is as an advisory body to Congress, and should
13 you just give Congress the advice that it wants to receive
14 in the context of the current political discussion or
15 deficit reduction, or should you give Congress advice that
16 is based on your best evidence and your best determinations?
17 I would think the latter would be more appropriate.

18 Secondly, there is an abundance of literature, as
19 a number of Commissioners have stated, on the value of
20 primary care but not specifically in terms of what
21 differential would get the achieved goals -- that is, of the
22 workforce and of the access that you've struggled with

1 today. I can't tell you standing here that, in fact, the
2 differential that would result by these proposed
3 recommendations over the course of 10 years would be enough
4 to achieve the goals. I can tell you that we've had some
5 modeling done by the Robert Graham Center for Studies of
6 Primary Care and Family Medicine, and we will take this back
7 to them and have them do some modeling on these as well.
8 And that will try to give us some information that we'll
9 share with the staff on whether or not this will achieve the
10 goals or have some unintended consequences. But like all
11 physicians who do not want to look a 30-percent cut in the
12 face January 1, whether you're specialists or primary care,
13 there's not only an expectation that that cut does not come,
14 but there should be some reasonable, modest improvement in
15 the Medicare reimbursement because they have given at the
16 office for so many years with the dysfunctional and flawed
17 formula.

18 Lastly, I would just encourage you to look further
19 and examine the possibility of trying to encourage, direct
20 patients and direct beneficiaries toward high-value
21 services, regardless of what those services are, by using
22 co-pay, co-insurance, and other kinds of things to glide

1 them in that direction because that's where we get the best
2 bang for the buck.

3 Thank you.

4 MR. HACKBARTH: Okay. We are adjourned for lunch,
5 and we will reconvene at 1:45.

6 [Whereupon, at 12:59 p.m., the meeting was
7 recessed, to reconvene at 1:45 p.m. this same day.]

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1 financial picture, and the changes in Medicare beneficiaries
2 that we expect over the next few years.

3 The next section discusses features in the health
4 care marketplace that are germane for Medicare payment
5 policy. This is in response to requests from some
6 Commissioners that we perform an environmental scan of the
7 health care delivery system. So we are particularly
8 interested in your thoughts on that chapter.

9 And I will conclude by bringing up some features
10 of the current system which may imply that a share of health
11 care spending is misspent, by which we mean it does not
12 improve ultimate outcomes.

13 As I go through, some items that I only briefly
14 mention are described more in detail in your mailing
15 materials and I can provide more information on question.

16 On the next two slides, I will move quickly
17 through the trends in national health spending. As you can
18 see from the chart, the share of economic activity devoted
19 to health care is projected to grow from about six percent
20 in 1965 to nearly 20 percent in 2019. In 2011, the Medicare
21 program accounted for around 3.6 percent of GDP. Since the
22 government began tracking the national health expenditure

1 accounts in 1965, the average annual growth rate for per
2 capita health care spending has been approximately 8.5
3 percent, or 2.6 percentage points higher than GDP per
4 capita, and these rates do not differ substantially across
5 different payers.

6 This year, growth in the national health
7 expenditures slowed significantly, largely due to the
8 recession. Total health care growth was 3.9 percent, the
9 lowest rate since they started tracking the national health
10 expenditures in 1965. And GDP growth was nearly the same in
11 growth in national health expenditures.

12 Medicare spending growth was 4.5 percent from 2009
13 to 2010, as you can see on the slide. This is substantially
14 lower than in the recent past. Over the previous ten years,
15 Medicare spending grew around 8.7 percent annually, or about
16 7.4 percent per year per beneficiary. Health care spending
17 growth in 2010 was significantly less than recent trends for
18 most payers except for Medicaid.

19 And, finally, these figures will be shortly
20 updated when the final estimates of the 2010 health
21 expenditures are released.

22 As I previously noted, per capita or per enrollee

1 health care spending is at least two percentage points
2 faster than economic growth for most time periods.
3 Understanding the reason for the growth in health care
4 spending is critical to successfully designing an
5 intervention to slow it. Most analysts believe that
6 technology is the largest single contributor to health care
7 spending. Technology in this framework casts a very wide
8 net. Another way of thinking of it is all changes to the
9 practice of medicine, the development targeting expansion
10 and diffusion of a medical intervention.

11 The share of health care spending growth
12 attributed to the other factors listed here is debated and
13 the interaction effects are likely notable, but most
14 analysts agree that price, competition or consolidation,
15 regulation, health insurance, income, and other demographic
16 factors have an effect on health care spending growth.

17 As you saw on Slide 3, government spending
18 accounts for approximately 45 percent of all health care
19 spending, and so their fiscal picture is tied very closely
20 to health care spending growth.

21 First, State and local governments face short-term
22 imbalances caused by economic conditions that increase

1 spending on income assistance programs at the same time that
2 revenues fall. Over the long term, States face similar
3 challenges to the Federal Government, an aging population
4 and per capita health care spending growth, even though
5 States receive Federal matching for their Medicaid programs.

6 Turning to the Federal Government, the fiscal
7 picture shows the effects of the short-term recession in
8 concert with a long-term structural deficit caused by the
9 aging of the population and health care spending growth.
10 And just to clarify, while over the next 30 years the
11 population aging will have a roughly equal effect on
12 spending for Medicare and Medicaid as per beneficiary health
13 care spending growth, over the long term, the growth in
14 health care spending per beneficiary is dominant, accounting
15 for 70 percent of the rise in spending for those programs
16 under CBO's baseline.

17 To focus on the Federal fiscal picture, as you can
18 see in the chart, Medicare and Medicaid together make up 23
19 percent in total Federal spending, and this will grow to 28
20 percent by 2021. CBO projects the current deficit picture
21 to improve somewhat as the economy recovers. However, there
22 remains a long-term structural mismatch between revenues and

1 spending. I would also note that this picture reflects in
2 some ways a best case scenario, since it reflects the
3 current law assumption that revenues will increase, for
4 example, that the 2001 and 2003 tax cuts expire and there is
5 no AMT relief, and that spending will not increase above
6 baseline, for example, that the physician payment cut under
7 the SGR goes into effect. If those assumptions are not met,
8 the revenue line would be lower, the total spending line
9 would be higher, and the yearly deficits would be larger.

10 There are some reasons to expect that Medicare's
11 growth could differ from private health insurance. First,
12 the mix of services is different. Medicare's benefit design
13 and payments to providers differ from commonly available
14 plans in the private market. And third, the health status
15 and demographics of the Medicare population differ from the
16 population with private insurance.

17 However, as you can see here, the growth rates for
18 Medicare and private insurance are quite similar, indicating
19 that competition as it exists for the market for private
20 health insurance and administered pricing through Medicare
21 has resulted in similar growth rates.

22 I would also draw your attention to the blue line,

1 which shows GDP per capita, which has trended about two
2 percentage points lower than Medicare or private health
3 insurance growth. And the theoretical outcome from health
4 care spending growth at two percentage points above GDP
5 growth is an entire economy devoted to health care. So most
6 models assume that health care spending growth must slow to
7 closer to GDP plus one percentage point or below.

8 Turning now to Medicare's projections, over the
9 next ten years, Medicare is projected to grow much slower
10 than any period of recent history, growing 5.9 percent each
11 year. This is composed of 2.7 percentage point growth in
12 the number of beneficiaries and three percent growth in per
13 beneficiary spending. In contrast, over the prior decade,
14 total Medicare spending growth was 8.7 percent a year. The
15 number of beneficiaries grew by 1.3 percent and per
16 beneficiary spending was 7.4 percent.

17 One other notable feature on this slide is the
18 difference in growth rates for each part of the program.
19 Part A, which is largely subject to the recent update
20 reductions in PPACA, has relatively low projected per
21 beneficiary growth when compared with recent history.

22 The Part B estimate is driven mainly by the 30

1 percent payment cut in physician fees in 2012. If physician
2 fees were updated by the MEI, the overall annual growth rate
3 for Part B would be 8.1 percent a year over the next ten
4 years versus 5.8 percent.

5 And Part D is projected to grow more quickly than
6 it has in the last five years, which implies use of more
7 prescription drugs or of more expensive prescription drugs.

8 Despite this slower projected growth, Medicare is
9 still estimated to reach six percent of GDP by 2040, and the
10 Hospital Insurance Trust Fund will be unable to pay full
11 benefits after 2024. Over the long term, the Trustees
12 assume that Medicare spending per beneficiary will grow by
13 GDP minus 0.1 percentage points for Parts A and B, or about
14 four percent a year. Part D is projected to grow at about
15 GDP plus one percentage point, or about 5.1 percent a year.
16 And these growth rates, again, are much slower than
17 historical averages.

18 One important effect of this growth is its impact
19 on beneficiaries, which happens in three ways. First, there
20 is no catastrophic maximum for cost sharing in Medicare so
21 that out-of-pocket exposure is theoretically unlimited.
22 Second, the parameters for cost sharing and premiums are

1 generally indexed to Medicare spending growth. And third,
2 there are some health expenditures that Medicare does not
3 cover.

4 Medicare's spending growth means that a
5 beneficiary's average out-of-pocket costs will increase
6 faster than Social Security benefits, which generally grow
7 with wages. And Social Security makes up about 40 percent
8 of the average Medicare beneficiary's income in retirement.

9 As the number of Medicare beneficiaries will
10 increase by a third over the next decade, there are some
11 changes that we could expect in the makeup of these
12 beneficiaries. First, the Medicare population will get
13 younger over the next ten years as the baby boomers age into
14 entitlement.

15 Second, the racial and ethnic makeup of the
16 Medicare population will change. By 2050, over 15 percent
17 of the Medicare population will be Hispanic or Latino, up
18 from six percent today.

19 Third, some beneficiaries attaining Medicare
20 eligibility in the next ten years may have experienced a
21 decline in retirement asset balances, and as median income
22 has remained relatively flat over the past decade, they may

1 be slightly poorer, on average. And the rate of Medicare
2 beneficiaries who remain in the workforce after age 65 has
3 increased over time.

4 Finally, beneficiaries attaining entitlement may
5 be slightly less likely to have employer-sponsored coverage,
6 but after the PPACA coverage expansions take effect, they
7 may be more likely to have continuous health insurance
8 coverage.

9 Features of the health care delivery system have
10 implications for Medicare's ability to drive payment reform.
11 We have added this section in response to requests from a
12 couple of Commissioners who asked that we cover the health
13 care delivery system environment.

14 First, the presence of for- and not-for-profit
15 providers varies significantly across sectors with the share
16 of providers that are for-profit ranging from over 90
17 percent for ASCs to 30 percent for hospitals, and some areas
18 are changing rapidly. There are also differences in
19 financial performance between for- and not-for-profit
20 providers that could be a result of efficiencies or it could
21 be a result of strategic business decisions to enter high
22 profit product lines. There is also horizontal integration

1 among providers, with some sectors, such as dialysis and
2 long-term care hospitals, being dominated by two chains.

3 Second, the health care sector has grown during
4 the recent economic recession while other sectors have
5 either not grown or have contracted. This calls into
6 question the ability of a contracting non-health sector to
7 absorb cost increases from an expanding health sector.

8 And third, regulatory changes, many a result of
9 PPACA, are coming up in the next few years and could
10 substantially change the market for health care and the
11 market for health insurance.

12 As we are trying to be responsive to your request
13 for some of this information, we would welcome any
14 suggestions.

15 Despite the high level and rapid growth in health
16 care spending, there is some evidence to suggest that some
17 spending is inefficient and does not improve population
18 health or ultimate outcomes. First, while many researchers
19 believe that the aggregate increase in total health spending
20 has purchased reasonable value, it appears that the value of
21 the marginal dollar spent on health care is declining over
22 time.

1 The second piece of evidence that there may be
2 some inefficient health care spending is variation across
3 geographic regions that do not correspond to better outcomes
4 or increased severity of illness.

5 And third, despite years of attention to health
6 disparities, outcomes are still worse for individuals who
7 are racial or ethnic minorities and those who are low-
8 income. Furthermore, there is compelling evidence
9 aggregated in the Commission's June 2011 chapter on quality
10 improvement that low-income individuals and racial and
11 ethnic minorities often receive care from poorer-quality
12 providers.

13 And finally, many observers feel that the evidence
14 that the U.S. spends more on health care than other
15 countries yet does not have consistently better outcomes
16 indicate that some health care spending in the U.S. is
17 inefficient.

18 In conclusion, I would ask for your comments and
19 questions and will take suggestions on directions for the
20 chapter. I would particularly welcome comments on the
21 direction of the environmental scan piece of the chapter.
22 Thanks.

1 MR. HACKBARTH: Thank you, Kate. Nice job.

2 So let us begin with clarifying questions. Peter.

3 Mike. Mitra.

4 MS. BEHROOZI: No.

5 MR. HACKBARTH: No? Tom. Cori. Scott.

6 MR. ARMSTRONG: Sorry about this, but I just --

7 remind me again what the purpose of this chapter is.

8 MR. HACKBARTH: Kate, do you want to do that and

9 then I will supplement your answer.

10 MS. BLONJARZ: So the Commission's mandate

11 requires that the proposals -- the Medicare payment

12 proposals are placed in the context of Medicare payment

13 policy, and so this is one part of kind of completing that -

14 - fulfilling that mandate. I think there is also -- in the

15 Commission's mandate, there is a request that we consider

16 the budgetary proposals, the budgetary impacts, and that is

17 also part of it, so --

18 MR. HACKBARTH: Around about 2003 or so, the

19 Congress made some amendments in MedPAC's charge, the intent

20 of which were to make sure that we took into account the

21 fiscal implications of our decisions, and so this was one

22 thing that we did. The second was to begin accompanying all

1 of our recommendations with estimates of their fiscal
2 impact. And at the same time, we were also required to
3 begin recorded votes. This was a period where at least some
4 important members of Congress were worried that MedPAC was
5 making recommendations that were not sufficiently sensitive
6 to the budget situation. So this was one of a series of
7 changes.

8 In terms of the audience for this chapter, one
9 audience that I know exists is that there are people,
10 including some people on the Hill, staff people, who use
11 this chapter as an annual resource. It updates numbers on
12 spending trends and issues, and so it is a handy reference
13 for them to have on some of the basic statistics that they
14 need to inform their work. So that is where it comes from.

15 MR. ARMSTRONG: So I just was -- a reaction to
16 this is there seemed to be big issues that we talk about a
17 lot, like care coordination or managing the cost of
18 chronically ill populations, things like that, that really
19 are not addressed in this. Is that the kind of thing you
20 are looking for from me, or does that not matter?

21 MR. HACKBARTH: Trying to shape this chapter has
22 been an ongoing effort, and we have tried various approaches

1 to it, and I think it is fair to say that, right now, the
2 pendulum is swinging back towards a more basic chapter, a
3 more descriptive chapter, one that, frankly, is simpler to
4 write and for Commissioners to review.

5 At some points in the past, we have tried to delve
6 into big issues and it just sort of kept growing and growing
7 and growing and really became unwieldy in terms of its
8 length and in terms of the work required to do it. So we
9 are consciously trying to skinny it down again and have it
10 serve the basic function of here is an update on some big
11 trends and issues. Okay?

12 Kate. Bob.

13 DR. BERENSON: Yes. I have two points of
14 clarification. First, on Slide 4, the Medicare 8.7 percent
15 in the second column, do we know how much of that is from
16 the MMA's creation of a new benefit and the increased
17 spending for Part C?

18 MS. BLONIARZ: Yes. That is a good point. We can
19 get you numbers that take that out.

20 DR. BERENSON: You do not have a ballpark right
21 now?

22 MS. BLONIARZ: I am not sure I could speak to

1 that.

2 DR. BERENSON: Okay. So I would like to see that.

3 And then the second would be on Slide 9. It has
4 to do with the estimates of the change in beneficiaries for
5 Medicare Advantage. Is this a CBO estimate that you are
6 using, or --

7 MS. BLONJARZ: So these are -- the source for this
8 is the Trustees' Report.

9 DR. BERENSON: Oh, the Trustees' Report. I guess
10 what I would be interested in in maybe part of the market
11 surveillance is whether there is any information about the
12 new generation -- the next generation of Medicare
13 beneficiaries. My hunch is they are much more comfortable
14 with PPO/HMO-type products, restricted networks, tiered
15 pricing, and I am interested in whether, first, the
16 actuaries in any way factored in sort of receptivity of new
17 beneficiaries to those kinds of products, and I think in
18 looking at the demography of the population -- you have
19 mentioned Hispanics, et cetera -- I think that would be an
20 interesting area.

21 My own hunch is that enrollment will stay up
22 higher because new beneficiaries will be more comfortable

1 and may, in fact, be aging in from group health and may not
2 need to be -- so in any case, I am interested in that area.

3 MS. BLONJARZ: I would say two things on that.

4 One is that I am guessing that the Trustees do not build in
5 an explicit assumption, but maybe someone on the technical
6 panel would like to correct me on that.

7 The second part is that we did have a little bit
8 in the historical trend of employer-sponsored coverage over
9 time in the past ten years, seeing a shift from classic HMOs
10 and indemnity plans to more PPOs. And so if that has an
11 implication for new beneficiaries' willingness to accept
12 management, yes, that could play into it, as well.

13 DR. MARK MILLER: If I could just make one
14 commercial, as you know, Joan runs a process of touching
15 base with beneficiaries and providers and focus groups on a
16 range of issues that evolve a little bit from year to year,
17 and when we talk about benefit design in the next couple of
18 meetings, one element will be or may be what she has heard
19 on this very point.

20 MS. UCCELLO: Mike and I both serve on the
21 Medicare Technical Panel and we have been looking into MA
22 enrollment projections, and Mike can correct me if I am

1 wrong, but currently, the way they project enrollment in MA
2 is really based off of the extra benefits that MA plans can
3 provide. We, however, are considering alternate methods of
4 MA projections, but that is still in process right now.

5 DR. CHERNEW: Bob, Cori is right, but they have
6 looked at this issue, exactly the ones you have raised, and
7 do not find as much support in the data as you would expect
8 they would find, and I think as part of our little group, we
9 have looked at some of that data. You could look at it in
10 different ways, but they are certainly aware of the issue
11 and it remains to be seen how you interpret these data. But
12 it is not some overwhelming obvious flaw.

13 MR. KUHN: On Slide 12, on the final dot point you
14 have there, it talks about people being continuously
15 insured. I guess the reason I am curious about that is I
16 remember seeing some data, I think from a study from RAND at
17 one time, where it looked at people who were previously
18 uninsured and went into Medicare and the high utilizations
19 they had for the first four or five years, particularly in
20 cardiac and orthopedic.

21 If we have this new cohort of people that are
22 going to be coming in that have been continuously insured,

1 what does that mean in terms of future Medicare utilization?
2 Is that captured in the new numbers? And do we think that
3 then programs that manage them, like maybe Medicare
4 Advantage plans, are going to be more effective of dealing
5 with some of these folks with chronic conditions on a go-
6 forward basis?

7 MS. BLONJARZ: I think to the question of whether,
8 like, the Trustees or CBO assume different utilization in
9 the first few years, I would guess that they don't. I am
10 not sure, but we could find that out for you. But I think
11 that was -- it was along those lines that we were kind of
12 bringing the point up that if you have a group of people
13 attaining eligibility who have been continuously covered,
14 they may have less pent-up demand for health insurance.

15 MR. GEORGE MILLER: Yes, just real quick, same
16 slide. You mentioned the first bullet point about the
17 population increase. Have we been able to quantify and talk
18 about the impact of if that population becomes larger
19 Hispanic, what impact the disparities may have on the total
20 number and will solutions like Scott mentioned about care
21 coordination, would that help reduce overall spending, or do
22 you have a feel for that at all?

1 MS. BLONJARZ: This is kind of a descriptive
2 statement about what we expect the population will look
3 like.

4 MR. GEORGE MILLER: Okay.

5 MS. BLONJARZ: I think that is a really
6 interesting question, what you would expect the downstream
7 effects on the care delivery system to be, but I cannot
8 speak about that.

9 MR. GEORGE MILLER: Just curious. Okay.

10 MR. HACKBARTH: Mary.

11 DR. NAYLOR: Thank you for this. I am trying to
12 get a sense of poverty and the new data on poverty and a way
13 that it might be woven in here even to help us understand.
14 For example, looking at the rates of growth in Medicaid in a
15 context in which States are really, really trying to -- so
16 is it due to the growth of dual eligible in States? I mean,
17 is there a way we can make it more explicit? Also, the
18 historic slowdown. You talk about that in terms of reducing
19 -- people's out-of-pocket costs being reduced, private
20 spending being reduced. Does that mean people are delaying
21 getting services that they need?

22 MS. BLONJARZ: One thing I would like to spend a

1 little bit more time on is showing the changes in Medicaid
2 population over time, a little bit in this kind of context,
3 because I think there is -- both there is the new income and
4 poverty data, but States are also under constraints on
5 changing their Medicaid eligibility up until 2014 when the
6 Medicaid expansion goes into effect. So some of the, like,
7 typical levers that they have are not there, and I think
8 there is going to be some interesting dynamics going on.
9 There was also a Federal match, an increase in the Federal
10 match that expired last year. So that is another -- the
11 beginning of this year. That is another factor in what the
12 Medicaid enrollment looks like and what States are doing, so
13 --

14 DR. CASTELLANOS: It always bothers me when I see
15 comparison with other countries because they always look at
16 the OECD data. I just recently read some articles showing
17 that in the United States, we have actually some better data
18 showing that our emerging care, our critical care, et
19 cetera, is so much better than other countries. Do you have
20 anything on that that you could share with us?

21 MS. BLONJARZ: I can bring more information to
22 this point, but on the specific -- the specific information

1 we are citing here is OECD data, trying to link it to
2 ultimate outcomes, so survival, life expectancy, you know,
3 live births, things that are kind of persistent and can be
4 compared across countries. There is always an issue about
5 comparisons across countries because the systems are so
6 different. It is very hard to kind of adjust for all those
7 factors. But we can talk about different types of care and,
8 you know, if there is information on quality differences
9 across countries for different types of care.

10 DR. CASTELLANOS: Especially the emergent care,
11 the critical care, access to care, and stuff like that.

12 DR. BERENSON: Yes. Glenn wanted me to comment.
13 I coauthored a piece about two years ago looking at
14 available literature on where the U.S. stacks up and there
15 is a paucity of data on what we called rescue care, the
16 areas of critical care, emergency care, with some suspicion
17 that we do pretty well or are at the top and there is not a
18 lot of support for that.

19 On the other data -- and there is also, in some
20 cancer areas, we do very well. Some of the other areas, we
21 do not well. So I think there is -- I would be interested
22 in what you have seen that is new since I am going to try to

1 stay current, but we could not find very much in that area.

2 MR. GRADISON: Two quick things. First, at some
3 point, will there be any way to get a read on what the
4 slowdown in health expenditures over the last year or so has
5 meant to health?

6 MS. BLONJARZ: Yes. I think we -- it would be
7 interesting to see what kind of correlates there are with
8 ultimate health. I think one thing is that -- yes. We are
9 kind of interested to see what next year looks like and the
10 year after to see, you know, is this a sustained trend of
11 lower health spending, and if so, what would be the impact
12 on a whole bunch of downstream things, like population
13 health. But, yes, we can look into that and see what we
14 find.

15 MR. GRADISON: Thank you. And one other quick
16 thing with regard to international comparisons. I must
17 admit, it has bothered me at times when data was supplied
18 with regard to life expectancy at birth, which is fine, but
19 not with regard to life expectancy at age 65, which I think
20 is especially relevant to what we do around here. That is
21 our population, by and large. So I just caution you on
22 that, because my recollection from the data I have seen, and

1 Bob, you may have looked at this much more carefully than I,
2 is if you look at the life expectancy at age 65, we look
3 pretty darn good, ranked near the top.

4 DR. BERENSON: I do not think that is right. That
5 is a comparison that we had. We are in the mix, but we are
6 not at the top. But I am doing this from memory. We do
7 have a section in that paper on that. That is now a common
8 metric that people are using. I think it is age 60, is the
9 one that they are -- has become somewhat standardized in
10 OECD terms, but I would have to go double-check.

11 MR. HALL: Glenn, just a comment on that. I had
12 occasion to review some of this, including Bob's paper on
13 using life expectancy after age 65. So the current data
14 from OECD, I think, is that males are 12th of the countries
15 that are listed and women 18th. But if you look at the
16 actual mean life expectancy differences, they are often
17 measured in months. It is not that there is five years.
18 And the whole question is, in that period of 18 months that
19 has been gained, what are the implications in terms of the
20 quality of life during that period of time? That makes it
21 very difficult to draw major conclusions.

22 MR. GRADISON: Thank you.

1 DR. BORMAN: Yes, I would just ask, Bob, I do not
2 know if you were able to look at appendicitis deaths. That
3 is my recollection, for example. One of the places, it was,
4 like, acute MI, appendicitis, whatever, that there were some
5 data supporting that our rates were among the lowest if not
6 the lowest. So I understand that we are trying to cut some
7 broad brush strokes here and that level of detail may not be
8 appropriate. But I think maybe some balancing comment to
9 say that we do have certain areas in which we excel and that
10 that is worthwhile to kind of give it a little
11 counterbalance here. In the main, I found most of the
12 balance pretty reasonable.

13 MR. HACKBARTH: [Off microphone.] Okay. Any
14 Round Two comments? Peter.

15 MR. BUTLER: So you asked for comments on the
16 environmental scan. I kind of had mixed feelings about
17 this, and you, probably, too, or you would not have asked
18 the question. We are tipping our toe into kind of a little
19 different -- and it felt a little random in terms of those
20 environmental things that you decided to report on.

21 I think highlighting the trend towards more for-
22 profit ownership is a good one, although I would suggest

1 that the hospital ownership says it is 25 percent. It is 25
2 percent of hospitals, but it is probably far less than that
3 in terms of dollars because they tend to be smaller
4 hospitals. That is not a plus or a minus I am making the
5 statement around. It is just a clarification.

6 The industry consolidation, of course, is a theme
7 that we have tried to capture and will likely have a chapter
8 on. If you read this over, though, it is kind of all
9 negative. It sets -- the paragraphs start with concerns,
10 concerns, concerns, and yet, as we have all talked about,
11 ACOs require this kind of integration. We would not hold
12 Geisinger out as a concern. We would hold it out as a
13 model. So there is a little bit better balance there, I
14 think, in the wording.

15 And then at the end of that section, you only have
16 two sentences on insured domination. It says there are some
17 issues of market dominance by insurers in some markets. In
18 some States, one or two insurers dominate their market and
19 can force providers to accept lower payment rates. There is
20 no reference or anything that that is, in fact, the case.
21 It is like a statement. And the concern should be not that
22 they have purchasing power, but, in fact, that the premiums,

1 there is no demonstrated cost savings. In fact, that may be
2 good that they can extract lower rates and have purchasing
3 power. The real issue is the overall premium is perhaps
4 higher because of the market dominance. So it is a little
5 light on addressing the insured dominance and what the
6 issues might be, if we are going to choose to put it in this
7 section.

8 MR. HACKBARTH: There very recently, Kate, was a
9 paper published on this issue and the effect of
10 concentration on prices, and concentration on both sides,
11 purchaser and I think it focused on hospitals, didn't it.
12 So, actually, I can't remember that passage well, but there
13 is some new research that has been published on that.

14 And on Peter's last point, what it shows is that
15 the prices paid by the insurers are lower when the insurer
16 market is concentrated, but that does not necessarily
17 translate into lower premiums because there is not much
18 competition to hold the premiums down.

19 MR. BUTLER: Exactly. So that --

20 MR. HACKBARTH: That is a truer bottom line.

21 MR. BUTLER: That should be the real issue, not
22 how much necessarily they are paying the providers. It is

1 the cost of the system.

2 MR. HACKBARTH: Right.

3 MR. BUTLER: And then my last point is that while
4 you articulate the upcoming Federal policies and repeat back
5 and so forth, for those of us on the delivery side, because
6 this is an environmental scan of delivery, probably the
7 overwhelming thing in some States is Medicaid and the
8 States' fiscal health and the -- you know, I will not detail
9 you with what is going on in Illinois, but boy, is that
10 changing the landscape and just creaming potentially the
11 delivery system in unintended, or maybe intended, but very
12 disruptive ways. So it is in terms of the weighting of what
13 is going on in the environment, the fiscal health of all
14 government budgets at every level, but particularly the
15 State, is having dramatic impacts that we ought to be
16 watching.

17 MR. HACKBARTH: Under PPACA, of course, with the
18 huge increase in Medicaid enrollment as one of the primary
19 vehicles for expanding coverage, those effects would be
20 amplified.

21 Mike.

22 DR. CHERNEW: I thought that the chapter was

1 wonderful and some of the things I particularly liked,
2 including there is a lot of attention on the fact that there
3 has been a change in the drivers of spending growth away
4 from spending per beneficiary toward the number of
5 beneficiaries, and the chapter has a full table on that. I
6 think that is terrific.

7 The only two comments I would make is the first
8 one is, although you do this a lot, in some of the earlier
9 places, you talk about the forecasts as if they are really
10 predictions of what is going to happen as opposed to these
11 sort of current law things. And you are clear in some
12 places, very explicit that these assume the SGR cuts. But
13 other places, it is not always clear, and particularly early
14 on, I think it is important to be clear that they are not
15 really forecasts of what is going to happen. They are kind
16 of these current law sort of things.

17 And the second thing that I think is just really
18 challenging, and so I do not know exactly what to do, you
19 have the whole section in the environmental scan on the ACA
20 and it is kind of, you know, you have got, like, a page
21 about what the ACA did in health care. But the only thing
22 that I thought that really wasn't in there that I might have

1 thought would have been important is the stuff that talks
2 about all the payment change potential, the Center for
3 Innovation, the move towards doing all of those other types
4 of things, and essentially, and I say this perhaps because
5 it's on everyone's mind, including from our discussion
6 earlier, this trend in both the private and the public
7 payers to get away from the way we have paid in the past and
8 those discussions.

9 It is hard to do, quite frankly, in a non-
10 normative way, and I think you have tried very hard in this
11 chapter, and I agree, to do this in sort of a "here's what
12 happened," but, you know, just the fact that we're spending
13 an extra \$900-and-some-billion on the under-65 population
14 took a lot out of Medicare. Those things, I think, are
15 basically facts and it could be highlighted perhaps a little
16 more. But it requires some care to do it in a "just the
17 facts" kind of way.

18 MS. BEHROOZI: I also appreciated the breadth and
19 depth, I think, in ways that we might not have seen before
20 in some of the areas.

21 One of my areas of interest is the picture of the
22 beneficiary and what I mentioned earlier about their

1 declining economic fortunes, so I think that is really
2 important stuff that you have brought out, and I think that
3 that's probably going to be more important. I think it's
4 put out in the paper and in your presentation that the fact
5 that people will have so-called continuous coverage is an
6 important factor, but they are also possibly going to be
7 poor. They are poorer. We just had a report about the
8 poverty level being the highest it has been in a couple of
9 decades.

10 The continuously covered, I am not so sure is a
11 real factor. The timeline is to 2020, is that right, that
12 you are really talking about here?

13 MS. BLONJARZ: [Nodding head affirmatively.]

14 MS. BEHROOZI: So PPACA doesn't pick in until
15 2014. The penalty for not purchasing is only 750. The
16 policies for the non-Medicaid eligible are going to cost a
17 lot more than 750 and they are not going to cover that much,
18 so it is going to take a little while for people to actually
19 really roll into that coverage.

20 So I am not sure that that should be kind of up
21 there as a factor to the same extent that people's economic
22 decline, the general population's economic decline, should

1 be, particularly in light of what you have on Slide 4 about
2 the fact that out-of-pocket costs have risen at an average
3 annual rate of 4.3 percent over a decade that, you say in
4 the paper, incomes have remained flat. So that is a lot
5 more for people to be paying with no additional income to
6 cover it.

7 So I think also, then, some of the things that you
8 point out about insurance coverage, and not only the nature
9 of it changing but the take-up rate falling because it is
10 becoming more expensive because of cost shifting.

11 Then to talk about the, quote, "generosity" of
12 insurance coverage being a driver of higher utilization, and
13 I am not sure about the studies that are cited. They seem
14 kind of old. You know, maybe it seems a little less
15 relevant given all these other contextual factors that you
16 point out.

17 And then the last thing that I would just want to
18 note, and this is maybe a little parochial, health care
19 employment. You note how it has risen, and that is clear.
20 That is documented. But then it seems like it is a bad
21 thing because it is an imbalance in the economy. Well, you
22 know, there have been times in history when some industries

1 have grown, others have shrunk, and the balance changes. I
2 am not going to make an argument that this is all fine and
3 it is not of concern or whatever, but it is not all bad.
4 That is for sure. And I think it probably would be
5 worthwhile to note that the Medicare and the insured
6 population is going to be growing and so there may be a need
7 for more health care workers. Maybe we already have enough,
8 so maybe all that prior growth was what we needed to get to
9 the right point. Maybe we need some more growth. But I
10 thought that that was kind of a missing element, to talk
11 about the expansion of people who can hopefully be able to
12 access medical care because of coverage expansion.

13 MR. HACKBARTH: On this issue of rising health
14 care expenditures at a time when incomes are flat, not
15 growing, there was a piece of -- I think it was in Health
16 Affairs, published very recently. Did you pick that up?
17 Some of those numbers are striking, what rising health care
18 costs and rising premiums mean for families when incomes
19 have stagnated. So they might be interesting data to
20 include.

21 Tom. Cori.

22 MS. UCCELLO: Just building on something that Mike

1 said about -- it is not, I think, only making clear current
2 law versus what we actually expect is going to happen, but
3 also, there are differences in the long-term assumptions
4 that CBO uses versus the Trustees' Reports use. So tables,
5 graphs, whatever that are shown that use the different ones
6 are not necessarily going to be comparable to each other.

7 And then added onto that, the Medicare Technical
8 Panel may be proposing changes in those assumptions, but
9 those may or may not -- if there are changes suggested, they
10 may or may not even be ready by the time this report has to
11 be done, so that may not be relevant.

12 In terms of the characteristics of the Medicare
13 beneficiaries, and this kind of links to something that
14 Scott said, but I don't recall seeing anything in here --
15 there is talk about the trends in age, maybe some changes in
16 assets and those kinds of things, but maybe just even a, not
17 a trend, but more on this is what this population looks like
18 in terms of their chronic care needs, how many conditions
19 they have, what their health status is, something like that.

20 MR. ARMSTRONG: So just a couple of additional
21 points, and I am still not sure if this is relevant or not
22 for the report, but a few of them have been said. I don't

1 think we can over-emphasize, though, the allusion you have
2 made here to the interaction between Federal payment policy
3 and what is going to be happening in the States, not just
4 exchanges but the economic condition of our States. This is
5 a huge issue for us.

6 I would just say that it just seems to me that, as
7 Cori said, we profile what we think future beneficiaries are
8 going to look like. More and more of them are going to be
9 living longer and longer with chronic illness and our system
10 today is not designed to handle that. I just don't know how
11 we cannot talk about that. So many of the policy agendas we
12 are driving, whether it is ACOs or bundled payments or other
13 things, underlying all of that is helping a system deal with
14 the requirements of that kind of a population. So that just
15 seems relevant to me.

16 The final point I would make is that one part of
17 modernizing Medicare is the boomers, and I think it's
18 related to this recognition that there may be more and more
19 people more accustomed to more narrow networks or managed
20 care. But the discussion we started around changing the
21 benefit structure, where there are different incentives
22 actually for the beneficiary themselves, I think is also

1 going to be an important part of that evolution, and that
2 creates some context not just for the work we have already
3 teed up, but then potentially belongs in this chapter.

4 DR. BAICKER: I thought the environmental context
5 was really interesting and I had some thoughts on how you
6 might focus the scan, but you've largely done that. I think
7 it is great. It is focused on the factors that are likely
8 to affect the results of the other policy levers we are
9 looking at, the degree of industry consolidation.

10 I would add some measures of the penetration of
11 integrated systems, thinking about how Medicaid is
12 innovating in terms of managing care. All of those things
13 are going to affect the efficacy of our payment policy
14 levers, so that kind of context, especially what is going to
15 happen to prices and what is going to happen to
16 complementary management in other systems, would be helpful.

17 I am not a huge fan of looking at health care
18 employment at all because I think it is often misinterpreted
19 as a target for policy, like we should put more resources
20 into health care because it is the only place where we have
21 growth in employment. That kind of argument creeps in a lot
22 in a way that I think undermines the goals of good health

1 policy and I am not sure -- if I want to make more room for
2 some of those other environmental factors, I might take out
3 the page or so on employment because it's a red herring in a
4 way. If we are devoting resources effectively, then the
5 right number of people will be employed. We don't really
6 worry about how many people are employed in the auto
7 industry. We worry about good policy, or maybe we do worry
8 about that. I take that example back.

9 MR. HACKBARTH: [Off microphone.]

10 DR. BAICKER: Never mind. No, no, no, no, no.

11 [Laughter.]

12 DR. BAICKER: But the point is, we don't want to
13 live in a world where we're targeting health care employment
14 per se, and so I'd like to take a step away from that world.
15 Forget the cars.

16 DR. BERENSON: Yes. I just would pick up on Peter
17 and Scott's comments about what's happening at the States,
18 the pressure on Medicaid. But in particular, where you've
19 got a nice page and a half on sort of the implications of
20 the ACA on insurance products and coverage expansion, I
21 think having a little section on the potential implications
22 for providers with those changes, a shift of case mix into

1 Medicaid and into exchange health plans. At least on the
2 one hand there are more people covered and that should
3 generate increased revenue, will reduce bad debt. On the
4 other hand, reimbursement levels may come down
5 significantly.

6 And I don't think there's anything settled in this
7 area. I know there's been a big argument over the
8 likelihood of employers giving up insurance and moving
9 people into -- I don't think you can get into any of that
10 complexity, but sort of laying out some alternative paths
11 that might result, I think would be helpful.

12 MR. HALL: I learned a lot from this. I thought
13 it was very good. Just sort of a -- one environmental
14 question. You mentioned that there is the age distribution
15 and the projected age distribution of the recipients. We
16 don't say much about this curious population of people over
17 age 85 and even centenarians who are perhaps not large in
18 total numbers, but are writ very large in terms of health
19 care expenditures. Somebody has got to get a grip on this
20 at some point because it could really throw off a lot of our
21 projections, particularly in terms of hospital use.

22 The other is just a question on health literacy.

1 You probably have in mind the audience for this chapter, the
2 same audience that reads other MedPAC pieces of information,
3 and it probably is quite broad, I would think. So I think
4 some of us, for instance, would not have needed to be told
5 what Medicare A, B, and C and D represent. But on the other
6 hand, maybe some of us would also not know what some of the
7 unexplained abbreviations were, like MEI and a few things
8 like that. So maybe for consistency's sake, anything that
9 is put in capital letters and it cannot be pronounced should
10 not even appear in a lexicon.

11 [Laughter.]

12 MR. HALL: That is all. That is a piffy one. I
13 am sorry.

14 MR. GEORGE MILLER: Yes, and again, like Bill
15 said, this was a very well-written chapter and helped focus
16 my mind on a couple of things.

17 One quick thing, I want to pick up on something
18 that Bob said about the Medicare program and you mentioned
19 in the PACE chapter, and that is none of the recommendations
20 seem to deal with the difference in regulations between
21 Medicaid and Medicare and how difficult it is for providers
22 to walk through the minefield of deciding what is required

1 for a Medicare patient versus a Medicaid patient. And if
2 making the regulations smoother, transition better, one, it
3 would make it easier for providers, but could there be some
4 dollar savings by dealing with that issue, as well. And I
5 don't know if you've thought about that, but that just
6 struck me as potentially more people are unemployed, may go
7 on Medicaid, and to make that transition smoother, if there
8 is less of a bureaucratic burden in working between those
9 two programs and if you could better meld them together, if
10 coordination of care was better.

11 DR. NAYLOR: So this is where 17 Commissioners can
12 yield 17 perspectives. I think this might be the toughest
13 chapter imaginable to write. So I guess if I were to lend
14 any additional counseling beyond that which was already
15 articulated, is maybe let the facts speak for themselves.

16 I think this notion of using this as a great
17 opportunity to inform a wide range of people on the Hill and
18 others about what this population looks like, and so you
19 have heard that both in terms of socio-demographics, the
20 diversity, growing diversity of the population and how its
21 needs change over time. So 65 is not the same as 85 or 100,
22 et cetera. So that, I think, could be really helpful.

1 I've already spoken about poverty and just the
2 facts about what is happening to this population in the
3 context of changes at State policies.

4 And maybe where I would step back is in areas such
5 as trying to highlight issues in this chapter, because, you
6 know, care coordination means a ton of different things. So
7 if you were going to tackle what might be the three or four
8 or five key areas, I would start with defining them because
9 it is not connecting the dots between docs that is care
10 coordination. So if it represents an opportunity, maybe it
11 represents an opportunity to say, think about this issue in
12 the context in which the people that are receiving services
13 do.

14 So, I mean, it is a great chapter. I would just
15 maybe just let the facts speak for themselves.

16 DR. CASTELLANOS: First of all, I really like the
17 chapter. I thought it was very informative.

18 This is really probably a level one, round one
19 question. You know, I really like the questions about
20 consolidation and ownership. I think there can be a lot of
21 savings showed by looking into that, and I am really asking,
22 are we going to, later on in the year, are we going to be

1 looking at consolidation, both -- okay. Great.

2 DR. MARK MILLER: [Off microphone.] Yes, we are.
3 I just want, as always, to try and manage expectations a
4 little bit. There is work that we have done. It ended up
5 in the June chapter -- I need a nod, there we go -- in the
6 June chapter, where we were looking at the variation in
7 pricing. Remember, we had that discussion --

8 DR. CASTELLANOS: Right.

9 DR. MARK MILLER: -- kind of hospital and
10 physician. This is all on the private side. And then we
11 started to say, you know, what do we know about these
12 markets and could consolidation be playing into this? We
13 are trying to come back to that and get a more rigorous look
14 at consolidation and see if we can bring definitions back
15 into that. But it is very challenging.

16 DR. CASTELLANOS: Are we going to be able to use
17 that for potential savings to the Medicare program,
18 recommendations?

19 DR. MARK MILLER: I am not sure what savings you
20 would be looking for there.

21 DR. CASTELLANOS: Well, I look for over-
22 utilization specifically. I am talking about the physician

1 community, and I know I am a target, but three or four
2 doctors getting together to make a team of ten doctors, they
3 can own an MRI, they can own a CAT scan, they can own a
4 radiation center. I think it demonstrates ownership with
5 increased utilization.

6 MR. HACKBARTH: I agree, Ron, that ultimately, our
7 interest in this is because we think that there might be
8 some important policy implications and policy levers to
9 pull. That is a step down the road further than we are
10 right now, but that is the destination that we would like to
11 get to. But we have got to do some filling in of other
12 factual foundation before we get to the policy part.

13 Bill. Karen. Okay. Thank you very much, Kate.
14 Well done.

15 Our next session is on a mandated report to
16 Congress due next June, right, Mark?

17 DR. MARK MILLER: Yes.

18 MR. HACKBARTH: It's June?

19 DR. MARK MILLER: June 12th.

20 MR. HACKBARTH: June 12th of 2012.

21 DR. MARK MILLER: Yes, June 2012.

22 MR. HACKBARTH: Oh, June of 2012. I see.

1 And this is on rural health care for the Medicare
2 population.

3 And Jeff, are you going to begin? Whenever you're
4 ready.

5 DR. STENSLAND: All right. Good afternoon.
6 Today, we're going to talk about rural payment adjustments
7 to Medicare rates. This study is mandated by the Patient
8 Protection and Affordable Care Act. It requires that we
9 examine four issues. The first is access to care, which we
10 discussed last February. The second is special adjustments
11 to rural payment rates, which we will discuss today. And
12 we'll discuss rural quality and payment adequacy in future
13 public meetings.

14 Congress has asked us to report on special
15 adjustments that rural providers receive to their payment
16 rates. We'll examine the positive aspects of these
17 adjustments and discuss aspects of the adjustments that
18 could be improved.

19 MedPAC has recommended special adjusters in the
20 past, including a low-volume adjuster for hospitals. In
21 some cases, these payment adjusters may be needed to
22 preserve access. However, there are many rural adjusters,

1 and they are often enacted one at a time. The result is
2 there's no clear evident plan on how this set of adjusters
3 is supposed to work together to efficiently improve access
4 to care in rural areas.

5 In addition, the adjusters are not always targeted
6 to the areas in the most need of assistance. Some adjusters
7 apply to all rural providers, and this ignores the great
8 diversity across rural areas.

9 This, in part, stems from the broad definition of
10 rural which is used by CMS. CMS defines rural as all
11 providers outside of MSAs. The result is if a payment
12 adjuster is available to all rural providers that adjuster
13 will be available to both providers that are the sole source
14 of care in an area as well as to some providers that may be
15 providing duplicative services in a community with excess
16 supply.

17 The point is that the adjusters may not be
18 appropriately refined to take into account the differences
19 among different rural areas.

20 If we try to improve upon the current set of
21 adjusters, what kind of common principles could guide us?

22 The first question is what providers should be

1 eligible for the adjustments. This principle could be to
2 focus these adjustments on providers that are essential to
3 access. These would be providers that are more than a
4 certain distance from similar providers. Currently, some
5 policies use low volume as an eligibility criteria.
6 However, it's important to note that there are two types of
7 low-volume providers.

8 One has low volume due to being an isolated
9 provider in a low population density area. The low volume
10 is inevitable because there is not a sufficient population
11 in the market to generate high patient volumes. Under the
12 first targeting principle, these providers should be helped.

13 The second type of low-volume provider is one that
14 has low volume due to losing patients to nearby competitors.
15 Here, low volumes are not inevitable. Under the targeting
16 principle, these providers would not be eligible for special
17 payments.

18 After we identify who is eligible for the
19 additional payments, the question is how much should they
20 get. The third principle is to set the additional payment
21 proportionate to the special costs they incur due to being
22 low-volume, isolated providers.

1 Finally, after we know who will get the money and
2 how much they'll get, it is important to think about how we
3 pay the money. Different ways of payment carry different
4 incentives. All else equal, prospective adjustments have
5 stronger incentives for cost control than cost-based
6 adjustments.

7 Now we've talked about principles, and we can
8 discuss the different adjusters and how they may or may not
9 fit these principles.

10 This slide shows a list of recently enacted
11 payment adjusters for rural hospitals. We don't have time
12 to talk about all the adjusters. I just have two takeaway
13 points from this slide. The first one is that there are
14 lots of adjustments. Second, the second point is that some
15 of these adjustments are necessary for access and fairness,
16 and are the result of MedPAC recommendations.

17 These are adjusters in other sectors. My point
18 here is to point out that the IRF, the psychiatric hospital
19 and home health adjustments apply to all rural providers,
20 and this gets at the issue that some adjusters are not being
21 targeted to unique situations of particular rural areas.

22 So there is a large number of adjusters, and we

1 can't possibly address all of them in this meeting. So we
2 selected just three adjusters to talk about in order to
3 illustrate three points related to the principles.

4 First, we talk about critical access hospitals.
5 We show how the program was not targeted to isolated
6 hospitals for a period of time, resulting in dramatic
7 growth, which is a point that is often missed in the
8 literature. We will also use the critical access hospital
9 example to show how the increases in provider payments can
10 end up resulting in higher beneficiary cost sharing.

11 Second, we'll talk about low-volume adjustments.
12 There are lessons for targeting here, but we mainly use this
13 example to show how Medicare may need to recalibrate the
14 amount of special payment to bring it in line with empirical
15 estimates.

16 Third, we talk about telehealth. There is some
17 promise with certain new forms of telehealth, but we'll show
18 how despite modest additional payments, telehealth has not
19 resulted in a substitution of video conferencing for face-
20 to-face care.

21 The CAH program is an extension of the medical
22 assistance facility program started in Montana in 1988. The

1 Montana program originally had small hospitals that were all
2 35 or more miles away from one another.

3 When this program evolved into the national CAH
4 program in 1997, the rules were changed to allow states to
5 waive the 35-mile requirement. The states, in large part,
6 waived the distance requirement, and the program grew from
7 41 hospitals to over 1,300 hospitals.

8 Then in 2006, the rules were changed back to
9 require new CAHs to be isolated. But by the time the rules
10 were changed, there were over 1,300 CAHs that were
11 grandfathered into the program.

12 The net result is that the program helps more than
13 just isolated hospitals. On the positive side, the program
14 keeps small isolated hospitals open. This preserves access
15 to care in remote areas. So in this sense, the program is a
16 success.

17 However, the CAH keeps not only isolated hospitals
18 open but preserves almost all small rural hospitals even
19 when there's duplicative capacity in an area. There are 16
20 percent of CAHs that are less than 15 miles from another
21 provider.

22 The lesson is that it's easy for a rural payment

1 adjustment to expand its mission to the point where it's no
2 longer used just to preserve isolated providers that are
3 necessary for access.

4 We've seen the good that the CAH program can
5 accomplish for providers and for access. It has improved
6 profit margins and all but eliminated closures. The next
7 question is what are the financial effects of the program
8 not only on providers but on patients.

9 CAH has received about \$8 billion in Medicare
10 payments. This is about \$2 billion more than they would
11 have received if they were PPS hospitals. Almost half of
12 the increase is due to higher payments for post-acute care
13 that patients receive in CAH swing beds. Medicare, on
14 average, pays CAHs over three times the rate paid to SNFs
15 and PPS hospitals for post-acute care.

16 Most of the rest of the increase is due to higher
17 outpatient payments. Cost-based payments are significantly
18 higher than PPS rates for low-volume critical access
19 hospitals. However, most of the additional outpatient
20 payments are paid for with higher cost sharing that is paid
21 either by a beneficiary's supplemental insurer, out of
22 pocket by beneficiaries without supplemental insurance or by

1 the Medicare program as bad debt for those who do not pay
2 their cost sharing.

3 So the question is why is cost sharing so much
4 higher. The main reason is that cost sharing for CAHs is
5 equal to 20 percent of charges. Because charges are over
6 twice payments on average, this is equivalent to roughly 45
7 percent of the payments on average.

8 Now we shift to explaining the variability of co-
9 insurance at CAHs and showing how the cost sharing can
10 depend greatly, depending on an individual beneficiary's CAH
11 in their area. There's a wide variation in cost sharing
12 across providers, and this simply stems because CAHs are
13 free to set their own charges and they have wildly different
14 charges.

15 The first bar in this graph shows the number of
16 hospitals, about 500, that have decided to set their charges
17 at 150 percent of costs, or less. When charges are 150
18 percent of costs, that means co-insurance is roughly 30
19 percent of payments. Therefore, for the 500 CAHs in the
20 first column, co-insurance will be less 30 percent of
21 payments and this is only modestly more than PPS cost
22 sharing.

1 In contrast, look to the right of the graph. If a
2 CAH chose to set their outpatient charges at 300 percent of
3 costs, and some do, then their co-insurance would be equal
4 to 60 percent of the costs.

5 The point of the graphic is to show how the
6 payment adjustments to CAHs affect the beneficiary and, more
7 to the point, to show how the effect on the beneficiary
8 varies widely from CAH to CAH, depending on how the CAH
9 chooses to set its charges.

10 To summarize the points from the CAH example,
11 first, the CAH program keeps hospitals open, but it's not
12 focused just on isolated providers and Medicare could
13 address this targeting issue. Second, additional payments
14 to CAHs result in higher co-insurance from the beneficiaries
15 and their supplemental insurers.

16 If we kept cost-based payments for the providers
17 and tried to reduce the patients' cost sharing down toward
18 PPS levels, the result would be significantly more spending
19 for the Medicare program.

20 This raises the question: If we want to cap, or
21 reduce cost sharing at CAHs and bring it down toward the
22 level of PPS hospitals, how could that be paid for?

1 One option is to use savings from focusing the
2 program. Just to illustrate one way this could work is all
3 CAHs could be required to be some minimum distance from
4 other hospitals. Maybe CAHs that are a medium distance
5 could get fixed dollar add-on, and possibly the most
6 isolated hospitals, those that are 30 or 35 miles away from
7 another provider, could continue to get their reimbursement
8 based on their full costs.

9 A second option is just to wait until there's a
10 broader reform of the Medicare benefit and cost sharing in
11 general.

12 The second special adjustment to talk about today
13 is the hospital low-volume adjustment.

14 MedPAC recommended a low-volume adjustment
15 following MedPAC's 2001 report on Medicare in rural areas.
16 A key feature was the adjustment was empirically justified.
17 We saw that hospitals with very low volumes of total
18 discharges had higher costs. So we proposed a proportional
19 increase in payments per case to cover those costs for the
20 isolated hospitals.

21 However, in 2010, a more generous low-volume
22 adjustment was enacted. It deviates from past MedPAC

1 recommendations in three ways:

2 First, it's not focused on isolated providers.

3 Second, it's duplicative with the sole community
4 hospital adjustment. A sole community hospital adjustment
5 increases inpatient payments based on the hospital's
6 historical costs. So if a low-volume hospital historically
7 had higher costs per discharge, their payments would be
8 brought up to reflect these higher costs. However, they are
9 also eligible for the low-volume discount adjustment. This
10 is an example of how these programs, created one at a time,
11 can result in duplicative payments for a single problem.

12 Third, the low-volume adjustment is based on
13 Medicare discharges only, which is an issue, as we'll show
14 on the next slide.

15 This is an example to show the problem with basing
16 an adjustment on a hospital's Medicare share of discharges
17 rather than total discharges. The first row represents a
18 high Medicare share hospital. The hospital has 1,550
19 Medicare discharges and 2,200 total discharges. Because its
20 Medicare volume is close to 1,600 Medicare discharges --
21 that's the limit for the low-volume adjustment -- it only
22 receives a 1 percent increase in its inpatient payments.

1 But now look at the second row. This hospital has
2 600 Medicare discharges. So it receives an 18 percent
3 increase in its payments, but it has the same number of
4 total discharges as the hospital in the first row. So its
5 economics of scale problem is exactly the same as the first
6 hospital. In other words, the magnitude of the adjustment
7 is not connected to the magnitude of the economies of scale
8 problem at the two hospitals.

9 So in summary, past MedPAC recommendations on low-
10 volume differ from the current temporary policy in the
11 following aspects:

12 First, the MedPAC proposal is based on total
13 admissions.

14 It was based on an empirical estimate of the low-
15 volume on costs.

16 And third, hospitals would get either the low-
17 volume adjustment or another adjustment that increases
18 inpatient payments, such as the SCH payment, but not both.

19 In general, these examples show how the payment
20 adjustments can be messy and there may be a need for them to
21 be refined over time to bring them to the empirically
22 justified level.

1 And now, I'll turn it over to Matlin to talk about
2 telemedicine.

3 MR. GILMAN: As background for our discussion of
4 telehealth, 7 percent of rural beneficiaries report usually
5 traveling an hour or more to receive health care. A
6 longstanding goal of telehealth is to enable isolated
7 patients to access specialty consultations via
8 teleconference rather than travel long distances for care.

9 As a Medicare benefit, telehealth involves
10 services provided through live, interactive video
11 conferencing between a beneficiary and a practitioner.
12 Covered services include psychiatry and other office visits.
13 Telehealth services are provided by distant practitioners
14 such as physicians and nurse practitioners. Beneficiaries
15 receive telehealth services at eligible originating sites
16 such as their local rural hospital.

17 In 1999, Medicare first began paying for
18 telehealth services. As show in the left column, one
19 payment was split between two practitioners -- the distant
20 practitioner providing the service and the originating
21 practitioner required to be with the beneficiary.

22 In 2001, policy changes to expand the benefit were

1 made, and these are still in effect today. As shown in the
2 right column, distant practitioners now receive the full fee
3 schedule rate while originating sites now receive a separate
4 payment even if no originating practitioner is present as
5 this requirement was removed.

6 Medicare's payment to originating sites is
7 currently \$24. This \$24 is the difference between the
8 payment for a telehealth service and the payment for the
9 same service provided in person.

10 Additional efforts were made to encourage
11 telehealth, which I am happy to discuss on question.

12 Despite these changes to encourage telehealth,
13 practitioners rarely provide telehealth services to
14 beneficiaries. From our examination of claims data for
15 2009, we find that fewer than 14,000 beneficiaries had 1 or
16 more telehealth visits and that fewer than 400 practitioners
17 provided 10 or more of these services. Our findings match
18 what we have heard on our site visits to rural communities
19 over the years, where providers often have telehealth
20 capability but rarely use it.

21 Of the relatively small number of telehealth
22 services provided to beneficiaries, most are mental health

1 services including pharmacological management. This may be
2 appropriate given that the literature on the efficacy of
3 telehealth for mental health care is positive.

4 With regard to reasons for low levels of adoption,
5 we believe that two explanations found in the literature
6 stand out above the rest. First, telehealth requires
7 additional time of the specialist in some cases, and
8 reimbursement is not commensurate with the added time.
9 Second, specialists already have sufficient face-to-face
10 patient populations.

11 We now turn to two emerging types of telehealth
12 that may prove valuable for rural beneficiaries -- tele-
13 pharmacy and tele-emergency care.

14 North Dakota has about 10 years of instructive
15 experience with tele-pharmacy. Its large tele-pharmacy
16 project features live, interactive video conferencing that
17 connects distant pharmacists at central sites with pharmacy
18 technicians at remote sites. Through video conferencing,
19 distant pharmacists supervise pharmacy technicians, provide
20 patient counseling and order, verify and approve
21 prescriptions.

22 Currently, in North Dakota, over 50 retail sites

1 and 25 critical access hospital sites receives pharmacists'
2 support via teleconferencing. In the case of the retail
3 sites, the remote sites generate enough additional revenue
4 through pharmaceutical sales to fund their costs and the
5 cost of the supervising pharmacist. To date, all remote
6 pharmacy sites became self-sustaining after their first year
7 of operation, and since the project's inception in 2002 none
8 of the remote sites have closed. The positive results from
9 the project suggest that this may be a promising way to give
10 residents of small towns access to pharmacy expertise.

11 Now with regard to tele-emergency care, some rural
12 emergency departments use video conferencing for rapid
13 consultation with emergency care specialists at distant
14 sites. Findings from studies on this topic are positive and
15 suggest that the use of telehealth in emergency departments
16 may improve appropriateness of care by improving access to
17 trauma center expertise and may save money through avoiding
18 transports. However, independent studies are lacking.

19 Now Jeff will conclude with the discussion slide.

20 DR. STENSLAND: So we have covered a lot of ground
21 today regarding principles that could be applied to rural
22 payment adjustments. One potential avenue of discussion is

1 to discuss some of these principles, for example:

2 How should payments be targeted?

3 Is rural a sufficient target, or is low volume a
4 sufficient level of targeting?

5 Another question could be: Should the Secretary
6 periodically recalibrate the adjustments so they're
7 empirically justified?

8 And also, do you have any further issues that you
9 would like to bring up, either regarding critical access
10 hospital cost sharing or telehealth?

11 And that will open it up for discussion.

12 MR. HACKBARTH: Well done. Matlin, good job for
13 your first time out.

14 MR. GILMAN: Thank you.

15 DR. MARK MILLER: He has to buy drinks though.

16 MR. HACKBARTH: Right, you do know that you have
17 to buy drinks for commissioners after your first --

18 [Laughter.]

19 DR. MARK MILLER: No, no, it's the whole public.

20 MR. HACKBARTH: Oh, it's -- just kidding. Just
21 kidding.

22 DR. STENSLAND: [Off microphone.]

1 MR. HACKBARTH: Right, right, right.

2 Okay, clarifying questions for Matlin and Jeff.

3 Karen? No.

4 Bill.

5 MR. GRADISON: I admit this question is not very
6 well thought through, but is there some -- conceptually,
7 would it be possible to retain all the present programs but
8 have some overriding limitation not to exceed 101 percent of
9 costs or something like that?

10 DR. STENSLAND: It's possible.

11 MR. GRADISON: Yes? Because I appreciate each of
12 these programs has its own history, constituency. That's
13 how they ended up on the books. It's just that this may be
14 one of the first comprehensive examinations before it all is
15 added up together.

16 Thank you.

17 MR. GEORGE MILLER: Yes, on slide 4, please, the
18 statement, the last bullet point on the top part said that
19 providers may have low volumes due to losing patients to
20 nearby competitors. Do we know what the makeup of those
21 nearby competitors?

22 And this is my hypothetical question, and that is:

1 Is it a group of for-profit physicians coming in and taking
2 only a certain part of the population, or is it another
3 critical access hospital; there's just too many in that
4 market?

5 Do we know what makes up those competitors, why
6 they're losing volume?

7 DR. STENSLAND: Well, I think there's probably a
8 couple different cases. In a few cases, they might have a
9 for-profit competitor. And you can have a for-profit CAH;
10 it's possible.

11 But I think more often the case is you have a
12 market with 2 hospitals that are 10, 12, 15 miles apart from
13 each other, and they're splitting the volume in that market.
14 And they both maybe have communities where the farms are
15 shrinking in size, so the number of people per acre is being
16 reduced and the population is shrinking. But yet, they're
17 trying to maintain these two practices which maybe really
18 don't have the volume of people that they once did.

19 MR. GEORGE MILLER: So as a policy, we would say -
20 - and these are my words -- the two hospitals in that
21 community, you either to merge or we're not going to pay
22 either one of you?

1 DR. STENSLAND: That would be -- one option would
2 be to say you're not going to both get these extra payments.

3 MR. GEORGE MILLER: Okay.

4 DR. STENSLAND: You've got to kind of come
5 together before you start getting these extra payments. We
6 just don't think it's the best thing for the patient.
7 That's one way of doing it.

8 DR. MARK MILLER: Actually, it would be more
9 indirect. It would say this is how the payments flow, and
10 so the obvious choice for the hospital would be if I want to
11 get this, then maybe I ought to talk to my competitor --

12 MR. GEORGE MILLER: Okay.

13 DR. MARK MILLER: -- as opposed to ordering two
14 hospitals.

15 MR. GEORGE MILLER: Well, the second part of my
16 question, I still it's around one because I need to
17 understand how you define close proximity because you know
18 10 miles in North Dakota, South Dakota is different than 10
19 miles in Washington, D.C., both weather-wise, mountains,
20 rivers, that type of thing. So do we know where all of
21 these locations are?

22 And by your number, 16 percent, you're talking

1 about 195 hospitals out of 1,300.

2 DR. STENSLAND: That is something that I've heard
3 for a long time. And what we did back when we did the
4 critical access hospital report in 2005 is I did look at the
5 CAHs that were within 5 miles of another hospital, and I
6 thought well, maybe the story here is it's a river or it's a
7 mountain or there's some other reason why you can't get from
8 one to the other.

9 And so, I personally called all these places, and
10 I didn't talk to the administrator because they're sometimes
11 cued in as to what to say. I talked to the ambulance --

12 MR. GEORGE MILLER: Shame, shame.

13 DR. MARK MILLER: So I talked to the people that
14 drove the ambulances, and I would simply ask the ambulance
15 drivers how long does it take you to do a transport from
16 Hospital A to Hospital B, and it was always like 5 or 6
17 minutes. Is there any reason why you might not be able to
18 do it, and no, there really wasn't a reason.

19 So at least for those really close ones we went
20 through the process of saying really, is it mountains,
21 rivers, snowdrifts or whatever, and it didn't really appear
22 to be that case.

1 MR. GEORGE MILLER: The bridge was up.

2 [Laughter.]

3 DR. MARK MILLER: First, how Jeff spends his time,
4 different issue, but I remember having this conversation
5 with him too, and he is quite thorough, as he is in
6 everything.

7 I think the question -- and this is starting to
8 evolve into the second part of the conversation and you can
9 come back to it -- would be well, first of all, the mileages
10 that Jeff uses and talks about this are those definitions
11 which I can never pull right up, but this is secondary roads
12 and all of that.

13 And a question implicitly for the commissioners
14 would be well, would you set a distance and say okay, given
15 the conditions of the roads are hospitals within this range
16 basically close, and I think that's implicit in what's up on
17 the board here. You know in terms of if you're going to
18 target, would the Commission start to say --

19 MR. HACKBARTH: So what I hear you saying, Mark,
20 let me just make sure.

21 MR. GEORGE MILLER: Go ahead.

22 MR. HACKBARTH: So set a mileage, and there can be

1 exceptions, but you've got to come up with a compelling
2 rationale as opposed to the current framework which allows
3 very readily hospitals to be close together.

4 DR. MARK MILLER: And the other point I was making
5 is that the mileage would be determined on the basis of the
6 secondary road criteria, which is often used in rural areas
7 to take into account the point that you're driving at --
8 what about the conditions of these, what about the weather,
9 that type of thing. It wouldn't be on a paved highway.

10 MR. GEORGE MILLER: Right, right, right. No, I
11 agree with that.

12 If I could, on slide 8 again, 16 percent are less
13 than 15 miles apart. So that's about 195 hospitals. So
14 would this apply only to those on mileage, or are you
15 talking about all 1,300 CAHs?

16 DR. MARK MILLER: That's the question.

17 MR. HACKBARTH: So we'd have to choose a mileage
18 and where to draw, and that would determine how many are the
19 affected.

20 MR. GEORGE MILLER: Okay. All right.

21 DR. STUART: And now we know how to do that,
22 right? We just talk to the ambulance drivers.

1 [Laughter.]

2 MR. GEORGE MILLER: Some of them are not going to
3 be employed after this.

4 [Laughter.]

5 DR. STUART: This may duplicate something that
6 Bill said, and if it does, I apologize. But is this going
7 to some kind of a matrix of different kinds of overlaps and
8 ways that we can generate savings from reduced overlap
9 without any reduction in needed subsidies?

10 In other words, what kind of decision matrix are
11 you aiming for here?

12 DR. STENSLAND: I think that's part of the
13 discussion. You can go that way.

14 You could easily see the simplest thing would be
15 to say for every problem you only get to pick one of the
16 solutions, and if you have a low-volume problem, you can
17 pick your SCH payment or maybe your low-volume. You don't
18 get duplicate solutions for a single problem.

19 DR. STUART: What's your preference?

20 DR. STENSLAND: Something that's empirically
21 justified would be my preference, but I think there is a lot
22 of room for judgment calls on things like as you were

1 talking about -- the distance. I think that's not something
2 that's empirically clear -- oh, it's clearly 18 miles is the
3 right distance, or 12 is the right distance. I think it's
4 going to be a judgment call.

5 MR. HACKBARTH: Bruce, did you -- was this just
6 idle curiosity or do you have an approach in your head?

7 DR. STUART: No, I don't have an approach in mind,
8 and actually that was the reason that I raised this --
9 because the complexity of this, the interactions of these
10 things. When you read the chapter, you realize that it's
11 possible to do a two-by-two table, but it's more like a
12 rubric cube here than a two-by-two. And so, it really was
13 an open-ended question in terms of what's the best approach
14 here.

15 MR. KUHN: I'll save for round two my comments
16 about mileage because I do have some thoughts on that, but a
17 couple technical questions, one on page 9, if you can help
18 me, Jeff, understand a little bit about this issue of the
19 cost sharing.

20 And as I recall, and maybe Bob can help me reflect
21 on this, and Mark and others, but we had the same scenario
22 for prospective payment in the outpatient. And I remember,

1 Bill, for you, another crazy acronym. It was called, if I
2 remember right, FDO, formula-driven overpayment.

3 And so, we had it in the outpatient side --

4 MR. HACKBARTH: See, we can pronounce that.

5 MR. KUHN: Yes, we can pronounce them. Wait until
6 we get to RHQDAPU for quality. That's a fun one.

7 So we had that, and there was a 10-year glide
8 path, and we still might be in that glide path now, buying
9 that down as we go forward.

10 So one, this is not a new issue in the Medicare
11 program, but it was fixed on one side. We still have the
12 issue on the critical access.

13 So on the issue of critical access, what I'm
14 curious about -- so any background you can have that, but on
15 the critical access, the fact that Medicare beneficiaries
16 are paying up to 40 percent. The fact is that the critical
17 access hospitals are only still getting their 101 percent of
18 costs. What's going on here, if I understand, is the
19 Medicare program is getting the bargain out of the deal
20 because Medicare beneficiaries are paying more of what
21 Medicare ought to be paying as part of the process.

22 And so, it's not a characterization that the

1 critical access hospitals are doing anything wrong. It's
2 actually the Medicare program is actually getting a deal
3 here as they did on the FDO issue, where beneficiaries are
4 covering a larger cost of the Medicare program than -- well,
5 they're not getting their full entitlement of the program.

6 So I don't know. Am I understanding that
7 correctly?

8 DR. MARK MILLER: You've got the arrangement
9 correct. And I don't want to get into right and wrong, you
10 know, the ambulance drivers or anybody, for that matter,
11 George. But I think part of this outcome for the
12 beneficiary is what the hospital chooses to charge and how
13 much above costs they choose to charge.

14 You're absolutely correct that the benefactor in
15 this instance as the passive benefactor is the program. But
16 the active, you know, the actor who's causing this to happen
17 is what the hospital chooses to do on its charge, which then
18 in turn falls differentially on the beneficiary, which you
19 were trying to show also can vary from hospital to hospital.

20 Also, keep in mind that there may be insensitivity
21 here on the part of the beneficiary to the extent that they
22 have Medigap, to the extent that they have ESI, which is not

1 always the case.

2 And then, I think Jeff said this; if, for example,
3 the beneficiary is handed a bill that they can't deal with,
4 then it can also default to --

5 MR. KUHN: Bad debt.

6 DR. MARK MILLER: To bad debt.

7 So I think you're right about your
8 characterization, but there's also a couple of moving parts
9 that drive the outcome.

10 Jeff, I'm sorry.

11 MR. KUHN: And on those moving parts, I get that
12 and I understand about the movement of the charge masters
13 that can go on within hospitals. But at the end of the day,
14 the total amount that's being remunerated, with the
15 beneficiary co-payment, what Medicare ultimately pays the
16 hospital, still does not exceed 101 percent of costs. Is
17 that correct?

18 DR. MARK MILLER: That's correct.

19 MR. KUHN: So there is a cap there.

20 But I do think this is something that we ought to
21 look at and hopefully, in the report or somewhere down the
22 line, opine on this because it's taken care of for other

1 Medicare beneficiaries; it's not fair to them. And as we go
2 forward.

3 The second clarifying question I have is on
4 telemedicine, on page 18, and I'm just curious about the
5 tele-emergency care. And I'm just curious if you can -- a
6 lot of states have trauma systems that they've put in place.
7 A lot of them are in the process now or have updated their
8 stroke and stemi systems to the point where a lot of these
9 smaller, critical access hospitals are being bypassed as a
10 result of the protocols that are in the state.

11 So I'm curious about how, you know, the
12 utilization of telemedicine in the emergency area and how
13 that kind of syncs up with some of the -- if you got into
14 that, when you were looking at that, in terms of kind of
15 what the trauma systems are in the states and the protocols
16 that they exist right now.

17 DR. STENSLAND: I don't think we have anything
18 that actually ties into the trauma systems in the states,
19 but certainly what they do tell us in some of the literature
20 -- and this is often literature that's written by people who
21 are involved in this themselves, so it's often not an
22 external source doing this -- is that because they have

1 somebody that's an expert, say your neurologist is on the
2 other end of the line, or the ER doctor is on the other end
3 of the line when you have the person come into the ER. And
4 not only do they assist you in providing the care, one of
5 the things they might do is maybe say that transferring the
6 person isn't necessary, and there's a hope that sometimes
7 we're reducing the number of transfers because they can rule
8 out that you don't need to transfer them.

9 Tom can probably address this better than I since
10 he's been on the other end of the telemedicine situation,
11 actually dealing with this first hand.

12 I can do that now?

13 DR. DEAN: I can describe -- do you want me to do
14 that now?

15 MR. HACKBARTH: Just briefly.

16 DR. DEAN: We have a system. We are truly
17 isolated. Our hospital is 45 miles from the next nearest
18 hospital, which is another CAH. And about a year ago we
19 installed a system; that was the system that manages the
20 hospital put this in a number of small hospitals, and it
21 really has been a tremendous advantage.

22 What it is is we have a button on the wall of our

1 emergency room, we hit that button and we have an instant
2 video linkup with the main emergency room in the sort of
3 base hospital in Sioux Falls. There's an ER nurse and
4 almost immediate access to an ER doc there, and the nurses
5 in our case oftentimes use that even before we as the on-
6 call physicians get there.

7 And the thing that was really neat about is that,
8 first of all, it's a great reassurance for young
9 practitioners who are practicing in very isolated areas and
10 it's a very frightening position to be in. They don't know
11 what they're going to need because we get mostly relatively
12 straightforward things, but we get some big trauma every so
13 often. And when you only deal with big trauma occasionally,
14 that makes it even much harder to deal with, and so it's
15 reassuring from that point of view.

16 But the thing that was really -- the folks that
17 put this together -- and I wasn't involved with that --
18 really understood the needs. The office in Sioux Falls has
19 a book with all our support staff in it, and they will
20 actually call our lab people and our x-ray people who aren't
21 there at the time because if somebody comes in with a real
22 urgent problem in the middle of the night the only people

1 that are there are two nurses, and they have their hands
2 full doing the immediate stuff of getting the vital signs
3 and the getting the IV and getting the monitor hooked up,
4 and all that.

5 The fellow that organized this was a military doc,
6 and he said, you know, your people need to be with the
7 patient. We can do the phone calls.

8 Interestingly enough, sometimes when someone comes
9 in where there's an urgent problem, I will get a call from
10 Sioux Falls telling me I need to go to the hospital across
11 town.

12 And it's because -- and it really is a tremendous
13 addition.

14 The other thing they do is that the ER nurse
15 looking at this over the video screen keeps a lot of the
16 written records. They keep the flow sheets. They keep the
17 stuff that our own nurses are really too busy doing the
18 actual patient care, that a lot of times the record-keeping
19 gets shoved aside and ends up not being as good as it could
20 be. But somebody watching it on a video screen, it's pretty
21 easy for them to write down the stuff that goes on.

22 So it really has between a huge addition, both in

1 terms of, I think, the quality of what we do as well as the
2 reassurance for our own staff that we have quick backup.

3 And the docs come in, and the ER doc that also put
4 this together said, if we get somebody into the emergency in
5 one of the big hospitals we almost always have two
6 physicians there. We've got one guy at the bedside doing
7 the exam, trying to get the immediate, gather the data, and
8 we've got somebody else standing in the back kind of
9 thinking this over -- what do we need to do next, you know,
10 organizing what the plan of care.

11 He says, we can do that from a long ways away. We
12 just watch you, and we can help advise.

13 So it has been a very valuable addition.

14 I'm carrying on here, but obviously, I'm
15 enthusiastic about this. I've watched all the promotion
16 about telemedicine for probably almost 30 years, and it's
17 been the solution to rural health care for 30 years, and it
18 just has never evolved into that. This is one of the
19 elements, I think, that really meets a need in a very
20 realistic way.

21 MR. HACKBARTH: Thanks, Tom. That's very helpful.

22 Let me just piggyback on Tom's example to ask my

1 clarifying question. So I assume that that kind of a system
2 that Tom just described is paid for under the telehealth
3 provisions here. Is that correct?

4 DR. STENSLAND: Yes.

5 MR. HACKBARTH: So as I understand the policy
6 since 2001, the distant practitioner in Tom's example of a
7 Sioux Falls ER doc would be paid 100 percent of the fee
8 schedule. The originating organization, which would be the
9 critical access hospital in which Tom practices, would get
10 the \$24 payment.

11 Now in Tom's example, there are actually two
12 physicians engaged, at least two physicians, one on each
13 end. So my clarifying question is what happens to the
14 payment at the originating end for the physician who's
15 talking, maybe Tom talking, to Sioux Falls. How does he get
16 paid?

17 DR. DEAN: You know, ours is still a
18 demonstration, and so any of that applies.

19 MR. HACKBARTH: Okay.

20 DR. DEAN: But you know, in theory, you're right.
21 But I think right now it's being run through some grant
22 money.

1 But it's popular enough that most of the hospitals
2 feel it's important. It's offered as a subscription to the
3 hospital. Individual patients are not charged.

4 MR. HACKBARTH: Okay. So I'm trying to understand
5 whether this, in fact, either the 1999 policy or 2001
6 policy, pays adequately for the physician time involved. My
7 fear is that it does not, but I'm happy to be relieved of
8 that fear.

9 DR. STENSLAND: I think you could probably bill
10 for both the ER service and the consult. I'm not sure. We
11 can check into that for sure.

12 You would also have some sort of cost if you're a
13 critical access hospital for your equipment and even on-call
14 payments you might give to the doctor, and that's all
15 reimbursable under your cost-based reimbursement.

16 MR. HACKBARTH: Yes, yes. Okay.

17 Bob.

18 DR. BERENSON: I have a follow-up of that because
19 I was going to suggest looking into the tele-ICU model which
20 -- the VisiCUE product which the last I knew, basically,
21 it's hooking up patients who are critical care with a
22 monitor and physiological monitoring to a central, to a

1 separate bunker they call it, and you've got nurses and
2 doctors overseeing the care. I believe they've had
3 applicability to do ER care as well, and there's an emerging
4 literature on its application in rural areas.

5 I don't believe CMS pays the professional fees of
6 the clinicians in the bunker, in that separate location.

7 George is shaking his head yes.

8 MR. GEORGE MILLER: No, they don't.

9 When I was at Provena, in Illinois, we put it in
10 our seven hospitals around the area, and it was an
11 investment. We improved quality and had better outcomes,
12 and patients were managed better.

13 We used the same thing that Tom talked about,
14 where we hit a button when a patient may have crashed or if
15 the -- you call it a bunker. We call it air traffic
16 controller. If the physician observes changes in the
17 patient's temperature or blood pressure or respiration, then
18 he would activate the camera and then he would call us to
19 tell us to go in, or my nurses to go in, and do something.
20 But there was no additional reimbursement.

21 DR. BERENSON: I know they've gone to CMS and have
22 not gotten reimbursement. Now that was in the context of

1 sort of urban oversight, where you actually had ICU doctors
2 getting paid.

3 So I think it's worth looking into this whole
4 thing. This is a model that now monitors 10 percent of U.S.
5 hospital ICU beds, and I think there probably are some
6 lessons here for not only critical care in rural areas but
7 maybe emergency care.

8 I wanted to ask a different question on slide 9
9 again about critical access hospitals. I had forgotten,
10 Herb, the term, FDO, but you've reminded me.

11 But I dredged up from my past that when I was at
12 CMS and critical access hospitals first were created, there
13 was a limited length of stay of, I believe, 72 hours.
14 Patients couldn't stay more than 72 hours. That got changed
15 a couple years ago to an average of 72 hours. Or, is it 96
16 now?

17 DR. STENSLAND: Four days, yes.

18 DR. BERENSON: And then, looking at slide 9, it
19 looks like the excess spending is not associated with long
20 inpatient stays. It looks like it's somewhere else.

21 So has that issue -- I mean what was the rationale
22 in the first place? It sounds like the goal was to keep

1 hospitals going, who were mostly to screen and stabilize and
2 transfer, and that has evolved into something, you know,
3 sort of long-stay patients.

4 But is there a quality problem, I guess is my
5 question around critical access hospitals. What was trying
6 to be achieved? Has that just died, sort of died on the
7 vine?

8 DR. STENSLAND: I don't know what was trying to be
9 achieved, but my guess is what they were trying to prevent
10 was people saying, oh, we're going to get cost-based
11 reimbursement. Let's just keep them in there a really long
12 time because we'll be able to absorb more and more and more
13 of our fixed costs.

14 And basically, when it started, four days was the
15 average. So they just said well, let's not let them go
16 above the average. I don't think there was a lot of complex
17 analysis into it.

18 And then later on, they changed it from a maximum
19 of four days to an average of four days. It's almost never
20 a binding constraint.

21 The other thing to remember is that observation
22 care doesn't care toward this, and some of about 15 percent

1 of the CAH patients start out in observation care. They get
2 a separate outpatient payment for that, unlike PPS
3 hospitals, and then they move into inpatient care.

4 DR. BERENSON: That's helpful. So there wasn't
5 any primary concern about wanting to triage patients out of
6 the rural hospital to an urban hospital. Your point about
7 putting a limit on the cost-based reimbursement seems to
8 have been the motivation.

9 DR. STENSLAND: Yes, I think so.

10 DR. BERENSON: That's plausible. That's
11 plausible.

12 DR. BAICKER: Two quick clarifying questions, one
13 about the telemedicine, I got the impression at first that
14 there was limited success of this in the Medicare population
15 in rural areas, but then it sounds like there is wider
16 adoption in other places.

17 But I'm not sure whether those anecdotes are
18 representative of a wider adoption, or whether really nobody
19 is using telemedicine anywhere and it's not about our
20 payment policy -- it's just never taken off -- or whether
21 our target population is not taking as much advantage of it
22 as some other target populations which might suggest that

1 it's more about our payment policy.

2 MR. GILMAN: We just looked at volume within the
3 Medicare population. So I don't have any numbers for you
4 outside of Medicare population.

5 I know that there was a report in 2007 that says
6 that as of 2005 there were about half of states had some
7 private telehealth coverage and about 35 states received
8 reimbursed for telehealth services from Medicaid, but that's
9 the extent of what I know about telehealth outside of the
10 Medicare population.

11 DR. BAICKER: Thanks.

12 DR. MARK MILLER: And Jeff, I didn't know if you
13 wanted to get into this, and this might not quite be an
14 answer to your question.

15 But the other thing -- and it sounded a lot like
16 what Tom was saying -- is we and other people went out to
17 rural areas as we were getting cranked up on this report a
18 year or more ago and talked to them and asked this question
19 as we went. And it sounded a lot like what Tom said is that
20 a lot of people thought this was something that would sweep
21 the nation or the rural areas, and it didn't so much, and
22 there was a lot of difficulty for providers to take it up,

1 breaking their flow of their practice of medicine the need
2 to touch the patient.

3 But then, what you see is these little things crop
4 up. We reported to you a while back -- and I'm sure it's
5 just in the flood of information -- mental health
6 evaluations are one of the thing where it is used at least
7 with some frequency. You don't have to touch the patient.
8 It's all communication. And then, these examples -- the
9 pharmacy management -- so it's not broad-based. It's sort
10 of almost service-driven.

11 But you may have views on that.

12 DR. BAICKER: And one other unrelated clarifying
13 question, I was very surprised to read about the variability
14 in charges at these hospitals and how that affected co-
15 payments. And especially with the Medicare backstop for bad
16 debt, I began to wonder well, why isn't everyone charging
17 more.

18 And I wonder if you have any information about the
19 source of the variability in charges. Is it correlated with
20 changes in volume? I could imagine it driving patients
21 away, or I could imagine it being correlated with initial
22 volume levels.

1 Is it correlated with you know, any kind of
2 hospital characteristics that would explain why there's such
3 a huge disparity?

4 DR. STENSLAND: This is a lot of just the
5 individual decision of the board of the hospital and the
6 administration of the hospital -- how high are we going to
7 set our charges and are we really worried about the people
8 without insurance around here, or maybe we're not quite so
9 worried about that and we're getting paid discounts to
10 charges from the private insurers, so it's kind of tempting
11 just to keep on raising our charges.

12 And there's also a regional element here, like if
13 you look at people up in the Upper Midwest, they tend to be
14 more in the 150 column. When you're out in California, it
15 tends to be much higher.

16 The bigger PPS hospitals are going to be more in
17 the 300 range here. You know, if you looked at the big PPS
18 hospitals they're all going to be over at the right-hand
19 side.

20 So there are some regional differences and some
21 characteristic differences, but really it's kind of a
22 hospital-by-hospital case.

1 MR. BUTLER: Matlin, I wouldn't want this hazing
2 opportunity to end quite yet.

3 [Laughter.]

4 MR. BUTLER: So telemedicine - I am curious,
5 generally curious, on the mental health a little bit more
6 because it surprised me it's 62 percent.

7 So Mark referenced evaluations. Are these crisis
8 situations where you're getting an initial diagnosis? Are
9 they more often maybe refilling prescriptions in a
10 convenient way?

11 Do you have any kind of sense of what the typical
12 visit looks like in the mental health?

13 MR. GILMAN: Yes. So 42 percent of all of the
14 telehealth services that were provided to beneficiaries in
15 2009 were pharmacological management. So this is medication
16 management involving evaluation of how a medication is
17 affecting the patient, determining the proper dosage level,
18 prescribing medication and notifying of any drug
19 interactions or adverse drug effects.

20 And less than 10 percent was individual
21 psychotherapy, and another about 7 percent was
22 psychiatrists' diagnostic interview examinations.

1 So these were the three mental health services
2 provided.

3 MR. BUTLER: Good answer.

4 DR. CASTELLANOS: Good job.

5 MR. GILMAN: Thank you.

6 MR. HACKBARTH: So let me kick off round two with
7 a question about CAHs, so slide 8.

8 Help me out, Jeff. It seems to me that one of our
9 previous discussions of the CAH issues, one of the aspects
10 of this that we looked at is what is the impact of the rapid
11 growth of the number of CAHs under different payment rules,
12 what's the impact of them on PPS hospitals that may be
13 relatively nearby.

14 So you have hospitals being paid on two different
15 payment systems, close proximity, competing for patients.
16 Do you remember the conversation about that and could you
17 just refresh my collection? Is that an important issue or
18 not?

19 DR. STENSLAND: I think it's probably not a huge
20 issue. We do hear anecdotal stuff from people that run PPS
21 hospitals, and they say I can't compete with my neighbor
22 because they're getting much more than I am per discharge

1 and I'm not a PPS hospital and I have to compete for the
2 same workers because we're 20 miles apart.

3 And so, there is that anecdotal stuff. We don't
4 have hard data.

5 MR. HACKBARTH: Okay, continuing with round two.

6 Karen.

7 DR. BORMAN: I particularly liked your table that
8 compared sort of what the different designations did in the
9 agenda materials. I think to me the thing that's most
10 important about this is figuring out where the overlaps are
11 and assessing what of those are appropriate or
12 inappropriate.

13 I'm somewhat reminded of the conversations we had
14 surrounding the overlap between IME and DSH, and the
15 tremendous -- there was a spectrum of overlap of hospitals
16 who get one or the other or both, and we attempted to parse
17 through it. And I think to me that's something that would
18 be very helpful here as we see that, where are the overlaps
19 and if there are some that essentially appear to be
20 duplicate payment essentially for the same reason, then
21 helpful to parse that out.

22 Otherwise, I like the way that you organized it by

1 the criteria that we could potentially use, but that sort of
2 overlap picture, I think, would be helpful in trying to do
3 some space validity here also, not just the side-by-side
4 parsing.

5 DR. CASTELLANOS: Two questions. One, again, one
6 of the biggest concerns we have in an urban hospital is
7 psychiatric care. We don't have psychiatrists that take
8 call at hospitals anymore because they don't want to be
9 running to the emergency room every day, every hour. These
10 are not critical access hospitals. These aren't rural
11 hospitals. Is that telemed available to non-rural
12 hospitals?

13 MR. GILMAN: Under conditions of payment for
14 telehealth services provided to Medicare beneficiaries, the
15 originating site where the patient is has to be located in a
16 rural area.

17 DR. CASTELLANOS: And you're defining the rural
18 area?

19 MR. GILMAN: Outside of an MSA area.

20 DR. CASTELLANOS: Okay. Well, that answers that
21 question.

22 Can you put on slide 10 because this is very

1 concerning to me about co-insurance for the Medicare
2 beneficiary?

3 What's the difference between the charges for a
4 same, identical procedure being done at one critical access
5 hospital to another? To me, it would be a very similar
6 charge.

7 DR. STENSLAND: Every hospital can set their own
8 charges. So it may easily vary by 100 percent. I think
9 there are some examples in there. They might decide to
10 charge you \$700 for that CT scan. They might decide to
11 charge you \$1,400 for that CT scan. And it does vary from
12 hospital to hospital. There's no regulation on the charges.

13 DR. CASTELLANOS: There's no regulation. Is there
14 any concern about that and are there any issues that perhaps
15 we in MedPAC can make recommendations because that's totally
16 unfair? I mean it really is. And I'm talking about the
17 Medicare beneficiary.

18 MR. HACKBARTH: That's the issue here --

19 DR. CASTELLANOS: Right.

20 MR. HACKBARTH: -- is we do we want to impose some
21 rules that assure that the Medicare beneficiaries are
22 properly treated.

1 DR. MARK MILLER: And just to be clear, the
2 charging practices, even though we're discussing them in the
3 context of CAHs, hospital charges vary across-country,
4 hospital to hospital --

5 DR. CASTELLANOS: I understand that.

6 DR. MARK MILLER: Okay. Right, just so it's not,
7 for anyone listening, this phenomenon of charges. The
8 reason it matters here is this drives what the beneficiary
9 pays.

10 And I think in response to Herb's point, one thing
11 I was trying to get us to think about is if you want to
12 choose to solve this problem you might have to also, at the
13 same time, think about whether there is some kind of a
14 limitation on variation in charging because otherwise it
15 kind of gets to Kate's point, which is if I can just run the
16 charge up and it runs through bad debt, or for some reason
17 the beneficiary. So it might be in this instance we have to
18 think about that.

19 DR. CASTELLANOS: Yes. Well, that's the question
20 I'm asking.

21 DR. MARK MILLER: In other words, I'm seeing your
22 point, yes. Right.

1 DR. CASTELLANOS: That's the question I'm asking.
2 And do we have the authority to look into that and maybe we
3 should?

4 MR. HACKBARTH: Yes.

5 DR. NAYLOR: Honestly, it just seems to me that
6 this slide gives us at least one path, and I don't what is
7 the best, but thinking about taking a look at those critical
8 access hospitals that are charging over 150 percent. But it
9 also seems to me that the decision matrix should link with
10 quality and access findings as well.

11 So I know that these are in future presentations,
12 and I'm just wondering if at least one path is to say not
13 that we shouldn't be concerned about access for the
14 hospitals that are charging less than 150 percent, but
15 whether or not that becomes a way to look at this -- what
16 are we seeing in terms of access outcomes, quality outcomes
17 relative to use of co-insurance, differentials in co-
18 insurance.

19 MR. HACKBARTH: Round two.

20 George.

21 MR. GEORGE MILLER: Yes. Notwithstanding all that
22 has been said about this issue and this slide, just overall,

1 getting it right is important, and I think that's why this
2 discussion is appropriate.

3 But I would like to point out though, even with
4 this information, the concerns that we're having, we still
5 have some inequities with access to care, physicians
6 locating in rural communities and their age, and
7 distribution of surgeons and other physicians in the
8 communities.

9 And again, I want to be very clear. I'm not at
10 all justifying what has happened in the current payment
11 stream, but as we change that to make it fair and equitable
12 and correct, we may have some effects on those issues --
13 access and getting physicians to come to rural areas.
14 Particularly, I think I read earlier about surgeons. I
15 think it was in the chapter. So I want to caution us on
16 that point, but to do this fair and equitable.

17 And to Ron's point, any hospital in America can
18 charge whatever they want. So it's not just restricted to
19 critical access hospitals. But from a policy standpoint, we
20 certainly should address that issue so that someone is not
21 paying more out of their pocket from that perspective.

22 DR. STUART: I'd like to add a couple of thoughts

1 about tele-pharmacy. So I'm going to pick on Matlin as
2 well.

3 One is that the term isn't used, but all Part D
4 plans are required to do something called medication therapy
5 management, and most of the plans use telephonic
6 communication, and in a very real way that really is a tele-
7 pharmacy.

8 Now I'm not sure how that helps you in this
9 chapter, although one question might be does medication
10 therapy management offered through Part D provide some
11 access to pharmaceutical knowledge that rural residents
12 might have trouble getting to if distance to a pharmacy is a
13 problem. So that might be something that you could -- I'm
14 not sure that you're going to find information on it, but
15 you might just put it away as something that would be useful
16 to look at over the coming months.

17 The second thing -- and this goes well beyond
18 rural providers. Most states require that if a pharmacy is
19 open there has to be a pharmacist on the premises.
20 Increasingly, pharmacies are open 18 hours a day, even 24
21 hours a day. Obviously during the evening hours, the volume
22 is really low and probably doesn't even, in some cases,

1 doesn't even warrant having a pharmacist on the premises.
2 But tele-pharmacy strikes me as being something in which
3 there could be some real savings in terms of economies of
4 scale, having somebody offsite that would be available and
5 communicating with the technicians who are at the sites.

6 I don't know whether this is even possible under
7 current state law or whether this is something that you come
8 up with, but again, it's one of those things that we might
9 be, in our larger role, interested in looking at beyond just
10 the rural application.

11 MR. HACKBARTH: So Bruce, just help me think
12 through this. So the first example of the medication
13 therapy management that the Part D plans are required to do,
14 there's no separate payment for that. It's a cost that's
15 rolled into the bid that they make for the business that
16 ultimately influences the premiums that they collect,
17 correct?

18 DR. STUART: That's correct.

19 MR. HACKBARTH: In the case of 24-hour coverage in
20 the pharmacy mandated by state law, I assume that when a
21 Part D plan negotiates with pharmacies about the amount that
22 will be paid for filling prescriptions that's one of the

1 costs that pharmacies build into their cost structure and
2 negotiate with plans. Is that correct?

3 DR. STUART: Well, it typically would not be part
4 of the negotiation. I mean it would be the negotiations
5 typically go -- well, if it's with an independent pharmacy,
6 I suppose it would.

7 But for the chains, the chains have other reasons
8 for being open because they're obviously selling much more
9 than just pharmaceuticals.

10 MR. HACKBARTH: Yes.

11 DR. STUART: But having the pharmacy open is a way
12 to get somebody into the store.

13 MR. HACKBARTH: Yes. Right.

14 DR. STUART: But you could still get somebody into
15 the store and get the prescription filled if the pharmacist
16 wasn't there.

17 So I think it's not a Part D issue here --

18 MR. HACKBARTH: Yes.

19 DR. STUART: -- in terms of the negotiation with
20 the plans. It would be something -- is there a way actually
21 to make the provision of pharmaceutical services less
22 costly?

1 MR. HACKBARTH: Okay. So the way I was thinking
2 about it is why should Medicare be paying any more money.
3 The way we pay, provide coverage, drug coverage for Medicare
4 beneficiaries is through the Part D structure.

5 DR. STUART: That's a good question.

6 MR. HACKBARTH: Bill.

7 DR. HALL: Matlin, in your review of the
8 literature, did you find any specific what might be called
9 geriatric-specific uses of telemedicine? I'm particularly
10 thinking of nursing homes or of older people living alone in
11 the community.

12 I mean I understand the issue of emergency
13 medicine and tele-pharmacy and possibly trauma, but anything
14 that you came up with highly specific to this sort of
15 somewhat compromised and frail population?

16 MR. GILMAN: I didn't see anything on that. I
17 didn't look for it because nursing homes are not qualified
18 to be originating sites.

19 DR. HALL: I know. Right. Okay. So that
20 wouldn't even enter into it.

21 See, I think an extension of this is there's a lot
22 of interest in what might be called more electronic

1 monitoring of frail individuals rather than hauling them
2 into the emergency room every time someone thinks they may
3 be dizzy or have a fall, and there may be some very unique
4 and useful applications. So it probably would be worthwhile
5 for us looking for some kind of medical home runs here
6 somewhere down the line which might develop a highly
7 specific use that could very much substitute for a much
8 higher, or highly priced, interventions.

9 MR. HACKBARTH: Just to make sure I understand,
10 Medicare does not pay for any remote monitoring of the sort
11 that Bill is talking about, is that correct?

12 DR. STENSLAND: It doesn't pay separately, but you
13 could be getting a home health benefit and maybe getting
14 this episode payment and the home health company might
15 decide, well, what we are going to do is have somebody come
16 every fourth day and on every day we will have somebody get
17 on the telemedicine with you.

18 MR. HACKBARTH: Right. Right.

19 DR. STENSLAND: And that could be paid -- bundled
20 part of the payment.

21 MR. HACKBARTH: But if they are not being served
22 under home health, they are at home and just interacting

1 with their physician, there is no separate payment.

2 Herb.

3 MR. KUHN: Thanks again for the good work on this
4 paper. Everything that we are doing on this chapter has
5 been top-notch so far.

6 This issue now is near and dear to my heart.
7 After spending 30 years here in the D.C. area, I am now
8 living in a rural area, so I pay very close attention to
9 these issues. This past year, I got a lot of windshield
10 time. I think I drove more than 35,000 miles this last
11 year. Many of those miles were visiting rural hospitals and
12 many, many Critical Access Hospitals. So what I would say
13 is that a mile is not necessarily at a mile, and I think to
14 kind of think about these terms of mileage distance, I think
15 we have just got to be very careful about absolutes. Again,
16 this is based on a lot of time looking through a windshield
17 on a lot of highways and a lot of double-yellow lines
18 between those hospitals.

19 Because, you know, you get into these -- you come
20 up with all kinds of scenarios, and I think, Jeff, you have
21 come up with some, but if you have got Hospital A and
22 Hospital B here and they may be 15, 20 miles apart from one

1 another, but then you have got Hospital C, and if B is gone,
2 what is the distance now between A and C? So, again, it is
3 hard to look at a national map. It is hard to deal with
4 absolutes. It is really community by community out there.
5 So I would just make that observation about mileage.

6 We talked about the issue of the cost on the
7 outpatient issue and I think that's one that we absolutely
8 have to address.

9 The other thing I was interested in was in the
10 reading and on page nine and this chart that we have, and I
11 thought it was really good about the selected rural payment
12 adjustors. One of the things that probably was not on the
13 chart is we spent a lot of time earlier this year and had a
14 chapter in the June report on FQHCs. That activity probably
15 ought to be listed on here, as well, and I think would help
16 kind of fill that out some.

17 The other area that I noticed in the reading that
18 was very interesting to me was the swing bed issues and the
19 dollars attached to that. But as I read that, and then went
20 clear to the back at the end on page 31 and read the
21 footnotes, then it became clear to me kind of what was going
22 on and it really is kind of a cost allocation issue. It

1 seems to me that we are allocating room and board to swing
2 beds and to acute care episodes. It is the ancillaries that
3 really kind of bring up the rates in so many different
4 areas. And so it appears, and Jeff, you can correct me if I
5 am wrong, why swing bed rates are so high is because,
6 really, the acute care side is staying low or not growing
7 much, and if we had maybe a more factual cost allocation, we
8 might have a more realistic cost in terms of what the acute
9 care side is and get something more what it should be on the
10 swing bed.

11 Am I characterizing that correctly? Is it really
12 just kind of a cost allocation issue? That is just the
13 quirkiness of what is going on on the swing bed side?

14 DR. STENSLAND: There are two things going on.
15 One is the cost allocation, just as you said. The other is
16 hospitals just are generally more expensive than SNFs on a
17 per day basis, room and board.

18 MR. KUHN: Okay. But I think that is one that it
19 would be interesting to look at a little bit more.

20 And then finally, on the issue of duplicative
21 payments, if I understand right, whether it is a critical
22 access, a sole community provider, all of these, they are

1 pretty much exclusive. The only really duplicative payment
2 is this issue of the low-volume adjustor that expires at the
3 end of next year. So everything else pretty much stands
4 alone. That is kind of the overlay in terms of duplication
5 right now, is that correct?

6 DR. STENSLAND: That I can think of right now,
7 yes.

8 MR. KUHN: Okay. Thank you.

9 DR. BERENSON: Yes. Could you remind me of the
10 circumstances of this recent Massachusetts brouhaha with the
11 two Cape Code hospitals getting redesignated and raising
12 wage rates, and is this something we need to -- we should be
13 addressing in these designations?

14 DR. STENSLAND: So we discussed that in the
15 comment letter, and it is not really a rural issue so much,
16 because what they say is it involves the rural floor. So
17 the assumption is that the wage costs in urban areas must
18 always be bigger than in rural areas. That is kind of the
19 assumption behind it. So then they say, urban areas, you
20 will always get a wage index at least as high as the rural
21 areas.

22 And what happened is you really didn't have any --

1 and it only counts for PPS hospitals, what your wage index
2 is. You didn't have any PPS hospitals in Massachusetts that
3 were rural, but you did have a couple of CAHs, and one of
4 them being on Nantucket, and Nantucket is an expensive place
5 to live and they, you know, fly people in to do work. And
6 so their wage rates are actually quite high.

7 The way it worked is, well, if Nantucket went from
8 being a CAH to being a PPS hospital, all of a sudden, they
9 are the floor. Then everybody in Boston has to get paid at
10 least as much as people in Nantucket and in other urban
11 areas of Massachusetts, at least as much as the people in
12 Nantucket according to the rural floor. So they became a
13 PPS hospital. Then that set the floor for the State.
14 Boston and everybody else, the wage index went way up.
15 Hundreds of millions of dollars into Massachusetts and
16 hundreds of millions of dollars out from everybody else.
17 So, like, a two-tenths of a percent cut on everybody else
18 across the country to pay for the increase in Massachusetts.

19 MR. HACKBARTH: And the Boston hospitals paid
20 Nantucket to make sure that they were not left --

21 DR. STENSLAND: Well, they are part of the same
22 system, but I don't know exactly what they were doing with

1 each other.

2 [Laughter.]

3 MR. KUHN: I think if you just -- if you go to the
4 hospital's website, it is pretty clear they are being
5 indemnified for that. But I will compliment MedPAC staff in
6 terms of both their inpatient comment letter and their
7 outpatient comment letter that addressed this issue. You
8 know, when we talk about mispricing, I think this is a
9 classic example of mispricing in the Medicare program.

10 MR. HACKBARTH: Yes. So Bob raised it in the
11 context of this report, potentially, whether it is something
12 we need to address here. My understanding is that our
13 hospital wage index proposal would have addressed this
14 issue, so I don't think we need to -

15 DR. BERENSON: That is what I wanted to know. It
16 seems like we have got another vehicle for dealing with it.

17 MS. UCCELLO: Building off of kind of what Karen
18 was saying about the overlap, I mean, if we are thinking
19 about some of the particulars, well, what do we do if
20 hospitals who qualify for two or more of these payments and
21 how do we decide, well, do we give them the greater of one
22 or -- I think I'm just looking for some more kind of

1 information that can inform that process, even if we defined
2 low-volume in a better way to be total rather than just
3 Medicare and then looked at that in combination with being a
4 Critical Access Hospital. Do two of them together -- are
5 there any reasons for providing them a little more than just
6 the greater of one or the other, or those kinds of issues to
7 help us think through that.

8 And in terms of the mileage, I mean, I appreciate
9 what other people have said about a mile is not a mile, but
10 when George was talking about ten miles in a rural area
11 versus ten miles in a city area, I was actually thinking the
12 exact opposite of where he was going. You know, living in
13 the Washington area, driving ten miles can take me forever,
14 and so I might not go.

15 [Laughter.]

16 MS. UCCELLO: So I think those kinds of things are
17 also important to think about when we are thinking about
18 equity.

19 MR. HACKBARTH: [Off microphone.] Any comments
20 about the first issue?

21 DR. STENSLAND: Yes, I think we can go and do
22 that. Usually, for most cases, as Herb said, is it is you

1 might qualify for several of them and you pick which one
2 gives you the most money. Then there is this low volume,
3 which you can get both.

4 So I think the general principle is if you have
5 just a single problem, then you only get that solved once.
6 If you have two problems, then maybe you still get two
7 payments, like you can be a sole community hospital and you
8 will get an increased inpatient payment, you will get an
9 increased outpatient payment, and if you have an issue with
10 your volume that causes both of those problems, maybe that
11 is appropriate, but it might not be appropriate for you to
12 get an extra inpatient payment and then another extra
13 inpatient payment.

14 DR. DEAN: I would -- I wanted to reinforce and
15 say I totally agree with some of the initial problems about
16 the problem that the rural definition causes and the fact
17 that within that category -- we have talked about this
18 before and it has been a problem ever since I have had
19 anything to do with rural health policy because there are
20 huge differences between the adjacent areas to MSAs compared
21 to places like where I live. There are just dramatic
22 differences. And so you tend to lump -- we really need more

1 sensitive measures.

2 I wasn't quite sure it was fair to say what these
3 facilities cost compared to PPS facilities. The implication
4 is that they're inefficient or they're not using resources
5 properly or whatever. I mean, if PPS worked, which it does
6 not work in these isolated rural facilities, it would be
7 there, and the only reason these other programs are there is
8 because PPS doesn't work. And so I guess maybe I'm over-
9 sensitive, I don't know, but I think those kind of comments
10 tend to, I think, give the wrong implications. Now, maybe
11 they're useful for -- I mean, it is more expensive. I
12 certainly agree with that. But, anyway, so much for that.

13 The telehealth thing is a problem and it has great
14 potential and it just has been very slow to realize that.
15 There are a lot of barriers, and the payment is only one of
16 the barriers. The issue of logistics, getting the
17 consultants to make the trip to come to wherever the studio
18 happens to be is a problem.

19 The credentialing drives us absolutely bananas.
20 Every time -- I talked about this emergency set-up. But
21 every time McKennan, which is the base hospital in Sioux
22 Falls, adds a new ER doctor, that person has to be

1 credentialed in our facility. And we get these tons of
2 credentialing. It is a tremendous burden.

3 The payment is an issue. I like to say there are
4 a lot of logistical problems, and the technology has gotten
5 better, but it is like a lot of things. It is like half the
6 PowerPoint presentations. You go to put them on and they
7 don't work and so you pull up the thing and all of a sudden,
8 and then you have got to fiddle with the equipment, and if
9 you don't have the technical people there, it is just not
10 nearly as smooth as we think it should be. But it is
11 getting much better. We are learning more about it. We are
12 figuring out, I think, where it really has application. So
13 I think, you know, it should continue to be supported, but
14 it is a long way from a mature technology, even though it
15 has been around for a long time.

16 I guess, just as a final comment, the idea that a
17 facility is reimbursed their costs does not guarantee
18 profitability in any way, shape, or form. You know, I sit
19 on the board of a hospital that is about 85 percent
20 Medicare, gets the CAH reimbursement, and yet they have lost
21 money as often as they have made money because, first of
22 all, it is 101 percent. That is a one percent margin, which

1 is not a great margin as any administrator will tell you.
2 Second, it is 101 percent of what Medicare considers
3 legitimate costs, which is also very limited. Plus there
4 are -- it does not apply to anybody that is not Medicare.

5 So it is a tremendous help, and you have heard me
6 say that this program has been a tremendous contribution to
7 stabilizing rural health services. On the other hand, to
8 sort of imply that it is a gravy train, I think, is
9 misleading.

10 MR. HACKBARTH: I don't think that anybody means
11 to imply that it is necessarily a gravy train, but there is
12 the clear implication that that method of payment has
13 implications for how institutions behave. You know,
14 ideally, what we would do is pay at adequate levels for
15 efficiently provided very small hospitals in isolated areas,
16 so if you really do it well there is a reward and you can
17 make a profit that can be applied to maybe some of your
18 other activities. And as you say, the cost reimbursement
19 approach doesn't permit that. And so -- well, I'll leave it
20 there. It's just inherent in cost reimbursement that there
21 are some problems.

22 DR. DEAN: I understand that, and I don't

1 disagree.

2 MR. HACKBARTH: Yes.

3 DR. DEAN: I'm just saying that knowing what goes
4 on, at least in one facility that I'm pretty familiar with,
5 they watch their pennies very carefully, because if they
6 don't, their bottom line turns negative in a hurry, so -

7 MS. BEHROOZI: I'll be gentle since Tom is
8 sandwiched between two city folk here --

9 [Laughter.]

10 MS. BEHROOZI: -- but I had also written down,
11 Cori, Herb's quote, "a mile is not a mile," because that's
12 my line.

13 [Laughter.]

14 MS. BEHROOZI: St. Vincent's hospital closed on --

15 DR. DEAN: I agree with both of you.

16 MS. BEHROOZI: Okay. See, we're all friends.

17 DR. DEAN: Ten miles in my area is about eight
18 minutes.

19 MS. BEHROOZI: Yes, eight minutes. Oh, my gosh.
20 It takes eight minutes to hail a cab in New York.

21 [Laughter.]

22 MS. BEHROOZI: And get an ambulance to get to you,

1 much less to get you to the hospital, especially when we
2 have had a closure of St. Vincent's in Manhattan on the
3 Lower West Side. You know, if you look at a map and you use
4 highway judgment, you would say, so what? Look at all these
5 other hospitals, you know. But if you, like I said, really
6 try to get there, forget rush hour, just normal time, it --
7 I can tell you this. My son goes to school on 114th Street.
8 I am in Park Slope Brooklyn. It is 12 miles. That doesn't
9 sound like very much. There is no way for us to get to each
10 other on a good day in less than 45 minutes -- on a good
11 day. Maybe if I had red lights on the top of my car it
12 would go a little faster, but that is 12 miles.

13 Anyway, so just on this issue of whether or not
14 it's a gravy train -- I would not have selected those words
15 at all, Tom --

16 [Laughter.]

17 MS. BEHROOZI: But it is a little striking that
18 the program has gone from 41 hospitals to 1,300 and not a
19 one of them has closed in 2008 and 2009, anyway, right?

20 DR. DEAN: But a large number closed before that.

21 DR. STENSLAND: Yes.

22 MS. BEHROOZI: Before the program started, or

1 before 2008?

2 DR. STENSLAND: And I think there probably was a
3 couple CAHs that even closed after it started, but not very
4 many.

5 MS. BEHROOZI: Okay. And there were more -- a
6 higher proportion of urban hospitals, although we know urban
7 is everything that's not rural, so that's a lot of different
8 places -- a higher proportion that were closing before this
9 program went into effect. So I do think the fact that there
10 has been such a low closure rate is kind of a striking fact,
11 but we don't know whether that's because they're all needed,
12 or -- I mean, you make a reference in the paper to the --
13 that's the result of the increase in profitability of CAHs,
14 and at the risk of you guys killing me because I'm asking
15 you to do more work, the analysis that you do when we're
16 looking at the updates for costs and margins among hospitals

17 I wonder -- I mean, you know, there's a line for
18 rural. I wonder if it's possible to or worth the exercise
19 to kind of drill down on the hospitals that receive these
20 different add-ons, particularly the ones with the combined
21 add-ons, because obviously 101 percent means the margin is
22 one. I get that, or the Medicare margin. But then their

1 costs might be very high relative to other providers or
2 something like that. I wonder, if it's not too burdensome,
3 to look a little bit deeper at the data to see how much is
4 maybe related to things that are empirically justified or
5 things that we value.

6 I just actually wanted to ask a question about the
7 41 to 1,300, and I should have asked it in the first round.
8 Were any of those newly opened or were they all transfers
9 over from PPS?

10 DR. STENSLAND: There's a handful of newly formed
11 hospitals that are CAHs, but the vast majority of them used
12 to be PPS hospitals.

13 MS. BEHROOZI: One last comment. I think Jeff
14 should give a seminar on research methods.

15 DR. CHERNEW: So my first comment, just to get it
16 out there, is I think more attention on targeting as in the
17 discussion topics is crucial. I don't have a particularly
18 good answer for what it is, but there has to be a
19 recommendation in there somewhere and we should make it.

20 The second comment is I'd be interested to know if
21 there's any thoughts or implications or interactions when we
22 think about this in the context of broader payment reform.

1 So this is all in the context of what we're doing in fee-
2 for-service, then we get out of fee-for-service and we have
3 this. But if we move away from some of these other things,
4 what does this mean and are we just saying one way or
5 another that all these other things that we're doing in the
6 Medicare system are just not relevant out in these other
7 places? And so I think some comment about that somewhere in
8 the rural report would be valuable.

9 And, frankly, I have no idea. MA plans have a
10 hard time operating in these areas and I have no reason to
11 believe that ACOs would have a tremendously easier time
12 operating in these areas, but it seems that if we're going
13 to have big discussions about payment reforms and stuff, we
14 should at least not exclude these markets. So I don't have
15 a good sense of that.

16 And the last very minor point is your chart talks
17 about the variation between outpatient charges relative to
18 cost in that famous why, you know, some are really high, and
19 that's really useful and I do believe there's a huge
20 variation in charges. I don't know if cost is always the
21 best metric because it assumes that cost itself is some sort
22 of fixed thing and they're marking up over cost. So I could

1 envision wanting to know how much variation there is
2 relative to, say, I don't know what the PPS rate would have
3 been. How are the charges different from some other metric
4 that I think the hospitals don't have as much potential
5 control over one way or another.

6 MR. BUTLER: Last, hopefully not least, but brief.
7 I have, like, six points in 60 seconds. How about that.

8 In the context of where the chapter is headed, so
9 number one is I think there is probably enough money and
10 reasonable access, is one conclusion.

11 The second is don't forget the demographics of
12 this community is older than usual. It's disproportionately
13 Medicare. So as our decisions go, so goes the system more
14 than in other areas.

15 Third point, these communities often are dependent
16 on, like, one good administrator and about two doctors can
17 hold the whole thing together, and you have to think about
18 that as these things are put in place.

19 Fourth point is that there's about \$2 billion, I
20 think it says, that are -- call them add on, call them
21 payments higher than what the fee-for-service would be on a
22 base of \$8 billion or something like that. So a lot of this

1 is around how do you make technical adjustments to that in a
2 more targeted way that may be less than that because it's
3 real money. And I would say on this point, which is longer
4 than ten seconds, but it's kind of a staff capacity issue,
5 you know, because we're not going to, as a committee, come
6 up with -- I think we'd all say, yes, give us a good
7 suggestion here. We can support it.

8 But it requires some careful analytics, because my
9 next point is, first, do no harm. Don't get too dramatic.
10 This isn't all that messed up and it's not where all the
11 money is.

12 And the last thing, Matlin, telemedicine is
13 important, but other things -- end on a positive that there
14 are lessons to learn from the rural health that can be,
15 should be transported to the rest of the system.

16 MR. HACKBARTH: Thank you. Good work, Matlin,
17 Jeff. Obviously, more on this one to come.

18 And our last item on today's agenda is
19 coordinating care for dual eligibles through the PACE
20 program.

21 MS. AGUIAR: Good afternoon. During this
22 presentation, we will discuss the results of an analysis of

1 the program of All-Inclusive Care for the Elderly, also
2 known as PACE. This analysis is part of our ongoing work
3 considering how to improve care coordination for dual
4 eligible beneficiaries.

5 The Commission has been focusing on these
6 individuals because they qualify for both Medicare and
7 Medicaid benefits and many are frail or disabled. I would
8 like to thank Carol Carter and Carlos Zarabozo for their
9 guidance on this project.

10 Carlos is sitting with us today because Medicare
11 payments to PACE are based on the Medicare Advantage payment
12 system and he will be available to answer any questions you
13 have on the general MA payment system.

14 During today's presentation, we will discuss the
15 background information on the PACE program and we'll present
16 the key findings of interviews with PACE providers. After
17 that, we will discuss our analyses of the Medicare payment
18 methodology for PACE and CMS's quality data reporting
19 requirements. Finally, we will discuss options to improve
20 the PACE program.

21 MS. KELLY MILLER: I will now give you some
22 background on PACE. PACE is a provider-based program that

1 enrolls nursing home certifiable beneficiaries age 55 and
2 over with the goal of keeping them in the community. PACE
3 enrollees must be certified by their state as eligible for a
4 nursing home level of care.

5 The PACE program centers around a day care center
6 where enrollees go to receive therapy and medical services
7 in a setting that promotes health and wellness. PACE
8 providers utilize an interdisciplinary care team, or IDT,
9 that provides intensive monitoring and care management at
10 the day care center. The details of the staff on the IDT
11 are in your paper.

12 PACE is a small program. There are currently 77
13 PACE sites in 28 states serving just over 21,000 enrollees.
14 PACE providers receive a capitated payment from both
15 Medicare and Medicaid for dual eligible enrollees. Each
16 state determines their own methodology for the Medicaid
17 payment. Some pay a blend of nursing home and home and
18 community-based services rates.

19 We will review Medicare payments to the PACE
20 program later in the presentation.
21 PACE providers also have the flexibility to pay for clinical
22 and non-clinical services authorized by the IDT and an

1 enrollee's plan of care, regardless of whether those
2 services are covered under the traditional Medicare or
3 Medicaid benefit packages.

4 One evaluation of PACE found that PACE enrollees
5 had significantly lower rates of hospitalizations, nursing
6 home utilization, and mortality compared to beneficiaries
7 that were eligible for PACE but chose not to enroll.

8 MS. AGUIAR: The next four slides present the key
9 findings from our site visits and interviews with
10 management, IDT, and sponsor staff at seven urban and rural
11 PACE providers. The providers were located in Colorado,
12 Virginia, Pennsylvania, North Dakota, North Carolina, and
13 Iowa. I'm sorry, that was in Idaho.

14 First we hypothesized enrollees at the rural PACE
15 sites would less frequently attend the day care center than
16 enrollees at the urban sites because of the challenges
17 associated with transporting beneficiaries across long
18 distances or mountainous regions to get to the center. We
19 also hypothesized that rural PACE staff would support a PACE
20 without walls program.

21 This is a conceptual model of care that includes
22 most principles of the PACE model, but does not include the

1 day care center. Without the day care center, PACE would be
2 less capital intensive and could serve beneficiaries that do
3 not want to attend a day care center-focused program. We
4 did not find that rural PACE sites relied less on the day
5 care center or that they supported a PACE without walls
6 program.

7 On average, enrollees at the rural PACE sites
8 attend the day care center three days a week. In addition,
9 staff at the rural sites strongly stated the importance of
10 the day care center to the PACE model, because without it,
11 they said they would not be able to closely observe
12 enrollees or discuss their concerns with their colleagues
13 during the daily meetings at the center. This finding
14 suggests that more work is needed to develop a PACE without
15 walls model.

16 Our second finding is that programs are generally
17 small and enrollment is slow. Because sites are small,
18 reaching enrollment targets can help them operate at or
19 above break-even. The sites in our study enrolled between
20 50 and over 400 beneficiaries, and monthly enrollment
21 typically averages two to five beneficiaries.
22 PACE staff identified a number of enrollment barriers. For

1 one, some beneficiaries do not want to enroll because they
2 do not want to change from their existing primary care
3 physician or because they do not want to attend the day care
4 center.

5 Second, in some states, the local state agency
6 that makes the certification for a nursing home level of
7 care also operates a home and community-based program, and
8 competes with the PACE site for the beneficiaries.

9 Third, PACE providers receive a prospective
10 capitation payment from Medicare and Medicaid at the
11 beginning of each month and do not receive retrospective
12 payment for beneficiaries enrolled after the first of the
13 month. Because of this, sites have not been able to enroll
14 some beneficiaries that are in immediate need of services.

15 We were also interested to know whether the PACE
16 model could serve nursing home certifiable Medicare
17 beneficiaries under the age of 55. Enrolling the under-55
18 Medicare beneficiaries could help sites reach their
19 enrollment targets and break even faster. It would also
20 give access to PACE services to a population that is
21 excluded because of their age.

22 Most PACE staff were supportive of enrolling the

1 under-55, stating that these beneficiaries could benefit
2 from PACE, and they noted instances where they had to deny
3 enrollment to a beneficiary because of their age. Staff
4 also stated that the under-55 population may clinically
5 differ from their current enrollees and that they might have
6 to make some changes to the program if they enroll these
7 beneficiaries.

8 As you can see on the slide, possible changes
9 included scheduling days of attendance at the day care
10 center by age groups or by enrollee conditions, adding staff
11 with competencies appropriate for working with this
12 population, offering separate activities for the younger
13 enrollees, and providing more individual or -- I'm sorry --
14 or group behavioral health therapy.

15 Now I am going to discuss information that we
16 received from PACE staff about their financial performance.
17 Staff told us that starting a PACE program typically costs
18 between \$2 and \$3 million per site. PACE sites secured
19 these funds from their sponsoring organizations or through
20 grants from other institutions.

21 The rural sites were eligible for a temporary
22 outlier protection under the Rural PACE Demonstration. And

1 although most of the sites did not use the outlier
2 protection, staff stated that having it available was an
3 incentive to their sponsoring organization to open the PACE
4 site.

5 As you can see in the middle column, staff
6 reported the average monthly Medicare payments ranged from
7 \$1,700 to \$2,600 per member per month. Staff from all PACE
8 providers stated that the flexibility they have to blend
9 Medicare and Medicaid funds and to use Medicare funds to
10 cover non-clinical services enabled them to intervene with
11 any necessary services.

12 Finally, as indicated in the last column, four of
13 the seven sites we interviewed reported operating above
14 break-even. We observed that the PACE sites were at
15 different stages in their understanding that under a
16 capitated payment system, they have to balance enrollees'
17 needs with the costs of the services.

18 The sites that did understand this were the ones
19 that reported operating above break-even. The sites that
20 reported operating close to or below break-even stated that
21 they were beginning to realize that they had to balance
22 needs with costs, and were introducing that concept to the

1 IDT.

2 We will now move on to the results of our analysis
3 of the Medicare payment system for PACE. And Kelly will
4 begin by giving an overview of the Medicare payment
5 methodology.

6 MS. KELLY MILLER: Medicare payments to PACE
7 providers are based on the Medicare Advantage, or MA, risk
8 adjustment system. As you know, under this system, a county
9 benchmark rate is multiplied by an individual participant
10 risk score to determine each enrollee's risk-adjusted
11 payment.

12 However, PACE payments differ from payments to MA
13 plans in a number of ways. First, beginning in 2012, CMS
14 will use the revised HCC model to risk adjust payments to
15 PACE. This is important because the revised risk adjustment
16 model adds dementia as a condition. This will affect
17 payments to PACE providers as many PACE enrollees have
18 dementia. MA plans, on the other hand, will continue to be
19 paid based on the non-revised HCC model.

20 Next, payments to PACE providers are adjusted for
21 frailty, in addition to the HCC risk adjuster. The frailty
22 adjuster is calculated from the Health Outcome Survey and

1 payments for each enrollee are increased by the providers'
2 frailty score. The rationale behind the frailty adjuster is
3 that the risk adjustment system predicts Medicare
4 expenditures based on diagnosis and demographics, but does
5 not consider a beneficiary's frailty.

6 To encourage the expansion of PACE into rural
7 communities, Congress authorized a rural PACE provider grant
8 program in the Deficit Reduction Act of 2005. Rural PACE
9 sites awarded grants had access to an outlier pool for their
10 first three years of operation to defray exceptional costs
11 of Medicare acute care. All the rural sites in our study
12 participated in this demonstration.

13 MS. AGUIAR: Now I am going to discuss two areas
14 for improvement to the Medicare payment methodology that we
15 have identified. First, as you know, PPACA revised the
16 county benchmarks for MA plans in order to better align
17 spending on the plans with the fee-for-service spending.
18 And even though PACE providers are paid on the MA payment
19 system, they were exempt from this change, and therefore,
20 are paid on the pre-PPACA benchmarks. As a result, in the
21 majority of counties PACE sites operate in, Medicare spends
22 more on each beneficiary that enrolls in PACE than it would

1 if a beneficiary remained in fee-for-service.

2 The second area for improvement is the MA risk
3 adjustment system. Our preliminary analyses suggest that
4 the current system under-predicts costs for very complex
5 patients. This impacts PACE because PACE providers enroll
6 very complex patients. Dan Zabinski will discuss this issue
7 and other analyses of the risk adjustment system in more
8 detail during tomorrow morning's presentation.

9 Our last finding is based on a review of CMS
10 quality data reporting requirements for PACE providers. CMS
11 monitors PACE providers' quality of care and requires them
12 to report a number of outcome measures which are listed on
13 the slide. However, CMS does not publicly report outcome
14 data that it collects on PACE providers.

15 Based on all of our analyses, we conclude that the
16 PACE model does provide a fully integrated model of care.
17 Positive characteristics of the program include that the
18 model has been shown to reduce hospitalizations and nursing
19 home use, and includes the key components that are most
20 likely to improve care coordination for dual eligible
21 beneficiaries, full integration of all Medicare and Medicaid
22 benefits, including all long-term care and behavioral

1 health, capitated Medicare and Medicaid payments, full risk
2 assumed by the providers, and the flexibility to blend
3 Medicare and Medicaid funds.

4 However, there are areas of the program that can
5 be improved and I will discuss these over the next few
6 slides.

7 First, we have identified ways to expand
8 enrollment into PACE. It should be noted, though, before we
9 go into those options that even if steps are taken to
10 increase enrollments, PACE is likely to remain a small
11 program and is not likely to serve large numbers of dual
12 eligible beneficiaries.

13 As you see in the slide, one concern is that there
14 are nursing home certifiable Medicare beneficiaries younger
15 than 55 who can benefit from PACE services, however, cannot
16 enroll because the PACE statute limits eligibility to
17 beneficiaries 55 and older.

18 One option is for Congress to remove the age
19 eligibility criteria to permit PACE providers to enroll
20 these beneficiaries. The under-55 enrollees could differ
21 clinically from the existing PACE population and providers
22 might have to make some changes to their program to

1 accommodate these beneficiaries.

2 Please note that while this change would allow
3 PACE providers to receive Medicare payments for
4 beneficiaries under the age of 55, states would still have
5 the discretion to decide whether to contract with PACE
6 providers to enroll these beneficiaries for their Medicaid
7 benefits.

8 A second concern about enrollment is that as
9 previously discussed, PACE providers have lost some
10 potential enrollees because they cannot receive prorated
11 payments for beneficiaries that are enrolled after the first
12 of the month. An option to address this is for CMS to
13 prorate Medicare capitation payments for beneficiaries
14 enrolled for a partial month.

15 However, states would need to also make this
16 change in order for PACE providers to receive full prorated
17 capitation payments for dual eligible beneficiaries.
18 This slide presents an option to address the issue that
19 Medicare spending across all PACE enrollees is high relative
20 to fee-for-service because PACE providers are paid on the
21 pre-PPACA county benchmarks.

22 One way to address this is to base Medicare

1 payments to PACE providers on the PPACA revised benchmarks.
2 This option would lower Medicare spending on PACE, better
3 align it with fee-for-service spending, and make the payment
4 methodologies for the benchmarks consistent between PACE and
5 other integrated care programs that are paid on the MA
6 system.

7 I also discussed our concern over the MA risk
8 adjustment system for very complex patients. We are not
9 discussing options to improve the risk adjustment system now
10 because we are currently assessing changes to the system.
11 Any changes we identify would likely have the effect of
12 redistributing payments from MA plans that take less complex
13 patients and towards PACE and other plans that enroll highly
14 complex patients.

15 In the future, we will also assess the role of the
16 frailty adjuster to PACE payments in light of changes we
17 identified to the risk adjustment system.
18 We are also concerned that new PACE providers will not have
19 the benefit of an outlier protection.

20 An outlier protection could have the effect of
21 helping to persuade sponsors to open new PACE sites, as it
22 did during the rural PACE demonstration. This could

1 particularly be necessary if sponsors are hesitant to open
2 new sites because of any future changes to the PACE
3 benchmarks or to the risk adjustment system that we
4 identify.

5 An option to address this is for CMS to create an
6 outlier pool for new PACE programs during their start-up
7 phase. The pool would only be available for a few years
8 during the start-up phase and could only used on high acute
9 care expenditures for Medicare beneficiaries.

10 In order to not increase total Medicare spending,
11 CMS could finance the outlier pool through a reduction in
12 Medicare payments across all MA plans or from the reduction
13 in the PACE benchmarks. However, PACE is a small program
14 and the outlier pool would likely be small, and any
15 remaining funds in the pool at the end of the calendar year
16 could be returned to the plans.

17 Our final concern is that quality data on PACE
18 providers is not available to the public. One option is for
19 CMS to publicly report the quality data that it collects
20 from PACE providers. This would enable beneficiaries, their
21 caregivers, and the policy community to evaluate and compare
22 the quality of care among PACE providers.

1 We cannot report the perspective of staff on this
2 option as we did not ask them about this during our
3 interviews. However, before CMS were to publicly publish
4 any quality data, the agency would need to determine how to
5 accurately report the measures, given the small sample sizes
6 of PACE providers. For example, CMS could combine data for
7 multiple years to achieve a large enough sample size to
8 report the data.

9 We will end today's presentation with questions
10 for your discussion. Is there more information you would
11 like on any of the options? And should the Commission
12 consider any of these options as future recommendations?
13 Thank you.

14 MR. HACKBARTH: Okay, thank you, Christine and
15 Kelly. Good job. Let me just try to put this in context
16 for my own benefit, if for nobody else's. So for a period
17 of some months now, we've been wrestling with this challenge
18 of improving care for duals. Well, hopefully, also better
19 managing the costs.

20 We've identified some core problems, including the
21 fact when the patients are covered under two different
22 insurers and we're, by definition, almost talking about a

1 particularly complex group of patients. There are all sorts
2 of weird incentives that interfere with the proper
3 coordination and management of care, both hurting quality
4 and causing us to miss opportunities for potential cost
5 savings.

6 So we've started to look at different models for
7 bringing together the different payment streams, and even
8 more importantly, better coordinating the care and assuring
9 that patients receive appropriate care. PACE is a model
10 that's been around for a long time, and I think many of us
11 have favorable impressions of the model, both from what
12 we've read, and also from having served with Jennie Chin
13 Hansen for six years. So I have a very good impression of
14 the PACE model.

15 What I hear today's presentation saying, Yes, it
16 can do some good things, but in here in the model are some
17 features that mean that it's never going to be really
18 prevalent among the dual population. And some of those have
19 to do with things like the day care element built into it
20 and there are some others as well.

21 So we've now been presented some options that can,
22 at least at the margin, improve payment for PACE, and

1 perhaps at the margin broaden participation in PACE, both in
2 terms of the number of beneficiaries participating and maybe
3 getting more PACE organizations created.

4 But again, there are inherent limits as to how far
5 this particular model is going to spread. In and of itself,
6 it is never going to be a solution for our challenges with
7 dual eligibles. For that, we will have to look elsewhere to
8 more flexible models for coordinating and integrating care
9 and combining payment streams.

10 Is that a fair summary?

11 MS. AGUIAR: Exactly. And also one of the reasons
12 we also wanted to look at the PACE model was because since
13 it is one of the truly completely, fully integrated
14 programs, I mean, it covers all long-term care, all
15 behavioral health care, end of life care, you know, we
16 wanted to see what can we learn from this program that then
17 we could see how we could -- what best practice equivalent
18 from this program that we could then apply to other types of
19 integrated care programs.

20 And so there's also that, and some of the
21 specifics of that we did touch upon in the mailing
22 materials, as you know.

1 MR. HACKBARTH: Okay.

2 DR. MARK MILLER: And the only thing I would add
3 is, yes, and so we're going to try and do some work here on
4 PACE, and then looking ahead, the months and into the
5 spring, we'll be talking about these other models and other
6 issues on the broader issue of managed care -- coordinating
7 care for dual eligibles. So this isn't the end of the
8 discussion, but we're just trying to deal with this whole
9 PACE piece before we move on.

10 MR. HACKBARTH: Peter, do you want to kick off
11 clarifying questions?

12 MR. BUTLER: Right. I want to understand the math
13 on the risk side a little bit better. The 21,000 enrollees
14 nationally at 77 sites, which is about 270 per site, but you
15 cited it ranges from like 28 up to 2,500, 2,600 per site.
16 So when we looked at ACOs and things like that and risk and
17 so forth, these are fully capitated people with pool sizes
18 that is dramatically lower than what we generally would
19 recommend. Yet, they're making money on balance and they
20 have an outlier provision that obviously must help and help
21 a lot.

22 So tell me how that works --

1 MS. AGUIAR: Sure

2 MR. BUTLER: -- and how big some of these are,
3 because in general, these are the things that if they were
4 taken on Medicare capitation, half of them would go belly up
5 pretty quickly and now you really have got problems.

6 MS. AGUIAR: Right. I would say -- so the outlier
7 protection was only for the rural PACE sites during the
8 demonstration, and that only lasted for a few years. The
9 angle on that one is, what we heard, is that most of them
10 didn't actually have to use it, but the fact that it was
11 there was an incentive to their sponsor to start it.

12 So that was sort of our rationale for proposing an
13 outlier protection as an option. And, you know, I would
14 say, I think they -- I don't want to say that it's
15 impossible. They enroll the very sick population, so as you
16 were saying, like a very frail, very complicated patient. I
17 think on the -- from what we've seen -- and again, this is
18 anecdotal evidence when they talk to us about their Medicare
19 and Medicaid payments. We're not able to verify that.

20 From what they say, they sort of, you know, they
21 get their Medicare stream. The Medicaid payments did seem a
22 bit high in some of the states, you know, the providers that

1 we spoke with. They're able to blend that and then they
2 really have the flexibility that a SNP doesn't have to cover
3 clinical and non-clinical services. So they are able,
4 because they have this day care center model, they look at
5 them so closely they can notice very minor changes.

6 We went to one where they were able to weigh them
7 every single day to see -- you know, and a slight
8 fluctuation in weight meant something and they were able to
9 intervene right then. And so, the fact that they're able to
10 cover clinical/non-clinical services, blend these payments
11 together, and then have this, you know, just sort of very
12 intense enrollment that they can intervene really early.

13 And so, now that that's said, you know, we had --
14 the majority of the sites that we had visited were operating
15 at or above break-even. And so, it was a bit of a surprise
16 when we visited the ones that weren't. And they were very
17 forthcoming to us, that it was because they were not
18 balancing. You know, if the IDT recommended something, they
19 were just approving it, and so they weren't really looking
20 for less cost-effective options.

21 So as under any capitated system, you still need
22 to be able to balance needs with cost of services, but it is

1 a model that the -- you know, we have seen that they are
2 able to treat these individuals until the end of life and
3 still be successful financially.

4 MR. HACKBARTH: But could I just pick up on
5 Peter's question? What I heard in the first part of Peter's
6 question is a question about just the statistics of this

7 MR. BUTLER: Sure.

8 MR. HACKBARTH: We have an actuary here who can
9 help us.

10 MR. BUTLER: Four or five cases can vary the whole
11 thing.

12 MR. HACKBARTH: Yeah. When you're talking about
13 such a small population, the random variation and the cost
14 per enrollee is very large, and for these organizations, it
15 would be very vulnerable to a couple bad seriously ill
16 patients, putting them under. So what are we missing?

17 MS. AGUIAR: Right. I would say I think there are
18 probably sort of two things. I mean, one is when they get
19 the patients initially, these are frail -- you know, they
20 otherwise would be -- they have to be certified to otherwise
21 have been in the nursing home within six months. But when
22 they get them, they have to be able to live safely within

1 the community.

2 So even though they are sort of very high need,
3 they may not necessarily be high need in terms of
4 hospitalizations, ER -- if they're being managed. So if
5 they come into the PACE site and they're managed well, you
6 may not be getting the high acute care expenditures on them
7 because the care coordination is so intense and the
8 management is so intense, and I think that does help.

9 They do also have reinsurance, as Carlos was
10 reminding me, and so again, that helps as well. You know,
11 we did hear at one of the sites said that they were able to
12 break even, I believe, within 11 months or 18 months, very
13 quickly, and they attributed that to because they didn't
14 have any high cost outliers.

15 And so even though they're accepting this very
16 frail population, they really seem to sort of get them at a
17 point where they could hopefully, with intensive, you know,
18 more primary care, less expensive interventions, prevent the
19 high cost outliers like extended hospital stays. So I think
20 from what we've seen, that seems to be how they're able to
21 do it.

22 MR. HACKBARTH: Mary and Bruce, did you have

1 something to contribute on this point?

2 DR. NAYLOR: I would comment on the risk pools
3 that are required for each of the sites, so either
4 reinsurance program or these sites have to have very high
5 risk pools available for those people.

6 MR. HACKBARTH: Bruce?

7 DR. STUART: High spenders doesn't necessarily
8 mean high risk. In other words, if you've got a very
9 homogeneous population, the actual risk might be reasonably
10 low, at least in respect to the average cost. And that's
11 what it strikes me that you're doing here, is that you're
12 really trying to get a homogeneous population that meets a
13 particular set of standards.

14 And it would be really useful -- I don't know
15 whether you could get it -- but to see individual variation
16 in cost for people in these plans, because I think that
17 would address the question that Peter has raised. It may
18 not be possible because they're capitated.

19 MR. HACKBARTH: Okay, thanks for that. Mike,
20 clarifying questions?

21 DR. CHERNEW: First, I can't believe that these
22 people wouldn't have a lot of variation given the way --

1 even if they were incredibly homogeneous -- if they were
2 exactly the same, I just have to believe that there's just a
3 lot of variation in what they're spending. So I think the
4 reinsurance has to be the key.

5 But the question I had was, what's the magnitude
6 of the hospital savings of these types of things? There's a
7 lot -- usually a relatively modest percent change in the
8 risk of hospitalization can be a really big deal if the
9 baseline risk of hospitalization is really very high.

10 MS. AGUIAR: Right. So I can't directly answer
11 that question because we heard anecdotally from them, and at
12 least one of the sites gave the examples of some of their
13 frequent flyers, that as soon as they got them in and they
14 got them managed, they were able to reduce the number of
15 hospitalizations.

16 We don't have any quality measures to be able to
17 see, which is one of our concerns, exactly how much, you
18 know, what the hospitalization rate is. And again, that
19 also goes back to the issue of how they're paid, because
20 since they are paid a capitated rate -- so I'm not sure if
21 you're asking like sort of compared to fee-for-service what
22 the savings would be.

1 DR. CHERNEW: Well, I guess the point is, the
2 savings from hospitalizations all accrue to the PACE
3 program, and it sounds like they basically invest those
4 savings in these other set of services, so then they have
5 better quality and they come close to breaking even.

6 And so, the basic question I was trying to figure
7 out is, if they were reducing the hospitalization rate by 10
8 percent, that could be a lot of money that they could --
9 they would either keep it or they would be able to invest in
10 better quality. But if they were reducing hospitalizations
11 by just, you know, a small fraction, maybe not so much.

12 MS. AGUIAR: And I agree with you and we honestly
13 really did try to get to that level of information. When we
14 spoke with the sites, we weren't able to. The most that we
15 were able to get from them was that they track the number of
16 hospitalizations, nursing home utilization, things like
17 that, each month.

18 And so sometimes they gave us those numbers, but
19 we didn't have a sense of, Okay, well, what was it when they
20 first came in or what was their hospitalization rate before
21 they came in. So unfortunately, we don't have that data.

22 DR. MARK MILLER: Maybe we could follow up on this

1 question. Go back and look at the evaluation and see
2 whether there was any breakout there that would direct us to
3 answer his question. So that's another place we'll look.

4 MS. BEHROOZI: Actually, I was thinking about
5 that. If they're comparing it to a baseline group, then
6 that's kind of like a risk adjuster kind of thing. What's
7 the -- it sounds more like a before and after as opposed to
8 this group versus that group.

9 If there's an equivalent group, then that might
10 serve as a basis for risk adjusting. And they're only going
11 to be saving money if they're getting paid based on the
12 appropriate risk level that these people would otherwise
13 have been going to the hospital a lot. So, you know, you've
14 already emphasized the importance of getting risk adjustment
15 right.

16 So my question was, you referred, Christine,
17 actually in responding to Glenn, about how this is an all-in
18 payment, right? And so, then doesn't it differ from
19 Medicare Advantage, which doesn't include hospice, right?
20 Is there anything else that Medicare Advantage doesn't
21 include?

22 MS. AGUIAR: So I'm going to defer to Carlos if I

1 get this wrong. But I believe you could be in Medicare
2 Advantage and if you need hospice, you can go back into fee-
3 for-service. Is that correct?

4 MR. ZARABOZO: In the Medicare Advantage
5 situation, you can elect Medicare hospice and then you
6 maintain your enrollment in the Medicare Advantage plan.
7 The payment to the plan is only for the rebate dollars. So
8 you're still entitled to whatever, like dental coverage or
9 whatever, but you are not, in a sense, no longer enrolled in
10 that plan.

11 MS. BEHROOZI: My question really goes to the
12 payment to the entity. It's not apples to apples. If the
13 payment to the MA plan isn't intended to cover hospice,
14 where is -- the payment to the PACE plan is intended to
15 cover hospice. So that if you just compare it to the
16 benchmarks --

17 MR. ZARABOZO: No, it is the same old payment
18 level. That is, the PACE benchmark was equal to the MA
19 benchmark in a given county. They don't do the computation
20 of are there any rebate dollars, any difference between --
21 they don't do the bidding part. They get the straight
22 benchmark. And it is only -- I mean, that is intended for A

1 and B, as you say.

2 MS. BEHROOZI: Right, but what PACE is supposed to
3 provide is a bigger basket of goods, or whatever.

4 MS. AGUIAR: Right.

5 MS. BEHROOZI: Okay.

6 DR. MARK MILLER: In addition to the benchmark
7 payment on Medicare, they get a payment from Medicaid.

8 MS. AGUIAR: Right, right.

9 MS. BEHROOZI: Right.

10 MS. AGUIAR: And the frailty adjuster as well

11 MS. UCCELLO: I apologize if you already talked
12 about this, but back to the outlier payments and the
13 reinsurance, if reinsurance is already available, then why
14 are outlier payments needed?

15 MS. AGUIAR: When we spoke -- and again, this is
16 the perspective of the individual providers. You know, they
17 did say to us that the cost of reinsurance was very high and
18 that the deductible -- even if the cost wasn't high and
19 that's sort of a per-person basis, the deductibles are very
20 high.

21 Sort of the reason why we put up an option to have
22 an outlier pool would be because in the event that it sort

1 of has the same impact on sponsors wanting to open new
2 sites, that it did during the rural PACE demonstration. And
3 then in light of any changes to the benchmarks that we end
4 up proposing or recommendations or any future changes to the
5 risk adjustment and frailty adjuster, we were concerned that
6 maybe sponsors would be less reluctant, and so we thought,
7 you know, this is sort of a way to try to spur people to get
8 in.

9 And looking at the experience of it in the rural
10 PACE demonstration, it was hardly not used at all. It was
11 almost -- you guys could think of it like a security
12 blanket, the fact that it was there, and, you know, from
13 what we heard from the sponsor sites.

14 MS. UCCELLO: One more question. The age 55 and
15 above requirement in law, is there any background for why
16 that requirement was included?

17 MS. AGUIAR: Unfortunately, we don't know the
18 historical basis for why that was put in there. What we
19 heard from the PACE staff themselves was that some of them
20 felt that that was an arbitrary, sort of distinction. I
21 mean, I'm sure there was a rationale when that was put back
22 in, and I think, you know, where they're coming from is

1 they've said that they see people who are 53, 54 who
2 completely qualify, yet they can't enroll them.

3 MR. ARMSTRONG: First, just to clarify, a couple
4 of times you said there's limited reported information about
5 the health or other outcomes for the population of patients
6 cared for. That's correct? So there's no way to compare
7 with SNPs or with just fee-for-service, Medicare, how well
8 our investment in PACE programs is achieving certain
9 outcomes for the health of those populations?

10 MS. AGUIAR: Exactly. And CMS does monitor this
11 program very closely. I mean, they've got -- they have to
12 have a quality improvement program. They've got this thing
13 called Level 1 reporting, which is what they have to report,
14 which is what we had in the slide. If they're sort of like
15 an infectious disease or a fall of a certain type, then that
16 sort of -- they have to report that and then that kicks off
17 like a root cause analysis. So they're very closely
18 monitored.

19 The thing is, that data is not publicly reported
20 and I think part of it, I would imagine, is because they are
21 so small. You really have to think of how to be able to
22 report this in a meaningful way.

1 MR. ARMSTRONG: That's a good point.

2 MS. AGUIAR: And so, we were thinking, Okay, that
3 would be step one. Now, whether or not that could be
4 compared to SNPs or -- I mean, ideally, down the road, you
5 would be able to compare, you know, PACE with the fully-
6 integrated dual eligible SNPs and the DSNPs and that sort of
7 thing. We're not there now.

8 MR. ARMSTRONG: Right. So my other question, I
9 think, with respect to the context that you are setting,
10 dealing with a dual eligible population is a huge issue for
11 us overseeing the Medicare program, right?

12 And so, here we are reviewing the PACE program,
13 what we know about that, but that's just one of a variety of
14 different programs that we support through our payment
15 policy to care for these populations of patients, the dual
16 eligible SNPs, some kind of coordination that takes place in
17 the fee-for-service payment structure, and for the most
18 part, it's just totally unmanaged, right?

19 So the question that I have is, are we here to
20 look for ways of improving the PACE program? Are we here to
21 try to learn from the PACE program what are the things that
22 we should take to a future discussion that will help us

1 figure out how in the world do we really do something for
2 dual eligibles?

3 MS. AGUIAR: And I would just say it's both. You
4 know, for right here, we really wanted to be able to present
5 to you, This is what we heard about PACE and since there has
6 been evidence that this program -- you know, it has all of
7 the components of what we would say are, you know, a true
8 integrated care program has and we see that it works in
9 urban and rural.

10 And, you know, there are ways, as Glenn was
11 saying, you could expand it on the margins. You could
12 improve the PACE. You could improve the payment system, you
13 could maybe open access a little bit to it. So we did want
14 to bring this to you all now in the fall for you to be able
15 to see that, and if this is something you are interested in
16 in moving towards recommendations.

17 At the same time, we definitely -- you know, in
18 places of the report we're noting aspects of the PACE
19 program, specifically the flexibility they have to cover
20 non-clinical services, and the fact that they can blend
21 Medicare and Medicaid payments rates, you know, at the
22 provider level.

1 These are issues that are being talked about not
2 only in the dual SNP and the fully-integrated dual SNP
3 worlds, but also on the CMS demonstrations that are going on
4 now. And these would be the 15 state CMS demonstrations
5 going on. There's also sort of two other demonstrations
6 going on with CMS. And so, even though we're sort of
7 looking at, Okay, we know what works in PACE, and then we
8 intend to come back to these other integrated care programs
9 with those components.

10 But we also wanted to sort of, you know, prep you
11 all so that you heard it about it first before, and then we
12 brought it up again in the spring.

13 DR. BAICKER: Two quick related data questions.
14 You talked about the limited availability of outcomes, but
15 mentioned that there were improvements in hospitalizations
16 and some measurable things. I would imagine that part of
17 what is attractive about the program is that people want to
18 stay in the community and that they're getting care that
19 matches more closely their preferences.

20 And so, I wonder if there are any measures
21 available that would capture beneficiary satisfaction or any
22 of those less tangible things than the sort of right tail

1 events of hospitalizations, although maybe they're not so
2 rare in this population.

3 MS. AGUIAR: Some of the individual PACE providers
4 that we spoke with do collect provider -- patient
5 satisfaction surveys. CMS requires them to do the program's
6 QAPI, and then I'm just blanking on what that stands for
7 right now.

8 DR. BAICKER: Of course, QAPI.

9 MS. AGUIAR: Yeah.

10 [Laughter.]

11 MS. AGUIAR: And so, one of those -- I believe
12 that one of those -- and so, they have sort of like buckets
13 of things you have to collect, like utilization is one. And
14 one of them, I do believe, is some sort of patient, family,
15 provider satisfaction model. But that, I don't believe, is
16 as standardized across the sites since they do have leeway
17 to kind of pick which measures than the ones that we had on
18 the slide, which they have to report.

19 So there are -- and I believe, I would say, most
20 of the PACE sites, right, that we spoke with were collecting
21 the patient satisfaction. But again, that's not required.
22 I don't believe that one is required or defined in terms of

1 how they should -- I don't know if they are all defining it
2 the same way.

3 DR. BAICKER: And, of course, you'd want not only
4 them, but you'd want a sample of people who weren't in them
5 so that you could see how good a job they were doing. So I
6 wondered if there was any linkage to MCBS-type data or CAHPS
7 data, something that would indicate beneficiary satisfaction
8 with their plan.

9 DR. MARK MILLER: Not the second connection to a
10 group that weren't in it, but in the things that are
11 currently being collected, I thought there was grievance and
12 appeals, and enrollment and dis-enrollment.

13 MS. AGUIAR: Yeah, I was going to say that.
14 That's kind of the other side of it.

15 DR. MARK MILLER: Which starts to move it in
16 another direction, and I think the main issue, in case this
17 is not crystal clear, it's not that data elements aren't
18 being collected. It's that they're being collected and then
19 just not made public, is kind of the question.

20 MS. BEHROOZI: So, yeah, there are two different
21 problems. Either we need to get access to those data or
22 they could be collected if they weren't, but then a related

1 data question is, the nice version of the story is that all
2 of this coordination leads to the improved outcomes because
3 they can really examine people regularly and coordinate non-
4 typical services and all that.

5 The other version is, it's a selection of -- you
6 know, they're taking enrollees who look different from
7 people who aren't enrolling in this and that it's not a
8 treatment effect, it's a selection effect. So is there data
9 available on the initial characteristics of people to let us
10 know, are these plans do a better job than average or are
11 they just getting a better tranche of patient than average?

12 MR. HACKBARTH: Bob?

13 DR. BERENSON: Yeah.

14 MS. BEHROOZI: Was there an answer to, is there
15 data available on pre-existing characteristics?

16 MR. ZARABOZO: Well, yes, they're coming from fee-
17 for-service, yes. We would have that information, yeah.

18 DR. MARK MILLER: Wait.

19 MR. ZARABOZO: We would have claims information.
20 I'm not sure whether the PACE enrollees are in CAHPS or not.
21 That I don't know.

22 DR. MARK MILLER: Once again, I hate to keep going

1 back to this well, but I guess the other question I would --
2 a potential source for some information on her point would
3 be -- I would imagine this question came up in the
4 evaluation and whether there was a control group and how
5 they dealt with the selection effect, whether they could
6 measure a selection effect there. Maybe we could dive back
7 in and see if there's anything we can bring to bear on this
8 point.

9 MR. ZARABOZO: And another possibility is the
10 thing about prospective enrollees, they also report on who
11 they talk to and didn't enroll. So you could compare those
12 people to the people who actually did enroll.

13 DR. MARK MILLER: And that is data that is
14 currently being collected from the PACEs. Is that correct?

15 MR. ZARABOZO: You know who they are, essentially.

16 MS. AGUIAR: Yeah.

17 DR. BERENSON: I have two questions. First, I'm
18 trying to get my head around the concept of a provider
19 frailty score. As a previously frail provider --

20 [Laughter.]

21 DR. BERENSON: -- is it basically a function of
22 the individual ADLs and does it continually change as the

1 enrollment changes? In other words, it's really just an
2 average of the individual frailty adjustments?

3 MS. AGUIAR: Right. That's exactly right. It's
4 the HOSM survey, which Kelly could talk a little bit more
5 about what's in it specifically, but I believe that's given
6 every year. And then let's say in a given PACE provider
7 across all of their beneficiaries they have an average of
8 three to four ADLs. Then that's the bucket of the frailty
9 adjuster that they get.

10 I think that frailty adjuster, I think, is like 10
11 percent or something. And so then each of their --

12 MR. ZARABOZO: It varies depending upon the number
13 of ADLs.

14 MS. AGUIAR: Yeah, right, the number of ADLs. So
15 again, if on average you have, let's say, three to four ADLs
16 across your entire PACE population, there's a specific
17 frailty adjuster for that, and then that frailty adjuster is
18 applied to the payments for each enrollee. So each enrollee
19 payment is bumped up by that frailty adjuster.

20 DR. BERENSON: But does the frailty adjuster keep
21 changing as enrollment and dis-enrollment occurs, or is it
22 fixed for some period of time?

1 MS. AGUIAR: For a year.

2 DR. BERENSON: It's fixed for a year. I see.

3 MS. AGUIAR: So it's based on that survey and
4 every year when they --

5 DR. BERENSON: So it is a provider frailty
6 adjuster and not just a rolling average of the -- I got it.
7 The other one goes to the second purpose of all of this, is
8 what can this tell us about how do we deal with the larger
9 population of duals?

10 So my question, will we be able to know whether
11 dual eligible SNPs have looked at the PACE model and have
12 adopted forms of it, but not the -- you know, in other
13 words, have figured out in any way how to do without the
14 full adult day care or have figured out a way in which
15 beneficiaries can keep their doctor, but in a certain -- in
16 other words, how important is the PACE model to SNPs, I
17 guess is my question?

18 MS. AGUIAR: Right. I would say so, and again, if
19 you remember last February, I think it was, we reported on a
20 review that we did of the -- that Carol Kelly and myself had
21 done on the SNP models of care, and so we were sort of
22 looking for these exact things.

1 And again, unfortunately a lot of the detail just
2 wasn't there, but they were asked to talk about sort of the
3 interdisciplinary team and that is a piece -- that is a
4 component of the PACE model, the interdisciplinary team and
5 sort of how the interdisciplinary team functions within the
6 SNP.

7 And so, some of the models of care where there
8 were detail on that, you know, they did go into how they
9 have like case rounds or sort of team meetings. And so that
10 appeared to be less intensive. Again, this is a very small
11 sample where we were able to read this about. Then you have
12 in the PACE model where they meet, they have daily morning
13 meetings, they have weekly IDT meetings. And so that's the
14 difference between what happens when you have a day care
15 center and, you know, sort of, and you don't.

16 But, you know, we have heard -- again, we heard a
17 little bit of -- I don't want to say complaint, the word is
18 maybe too strong, but we have heard this from some of the
19 SNPs, that they felt that the model of care requirements
20 were pushing them to look too much like PACE and were sort
21 of built off of PACE.

22 And so, again, to the extent that they are doing

1 some of this, I would say what we were able to see was this
2 aspect of maintaining the IDT, and they -- you know, sort of
3 assessing the risk. But we just didn't see the evidence in
4 the models of care that we reviewed, that they were doing
5 sort of the more intense daily monitoring. And again, you
6 need the day care center for that.

7 And I think, you know, this really gets to the
8 issue of why we wanted to look at PACE without walls,
9 because we wanted to sort of see how can you relax this
10 model, but can you relax it but still retain what works.

11 And again, we found that there really wasn't
12 support for that, which lends us to sort of think maybe,
13 again, if there's interest in the Commission, that would be
14 maybe something that we would, you know, sort of pursue
15 later.

16 And I think you could envision a PACE without
17 walls where you have this IDT that doesn't revolve around
18 this day care center. That could be almost like a model of
19 care that then could be adopted by a DSNP and by Medical
20 Home and by an ACO and that sort of thing.

21 MR. KUHN: Two questions. One is, in the
22 information that you shared with us, the PMPM for the PACEs

1 is between \$1,700 and \$2,600 per month, and I know it's not
2 an apples to apples comparison, because as you said, you get
3 the Medicare payment, the Medicaid portion, and then the
4 frailty and the benefit package is different, obviously.

5 But just so I get some sense of scale -- maybe,
6 Carlos, you know this information -- what's the range of
7 PMPMs for MA plans? Any idea?

8 DR. HARRISON: It's going to be probably \$800 to
9 \$900.

10 MR. KUHN: So \$800 to \$900, I think. Okay. So
11 I'm just looking for some scale from the difference. And
12 the second thing I was just curious about is kind of the
13 management of the program with CMS. My recollection -- I
14 could be off on here -- is that this program, you know, it's
15 one of those programs probably unique anywhere that's got a
16 footprint in both Medicare and Medicaid and CMS doesn't
17 cross those paths too often.

18 So I think for a long time, the PACE program has
19 run through the Center for Medicaid and state operations,
20 but my recollection is there was going to be a movement of
21 this over to the Center for Medicare, over to the Health
22 Plans, because it does look more like a health plan than a

1 Medicaid program.

2 Did that transfer of responsibility ever occur?

3 And if it did, have we seen any difference in terms of the
4 management of this program as a result of that transfer?

5 MS. AGUIAR: I have to tell you, we actually -- I
6 don't know the answer to that and we'll try to follow up on
7 that. We did struggle a bit with trying to identify who
8 exactly in CMS is responsible for this. And so that's
9 something that we're still tracking down.

10 DR. HALL: For the first round, as I understand
11 it, your methodology looked at two urban sites and five
12 rural sites. Is that right? Do you know the duration of
13 those programs? Were they long-standing, fairly new?

14 MS. AGUIAR: The rural sites were there for at
15 least three years because they were all part of the rural
16 PACE demonstration. The urban sites, I would have to go
17 back to see, and I'm going to say I'm not exactly even sure
18 if we sort of asked that them. But my recollection is that
19 they were perhaps either three years or longer. We didn't
20 speak with anyone who had just opened.

21 DR. HALL: So anyone who's been involved with the
22 PACE program, what you find out over time is that your

1 patient population ages up. So at some point, if you've
2 been very successful, people have stayed in the program,
3 they start to have a much greater need for hospitalization,
4 for consideration of hospice care; whereas, a new site, for
5 the first year, they're very enthusiastic because people,
6 even though they're labeled as frail, are sort of the early
7 frails. So that's an important kind of distinction that
8 might be worth looking at.

9 DR. STUART: I realize you do not have the
10 information listed up here, but I did want to ask a question
11 about dis-enrollment. Kate was concerned about selection on
12 enrollment, but there could also be selection on dis-
13 enrollment, and I would assume that patients who are
14 enrolled in PACE, at a point that they get -- they must be
15 in a SNF and they dis-enroll from PACE, or do they stay --

16 MS. AGUIAR: No.

17 DR. STUART: Okay, all right.

18 MS. AGUIAR: Yeah, yeah.

19 DR. STUART: Do you know anything about dis-
20 enrollment?

21 MS. AGUIAR: You know, a few years ago, we had
22 asked this of the National PACE Association and I want to

1 say it's about 5 percent. It's fairly small. And the major
2 reasons for dis-enrollment, I believe, are moving out of the
3 service area. So you have to reside within the PACE service
4 area.

5 You know, we heard anecdotally again, and sense
6 that people are dis-enrolling because they just weren't --
7 didn't really want to attend a day care center focus model,
8 you know, things like that. So those were sort of the main
9 reasons. But we do get the sense that it is very small.
10 And again, the PACE providers have them for life. So if
11 they are in post-acute hospital end of life, they're still
12 within the program.

13 DR. STUART: I think if it's very small, then the
14 issue of de-selection, if you will, is not a strong one.
15 But obviously it could be that these are the real outliers.
16 They never get to an outlier pool because they are, you
17 know, the patient is, I won't say coerced, but is
18 recommended that they would do better somewhere else.

19 MR. GEORGE MILLER: Yes. Do you have the
20 demographics for the 21,000 members?

21 MS. AGUIAR: No --

22 MR. GEORGE MILLER: Could you get that?

1 MS. AGUIAR: Let me check to see if we could get
2 that information. We did try to get that information on a,
3 you know, per site basis.

4 MR. GEORGE MILLER: Yeah.

5 MS. AGUIAR: I don't know if that would be
6 representative, but we could check to see if we could get
7 that.

8 MR. GEORGE MILLER: And then do you have a map? I
9 think in other sectors of the market, you were able to put a
10 map up of where the locations are of the PACE providers?
11 That would be helpful, just to know where they are.

12 MS. AGUIAR: Oh, sure.

13 MR. GEORGE MILLER: These seven sites --

14 MS. AGUIAR: We could do that.

15 MR. GEORGE MILLER: -- what states -- you said 28
16 states, 77 sites. I'd just be curious where they are. And
17 do you have a breakdown of how many are for-profit and not-
18 for-profit?

19 MS. AGUIAR: You have to be not-for-profit.

20 MR. GEORGE MILLER: Have to be. Okay.

21 MS. AGUIAR: Exactly. And the for-profits were in
22 -- there was a demo, right? There was a demo that was going

1 to allow for-profit.

2 MR. GEORGE MILLER: For-profit. I remember
3 reading it.

4 MS. AGUIAR: It didn't have any take-up.

5 MR. GEORGE MILLER: Okay, okay. And just finally,
6 I think Herb may have asked part of this question earlier,
7 but do you have a concept of the total spend where they may
8 be saving -- you know, you have coordinating care and if it
9 keeps them from going to the hospital, what that potential
10 could have saved? Did you do that type of analysis?

11 MS. AGUIAR: You mean to the actual PACE program
12 which is the Medicare program?

13 MR. GEORGE MILLER: To the Medicare program.

14 MS. AGUIAR: Right. So again, this goes back to
15 the situation that again, because PACE does save, you know,
16 reduces hospitalizations --

17 MR. GEORGE MILLER: Right.

18 MS. AGUIAR: -- you know, emergency care, it
19 should save relative to fee-for-service.

20 MR. GEORGE MILLER: Right.

21 MS. AGUIAR: And there was an analysis that was
22 done when it was in its demonstration phase, when it was on

1 a different payment system that did demonstrate and was able
2 to quantify that.

3 MR. GEORGE MILLER: Right.

4 MS. AGUIAR: The problem is now, though, that
5 because it's paid on the MA payment system and it's with the
6 higher benchmarks --

7 MR. GEORGE MILLER: Got you.

8 MS. AGUIAR: -- that we're not actually capturing
9 those savings.

10 MR. GEORGE MILLER: Right. Okay. Thank you.

11 DR. NAYLOR: So first let me just disclose that I
12 started the PACE program at the School of Nursing. It's
13 about 12 years old now and we'll have a lot to say in Round
14 2, and I'm not just channeling Jennie, but I want to make
15 sure we do channel her here today.

16 When you constantly talk about Medicare spending
17 pre-PPACA using county benchmarks, can you just -- I'm not
18 sure that I heard or maybe don't understand what are the
19 differences in those benchmarks, pre-PPACA and -- I mean, is
20 that the \$800 to \$900 versus --

21 MR. ZARABOZO: What PPACA did, as mentioned in the
22 mailing materials and in this slides, it will bring, in many

1 cases, the payment levels closer to fee-for-service levels
2 in a given county. But you had different levels. There's a
3 phase-in, an up to six-year phase in, and so some counties
4 will be at 95 percent of fee-for-service, some at 100
5 percent, 107.5 percent, 115 percent.

6 So in the end, it will be very close overall to
7 average fee-for-service as payment to MA plans, which is not
8 the case under the pre-PPACA benchmarks.

9 DR. NAYLOR: And that would be average for all --

10 MR. ZARABOZO: Across the country, right.

11 DR. NAYLOR: -- fee-for-service Medicare
12 beneficiaries, not thinking about this population. Is that
13 right?

14 MR. ZARABOZO: This is, I think, in MA -- where
15 does MA stand in relation to fee-for-service? It will be
16 eventually very close to average fee-for-service.

17 DR. NAYLOR: Do you understand the decision-making
18 behind not including PACE?

19 MR. ZARABOZO: I don't know that we know why. One
20 point, though, is that the PACE -- they do not participate
21 in the Star System, which is a source of bonuses for the MA
22 plans, so that's one minor point, in a sense. But they --

1 you know, it's under a separate provision of the statute and
2 we don't specifically know why they were not carried along
3 in the reform.

4 MR. HACKBARTH: In part it was to provide more
5 favorable treatment to an important population that's
6 relatively small. It doesn't have huge fiscal consequences,
7 so they were exempted from the ratcheting down under PPACA.
8 I don't know that, but I suspect that was part of the
9 thinking. Ron, clarifying questions?

10 DR. STUART: It's a very elementary question.
11 This program has been around for awhile. CMS has been
12 collecting this data. Why isn't it available?

13 MS. AGUIAR: So we again, and this goes along with
14 our difficulty to be able to find exactly who within CMS
15 would be responsible for this. We don't know exactly why
16 they aren't publishing it. I would imagine, though, that --
17 you know, when we're saying we would like for them to
18 publish it, we'd like for them to publish it, as Carl says,
19 in a meaningful way.

20 And so, in order to do that, you really have to
21 think, Okay, well, you have providers that are really so
22 small, you know, can you combine across multiple years? You

1 know, use it for an intensive monitoring population --
2 purpose, but they don't use it for sort of an access so that
3 beneficiaries and, you know, their caregivers could use it.

4 MR. ZARABOZO: And if you do publish it as is, so
5 to speak, it's hard to interpret what this means. I mean,
6 what is the benchmark for who's good, who's bad, if you're
7 just comparing one PACE plan to another. Are there special
8 characteristics that you need to take into account? Should
9 you do this kind of fee-for-service to, you know, PACE
10 enrollees to non-PACE enrollees?

11 In other words, what is the benchmark for
12 evaluating quality. It's very hard to know, so it would
13 need a lot of, I think, work before you could actually
14 publish something meaningful about these measures as
15 collected.

16 DR. STUART: Thank you.

17 MR. HACKBARTH: Bill, Karen?

18 MS. UCCELLO: I'm just interested in thinking
19 through more of the issues of this outlier and I'm happy to
20 kind of talk with you more offline.

21 But I think one thing to kind of keep in mind is
22 the relationship between the risk adjusters and how they

1 especially don't necessarily do as well with this
2 population, even with the dementia component and how that
3 may argue more for an outlier versus a re-insurance type
4 approach for funding this. So I need to think through it
5 more, but that's where I'm thinking right now.

6 MR. ARMSTRONG: I mostly got it out of my system
7 the first round and I'm sure Mary and Bill will cover
8 anything else I think of saying, but I did just want to
9 confirm that as we go forward with this analysis, that we
10 really recognize, there's a portfolio, if you will, of
11 different programs that are alive and producing different
12 various results through our Medicare program serving dual
13 eligible patients.

14 And I'm assuming that what we want is some
15 assessment that tells us, Well, what are we getting and what
16 are we not getting from each of these elements so that we
17 can generalize about what the policy agenda will be on down
18 the road? And so, I just -- I'm presuming that's really
19 what we're trying to do here and I just wanted to clarify.
20 I think that's really important work.

21 DR. BERENSON: Yeah, I would just confirm what you
22 said in response to Scott before, which I think we have two

1 purposes here. I mean, I think we are now engaged in the
2 PACE program and can make some useful recommendations, but
3 the ultimate, more important part of this inquiry seems to
4 me for the much larger population and what the lessons are
5 here.

6 So I endorse the sort of two -- the two purposes
7 of part of what you said we're doing here.

8 MR. HACKBARTH: Kate, did you have comments?
9 Herb? Bill?

10 DR. HALL: Well, Bob, building on your comments, I
11 think it would be very useful to carry this analysis
12 further, not only in terms of the mechanics of successful
13 PACE programs, but also if it isn't too much of a stretch,
14 these are our Nation's sort of models of Medical Home and
15 even, arguably, the Accountable Care Organizations.

16 A good PACE site has everybody working totally to
17 the very ceiling of their scope of practice. They're very
18 open to different kinds of models of care providers. For
19 example, in some of the PACE sites that I know, including
20 ours in Rochester, the bus driver is perhaps one of the most
21 key individuals in the entire team because he or she really
22 knows what's happening with frailty.

1 And they're the ones that can sense, almost by
2 just seeing how people are moving into the bus, whether
3 there's a problem or not. This is something that whatever
4 it is, it's something that I'm sure is quite translatable.
5 On a larger plane, though, this requires a very different
6 type of medical personnel working in these sites. High
7 sensitivity to alternatives to hospitalization, having
8 worked through all the ethical problems of, am I just trying
9 to save money or am I trying to provide the highest quality
10 of life, very, very critical and important questions.

11 And the people who stay in these sites, in my
12 experience, just rise to the occasion. They're saints, in
13 many ways. Now, why is that important? Because I think we
14 can probably learn, particularly from the successful sites,
15 what have they been able to do to take providers and put
16 them into this situation and make it work? So I hope that
17 you can do that as you move forward.

18 DR. STUART: Well, now we know that if you put the
19 bus drivers together with the ambulance drivers, you're
20 going to be able to solve this problem of rural health care.

21 MS. BEHROOZI: Thank you for the plug for health
22 care workers, yes.

1 DR. HALL: All we need is an acronym for that.

2 [Laughter.]

3 DR. STUART: I have one, you know, observation on
4 what Ron raised about access to these data. I can
5 understand why CMS does not publish these on a plan-by-plan
6 basis, but that wouldn't apply to publishing them on an
7 aggregate basis.

8 So would it be possible to get the rates of these
9 things over the 77,000 people that are, you know, that are
10 receiving these services, and then you might have some
11 errant way that you could compare this to the Medicare
12 population at large?

13 I'm not sure how far you'd go up with that, but I
14 think that would go some way to helping us try to understand
15 what this population is getting.

16 MR. HACKBARTH: If only we can find the person in
17 CMS who has the data, right?

18 [Laughter.]

19 DR. STUART: The second thing I want to raise, and
20 this has not been talked about yet today and I don't want to
21 suggest that this open up a whole new round of discussion,
22 but it's obvious that this is -- we're worried about the

1 Medicare side of a Medicare plus Medicaid population.

2 And so the question to you would, is there
3 something about your site visits, because they were in
4 several states, that tells us something about the ability of
5 these plans to prosper as a function of the state Medicaid
6 policies?

7 MS. AGUIAR: So we were -- and again, this is from
8 what they told us about what their rates were. We were
9 somewhat surprised by how high the rates were. They do tend
10 to be a blend of home and community-based services and
11 nursing home rates. And some sites -- some of the staff at
12 some of the sites really did acknowledge that they are
13 fairly high because they had like high nursing home rates in
14 those states, so they were benefitting from that.

15 But again, even in one of the states that I'm
16 thinking of that really did have the high Medicaid rates,
17 they still were not operating at or above break-even. And
18 so, that sort of led us to this observation that we spoke
19 about that, you know, even within both the Medicare and
20 Medicaid capitated payments and the ability to blend and the
21 ability to cover even non-clinical services, you really do
22 have to -- we found that, you know, the sites that really

1 understood this was a capitated system and they had to be
2 able to look at cost-effective measures, were the ones that
3 were able to be profitable.

4 DR. NAYLOR: Now, I was going to say how long do
5 we have? I think the PACE model, first of all, I believe
6 everything can be improved. So let me start there. But the
7 PACE model has had a really interesting history. It started
8 in the 1970s as a site that then the Robert J. Wood
9 Foundation invested in to say, Can we learn from this and
10 scale it to maybe 10 to 15 sites, rigorously evaluate it,
11 and then the Federal Government says, This really is showing
12 something important for a very high-risk population who
13 would otherwise be in nursing homes and who want to stay in
14 their community.

15 And it has been rigorously evaluated since. So I
16 think one of the things we'll want to do is just get all of
17 the published accumulated evidence on the PACE program in
18 which there have been comparisons between PACE and at least
19 a comparable risk population.

20 And that's where we've learned that it has, in
21 fact -- I mean, this is full clinical integration and full
22 payment to achieve that. So we assume -- the program

1 assumes full responsibility for primary, chronic, acute,
2 post-acute, hospice, all of that care, and full risk for it.

3 And it has, in many ways, figured out how to be a
4 learning health system in its own model, meaning sharing
5 with each other things that work and don't work, et cetera.
6 So I think in our path, as a country, from fragmentation to
7 integration, it has a lot to tell us as a model.

8 It's not perfect, but I would hope that as we move
9 forward, that this is where we can think about how payment
10 policy and delivery systems need to be linked to outcomes,
11 and thinking about, we don't lose something really important
12 in our efforts.

13 I mean, in some ways, and I would say within CMS,
14 talk to Melanie Bella, the Federal health coordinated
15 counsel center, whatever it is, and her team who are
16 spending every day now trying to align what PACE has done,
17 which is, how to align benefits to match service needs and
18 to get to better care and reduce costs. I suspect she might
19 have the data that you're talking about, or at least tell
20 you where it is.

21 But I would also say, the PACE sites are providing
22 excellent data, and so it is an issue of maybe the public

1 disclosure in exactly the form that you're talking about.

2 So I'm just cautioning us to make sure that, you know, as we
3 move toward improvements, we really are sensitive to also
4 not getting us to a place where we lose what is the great
5 value here for a population.

6 Let me also say that things are changing daily
7 with the state changes in Medicaid reimbursement it's
8 having. So this is a great experiment in place of what's
9 happening and what might happen that might be different,
10 even six months ago or whenever your visits were, than
11 today.

12 So the rates are quite different today, full
13 rates, than they were even a few months ago. Anyway, I
14 think it's an opportunity especially to think about lessons
15 learned, to bring this to the broader population of dual
16 eligibles.

17 DR. MARK MILLER: Just one real mechanical point
18 for everybody. We do talk to Melanie Bella actually once a
19 month. She's been briefed on this, knows where we are and
20 what we're doing, and also on MACPAC as well. Same drill.
21 They've been briefed on this. We talk to them at least once
22 a month, if not more frequently. So we're staying connected

1 to that crew.

2 MR. HACKBARTH: Thanks, Mary. Ron, Round 2
3 comments? Bill, Karen?

4 DR. BORMAN: Just one brief comment and I think
5 that probably everyone here acknowledges all the great
6 benefits that potentially are here. I think we all have the
7 question of generalizability and that remains to reach some
8 final conclusion.

9 Along that line, I would just say that hopefully,
10 as we look at data and make generalizations, I'm
11 recollecting within this past year, I think it was presented
12 at the American College of Cardiology, a study looking at
13 daily contact with certain patients with heart disease in an
14 attempt to try and reduce some of the potential morbidities.

15 And somewhat to their surprise, the data did not
16 come out strongly in favor of that. And so, I think we just
17 need to be a little bit careful about, because it works in
18 one setting, that it will generalize to a very large
19 population in other settings, which I'm sure is not what
20 anyone is advocating.

21 DR. NAYLOR: And actually, I'm talking about --

22 DR. BORMAN: As we identify key features, we want

1 to make sure that before we say we advocate this feature for
2 other parts of the program, that we look at relevant data
3 from other than PACE about those key features. And that's
4 the only thing.

5 MR. HACKBARTH: Okay, well done. Thank you all.
6 And we'll now have our brief public comment period. And
7 please begin by identifying yourself and your organization,
8 and limit yourself to no more than 2 minutes.

9 MR. BLOOM: I'll do my best.

10 MR. HACKBARTH: When this light comes back on,
11 your time will be up.

12 MR. BLOOM: Can I use 2 minutes when the
13 microphone starts here?

14 MR. HACKBARTH: It's on.

15 DR. MARK MILLER: It's on.

16 MR. BLOOM: My name is Shawn Bloom. I'm CEO of
17 the National PACE Association. I'd like to begin by
18 expressing my appreciation for the work that you've done in
19 looking at PACE.

20 I'd like to take my short 2 minutes to actually
21 make some observations and clarify some things I've heard
22 today that we'll certainly follow up with.

1 First off, I think it's important to not that the
2 duals are a very diverse audience, a very diverse
3 population. We serve a very small segment of the duals, so
4 I think kind of generalization about how we compare to the
5 duals with respect to costs and models of care and
6 approaches to care, I think we need to be really thoughtful
7 about that.

8 Two, we are a provider of care. We're not a
9 health plan. There's a big distinction between integrating
10 financing at an insurance health plan level and actually
11 integrating care, as PACE does, fully at the provider level.
12 That's a significant distinction and one I would hope you'd
13 look into.

14 With respect to quality data, we share your
15 concerns. We submit mountains of data to CMS. We have with
16 our own initiative, we're developing our own quality outcome
17 measurement set. We have something called Data PACE 2. We
18 collect a huge amount of diagnostic prescription drug
19 utilization data, outcome data, and we give that back to
20 PACE programs for performance improvement. So we ourselves
21 would welcome the opportunity and actually have recommended
22 to CMS that we have a PACE-specific data set. So we'd

1 welcome that.

2 I think it's important to note with respect to
3 payment that looking at the county rates alone and making
4 judgments about whether we're overpaid or underpaid is kind
5 of a gross measure. I think it's important to note our
6 payments have actually dropped 9 percent in the last 3
7 years. We're expecting another 3 percent reduction in 2012;
8 whereas, I think the MA plans, if you looked at their
9 overall rates, they've been relatively stable. So I think
10 looking at county rates alone as a measure of our payments
11 is -- I'd caution you on that, quite frankly.

12 With respect to Congress' recognition of PACE in
13 PPACA, having been in those discussions, I think there's
14 enough research out there to indicate that the general HCC
15 model, which is based on the general Medicare population,
16 grossly underpredicts at the edges; hence, a statutory
17 requirement for CMS to come up with a frailty adjuster.
18 We've just completed 3 years of analysis of a comparable
19 population with Duke University and their actuaries, and
20 we're going to be meeting with the staff at MedPAC next week
21 to share that. And so we really hope that the Commission
22 has a chance to kind of look at that and look at the

1 performance of the HCC model, because I think comments about
2 that PACE is always going to be higher than anybody outside
3 of fee-for-service is a little concerning to us.

4 Lastly, with respect to kind of obstacles to
5 growth, we have been working a lot with CMS and the states
6 to identify what those obstacles are. I would say in about
7 a fourth of our states we have enrollment caps where we've
8 been artificially capped in terms of our growth, as well as
9 in most states it takes four to six weeks to get in PACE,
10 but you can get in a nursing home in a day.

11 So there are some fundamental obstacles in the
12 system out there that are not reflective of PACE's ability
13 to grow or desire to grow but, rather, I think inherent to
14 the enrollment systems in the state.

15 I've got a lot of other points, but I'll leave it
16 to our letter that we'll follow up in clarification. But
17 I'd be happy to answer any questions. We have mountains of
18 data. If you'd like to see it, we'd be happy to provide it.
19 We could answer probably half the questions that were raised
20 today, and we'd be happy to do so moving forward.

21 Thank you.

22 MR. HACKBARTH: Okay. Thank you.

1 We are adjourned for today and will reconvene at
2 8:30 a.m. tomorrow.

3 [Whereupon, at 5:30 p.m., the meeting was
4 recessed, to reconvene at 8:30 a.m. on Friday, September 16,
5 2011.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, September 16, 2011
8:30 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
WILLIAM J. HALL, MD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

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1 P R O C E E D I N G S [8:30 a.m.]

2 MR. HACKBARTH: Okay. It's time for us to get
3 started. We have three presentations scheduled for this
4 morning, the first being on risk adjustment in Medicare
5 Advantage. Dan, whenever you're ready.

6 DR. ZABINSKI: Thank you. In Medicare Advantage,
7 plans receive monthly capitated payments for each enrollee,
8 where each payment is the product of a local base rate and
9 the risk score for the beneficiary. CMS derives these risk
10 scores from the CMS hierarchical condition category (CMS-
11 HCC) risk adjustment model, and the risk scores represent
12 each enrollee's expected annual Medicare spending relative
13 to the national average.

14 The CMS-HCC uses data from each enrollee to
15 determine the enrollee's risk scores. The enrollee's data
16 falls into two broad categories: demographic and
17 conditions.

18 The demographic data include the enrollee's age,
19 sex, Medicaid status, institutional status, and whether the
20 enrollee is aged but was originally eligible for Medicare
21 because of a disability.

22 The medical conditions are from conditions

1 diagnosed in patient encounters the previous year during
2 hospital inpatient stays, hospital outpatient visits, and
3 physician office visits. These diagnoses are then
4 categorized in broader condition categories called HCCs, and
5 there are 70 of them in the current version of the model.

6 CMS then uses demographic data, the medical
7 conditions, and Medicare fee-for-service spending at the
8 beneficiary level in a regression model that produces
9 coefficients for each demographic variable and each HCC,
10 which CMS then uses to determine risk scores.

11 As an example of how risk scores are determined,
12 consider an example of a female, age 68, who is on Medicaid
13 and has been diagnosed with COPD. For this beneficiary, the
14 following coefficients from the CMS-HCC apply: for a female
15 age 65-69, 0.30; for a female on Medicaid and aged, 0.18;
16 and for all beneficiaries with COPD, 0.40. Then to
17 determine this beneficiary's risk score, you simply add the
18 coefficients that apply: 0.30 plus 0.18 plus 0.40 equals
19 0.88.

20 Now, despite having COPD, this person's risk score
21 is actually below the national average, which is 1.0 each
22 year. That result simply indicates the importance that age

1 can have on a beneficiary's risk score. For example, if
2 this person was age 75 or older, her risk score would have
3 been greater than the national average of 1.0.

4 The general purpose of the CMS-HCC risk scores is
5 to adjust the MA payments so that they accurately reflect
6 how much each enrollee is expected to cost. Accurate
7 payments prevent overpayments and underpayments that are
8 systematic with respect to each enrollee's characteristics.

9 From this perspective, the CMS-HCC is much better
10 than the demographic model that was previously used to
11 adjust capitated payments. However, concerns remain over
12 the CMS-HCC.

13 First, despite paying more accurately than the old
14 demographic model, there still may be systematic
15 overpayments or underpayments for enrollees with specific
16 conditions or characteristics. For standard plans that
17 enroll a wide range of beneficiaries, these overpayments and
18 underpayments should largely offset. But plans such as SNPs
19 and PACE plans that focus on complex patients with specific
20 characteristics may be systematically underpaid for their
21 specialty group.

22 Second, to the extent there are systematic

1 overpayments for some beneficiary groups, there may be
2 opportunities for plans to benefit from favorable selection.

3 Finally, research from the Dartmouth group
4 indicates there are regional differences in level of service
5 use in fee-for-service Medicare that leads to regional
6 differences in the coding of conditions. If these regional
7 coding differences carry over into Medicare Advantage, plans
8 that are in regions where coding is most intensive will have
9 higher payments than plans that are in areas where coding is
10 less intensive. Over the next few slides, we'll cover these
11 issues in greater detail.

12 An important feature of an effective risk
13 adjustment model is that it addresses enough of the
14 variation in beneficiaries' costliness to minimize
15 opportunities for plans to financially benefit by enrolling
16 beneficiaries with certain risk profiles -- that is,
17 favorable selection.

18 A concern that some may have about the CMS-HCC is
19 that it has an R-square of 0.11, meaning that it accounts
20 for about 11 percent of the variation in Medicare spending
21 at the beneficiary level. This may sound very low, as it
22 suggests that it leaves 89 percent of the variation

1 unexplained. However, much of the variation in Medicare
2 spending is strictly random and cannot be predicted by any
3 risk adjustment model. Research by Newhouse and colleagues
4 and by van de Ven and Ellis estimate that a lower bound on
5 the variation that plans can predict is 20 to 25 percent,
6 with the remainder being random and not predictable.

7 Therefore, the CMS-HCC might be explaining about
8 half of the predictable variation. This is much better than
9 the old demographic model, which explained about 1 percent
10 of the variation in Medicare spending, but it also suggests
11 that systematic payment inaccuracies may be occurring.

12 We have identified two possible underlying reasons
13 that systematic payment inaccuracies could occur under the
14 CMS-HCC. First, within a given HCC or condition category,
15 the costliness of beneficiaries varies. For example, not
16 all beneficiaries with congestive heart failure are equally
17 costly to treat, so plans can be hurt financially by
18 attracting the highest-cost beneficiaries in a given HCC.

19 A second possibility is that the CMS-HCC model is
20 calibrated with cost data from fee-for-service Medicare.
21 Newhouse and colleagues compared the relative costs incurred
22 in treating conditions by a specific Medicare Advantage plan

1 to the relative cost of treating conditions in fee-for-
2 service Medicare.

3 For some conditions, the relative cost in the MA
4 plan is lower, for others it is higher than in fee-for-
5 service Medicare. And to the extent these differences
6 between Medicare Advantage and fee-for-service Medicare
7 occur, MA plans can be hurt or benefit financially depending
8 on the conditions of the beneficiaries they attract.

9 For example, the relative cost of treating end-
10 stage liver disease is about 50 percent higher in the MA
11 plan than in fee-for-service Medicare, while the relative
12 cost of treating diabetes with renal manifestation is more
13 than 60 percent higher in fee-for-service Medicare than in
14 the MA plan.

15 Now, if cost variation within HCCs is a source of
16 systematic payment inaccuracies, adding variables to the
17 CMS-HCC has been suggested as a way to reduce them.
18 Possibilities include adding conditions to increase the
19 number of HCCs; adding socioeconomic variables such as
20 beneficiary's race and income; or adding the number of
21 conditions that each beneficiary has.

22 However, analyses so far suggest that adding

1 conditions or socioeconomic variables may be of limited
2 value. For example, adding conditions would improve the
3 payment accuracy for the specific conditions added, but Pope
4 and colleagues have found that adding more conditions to the
5 current model would produce only slight increases in the
6 model's R-square. So, in a general sense, the benefits are
7 limited.

8 Also, we did a cursory exploration by adding to
9 the CMS-HCC three variables for race -- black, Hispanic, and
10 other non-white -- as well as a variable for the median
11 income of each beneficiary's county of residence. This
12 produced small coefficients on the race variables as well as
13 a small increase in the model's R-square.

14 We are hopeful that adding the number of
15 conditions will be helpful, but the efficacy of such a
16 change is largely unknown. Conceptually, it would help
17 increase payments for those who are relatively sickly and,
18 consequently, high cost, which would help reduce the
19 benefits of favorable selection. In the end, improving the
20 payment accuracy would cause a redistribution from plans
21 that are getting overpaid to those that are getting
22 underpaid.

1 Alternatively, if payment inaccuracies are driven
2 by the cost differences between fee-for-service Medicare and
3 Medicare Advantage, then the solution is straightforward.
4 You can just use the cost data from MA plans to calibrate
5 the CMS-HCC model, which is something CMS is planning to do.

6 Next we turn to the effect that payment
7 inaccuracies have on plans that serve patients with complex
8 needs. Substantial research indicates that in some cases
9 the CMS-HCC results in systematic underpayments for some
10 groups and overpayments for others. For the typical plan
11 that enrolls a broad range of beneficiaries, these payment
12 inaccuracies should largely offset. But PACE and SNP plans
13 may not be able to make these offsets because they focus on
14 specific beneficiary groups.

15 On this table we use what are called predictive
16 ratios to indicate the extent to which the CMS-HCC overpays
17 or underpays for beneficiaries with specific characteristics
18 that are often the focus of plans concentrating on complex
19 patients.

20 First, the idea of a predictive ratio is that for
21 a predicted group of beneficiaries, it is the costs
22 predicted for that group by the CMS-HCC divided by the

1 actual Medicare costs for that group. So a predictive ratio
2 less than 1.0 indicates that the CMS-HCC underpays on
3 average for the group. A predictive ratio greater than 1.0
4 indicates that CMS-HCC overpays on average for that group.
5 And a predictive ratio equal to 1.0 indicates CMS-HCC pays
6 accurately on average for the group.

7 In the first column of numbers, we have predictive
8 ratios that we derived from the version of the CMS-HCC that
9 CMS currently uses in Medicare Advantage. As you can see,
10 the CMS-HCC underpays by about 5 percent on average for
11 Medicaid beneficiaries, it overpays by about 3 percent for
12 patients with diabetes and overpays for prostate cancer by
13 about 9 percent. But perhaps of most interest to plans
14 serving complex patients are the last two numbers indicating
15 larger underpayments for dementia and beneficiaries who have
16 five or more conditions.

17 In the second column of numbers, we have
18 predictive ratios from a version of the CMS-HCC that CMS
19 will use for PACE plans in 2012 and has proposed for use but
20 has yet to implement for Medicare Advantage.

21 For Medicaid, this model does a little better but
22 it still underpays for Medicaid by about 3 percent, for

1 diabetes it pays quite accurately, and for prostate cancer
2 in still overpays, in this case by about 6 percent.

3 It also represents a large improvement in the
4 predictive ratio for beneficiaries who have dementia because
5 this proposed model has an HCC for dementia while the
6 current version of the CMS-HCC does not.

7 For beneficiaries who have five or more
8 conditions, this model still strongly underpays. These
9 large underpayments for beneficiaries with five or more
10 conditions is one reason why we think adding the number of
11 conditions to the CMS-HCC may hold promise for improving the
12 model's predictive power.

13 The final point of discussion is regional
14 differences in the coding of conditions. Song and
15 colleagues from Dartmouth showed that in fee-for-service
16 Medicare conditions are coded more intensively in regions
17 where service use is high, which results in higher average
18 CMS-HCC risk scores among fee-for-service beneficiaries in
19 those regions.

20 If these regional differences in the coding of
21 conditions also occurs in Medicare Advantage, plans that are
22 in high-coding regions would receive higher payments for an

1 otherwise identical beneficiary compared with plans that are
2 in regions with less intensive coding.

3 However, all MA plans have an incentive to code
4 conditions as intensively as possible, irrespective of their
5 region. Therefore, it is plausible that regional
6 differences in coding are similar or non-existent among MA
7 plans. Ultimately, we need to determine whether there are
8 regional differences in coding among the MA plans.

9 But if we do find regional differences in coding
10 intensity among MA plans, how should this issue be
11 addressed? One alternative is to use an approach similar to
12 Song et al. and determine if the intensity of coding among
13 MA plans varies by region. Then you can evaluate whether
14 any regional differences in MA coding affect the average MA
15 risk scores in each region. Finally, you can then adjust
16 the risk scores in each region based on how much the coding
17 differences affect the average risk score in the region.

18 For example, if coding intensity raises the
19 average risk score in the region by 10 percent above the
20 national average, you can use your results to reduce all
21 risk scores in the region by 10 percent so that they match
22 the national average.

1 The next steps we plan to undertake for the
2 immediate future involve more intensive investigation of the
3 issues we've discussed today. First, we'd like to determine
4 if plans that focus on complex patients are systematically
5 underpaid under the CMS-HCC.

6 Secondly, we'd like to evaluate alternatives for
7 improving the predictive power of the CMS-HCC to help reduce
8 systematic underpayments and overpayments.

9 Finally, we'd like to investigate the extent of
10 geographic differences in coding among MA plans.

11 Now I turn things over to the Commission for their
12 discussion.

13 DR. MARK MILLER: And I would take just one minute
14 for the Commissioners who I think have some context, but
15 certainly for the public, if they're unclear on the context.

16 This is obviously a very technical presentation,
17 but it links to a few things. The first thing to keep in
18 mind is this is just kind of the standard issue that MedPAC
19 deals with on payment accuracy. So managed care plans are
20 serving Medicare populations, and depending on the draw of
21 your population, you can be at greater or less risk,
22 depending on how accurate the underlying risk adjustment.

1 So there's a constant process of trying to improve that and
2 be more accurate. So that's one thing to attach your mind
3 to.

4 A second thing is this: As you know, in the
5 Commission we have an ongoing conversation about managed
6 care plans and coordinated care plans that take very complex
7 populations -- dual eligible populations, multiple chronic
8 conditions. This links to the PACE discussion we had
9 yesterday, the upcoming special needs plans discussions that
10 we're going to have. And if we want to encourage people to
11 take very complex patients and try and coordinate their
12 care, you also have to have this back in behind that risk.
13 And what Dan is showing you is that CMS is improving the
14 risk adjustment system, but it still is falling short for
15 plans who take these kinds of populations.

16 The last comment -- and then I'll stop; I'm sorry
17 to take the time -- is that at the moment we think one of
18 the most encouraging directions to go in is look at these
19 terms where you bring in measures of beneficiaries who have,
20 say, Medicaid and five chronic conditions as a way to
21 increase the accuracy as opposed to some other strategies
22 that people have proposed which do improve but not at the

1 level that we're finding on a preliminary basis using this
2 other strategy.

3 Then the other two stray -- not stray, but other
4 strands are, Bruce, the encounter data, which I know this is
5 a new thought for you.

6 DR. STUART: [off microphone].

7 [Laughter.]

8 DR. MARK MILLER: Right. I will explain what that
9 is. The encounter data could be a completely different way
10 to go at this, but how fast that comes on and building
11 models is an issue. And then a few people, including Bob,
12 have raised this question about, well, what about this
13 geographic variation in coding? But the main thing, linking
14 to the PACE discussion and the upcoming special needs and
15 other plans discussion about plans taking complex care
16 patients and how do we get their payments right.

17 MR. HACKBARTH: Thanks. Round one clarifying
18 questions?

19 DR. CHERNEW: How many years of data do they use
20 in order to figure out what conditions you have?

21 DR. ZABINSKI: Just one. The previous year. It's
22 a prospective model. We want to estimate cost.

1 DR. CHERNEW: And new enrollees just get age --
2 like 65-year-olds just get --

3 DR. ZABINSKI: It's a demographic -- age, sex,
4 Medicaid I think.

5 MS. BEHROOZI: In terms of the -- on Slide 8 you
6 say if it is due to cost differences between fee-for-service
7 and MA. Do we know what the sources of those cost
8 differences are? Is it because of the population? For
9 example, with ESRD being 50 percent more expensive, is it
10 that the plans are doing something and spending more money,
11 or is it that the more expensive patients have gravitated
12 there? Do you know?

13 DR. ZABINSKI: I'm trying to think back to the
14 paper. I don't think they really got into why the cost
15 differences occur. You know, they're just showing that
16 they're there and that's an issue.

17 DR. DEAN: On Slide 7, again, the issue of the
18 differences in the cost of treating patients between MA and
19 fee-for-service, was that study nationwide? I just wonder,
20 are they reflecting here the situation in a given area, or
21 really are these nationwide data?

22 DR. ZABINSKI: My recollection from the paper is

1 that they were able to get cost data from a plan. It was a
2 large plan, but a plan that had, you know, many --

3 DR. DEAN: So it was a single plan.

4 DR. ZABINSKI: Yes. I'm not sure how nationwide
5 it was, but it was a single -- it's something to think
6 about, basically.

7 DR. DEAN: Yeah. Is there any data about overall
8 the population that's enrolled in MA versus fee-for-service?
9 If I remember, years ago in the Medicare Plus Choice plan,
10 there really was some data that showed that lower-risk
11 patients tended to gravitate toward the managed care plans,
12 and those with higher risk and more problems stayed in
13 traditional Medicare. Do you know if that's still true?

14 DR. ZABINSKI: I think it's still true. Carlos
15 might be able to -- is he here? Do you know if that's still
16 true?

17 MR. HACKBARTH: Come to a microphone, Scott.

18 DR. HARRISON: The average risk score is moving
19 towards one in the plans, so it's been moving over time.
20 But, you know, if the risk scores are not accurate, then we
21 don't know anything more.

22 DR. DEAN: Okay. Thank you.

1 [Laughter.]

2 DR. BAICKER: You mentioned on Slide 6 that the
3 risk adjusters are likely to be accounting for about half of
4 the predictable variation. How are they doing -- what was
5 the model that generated the 20-percent predictability? And
6 why can't we use that?

7 DR. ZABINSKI: That wasn't a model. It was sort
8 of looking at -- you know, it's something -- they sort of
9 gathered information together.

10 DR. BAICKER: Introspection?

11 DR. ZABINSKI: Largely, yeah. I think that's a
12 good way to put it.

13 MR. HACKBARTH: Dan, didn't you say that that was
14 Joe Newhouse that --

15 DR. ZABINSKI: Yeah, there's two papers on -

16 MR. HACKBARTH: So you could ask Joe and report
17 back to us.

18 DR. BERENSON: Unfortunately, I have some
19 clarifying questions. First, on page 6, which you've got
20 up, I just want to understand the first bullet, "meaning it
21 explains 11 percent of variation in spending." Is that in
22 the next 12-month period, spending with that lag? Is that

1 what that means?

2 DR. ZABINSKI: Yeah, I think...

3 DR. BERENSON: Okay. So it predicts spending in
4 the next year.

5 DR. ZABINSKI: Right.

6 DR. BERENSON: Okay. Second is when you talk on
7 11 about MA plans having an incentive to code, what are the
8 rules -- I don't think MA plans can come along and put on
9 their own codes. They have to accept claims or encounter
10 data from providers. Could you go over what they have
11 prerogatives to do and don't do with regard to coding?

12 DR. ZABINSKI: Well, you know, this is just
13 largely logic. You know, plans want to get paid as much as
14 they can, so they want to encourage their providers to code
15 as much as they possibly can.

16 DR. BERENSON: But they can only accept the
17 diagnoses that come in on encounter data or claims.

18 DR. ZABINSKI: Yes.

19 DR. BERENSON: They can't use a different database
20 to say we happen to know this patient has diabetes, so we're
21 going to put diabetes on it.

22 DR. ZABINSKI: Right, yeah.

1 DR. BERENSON: So the point I'm making is it's one
2 step removed from the providers themselves, and so that's my
3 third question, is physician group practice and ACOs where
4 the providers may have a direct incentive for coding. I'm
5 aware that in the PGP demo evaluations, in the second-year
6 evaluation the evaluators thought that the major savings,
7 the apparent savings that the PGP groups were producing was
8 really around code intensity. Do you have any idea whether
9 that finding has continued through the five years of the
10 demonstration?

11 DR. ZABINSKI: No, I don't know.

12 DR. BERENSON: I'd be interested in finding that
13 out. I think the extent to which we have regional variation
14 in sort of baseline coding practices could be exacerbated
15 when physicians may have a direct incentive, or hospitals.
16 And I'd be looking at this more in the context of ACOs,
17 frankly, than MA plans, which are one step removed.

18 MR. HACKBARTH: So, Bob, either you or Dan, it
19 might be helpful just to explain a little bit more the
20 difference in coding incentives between provider and fee-
21 for-service and an MA plan. Fee-for-service providers have
22 every incentive to be paid more as well. Could you just

1 explain a little bit about how it works differently?

2 DR. ZABINSKI: Should I handle it or --

3 DR. BERENSON: Either one.

4 DR. ZABINSKI: Okay. Well, in fee-for-service --

5 DR. MARK MILLER: I want Scott or Carlos to join
6 you [off microphone].

7 DR. ZABINSKI: Okay. In fee-for-service, you
8 know, physician's office fee-for-service, and they get paid
9 by the procedures that they do. As far as coding
10 conditions, the payment isn't really affected by that. But
11 in Medicare Advantage, the MA risk score and, hence, the
12 payment gets affected by the conditions that the patient
13 has. So there may be some disconnect between fee-for-
14 service and Medicare Advantage in terms of coding of
15 conditions on the claims.

16 DR. MARK MILLER: This is exactly the conversation
17 that I wanted to get into in responding to your question.
18 On its face, just standard fee-for-service, because the
19 diagnosis and so forth doesn't necessarily say for a given
20 physician visit influence what the physician gets paid. You
21 could sort of argue that there's not a lot of incentive
22 there. And what you were saying was that there was this

1 distance between the MA plans and the providers. And why I
2 wanted either Carlos or Scott up at the table, regardless of
3 whether they wanted to be there or not, was --

4 [Laughter.]

5 DR. MARK MILLER: And, apparently, I guess Carlos
6 lost the draw -- is there was some -- you know, during the
7 implementation of the change in the payment system that
8 managed care plans were working with their provider groups
9 to train them for the coding, which I don't want to imply is
10 nefarious. The coding system changed, and so they had to
11 work with their groups. But the distance between, you know,
12 the plan and the providers is not perhaps as distant as you
13 were --

14 DR. BERENSON: I mean, and, in fact, I have a
15 question, which you may or may not be able to answer today.
16 When I was sort of grappling this issue before Herb showed
17 up, one of the issues we spotted was the fact that the
18 instructions to physicians in filling out the HCFA 1500, if
19 that's what it's still called, is put down the reasons for
20 the visit. It was not put down what conditions the patient
21 has. And you're allowed four conditions. And --

22 MR. KUHN: It's up to eight now [off microphone].

1 DR. BERENSON: It's up to eight now? But it's
2 still the reason for visit? In some cases what that would
3 mean is that even though the patient may have diabetes or
4 some underlying chronic condition, the reason for the visit
5 may never have been recorded, and yet the plan is supposed
6 to be recording, you know, the conditions that the patient
7 has. So I don't know how that has worked out. Maybe Bruce
8 does.

9 DR. STUART: I think it's important to note that
10 the conditions are taken from all Part A and Part B claims.
11 It's not just Part B claims. In the fee-for-service sector,
12 there is an incentive to upcode on Part A claims because
13 that will affect the DRG assignment. And so it's really,
14 you know, the extent to which most of the codes come from
15 inpatient codes as opposed to physician codes that would
16 make that distinction.

17 DR. CHERNEW: Can I just say [off microphone] --
18 the other thing is it's not necessarily just one code. In
19 other words, you could have diabetes coded on a visit. All
20 of the other miscoding might be irrelevant, coded or not,
21 because if there's, you know, at least a certain amount of
22 codes for diabetes, there could be a lot of variation in

1 coding, but they still know you have diabetes. So this is
2 only when you're going sort of at the margin of we have no
3 record of you of diabetes versus now you do have diabetes.
4 I don't know if the number of codes for diabetes makes a big
5 difference, although it depends on the --

6 DR. STUART: The number makes no difference, but
7 there are five, as I understand it, HCCs for diabetes.

8 DR. CHERNEW: Right.

9 DR. STUART: And what they do is they code the
10 severity of the condition based upon, you know, the sequelae
11 of the disease.

12 MR. HACKBARTH: Okay. Clarifying questions [off
13 microphone]?

14 MR. KUHN: Dan, just one question. We've been
15 talking about the HCC risk adjuster for both PACE and MA.
16 What other Medicare programs is the HCC score used for? Is
17 it going to be used like for medical homes, ACOs, disease
18 management, other activities?

19 DR. ZABINSKI: It's conceivable it could be. I'm
20 not sure if there is any distinct plan to use them anywhere
21 else, but I guess it could be.

22 DR. HALL: I'm still a little stuck on Slide 11

1 and what you mean by the term "conditions are coded more
2 intensively in high-use regions." From a clinical
3 standpoint, that's not intuitive that most of these chronic
4 diseases or acute exacerbations intuitively have regional
5 differences that would be of that order magnitude. Is that
6 what you were saying, for instance, that in Schenectady
7 there may be a lot of diabetes, severe diabetes, but in
8 Albany there might not be?

9 DR. ZABINSKI: The whole idea here is that some
10 regions' service use -- for whatever reason, use of medical
11 services is higher than others. You know, the classic is
12 Miami is very high and Minneapolis is very low. Because
13 people are visiting doctors more frequently, having more
14 encounters with the medical system, they will end up having
15 more conditions coded than somebody in Minneapolis who might
16 otherwise have the same health -- are equally healthy.

17 DR. HALL: Okay, maybe higher risk scores with --

18 DR. ZABINSKI: Right.

19 DR. HALL: I'm sorry. Higher intensity scores
20 given each diagnosis.

21 So what if you compared this to the Dartmouth
22 Atlas, for example, that shows regional variations in use of

1 various medical and surgical procedures? I guess what I'm
2 saying is: Is this just smart coding and some places are
3 smarter than others? Or is this really another signal that
4 points up the tremendous regional variation that's
5 inexplicable around the country.

6 DR. ZABINSKI: I think it's the latter.

7 DR. MARK MILLER: Again, I think if, you know, the
8 Dartmouth folks were here, this is what they would say --
9 and we did some work on this. So you have all of this
10 regional variation. What you don't want to do, among other
11 things, is attribute some high level of utilization to an
12 area and then not take into account the potential for higher
13 risk or disease burden.

14 And so we kind of go in and risk adjust the data
15 and say, okay, then look at -- we also adjust for some other
16 stuff, but we then look at that, and that's a fair
17 comparison. I think the Dartmouth people would say: But
18 you have to be careful. You're overcorrecting.

19 DR. HALL: Right.

20 DR. MARK MILLER: Because some areas have all
21 these codes, and so you're attributing higher risk to that
22 area when maybe some of that higher risk is really a product

1 of differences in coding as opposed to true underlying
2 disease burden.

3 Are you okay with that, Dan?

4 DR. ZABINSKI: Yep.

5 DR. DEAN: I think it was probably this paper, but
6 I remember reading that they actually looked at people that
7 moved from one region to another, and all of a sudden, their
8 number of conditions went up. The same person, when they
9 moved to a high-use area, they --

10 DR. HALL: They got sicker.

11 DR. DEAN: -- had a significant number of more
12 codes added. So it was kind of a shocking observation.

13 DR. MARK MILLER: And I don't want to -- I want to
14 say this very carefully because, you know, we talk to the
15 Dartmouth people all the time. And it was a well-done
16 piece, and we think that there's something there, and
17 there's probably a reason to look at this. But also, Dan, I
18 recall there was this notion that people who move are more
19 likely to be sick. And that interaction got a little
20 complicated, too.

21 DR. DEAN: Yeah [off microphone].

22 DR. STUART: Or healthier. You know, the

1 snowbirds.

2 MR. HACKBARTH: Okay. Clarifying questions?

3 DR. STUART: If we could look at Slide 10, please.
4 You were talking about some talk about adding cost data for
5 the MA plans for risk adjustment for MA plans. I'm assuming
6 that this proposed CMS-HCC still uses fee-for-service?

7 DR. ZABINSKI: That's right.

8 MR. GEORGE MILLER: Yes, just to follow up on
9 Tom's comment and Mitra's question concerning the difference
10 of treatment, Slide 7, I thought I had understood until just
11 this last conversation, so I'm going to ask this question.
12 Is there any evidence -- and I think Tom just mentioned it --
13 -- that the beneficiaries get treated differently by either
14 plans because of those regional variations? Or is this just
15 a technical, behind-the-scenes looking at the data for the
16 payment of the risk adjustment? Is there any evidence that
17 patients are getting treated differently by the different
18 plans, the beneficiaries?

19 DR. ZABINSKI: Not that I've ever heard of, but
20 anything, Carlos, that you're aware of?

21 MR. ZARABOZO: [off microphone] You mean mix of --
22 the issue would be whether the mix of services is

1 [inaudible].

2 MR. GEORGE MILLER: Right.

3 MR. ZARABOZO: The ESRD case, for example [off
4 microphone].

5 MR. GEORGE MILLER: That's a good example, end-
6 state renal disease.

7 MR. ZARABOZO: The ESRD case, it's likely the mix
8 of services is about the same, but for non-ESRD -- I mean,
9 for other people you would have, you know, relatively less
10 hospitalization, for example, more ambulatory care, things
11 like that.

12 MR. HACKBARTH: The whole premise of MA is that MA
13 will treat people differently; otherwise, there's little
14 purpose in doing it. Obviously, the question is what
15 they're doing differently better or worse.

16 MR. GEORGE MILLER: That's the question [off
17 microphone].

18 MR. HACKBARTH: And, you know, my own prejudice is
19 that, on average, it's better, you know, more efficient use
20 of resources, more intensive use of outpatient services,
21 avoiding potential hospitalizations and unnecessary
22 readmissions and the like. But you would hope that there's

1 a difference in the patterns of care in MA plans versus fee-
2 for-service. So --

3 MR. GEORGE MILLER: I would hope, but I guess my
4 concern would be: Are there differences by socioeconomic
5 groups or disparities or problems that we're not being able
6 to differentiate in the data? If this was one homogeneous
7 group and one group got better treatment, then I wouldn't
8 have any problem. That's my concern.

9 MR. HACKBARTH: Okay. I understand, and that's a
10 completely different set of --

11 MR. GEORGE MILLER: I don't know if we're able to
12 determine that from the data based on the socioeconomic
13 group or -- and you talked about regional variations that
14 Bob mentioned about -- those two cities in New York.

15 DR. STUART: Well, they have added race.

16 MR. GEORGE MILLER: I noticed they just added
17 race, but has that been a predictor to be able to determine
18 if there are differences because of race or other
19 demographic reasons?

20 MR. ZARABOZO: Well, with the encounter data, we
21 could look at, you know, by person essentially what the
22 differences are within a plan. It's possible to do in the

1 future, to look at those differences.

2 MR. GEORGE MILLER: Thank you.

3 DR. NAYLOR: I think this a twist on Mike's
4 question, but in the slide where you showed changes in
5 predictive value of five multiple chronic conditions before
6 and after the changes -- yeah, 0.88 to 0.89. Is your
7 assessment that the little change that you observed is the
8 result of just relying on the last year's data for
9 identifying the five or more multiple chronic conditions?

10 DR. ZABINSKI: 0.88 to 0.89 is no great shakes.
11 You know, it might be something due to, you know, perhaps a
12 different year of -- you know, just that the model was --
13 the models were calibrated with different years of data, and
14 so they're going to be slightly different, a slightly
15 different sample, and that alone might cause a difference.
16 But when I look at 0.88 to 0.89, I say they're doing the
17 same.

18 DR. NAYLOR: So we need to change how we're
19 collecting those -- I guess that's what I'm asking. Given
20 all the data about five or more chronic conditions and
21 relationships, it seems like it's a really important risk
22 adjuster. We need to change how to get to reliable,

1 predictable data.

2 DR. ZABINSKI: It's an idea we'd like to look
3 into, you know, adding the number of conditions to the
4 models.

5 DR. NAYLOR: Okay. And then dementia, is that
6 diagnosis only of dementia?

7 DR. ZABINSKI: Yeah, it has to be a condition
8 diagnosed.

9 DR. NAYLOR: Okay.

10 DR. BORMAN: A couple of comments and a question.
11 The question would be: Do we know that if the data were
12 calibrated by MA data what effect that would have on the
13 regional variation?

14 DR. ZABINSKI: No, that's something we don't know
15 yet.

16 DR. BORMAN: Because if that step resolves a lot
17 of this, then trying to parse this into a hundred other
18 explanations would seem to be investing time and energy that
19 maybe we could use better. So maybe that's a question to
20 answer. Is the base -- are we just in error in the base
21 data? So that would be just one question.

22 A couple of questions I'll save for the -- because

1 they're not really about anything you've presented exactly.
2 But I would make the comment that the risk adjuster I think
3 is also important for the notion of public reporting of
4 outcomes, that certainly one of the great concerns that all
5 segments of the provider community have about public
6 reporting of outcomes is having appropriate risk adjustment.
7 So this whole notion of risk adjustment is a hugely
8 important thing as we think about health care delivery and
9 specifically about Medicare payment.

10 Then I would also say that while the coding in a
11 fee-for-service payment model doesn't impact payment in the
12 same way as it does in an MA model, there are some sort of
13 hard stop kinds of things in terms of coding, making you
14 coverage eligible. And so there is some attention to coding
15 that, given a specific service provided, that there are some
16 edits about that both in the local coverage determinations
17 and at national levels, so that there is some attention
18 coding, and it may not be as intense perhaps as other pieces
19 of this.

20 And then the other thing would be that certainly
21 in many physician offices and whether they're organized as
22 groups or not, there is also often a variable of an interlay

1 of a coder in the office and abstracting. And so while the
2 plan may be a step away, there may, in fact, be differences
3 in how that manages an office. For example, a very small
4 single-specialty office is probably less likely to have
5 either that person or for that person to be perhaps as
6 highly trained as in a large multi-specialty group where
7 there is a busy throughput, people are actually extracting
8 coding data out. So there's a lot behind the scenes there
9 that could change this that I would think we would be very
10 challenged to parse out.

11 And then just to make sure I'm correct, if you
12 look at on Slide 6 where you say there's an R-square 0.11,
13 and then your next bullet, we're saying that there's,
14 ballpark, at least a minimum of 75 percent of variation in
15 spending that we just kind of don't have a handle on, is not
16 captured, we don't know what affects that. Is that right?

17 MR. HACKBARTH: It's random [off microphone].

18 DR. ZABINSKI: It's random.

19 DR. BORMAN: Yeah, in variation, okay. So that
20 our ability to impact this is a relatively small piece
21 compared to the part that we can't get control over. Is
22 that a fair statement? Or we think we can --

1 DR. ZABINSKI: My understanding is it's something
2 we just can't know.

3 DR. BORMAN: Okay.

4 MR. HACKBARTH: Put up Slide 4, please, Dan. So
5 in the current system, the second bullet, there are the
6 three categories: the gender, age, and the Medicaid, and
7 then the diagnosis. In your example here, they're all
8 equally weighted. Is that the way it works in the real
9 model?

10 DR. ZABINSKI: Yeah, I mean, each --

11 MR. HACKBARTH: And is there any empirical
12 foundation for equal weighting of these factors? It seems
13 to me that they might not be equal in terms of their
14 potential impact.

15 DR. ZABINSKI: Let's see how to say -- what they
16 try to do, they try to find out how much each characteristic
17 that a patient has, you know, will affect their next year's
18 costliness. And that's what they use. They say, okay,
19 having COPD will increase spending by an average of \$1,000;
20 being an 85-year-old woman will increase it by, you know,
21 \$1,500 versus some baseline. And that's what they use.

22 MR. HACKBARTH: So you're saying that there is an

1 empirical foundation for the equal weight of these different
2 coefficients.

3 DR. ZABINSKI: Yeah. You know, it's an impact on
4 the expected spending that the data bear out.

5 DR. CHERNEW: The coefficients are the weights, so
6 don't think of it as that they're being equally weighted.
7 The coefficients are the weights, so the coefficients tell
8 you the weights on the condition.

9 MR. HACKBARTH: I see.

10 [Inaudible comments off microphone.]

11 DR. CHERNEW: Although they do have interaction
12 [off microphone].

13 DR. ZABINSKI: Yeah, there are. Five or six
14 interaction terms.

15 MR. HACKBARTH: Yeah, okay. That's helpful.

16 Round two, questions or comments?

17 MR. BUTLER: So this is obviously an important
18 area and one that MedPAC staff, if not uniquely qualified,
19 is well qualified to pursue. I have a question. Obviously,
20 this is leading towards maybe, you know, exploring further
21 underpayment of complex, overpayment of simple. At what
22 point is there an ethical question that you're going to get

1 end of life -- you're going to get all the money going to
2 the complex end of life -- you know, paying the most for
3 people that are really obviously sick at end of life and
4 you're kind of, therefore, putting incredible amounts of
5 resources there because you risk adjusted it. Is there a
6 danger of -- how does that reconcile with the need to
7 address end-of-life issues where we spend so much money?

8 You know, ultimately if you risk adjust perfectly,
9 it feels like you're going to spend more maybe rather than
10 pursue other --

11 MR. HACKBARTH: To give Dan more time to think of
12 an answer, I'll take a swing.

13 [Laughter.]

14 MR. HACKBARTH: Obviously, that's a really
15 important question, but to me that's a question of medical
16 practice, and you wouldn't want to try to address that
17 through the risk adjustment system in Medicare Advantage.
18 You want to go way upstream or downstream and, you know,
19 address the fundamental question of how we care for
20 patients.

21 This isn't the lever to be pulling to try to
22 address that issue. This has to reflect our judgments that

1 we make as a society about the appropriate way to treat
2 people.

3 Okay, Dan, it's all yours.

4 DR. ZABINSKI: All right. I really try to get
5 away from dry statistical -- but that's my nature. I'm
6 sorry. And I hope this answers your question. In the risk-
7 adjusted model, end-of-life care, they're in the cost data.
8 The idea is, okay, you have somebody who has a stroke this
9 year and they want to predict their costs for next year.
10 Now, some of those people are going to get better and
11 they're not going to cost very much. Some are going to get
12 worse and they're going to die and they're going to cost a
13 lot. And the idea is to pay on average correctly for people
14 who have a stroke.

15 Does that answer your question at all?

16 MR. HACKBARTH: Prevailing patterns of caring for
17 people with stroke. And whether we choose to continue those
18 patterns of caring for people with stroke is a judgment of
19 medical practice and broader society values. It's not
20 something to be manipulated through the risk adjustment
21 scores in Medicare Advantage.

22 MR. BUTLER: But we keep talking tying payment to

1 cost, which is reinforcing --

2 DR. MARK MILLER: Let me --

3 MR. BUTLER: Obviously, it's a big societal issue,
4 but --

5 DR. MARK MILLER: I think a different way to think
6 about it is that if the current practice and delivery of
7 care is somehow wrong or flawed and somebody could
8 objectively say that, the underlying risk scores will, to an
9 extent, reflect that because if I'm pouring money into, say,
10 end of life -- let's just say objectively somebody could
11 step up and say you probably shouldn't be doing that, and
12 I'm not sure anybody's prepared to make that call, but, yes,
13 the underlying risk scores, because they reflect what's
14 actually happening, they will also reflect that.

15 Another look at this -- this is why, again, if
16 Bruce had been focused more on encounter data for the last
17 few years, when we get the encounter data and look at these
18 same relatives, if managed care plans are actually
19 practicing differently, then you'll see that, say, for a
20 stroke patient fee-for-service has this much variation
21 between a patient that looks like this and a patient that
22 looks like this, and managed care has this much, and that it

1 may reflect the variation across different types of patients
2 differently if they're truly practicing medicine
3 differently. And so another way to kind of get a look, you
4 know, from a different perspective is when you get the
5 encounter data, do you see the same spread, 0.4 for COPD or
6 0.18 for whatever that was, female, Medicaid. Do you see
7 what I'm saying?

8 So the answer is it does -- it reflects underlying
9 practices. It's hard to know what's right, but to know
10 whether that perspective is significantly different. When
11 the encounter data comes online, there will be a different
12 way to look at it.

13 DR. CHERNEW: I think this discussion just points
14 out the sort of problem with the paradigm behind this whole
15 thing, which is that there's some costliness inherent in a
16 patient, which there isn't. It reflects the practice
17 patterns of the organization that they're in, and that then
18 raises the broad question: What are you trying to do?
19 Right? Because if a patient moves from fee-for-service to
20 managed care, do you want to -- say they're more efficient
21 in treating a patient with diabetes. Do you want to just
22 reduce their payment because now they're more efficient and

1 they get less risk? Or do you want to say we're going to
2 pay what it would have been in fee-for-service? And that is
3 something that's beyond the statistical analyses for what
4 you want to do, and it reflects a whole series of incentives
5 of how people go in or they don't.

6 MR. HACKBARTH: I think that's a really important
7 point, Mike, and it seems like before we get the encounter
8 data, it might be good to think through that question as
9 opposed to, oh, let's get the encounter data and now what we
10 ought to do is match the payments to the encounter data
11 pattern. What are we trying to accomplish?

12 DR. CHERNEW: Right. And we shouldn't talk about
13 it like the patient is just inherently, just magically
14 they're cheaper. The plan is doing something to practice in
15 a different way, and the risk adjust, as Peter said, you may
16 need to think about that and how you set it up. But I think
17 the -- one of the ways in which these systems try and work
18 is making the system less sensitive to general variation in
19 coding. So it is not true that there's sort of a one-to-one
20 relationship between things like the number of codes and
21 what the risk score is. There is a relation between the
22 number of conditions and the risk score, but you have to

1 worry about how manipulable the system is. Do you get paid
2 more one way or another? So certain things, for example,
3 having more years of data as a general point of view, can
4 help you with certain things because then you can identify
5 the person had dementia. The issue would be are you more
6 likely to pick up a person with dementia if you use one year
7 of claims or two. And if the answer is you can get them
8 with two years of claims, having 12 claims for dementia as
9 opposed to one may not make a difference. Depending on how
10 much the system codes different severities of dementia and
11 how much those codes for severity depend on the number of
12 claims versus, say, other things that are related to the
13 claims, like where you are, procedures you had and stuff.
14 But the nuances of the system is not just a predictive
15 exercise. You have to think how much of that sort of
16 manipulable and reflect -- what practice patterns you want
17 to reflect and which practice patterns you don't, because
18 ideally you want some risk adjustment that would say this I
19 show much more you get paid for this type of patient in sort
20 of an efficient system throughout the entire -- you know,
21 and if you're not efficient and you pay a lot more for these
22 types of people, that's fine, we're not risk adjusting that

1 out, that's on you. And the way that the nuances of the
2 system can do that, and simple fixes like adding years of
3 data can help you because you can be more -- you'll be more
4 likely to capture did this person have X, Y, or Z. And you
5 have to worry about how much nuance in the definitions to
6 make because the more nuance you have, the more likely
7 you're affected by, say, inefficient practice patterns makes
8 it look like the person's more risky.

9 So that's my main comment. The only other comment
10 that I would make is I'm very hesitant to do regional
11 adjustments like was discussed here because the regional
12 practice patterns change, the incentives change once you do
13 the regional adjustment patterns. Not everybody in the
14 region is the same. And to the extent that some region
15 isn't coding -- it's crucial that the coding be accurate, so
16 we don't want the region that's intensive coding to be
17 coding things that aren't there. But I think it's going to
18 be very complicated if we try and put some after-the-fact
19 patch in to make everybody in the Southeast get X amount of
20 money because their doctors don't seem to code very much,
21 and vice versa, because of the -- you know, I don't know if
22 that really solves anything, and it does seem to make things

1 a lot more complicated.

2 DR. ZABINSKI: Just a quick point. We did -- this
3 was a long time ago, like in 2000 or something like that,
4 that we did recommend using two years of data, more of a
5 case of trying to smooth out fluctuations that might occur
6 from year to year for a patient.

7 DR. CHERNEW: [off microphone] coding. You could
8 have people go up and down. I'd like to see the results of
9 how much more stable two years of data is, you know, because
10 you could calibrate the risk, you know, more conditions in
11 two years. If you could calibrate the average down, it
12 would be more accurate.

13 DR. ZABINSKI: We have that in the works right
14 now.

15 MS. BEHROOZI: Just less sort of academically or
16 technically, this is just reminding me of some conversations
17 I've had with people over the last week. A study came out -
18 - I think it was last week -- not an academic study -- it
19 was done by a consulting firm -- about how health care
20 workers are more costly in terms of consuming health care.
21 And, of course, the alarms were sounding, oh, they're
22 sicker, they work shifts, and, you know, they lift heavy

1 patients and all of these things that, you know, absolutely
2 can have impacts on their health, but so are people in other
3 workplaces exposed to various things that can have impacts
4 on their health.

5 And then there was a recognition that, well, you
6 know, they are sort of closer to their health care providers
7 and can kind of go get a little more health care, or they're
8 more aware of the types of things that they should be -- and
9 guess what? Maybe they're actually healthier because
10 they're getting more treatment.

11 And so I've been talking a lot with people about
12 the pitfalls of using claims data to determine health
13 status. So, anyway, I think this is -- it's not just about
14 practice patterns of the providers, which it is a lot, and
15 it's not just about the coding. It's also about a whole lot
16 of other societal factors that go into whether somebody is
17 receiving treatment or what type of treatment they're
18 receiving. And so there should be sort of caveats and
19 limits on how we use that data.

20 Having said that, I am concerned about the
21 potential or, you know, maybe the demonstrated potential for
22 systematic underpayments for plans focusing on systematic

1 groups. Now that we have it sort of stated here in this
2 presentation, and as Karen said, it takes me back to
3 yesterday's presentation on PACE where I actually wrote in
4 the margin risk adjustment not only for payment but for
5 quality reporting. So we were talking about putting that
6 quality information out there, but I don't think we should
7 be rushing it if we don't feel like -- if the payments we
8 don't think are accurate, then the quality reporting is
9 going to be unduly, you know, negative or harsh or whatever.

10 DR. DEAN: Do you have any sense of what's going
11 to happen? We're just, as I understand it, about to move to
12 a new coding system, to ICD-10, which people tell me is
13 incredibly more complicated than ICD-9. It has got like ten
14 times as many codes or something like that. The current
15 system intimidates me. I try to find a code, and there's
16 already like 100 codes for diabetes, and there's supposed to
17 be ten times that or something in the ICD-10. I wonder,
18 what is that going to do -- I mean, theoretically, if it's
19 done properly, it should help this process. But to do it
20 properly from a clinical point of view scares the daylight
21 out of me. And so I'm just curious what impact -- I mean,
22 do you have any sense? Obviously nobody knows for sure.

1 DR. ZABINSKI: Just off the cuff, just thinking
2 about it, there might be, you know, just a learning curve at
3 first where they actually might have things inappropriately
4 coded and just through coding errors that, you know,
5 something gets thrown out, so that you have somebody who
6 might have diabetes gets coded improperly and doesn't get --
7 so it doesn't count. A first year or two problem.

8 DR. DEAN: Theoretically, this is going to pick up
9 all the nuances.

10 DR. ZABINSKI: Right.

11 DR. DEAN: Theoretically, because, I mean, I'm
12 already -- I'm sure that there are plenty of miscodings,
13 even in the relatively basic stuff that I do. And when you
14 add this many new codes, I don't know what impact that's
15 going to have.

16 DR. ZABINSKI: But I would hope after people get
17 used to using it that such errors would iron out, and
18 eventually, I think you should end up back to where you are.
19 But that's just speculation.

20 DR. DEAN: [off microphone].

21 MS. UCCELLO: This has been, I think, really
22 interesting. Tell me if I'm not thinking about this

1 correctly. In terms of Slide 8 and using the MA cost data
2 to calibrate the risk adjustment system, does that then mean
3 that the budget neutrality would be just across MA plans and
4 that there would no longer be kind of this overall budget
5 neutrality between -- in the system overall? And maybe
6 that's okay if we really think the underlying people are the
7 same, but to the extent that people are different between MA
8 and fee-for-service, there may not be an overall neutrality
9 to this.

10 DR. ZABINSKI: Okay. Budget -- let's see. I hope
11 I'm not being obtuse here, but budget -- you lost me a
12 little on the budget neutrality.

13 MS. UCCELLO: So I --

14 DR. MARK MILLER: I think this is what she's
15 saying. Okay?

16 [Laughter.]

17 MS. UCCELLO: Mark can translate.

18 MR. ZARABOZO: I'll translate what Mark says back
19 to you.

20 [Laughter.]

21 DR. MARK MILLER: And I appreciate that. You see,
22 I knew I needed Carlos up here.

1 I think what she's saying is this -- and,
2 actually, this issue has arisen in the past, Carlos, right?
3 Because I think what she's saying is this: If you switch
4 the data that you worked on for MA, let's say that on net --
5 let's just pretend for a minute -- that that resulted in a
6 risk -- or an average spend on net that came down for MA, so
7 let's say, you know, there's some efficiency, and so for the
8 same patient -- and that's the key thing. Do you know
9 you're dealing with the same patient? Does the cost or
10 expenditures come down? And do you say I'm not taking that
11 money out of the system, I'm just going to redistribute it
12 within MA on the new sets of weights? Or do you actually
13 pull out some portion of the dollars if the revised risk
14 score has somehow come down?

15 So if you're using fee-for-service data, your
16 average risk score was 1.02, then you ran it with MA data
17 and it ended up being 0.99, would you take that out or would
18 you redistribute the money through MA?

19 Is that what you think you're saying?

20 MS. UCCELLO: Yeah, I think so.

21 DR. MARK MILLER: And I think that's probably a
22 question. I'm not sure that any of the math or the

1 underlying risk adjustment systems would tell you the
2 answer.

3 DR. ZABINSKI: Here's what I do know. In a given
4 year, the initial -- just apply -- you know, if they take
5 the data and find out a national average risk score, usually
6 it's actually not equal exactly to 1.0, so they just do a
7 cut or an increase, depending upon where it falls. You
8 know, it's a couple percentage points every year. So in
9 that sense, if you get a slightly different average with MA
10 versus fee-for-service data, I think they would make --
11 they, CMS, they would make that adjustment. They would just
12 make a general --

13 DR. MARK MILLER: [off microphone].

14 DR. ZABINSKI: Yeah.

15 MR. HACKBARTH: I'm confused here. The math is
16 beyond me. It seems to me that the basic objective is to
17 pay the amount that the same person would have cost had they
18 remained in fee-for-service. And so --

19 MR. ZARABOZO: Well, right now --

20 MR. HACKBARTH: Just one more sentence, Carlos.
21 So if the average risk score in MA is less, the amount of
22 money should be less. Am I missing your point? You

1 wouldn't want to say, oh, we're going to make MA whole as a
2 program. That's the purpose of the risk scores. What am I
3 missing?

4 MR. ZARABOZO: Well, let's say, for example, that
5 the average risk scores was 1.0 in MA today. They would get
6 -- let's say it's all set at fee-for-service, they would get
7 fee-for-service. And that average risk score is the mix of
8 all enrollees in MA. Under the current HCC system, they
9 come out to 1.0.

10 The question is, in the following year, when
11 everything is moved to what are the relatives within MA, you
12 could potentially still have a 1.0, but you're saying a
13 diabetic in MA is far less costly than in fee-for-service,
14 so this diabetic in relation to other members of MA is at --
15 used to be at, let's say, 1.1 is now 0.9 in the MA world.
16 Other people are at higher levels or lower levels, but you
17 still end up with a 1.0. The distribution of who falls
18 within the different categories is now different. But you
19 could still be at -- you're still at 1.0 within that sector,
20 MA is 1.0. So in that case they will still get fee-for-
21 service equivalent of 1.0.

22 So it's just a matter of how much more costly is a

1 given individual in relation to another, using -- now we use
2 the fee-for-service standard. In the future it could be
3 using the MA standard. So you're still dealing with --

4 MR. HACKBARTH: The question I'm raising is: Why
5 would you shift to the MA standard? The policy is how much
6 would these people have cost us had they remained in
7 traditional Medicare.

8 MR. ZARABOZO: Right, yes. Exactly.

9 MR. HACKBARTH: And if an MA plan can do it for
10 less or shift resources among different diagnoses, fine.
11 But the payment is based on a fee-for-service reference
12 point.

13 MR. ZARABOZO: Yes, so that is the policy question
14 of do you want to go in that --

15 DR. BERENSON: I've got a potential answer for
16 you: Because the plans, if they see some patients are very
17 profitable, that might affect their selection activities.
18 In other words, if, in fact, diabetics are real profit
19 makers, then they're going to figure out how to get
20 diabetics and not get liver cancer patients, or whatever the
21 case may be. So you want them to not have an incentive for
22 cherrypicking.

1 DR. MARK MILLER: You could ask Cori [off
2 microphone].

3 MS. UCCELLO: I think my question was much more
4 simple.

5 [Laughter.]

6 MS. UCCELLO: I'm going to try again. Say that MA
7 plans actually are enrolling a healthier population. Say
8 their overall risk score is 0.95. Then kind of the flow of
9 funds is that they're getting less -- right? -- and the
10 system as a whole is somehow whole. But now if you're
11 saying you're just redistributing funds among MA plans, then
12 the MA is just rejiggering their money, but they're not --
13 but if they're getting paid in terms of a 1.0, they're
14 getting more than they would have if they were in fee-for-
15 service. And I could tell this is not being any clearer, so
16 I'll just --

17 DR. BAICKER: I don't think they're pegging it as
18 1.0 for any reason. They want the risk scores to be better,
19 but they could still -- they're not pinned at 1.0.

20 MR. PETTENGILL: It seems to me the question is
21 really: What's the benchmark? Is it fee-for-service or is
22 it MA?

1 DR. MARK MILLER: That's what I was thinking [off
2 microphone].

3 MR. PETTENGILL: That's the question. And if you
4 switched, then the question is: What's the average when you
5 start? In other words, if using fee-for-service data gave
6 you a value of -- what would it be now? 1.03?

7 MR. ZARABOZO: Sure.

8 MR. PETTENGILL: Okay. So it gave you a value of
9 1.03, but you switched to using the MA weights and you
10 calibrate it to 1.0, there's that 3-percent differential.
11 What do you do with it? Do you take it away? And even
12 then, beyond that, from year to year when you're using the
13 MA weights, what happens to the spending? The spending is
14 governed, in effect, by the MA weights and the distribution
15 of MA encounter data. But it has no connection anymore with
16 fee-for-service. So now you've lost your benchmark.

17 MR. ZARABOZO: But the question there is, if
18 they're at 1.03, they will get today 1.03, let's say. So,
19 again, if tomorrow -- and let's say there are only two
20 enrollees, one of them is twice as sick as the other,
21 according to the fee-for-service measure of sickness based
22 on claims, diagnosis. If tomorrow they switch to another

1 system and it turns out they are equally sick, you know, as
2 measured by the MA distribution of how much it costs to
3 serve these people, they are equally costly, you have a
4 different relative between the two, but you're still saying
5 they are at 1.03 with respect to fee-for-service. That's
6 the question. Are you going to keep them at 1.03? Or is
7 there some reason for saying, well, these two are now
8 equally costly because MA is so much more efficient at
9 providing care and, yes, because of that we want to reduce
10 their expenditures?

11 Now, MedPAC has said the benchmark should be more
12 or less at fee-for-service, so that, again, is the policy
13 question. Are you going to keep the benchmark, which is the
14 basis of payment, which is then adjusted by the individual
15 risk score, which today is one thing, but if there's one
16 plan enrolling these two people, today they get one amount,
17 tomorrow they will get the same amount, it's just that one
18 person will be paid more, the other person will be paid
19 less. Next year each person will get the same. But we'll
20 still be 1.03 unless somebody says, no, we need to do 95
21 percent AAPCC kind of thing because these people save money
22 and we want some of that savings, is the old policy.

1 MR. HACKBARTH: I have the feeling that we're
2 talking about something important. I'm not really sure, but
3 I think this is an important conversation. But the fact of
4 the matter is we're not going to resolve it today, and we
5 are already at 9:37, so we're 7 minutes over. So we need to
6 move on. We've got a hard stop at the end of today because
7 people have to catch airplanes and the like. So we've got
8 to finish on time.

9 So I want to get through the remainder of this
10 round, but we're going to need to pick up the pace here so
11 we don't have to take too much from the other presentations.

12 MR. ARMSTRONG: Thank you. My intention was to
13 bring you back to the parallel universe that I live in and
14 that I can relate to and acknowledge that you asked us
15 questions, are these immediate next steps, steps that we
16 endorse, and I just want to say, yes, they are.

17 In particular, you know, reflecting on our
18 conversation yesterday about this huge issue the Medicare
19 program has with respect to dual eligibles and sickest
20 patients, making sure the coding is appropriate for that
21 population of patients seems to be an important agenda for
22 us.

1 The only other point I would make -- actually, on
2 the geographic differences, I worried about geographic
3 variation in practice patterns, less about coding myself,
4 but I don't think anyone really disagrees with me on that.

5 But one other point I wanted to make was that
6 given that we're anticipating enormous growth in the
7 Medicare program in the years and decades ahead, this issue
8 around coding in your first year in the program is something
9 that may become bigger. I don't know enough about that, but
10 I know there are some issues with that, and that just might
11 be something that somewhere we put it back on the table and
12 ask: Is there a better way for us to feel more confident
13 about the accuracy of that first year of coding in the
14 Medicare program?

15 DR. BAICKER: So I think the first order point
16 that Mike made is the one I'd want to focus on, that we want
17 plans to be selecting people they treat more efficiently.
18 We want there to be profit in that. We want them to siphon
19 off people that they can actually put more effective
20 practice patterns on.

21 Now, do we want to share that savings and should
22 the payment be something in between what they would be in

1 fee-for-service and what they actually cost the plan?

2 Maybe. But we don't want it to be just what they cost the
3 plan because those are the people we want moving over.

4 Now, what we are trying to avoid is a different
5 kind of selection where they're selecting not based on their
6 ability to provide effective care but, rather, on the
7 underlying characteristics of the patient that they are
8 better at observing than we are at observing. So we want to
9 have our risk adjustment match their risk adjustment in
10 terms of the ability to predict. It doesn't have to predict
11 100 percent. It's fine if it only predicts 20 percent as
12 long as the plans can only predict 20 percent and we can
13 match that up.

14 So should we do more sophisticated use of the
15 diagnoses, add years, add additional interactions? Of
16 course. If they can do that, we should do that too. In the
17 long run it seems like we would also want to have something
18 that was not subject to coding manipulation, which is easier
19 said than done. But maybe if we had lab values or things
20 like that that were less subject to regional variation, we'd
21 do an even better job. And this seems of first order
22 importance not just for the Medicare Advantage program but

1 for all of the other things we think that piggyback on risk
2 adjustment. ACOs are only going to work if we do good risk
3 adjustment. The PACE program, all the other things we've
4 mentioned in the last years.

5 So this seems worth sinking a fair amount of
6 effort into, but let's not try to wipe out selection based
7 on efficiency of care.

8 DR. BERENSON: Very quickly, I endorse the
9 conversation that Mike and you had about going for multiple
10 years. The example I remember is congestive heart failure
11 apparently persists -- that's the term or art -- persists on
12 a claim less than 50 percent of the time from one year to
13 the next. So if we can get better accuracy by simply going
14 out two years, I think that would be a real thing to look
15 at.

16 And then I want to pick up the implication of
17 Mary's question from the first round. There's dementia and
18 then there's cognitive impairment. About half of seniors at
19 the age of 85 have cognitive impairments, and we need some
20 hard definition. I mean, I'm very -- I think it could be a
21 very important factor that affects cost, is real dementia,
22 but we would need some pretty clear guidance as to that

1 we're getting dementia and not just anybody who has
2 cognitive impairment.

3 MR. KUHN: One just quick kind of question or an
4 observation a little bit on this slide that's up here, and
5 the issue dealing with socioeconomic variables -- race,
6 income. I've been doing a lot of reading lately about, you
7 know, not only those issues but, you know, housing,
8 education, family structure. And I guess I'm taking a
9 little bit of a bank shot here, Glenn, so if you don't mind,
10 indulge me for a minute. But looking more at the issue of
11 how that might be impactful in terms of the area of hospital
12 readmissions. And so I guess I'm wondering if there is a
13 chance here that there might be some portability in the work
14 that we're doing here could ultimately help influence or
15 advance the thinking in some of these other areas where
16 looking for more refinements, particularly in the area of
17 the readmission activity and some of these other
18 socioeconomic variables that could impact that. So just a
19 thought as we continue this work, if there's that
20 opportunity to kind of get a two-fer out of this would be
21 kind of nice.

22 DR. STUART: Very quickly, on Slide 6. We've

1 touched upon the maximum cost that you can predict ahead of
2 time based upon -- this actually goes back to the late
3 1980s, a study that Newhouse directed using data from the
4 RAND health insurance experiment. They had lab values.
5 They had extensive socio-demographic information, a lot of
6 stuff that you would never have even if you have ICD-10.
7 That study, that initial study, indicated that the maximum
8 prediction was around 20 to 25 percent, not at least. And I
9 think that's important.

10 The only way you're going to get this thing higher
11 is by taking actual data, cost data from individuals closer
12 to the time in which you want to predict. And you can
13 become perfectly predictive if you take the cost at the time
14 that you predict, which is retrospective cost reimbursement.
15 You don't want to be there. And so Kate's point is a really
16 important one. You need to have -- you don't want to have a
17 perfect prediction. And down around 20 percent or 15
18 percent is fine if you've got a broad-based population.
19 That's the real key. Every one of these predictors, no
20 matter how good they are, whatever the R-square is, unless
21 it gets up to 80 or more, underpredict for costly patients
22 and overpredict for less costly patients.

1 And so what you really need to do is to focus on
2 that systematic part on the upper end, and as Mike said, get
3 away from this notion of just trying to maximize the
4 prediction. You just want to make sure that you're able to
5 cover the costs for patients that are at a point where these
6 predictors just don't work well.

7 MR. HACKBARTH: So let me pick up on that, Bruce.
8 When Joe Newhouse used to be on MedPAC, he would often say
9 that the pursuit of improved predictive power is ultimately
10 going to be a frustrating one, and he, at least at that
11 point -- I don't know if he still does, but at least at that
12 point he advocated for a blended payment system that
13 combined prospective payment with some cost-based payment.
14 And part of his argument, as I recall it -- and, Joe,
15 forgive me if I'm not accurately representing. But he said,
16 you know, if you really want to benefit from selection, what
17 you focus on in the disenrollment process, not the
18 enrollment process, because the highly skewed distribution
19 of costs, all you have to do is discourage -- encourage a
20 few very high cost people to disenroll, and that's much more
21 powerful than trying to screen at the front end. And
22 there's ultimately no way a policy can beat that. The best

1 defense that you've got is a mixed payment system that mixes
2 some combination of cost and prospective.

3 We don't need to go into that now, but I would
4 like to hear in our future discussions some consideration of
5 that perspective. And, again, let me just emphasize Joe may
6 have very different ideas now, but that's what he used to
7 say on MedPAC.

8 MR. GEORGE MILLER: Just briefly, I just would
9 like to be clear, at least in my own mind, what the ultimate
10 goal here is from the standpoint, as Kate mentioned, we want
11 the ability to have patients receive more efficient care
12 and, thus, are we going to save money for the system through
13 the MA plans, or is the goal something different for better
14 care and better delivery of care systems for the patients
15 who select? So for me, I just want that clarity.

16 DR. MARK MILLER: The goals may be different
17 longer -- the further out we go. I think this conversation
18 and the immediate concern is probably most captured by what
19 Bruce said. Inside the system there's probably some
20 systematic -- you know, if you have a perfect mix across all
21 patients, then the risk system is working fine. But if you
22 happen to be focused on the tail of the distribution, I'm

1 going to go to people who are nursing home certifiable,
2 multiple chronic conditions, disabled, whatever the case may
3 be, the system is probably falling short. And so the
4 immediate attempt -- and there are many longer-run goals
5 that have been raised here or issues have been raised. The
6 immediate attempt is, Can you get that system to shift and
7 get a little more equities to avoid the systematic
8 underpaying for the complex care patients? That is the
9 immediate thing for PACE and, you know, the spring
10 discussion on other plans who do that. But these other
11 goals and issues are also in play, but it's probably just a
12 little further down the road.

13 DR. NAYLOR: I think this represents a huge
14 opportunity to best match finite resources and services to
15 people's needs as they change over time. So I really
16 applaud the effort to focus on something very complex.

17 I also think that it could and should be used as a
18 way to drive to effectiveness and efficiency. We had to
19 rely on multiple years to get reliable data on multiple
20 chronic conditions. So it's not at all easy, and I
21 appreciate that.

22 Just a couple things just to highlight in terms of

1 what might be areas of risk that we need. We know, for
2 example, people with one condition and it's very severe is a
3 set of problems. People who have combinations of
4 conditions, like Stage IV heart failure and depression,
5 cognition more broadly defined is a really big issue. And
6 sometimes the nature of the problems, like not diabetes but
7 falls and delirium, when you pick them out, they become
8 really important opportunities to focus on predictions of
9 costs going forward.

10 So I also believe that, you know, people may cost
11 more over time because they have progressive problems, and
12 so the need for risk adjustment to be looking at and
13 monitoring and periodically being reassessed is important.

14 DR. CASTELLANOS: Just very briefly, Scott, you
15 said you were going to talk on your level. I'm going to
16 talk where I come from. I'm a practitioner. When I see the
17 word R-square and stuff like that, I understand it, but
18 that's not my real world.

19 I think the discussion we had today is very
20 important, and it's a continued conversation that we have
21 not just in the MA plans, but we had it a little bit
22 yesterday in the rural plan about the cost differences, more

1 important getting payment accuracy. And I think that's what
2 we really want to try to do here.

3 What disturbs me is the conversation of the
4 pattern of care, the variations, the regional
5 differentiation. You mentioned the diabetic may get one
6 kind of care if he's in this plan and another kind of care
7 if he's in that plan. When a patient comes in to see me,
8 I'm a urologist so I get them to take their clothes off and
9 I can't see what kind of insurance they have. I don't know
10 if they have any insurance. And I think it's appropriate
11 that this patient get the appropriate care at -- the right
12 treatment at that time in my office irrespective of their
13 insurance.

14 So how do we get patterns of care and how do we
15 get regional variations under some way of putting it
16 together all over? And something I've brought up for the
17 last three or four years is appropriateness. We don't have
18 appropriate criteria for the practitioner. And, Bob, you
19 hit into that last year with me. I think if we did that, I
20 think it would solve the significant variation that we have
21 in patterns of care and some regional variation.

22 DR. BORMAN: A question would be -- and we may not

1 know the answer today. If I understand things correctly,
2 many of the MA plans span a number of regions, or at least a
3 number of geographic areas or parts of geographic areas.
4 And does this coding variation in any way match up to a
5 plan's sponsor? Because that may reflect their corporate
6 ability to manage health care information in terms of
7 coding. And so it would just be a question. That might be
8 an alternative explanation.

9 I would echo Tom Dean in the sense that I do think
10 ICD-10 will change this a lot. And almost predictably,
11 anytime you change one of the reporting systems, there's a
12 transient drop-off, and then there's almost like a rebound
13 overshoot as everybody learned to code better. And we
14 certainly went into that some with the hospital discussion
15 last year about correcting for coding intensity, and I think
16 that's probably predictable.

17 I'll reiterate something that Bruce brought up in
18 terms of remember in MA plans they're looking at Part A and
19 Part B, and in Part A this is hugely important. These
20 entities will probably tend to have better information
21 transfer, and so what's in the Part A record will likely
22 move forward.

1 The other caution I would make is that as many
2 things as we think are wonderful about the electronic health
3 record, it enables wholesale bringing forward of information
4 without necessarily reviewing it. And I think there's
5 incredible danger here that patients will end up with 20
6 codes, many of which are no longer extant. And so the
7 notion, you know, that in Bob's and my area code to the
8 reason of this visit starts to have some merit again,
9 because you've got this background that's being brought
10 forward. You know, the problem list moves forward without
11 ever being entirely reconciled. Look at the effort that it
12 takes to do medication reconciliation, the notion of
13 everybody doing diagnostic reconciliation. There would be
14 no time left to talk to the patient or to the family. So I
15 think that that's something we should just be cautious about
16 as we go forward.

17 MR. HACKBARTH: Thank you, Dan and Carlos.

18 Next up is beneficiaries with high drug spending
19 under Part D.

20 [Pause.]

21 MS. SUZUKI: Good morning. The Part D program is
22 in its sixth year and enrollees continue to be highly

1 satisfied with the benefit, but Federal costs have grown
2 much faster than the economy. The growth has been
3 particularly high for payments Medicare makes of subsidized
4 spending for beneficiaries with high drug spending. If high
5 spending is driven by the need for expensive medications
6 that have no therapeutic substitutes, current Part D
7 structure that relies on price negotiations between plan
8 sponsors and pharmaceutical manufacturers may not be well
9 suited to control drug spending.

10 But if that is not the case, there may be ways to
11 change the pattern of drug use to better control program
12 spending without limiting access to needed medications. In
13 this presentation, we report on our findings from looking at
14 drug spending for beneficiaries with high drug spend.

15 So we just wanted to quickly review the Part D
16 benefit structure. The standard Part D benefit includes a
17 deductible, 25 percent coinsurance up to the initial
18 coverage limit, and some limited coverage until the
19 beneficiary has met the annual out-of-pocket spending limit,
20 which in 2011 is \$4,550.

21 In the catastrophic phase of the benefit,
22 beneficiaries pay about five percent coinsurance and

1 Medicare's subsidy covers 80 percent of the cost. That is
2 the piece that is shaded in red.

3 And as you will see in a minute, the subsidy has
4 been growing rapidly over the last few years, and you will
5 look at patterns of drug use for people who have spending in
6 the catastrophic phase of the benefit, and the goal here is
7 to understand whether expensive biologics or some other
8 factor is driving the growth in spending.

9 The key feature of the Part D program is that it
10 uses competing private plans to deliver drug benefits. Each
11 year, plan sponsors submit their bids to CMS and payments
12 are based on plan bids. Payments to plans consist of three
13 types of subsidies. The direct subsidy covers the cost of
14 Part D's basic benefit. This is based on the national
15 average of plan bids adjusted for the actual health status
16 of plan enrollees. Reinsurance covers 80 percent of the
17 spending above enrollees' annual out-of-pocket threshold,
18 and this is the piece that was shaded in red in the previous
19 slide. Finally, the low-income subsidy covers the cost
20 sharing and premiums for enrollees who have low income and
21 assets.

22 The first two subsidies combined cover, on

1 average, 75 percent of the cost of basic Part D benefits.
2 Plan sponsors bear the most insurance risk for spending
3 below the initial coverage limit, while Medicare bears the
4 majority of the risk of spending in the catastrophic phase
5 of the benefit.

6 The three subsidies that I just mentioned are
7 shown here. The LIS is in white, reinsurance in red, and
8 the direct subsidy in gray. The black bar at the bottom is
9 the payment Medicare makes to employers who offer retiree
10 drug subsidy -- drug coverage.

11 Two things to focus on here are payments for
12 reinsurance and the low-income subsidy, which are two of the
13 fastest growing components of Part D spending. Reinsurance,
14 which is the red piece, has grown from \$8 billion in 2007 to
15 \$11 billion in 2010 and is projected to reach \$13 bill in
16 2011. That is a cumulative growth of 60 percent over this
17 period. The subsidy covers most of the catastrophic costs
18 for beneficiaries who have very high drug spending.

19 Another area of concern is the low-income subsidy,
20 which has become the single largest component of Part D
21 spending. Spending for the subsidy totaled \$17 billion in
22 2007 and \$21 billion in 2010 and is projected to total \$22

1 billion in 2011. That is a cumulative growth of 34 percent
2 over this period. Understanding the drivers of this cost
3 growth will help us think about whether this is something
4 that can be addressed through changes in policy.

5 Each year, only a small share of Part D enrollees
6 have spending high enough to reach the catastrophic phase of
7 the benefit. In 2009, 2.4 million, or about eight percent
8 of Part D enrollees, reached the catastrophic phase of the
9 benefit. Those high-cost beneficiaries accounted for 40
10 percent of total spending.

11 Over 80 percent receive Part D's low-income
12 subsidy. Compared to other Part D enrollees, a higher share
13 of high-cost enrollees are enrolled in stand-alone PDPs.
14 They are also more likely to reside in institutions and be
15 disabled beneficiaries under 65.

16 In the next few slides, I will go through some of
17 the key findings from our analysis of the Part D data. This
18 table compares the high-cost beneficiaries to non-high-cost
19 beneficiaries. In 2009, eight percent of Part D enrollees
20 with the highest spending accounted for 40 percent of the
21 spending and 20 percent of the prescriptions, while the
22 remaining 92 percent accounted for 60 percent of spending

1 and 80 percent of prescriptions. So what we are finding
2 here is that high-cost beneficiaries are filling more
3 prescriptions on average and the cost of each prescription
4 is higher.

5 They filled, on average, 111 prescriptions
6 compared with 41 for non-high-cost beneficiaries. That is
7 over nine prescriptions per month, on average, compared with
8 less than four per month for non-high-cost beneficiaries.

9 The average cost per prescription was more than
10 twice as expensive as non-high-cost beneficiaries, costing
11 \$110 per prescription compared with \$42 for non-high-cost
12 enrollees.

13 Biologics are among the most expensive products.
14 Treatments for conditions such as multiple sclerosis and
15 rheumatoid arthritis can cost tens of thousands of dollars
16 per year. Beneficiaries taking one of those products are
17 likely to reach the catastrophic phase of the benefit.

18 So one of the things we looked at first is to see
19 if the use of biologics explained the difference in the cost
20 per prescription between high-cost and non-high-cost
21 enrollees. Surprisingly, however, in 2009, less than ten
22 percent of the high-cost beneficiaries used biologics, and

1 biologics accounted for a small share of drug use by this
2 population, less than one percent of prescriptions filled
3 and about six percent of the spending. So much of the
4 difference in the cost for prescriptions is not explained by
5 the use of biologics.

6 Another somewhat surprising finding is that many
7 of the drugs used by the beneficiaries are in classes
8 commonly used by other non-high-cost beneficiaries. The six
9 classes shown here are examples of the classes heavily used
10 by both high-cost and non-high-cost beneficiaries. These
11 classes account for roughly 40 percent of spending for both
12 groups.

13 Although high-cost beneficiaries use many of the
14 drugs commonly used by other Part D enrollees, they tended
15 to use more brand name drugs compared to other enrollees.
16 In 2009, 42 percent of prescriptions filled by high-cost
17 beneficiaries were for brand name drugs compared with 26
18 percent for other beneficiaries.

19 Some of the difference likely reflects differences
20 in health status and in the mix of drugs taken by high-cost
21 beneficiaries, but we also have found significant difference
22 within a given therapeutic class. For example, 75 percent

1 of prescriptions for antipsychotics filled by high-cost
2 beneficiaries were for brand name drugs compared with 47
3 percent for non-high-cost beneficiaries. Among diabetic
4 therapies, brand name drugs accounted for 62 percent of
5 prescriptions filled by high-cost beneficiaries compared to
6 33 percent for other beneficiaries. And as you go down the
7 list, you can see that there is a significant difference
8 between high-cost and non-high-cost beneficiaries for other
9 classes, as well.

10 So given that generic drugs cost significantly
11 less in most cases, some of the difference in the average
12 cost per prescription we saw between high-cost and non-high-
13 cost beneficiaries are likely driven by the choice of brand
14 name drugs over generic drugs.

15 So to summarize, the majority of the beneficiaries
16 who have high spending, spending high enough to reach the
17 catastrophic phase of the benefit receive Part D's low-
18 income subsidy. They have high drug spending because they
19 fill many prescriptions and the average cost of
20 prescriptions filled are more than twice as expensive as
21 those filled by non-high-cost enrollees. To date, biologics
22 have accounted for a small share of spending for high-cost

1 beneficiaries. Many of the therapies used are in classes
2 commonly used by other Part D enrollees. And although high-
3 cost beneficiaries are using many drugs in classes with
4 generic alternatives, they tended to use more brand name
5 medications compared to other Part D enrollees.

6 These findings raise some important issues.
7 First, high-cost beneficiaries filled more than twice as
8 many prescriptions as other beneficiaries. They filled over
9 nine prescriptions per month, on average, compared to less
10 than four prescriptions per month for non-high-cost
11 beneficiaries and that is a lot of medications.

12 Second, high-cost beneficiaries are filling more
13 brand name prescriptions compared with non-high-cost
14 beneficiaries even for drug classes where generic versions
15 are available.

16 There are several reasons for concern about some
17 high-cost beneficiaries potentially taking too many
18 medications. A patient prescribed multiple medications are
19 at an increased risk for adverse drug events, such as drug-
20 drug interactions that can cause or exacerbate medical
21 problems. Many of the ADEs are similar to problems
22 frequently experienced by the elderly, like falling and

1 confusion. And as a result, an adverse event may be
2 mistaken for a new medical condition and be treated with
3 additional medications, further increasing the risk of ADEs.

4 Taking a large number of medications can also put
5 them at risk for inappropriate medications. For example, as
6 measured by spending, antipsychotics are at the top of the
7 therapeutic class for high-cost beneficiaries. While much
8 of the use is by the disabled under age 65, a considerable
9 amount of antipsychotics are used by the elderly with
10 dementia. Studies have shown that use of atypical
11 antipsychotics is associated with an increased risk of death
12 for this population and FDA has issued a black box warning
13 for these products.

14 Finally, heavy use of medication can also result
15 in non-adherence of drug regimes as patients try to balance
16 increased cost, side effects, and the inconvenience of
17 taking multiple medications at different times of the day.

18 Although plans are required to have medication
19 therapy management programs that improve the quality of
20 medication therapies and reduce adverse events, so far, we
21 have not seen any data or evaluation to determine how well
22 these programs are working.

1 Plan sponsors have been very successful in
2 encouraging generic use by their enrollees. They do so
3 primarily through the use of tiered cost sharing. For
4 example, this year, median cost sharing for generic drugs is
5 \$7, while the median cost sharing for brand name drugs are
6 much higher, \$42 for drugs on preferred tiers and \$80 for
7 drugs on non-preferred tiers. These differences in cost
8 sharing amounts encourages their enrollees to use the lower-
9 cost drugs when such alternatives are available. But these
10 cost sharing do not apply to the majority of high-cost
11 beneficiaries since they receive Part D's low-income
12 subsidy.

13 Copays for dual eligibles with income less than
14 100 percent of poverty is about \$1 for generics and
15 preferred multiple-source drugs and about \$3 for all other
16 brand name drugs. Duals with incomes above 100 percent of
17 poverty pay \$2.50 for generics and preferred multiple-source
18 drugs and about \$6 for all other brand name drugs. Duals in
19 institutions do not pay any cost sharing.

20 On the one hand, the subsidy allows this
21 population to access needed medications. But on the other
22 hand, the copay amounts which are set in the statute may be

1 limiting how well plan sponsors can manage drug spending for
2 this population. Since many of the drugs taken by high-cost
3 beneficiaries are in classes where generics are available,
4 this provides an opportunity to consider a policy that would
5 encourage more generic use by this population. Policy
6 makers must balance the need to provide financial incentives
7 to choose the lower-cost medications with the need to also
8 ensure access to the medications without imposing financial
9 burden. In addition, the current exceptions process will
10 ensure that beneficiaries have access to therapies and lower
11 cost sharing amounts when medically necessary.

12 As for next steps, we will continue to monitor
13 issues caused by heavy use of medications by high-cost
14 beneficiaries and in the future explore how measures of
15 polypharmacy may be incorporated to rate the quality of
16 pharmaceutical care provided by plans.

17 In November, we will discuss incentives faced by
18 beneficiaries receiving the LIS and suggest policy options
19 to encourage the use of lower-cost drugs.

20 That concludes my presentation.

21 MR. HACKBARTH: Thanks, Shinobu.

22 Karen, clarifying questions. Ron.

1 DR. CASTELLANOS: In some of the other programs we
2 look at outliers, who ordered too many x-rays, too many lab
3 studies. I am not saying the person on Slide 6, if you look
4 at that, I am not saying the physician is inappropriate in
5 the number of prescriptions he is writing, but it is an
6 education process if it is brought back to him and saying,
7 hey, you are ordering a lot of prescriptions, is it
8 appropriate, as an education process. Is there anything
9 like that in this program, looking at outliers by physician
10 writing the order?

11 DR. SOKOLOVSKY: The Medication Therapy Management
12 Program is mainly a relationship between the plan and the
13 beneficiary, but in the past year or so, CMS has included a
14 requirement that the prescriber be provided information on
15 the number of drugs and potential problems with drugs that
16 beneficiaries are receiving. But as Shinobu said, we have
17 no information on what impact that is having, where it fits
18 in terms of all the other information that prescribers are
19 receiving.

20 DR. CASTELLANOS: [Off microphone.] Thank you.

21 MR. HACKBARTH: George, Round 2 question?

22 MR. GEORGE MILLER: Yes, and I don't know if this

1 is a Round 2 question, but is there any prohibition by
2 making the financial incentive for the beneficiary to pay
3 more if they use a brand name versus a generic, to use that
4 as the lever? If you get the generic, you pay nothing, but
5 if you use the brand name, you pay \$5 per prescription. Is
6 that a lever that can be used in this program?

7 MS. SUZUKI: Well, currently, the statute defines
8 the cost sharing amounts. So there is the \$1 cost sharing
9 for generics and multiple-source drugs for people who have
10 less than 100 percent of poverty and \$3 if they take brand
11 name drugs. But, as I said, for other enrollees who are not
12 LIS, they do see significant cost sharing differences
13 depending on which drugs they use, so \$7 for generics, much
14 higher amounts for brands, and the higher amount if it is on
15 a non-preferred tier.

16 MR. GEORGE MILLER: Okay.

17 DR. STUART: I am going to ask a question that
18 originates from the fact that there is no good drug therapy
19 for hearing loss, and you may have already answered this.

20 [Laughter.]

21 DR. STUART: CMS does have a system of collecting
22 information from the Part D plans regarding both the

1 criteria that they use to target people for MTM reviews as
2 well as the activities that actually went on during those
3 MTM reviews. Do you have access to those data, or will you
4 have access to those data? These are beneficiary-specific
5 data.

6 DR. SOKOLOVSKY: The short answer is, no, we do
7 not have access to it, but CMS in the next few months is
8 apparently going to begin to roll out some of the research
9 that they have done using the data. But so far -- and that
10 is as of yesterday afternoon. I do not have anything beyond
11 that.

12 DR. STUART: I think that there should be a real
13 effort on behalf of MedPAC to get those data, because if you
14 look at some of the implications that were in the chapter
15 that you didn't have a chance to go through in your remarks
16 today, it gives the impression that there's a potentially
17 very high rate of inappropriate prescribing going on here,
18 and yet every one of the people who were high-cost
19 beneficiaries should have been targeted for MTM review. So,
20 I mean, it leaves the impression that MTM either is not
21 doing what it's supposed to do or somehow these people are
22 just not getting it when they were supposed to be getting

1 it.

2 DR. SOKOLOVSKY: What I do have is numbers of
3 people both targeted and receiving MTM and those numbers
4 line up fairly closely. For example, in 2010, three million
5 people were eligible by the plan's definition for MTM
6 services and about 2.6 million actually received it. But
7 what they received and whether it had an impact, that, we do
8 not know.

9 DR. MARK MILLER: [Off microphone.] I think that
10 is the point, is that in conversations, I feel like I have
11 heard things like you can execute your responsibility by
12 writing a letter and saying, you are taking a lot of drugs.
13 You should have some consultation with your physician, or
14 you should comply with the directions very carefully, as
15 opposed to really how much intervention. So it may be that
16 MTM touched them, but effectively and on a continuous basis,
17 I think that is the thing that we need to delve into. Is
18 that okay, Joan?

19 DR. SOKOLOVSKY: Okay, except one thing different
20 is in the past year or so, CMS has required all the plans to
21 do an annual medication review for everyone who is a member
22 of the program. But again, what the results are of that, I

1 don't know.

2 DR. STUART: It starts in 2010 --

3 DR. SOKOLOVSKY: Yes.

4 DR. STUART: -- so it's going to be a little while
5 until you get that.

6 MR. HALL: Shinobu, can we put up Number 8, Slide
7 8 again, the nice technicolor one you had? No, Slide 8.
8 Okay. So just a question of compounding variables. So you
9 have controlled for drug class, so these are comparisons
10 within class of drugs. That is number one. Was there any
11 age stratification here?

12 MS. SUZUKI: I am sorry?

13 MR. HALL: Age stratification, or was this lumping
14 everybody over age 65 in who is Medicare eligible?

15 MS. SUZUKI: For this analysis, all the age groups
16 are lumped into one.

17 MR. HALL: I think at least you ought to do a spot
18 check to make sure that all those people in the high-cost
19 aren't in the 85 to 90 age range, which is about the
20 percentage of the population of Medicare that would be in
21 that, because that could start to explain at least which
22 group of people, people who are much less likely to take an

1 active role in managing their own medications and,
2 therefore, are more prone to not reading or throwing away
3 that letter that tells them that they are not supposed to do
4 that. Thanks.

5 MS. SUZUKI: One thing that we did look at, not
6 specific to each of the classes shown here, but overall,
7 high-cost beneficiaries tended to be younger, less than 65,
8 compared to the overall Part D population.

9 DR. BERENSON: On Slide 6, you have got the
10 average number of prescriptions per beneficiary. Are we
11 able to use this database to identify different medications
12 prescribed within any given period of time by these two
13 categories?

14 MS. SUZUKI: Yes.

15 DR. BERENSON: And are you looking at that issue
16 in particular? In other words --

17 MR. HACKBARTH: Be more specific.

18 DR. BERENSON: Polypharmacy. I mean, there are
19 111 number of prescriptions, but I would like to know
20 whether that represents five medications written over and
21 over during a year or 20 medications and getting some sense
22 as to the issue around polypharmacy and suggesting

1 approaches to managing multiple conditions.

2 MS. SUZUKI: We can certainly look into that. We
3 have spot checked some of the records where there were an
4 extremely high number of medications prescribed in the given
5 year and some -- I think it varies by person. It could be
6 repeated medications of the same class. It could be from
7 many classes. And it seemed to vary a lot by person to
8 person.

9 DR. MARK MILLER: Maybe the idea is to -- and I
10 don't want to say anything that you can't do, but develop a
11 measure of unique medications or something like that.

12 DR. BERENSON: Yes, that's fine. I am not exactly
13 sure where I want to go. I just wanted to know that there
14 is the ability to use this data. I mean, I think it would
15 go in a different direction around things like Beers Lists
16 and things like that, medications that seniors should or
17 should not be receiving. But I'm mostly interested in the
18 number of unique medications that somebody who is a high
19 user, or a high-cost user has and looking for variations to
20 see if some places, some PDPs or MA-PDs are managing that
21 differently systematically. So it is not just the number of
22 prescriptions, but the number of unique medications I am

1 interested in.

2 MR. ARMSTRONG: I think I know the answer to this,
3 but I tend to think of pharmaceutical costs and worry about
4 them in a couple of different contexts. One is the cost
5 itself and are we prescribing the right amount, are we
6 prescribing the right medications, and is it really being
7 managed.

8 But I also think of it as a cost of an input into
9 the overall health of populations, and sometimes more
10 expenses on pharmaceuticals actually lowers overall costs.
11 And I am just wondering if there is any information we have
12 about whether we could draw any conclusion from these
13 populations like that.

14 MS. SUZUKI: We are starting to look into that,
15 linking A/B claims to D data to see if there is any
16 relationship, but we are just starting on that.

17 DR. DEAN: Is there -- we just had the discussion
18 about regional variations. Do you know if there are
19 regional variations in these data? I mean, I suspect there
20 may be, but I wonder to what extent if you have that data.

21 MS. SUZUKI: I actually did not look into the
22 regional variation for this population but it is certainly

1 something that we could look at.

2 MR. HACKBARTH: If there is information on
3 regional variation in drug use overall, Kate has written on
4 that.

5 DR. BAICKER: Yes. We looked at variation in Part
6 D utilization overall, geographic variation, and saw there
7 were the usual spread and that it did not seem to offset
8 Part A and B. So it wasn't that the parts -- not looking at
9 the individual level but looking at the risk-adjusted area
10 level. The parts of the country where there was most
11 intensive use of Part D were not then systematically
12 offsetting, reducing usage in A and B. And we also saw
13 similar variations. We didn't look at high users per se,
14 but we looked at use of contraindicated things, high-risk
15 drugs. Among patients with dementia, certain drugs are at
16 much higher risk of creating falls, et cetera, and we saw
17 there were similar regional variations in the quality of
18 prescribing along those metrics.

19 DR. MARK MILLER: We also have some aggregate
20 geographic variation in the last geographic variation that
21 we did, which I am forgetting when we published that.

22 DR. MATHEWS: [Off microphone.] Last fall.

1 DR. MARK MILLER: Last fall. So there is some in
2 there. But to this exchange, the project that we are trying
3 to get off the ground -- we have just recently gotten off
4 the ground is to take that question about the A/B-D link and
5 try and test the proposition more narrowly, diagnosis and
6 specific patient condition, to see whether having drugs has
7 an effect on the A/B spend.

8 DR. DEAN: And on your list of the categories, you
9 didn't include the Alzheimer's drugs. I would think that
10 they would be a fairly big contributor, but maybe I'm wrong.
11 Do you know where they fall?

12 MS. SUZUKI: I can definitely look into that and
13 get back to you.

14 MR. HACKBARTH: Clarifying questions?

15 MR. BUTLER: Okay. A fair question and an unfair
16 question. The fair question is: The per capita spending
17 for the non-Medicare versus Medicare, which is growing --
18 are they growing at similar rates of increase, do you know?
19 Or would they be different? I'm just getting at the fact
20 that we have some unusual co-insurance, co-pays structurally
21 in Medicare that suggest to me maybe that's a cause of the
22 increase, but I would -- is the non-Medicare per capita

1 spending for drugs going up at a less or greater rate than
2 in Medicare?

3 DR. SOKOLOVSKY: Are you talking about non-
4 Medicare versus Medicare or non-LIS versus --

5 MR. BUTLER: Non-Medicare versus Medicare.

6 MS. SUZUKI: We can definitely look into that and
7 get back to you. For Part D, spending for the program has
8 increased by over 7 percent per year, and we can see what
9 the private sector is doing.

10 MR. BUTLER: I'm just trying to see how perverse
11 or messed up are the incentives within the Medicare program,
12 because they seem to be a little clearer and a little bit
13 more consumer sensitive, price sensitive, when you're non-
14 Medicare.

15 So the unfair question is -- and this will trip
16 into round two, but then I won't comment in two. How would
17 you go about determining the number or percentage of
18 Medicare beneficiaries that actually are in a position to
19 respond to the incentives themselves? They may be, as Bob
20 says, slightly cognitively impaired versus extremely
21 cognitively impaired. Others may just say this is very
22 complicated, I can't navigate it. Others may be in end-of-

1 life situations and so forth. How do you get at those that
2 really are not direct participants in making the decisions?

3 DR. SOKOLOVSKY: I don't know that we can really
4 quantify this, although in some of Shinobu's analysis, she
5 didn't count -- these were only community based. But to go
6 beyond that, we have been doing this round of focus groups
7 every year since about 2004, and at the beginning we would
8 talk to all beneficiaries about generic drugs versus non-
9 generic drugs, and everybody thought that -- not everybody.
10 I don't want to exaggerate. But there was a general feeling
11 that generic drugs were fine for other people but that they
12 were too sensitive and it wouldn't work for them. And when
13 we've done it most recently talking about drugs, the non-LIS
14 people are saying -- when they tell us the drugs they're
15 taking, they will apologize for taking a drug that's not
16 generic. You know, "I couldn't" -- "There was no drug in my
17 class for this condition, so I had to take a brand name
18 drug." Whereas, the LIS people are still telling us that
19 generic drugs don't work for them.

20 MR. HACKBARTH: So, Joan, you're saying that over
21 a relatively short period of time, there seems to have been,
22 in your focus groups at least, a significant shift in

1 attitude about generics?

2 DR. SOKOLOVSKY: Among the non-LIS population,
3 yes.

4 MR. HACKBARTH: Non-LIS.

5 DR. MARK MILLER: And I guess the other thing,
6 just to capture from that, in some gross ways we can take
7 populations that we think are probably not participatory in
8 these decisions like the institutionalized. But getting the
9 refinements into where people are on their cognitive
10 continuum, that I think, for example, is going to be very
11 difficult. It was an unfair question, is what I'm saying.

12 MR. BUTLER: I said, but it gets, I think -- you
13 know, an awful lot of the spending in these high-cost areas
14 are related to where they're in no position to make a
15 decision around their drugs.

16 MR. HACKBARTH: On the first issue, the rate of
17 growth, I think I read just in the popular press that the
18 rate of growth in drug spending for non-Medicare people has
19 turned down, it slowed, and just as it's lower in Medicare
20 than was predicted at the time of Part D enactment, but, you
21 know, whether it's turned down more or less, I don't know.

22 Round two?

1 DR. BORMAN: Just briefly, I think maybe it's
2 important to sort of say what are some of our goals here,
3 and I think that you've -- this is a really good drill into
4 an opportunity potentially to get payments more accurate or
5 more appropriate because it's not clear from what we can
6 tease out of this that there should be a higher brand name
7 drug use. What you're showing us is that evidence that
8 there should be similar generic use, I think, and that
9 certainly is an opportunity for us to say here's something
10 that could be an improvement in this particular program,
11 balancing against that the vulnerabilities of the LIS
12 population, which I think we typically go to great lengths
13 to do. That doesn't relieve us of the responsibility to try
14 and make it as cost-effective a program as we can while
15 being one that is appropriately supporting a frail and
16 vulnerable population.

17 And then I think the other thing, it's a little
18 more so in the chapter materials. I would be a little bit
19 cautious about emphasizing a particular class of drugs and
20 FDA warnings. That particular class of drugs, I think --
21 the example you cite, yes, indeed, there's an FDA black box
22 warning. I think if you talk to a lot of very skilled

1 practitioners in this area, they will share with you that
2 the difference, while statistically significant, is
3 relatively clinically insignificant for the patients that
4 are being treated. So I think if you're going to continue
5 to use that particular drug class example, an addition of a
6 sentence that there may be some controversy about that
7 implication or perhaps there's a less controversial example.
8 I just worry a little bit that when it comes out in a report
9 with MedPAC, all of a sudden there's going to be a whole
10 bunch of, you know, look, MedPAC says these patients should
11 not get this drug. And I think we would do a great
12 disservice to the population we've studied, plus geriatric
13 patients generally, if we wander into that particular area,
14 and at least in the written materials in the chapter, I was
15 struck that it did come up a number of times, and I'm a
16 little concerned about that. In today's world I think the
17 FDA might not approve aspirin. So we just have to be a
18 little bit careful there. You know, they're trying to do
19 their best for us, but I think the way we look at and screen
20 drugs sometimes has some issues.

21 DR. NAYLOR: A really excellent report, peeling
22 away at multiple layers of a really complex problem. And

1 what struck me was looking at the table in the report about
2 total number of prescriptions and how it differs between
3 low-income and the differences between the institutionalized
4 long term and not. So I think it's a really -- for the
5 health of the public and the people that we're trying to
6 serve, a really important area that we continue to pursue.
7 So I just want to thank you for this great work.

8 MR. GEORGE MILLER: Yes, while we're all struck by
9 the high-cost beneficiaries and the percentage, I believe,
10 in the category on page 8, the category of the percentages
11 go down. Have you been able to determine and find what are
12 the characteristics of those, say the 25 percent in the
13 first category, why they did not use as high-cost drugs or
14 any of those parallel numbers, the converse of those high
15 numbers, what was it that they did or why didn't they use
16 the high-cost drugs? Any characteristics about them within
17 the group that could lead you to determine how to get the
18 other folks to not use high-cost drugs?

19 MS. SUZUKI: I think it generally depends on the
20 availability of generic alternatives for each class.

21 MR. GEORGE MILLER: Okay.

22 DR. STUART: I'd like to comment on this page as

1 well, and Bill was asking the question about whether the
2 high-cost beneficiaries were stratified, whether there was
3 some kind of control for other characteristics that would
4 distinguish them from non-high-cost beneficiaries. I'm
5 assuming this is just -- there's no other variables that are
6 included here. Is that correct? Because we've done some
7 work on high-cost beneficiaries, and we find actually that
8 if you are LIS or non-LIS and are high cost, you tend to
9 have similar -- more similar patterns. Not that there
10 aren't any differences at all, so I think that's something
11 that you want to look at, particularly because what you're
12 focused on from a policy standpoint seems to focus on the
13 LIS. And if the LIS high-cost look like non-LIS high-cost,
14 then you might go in a slightly different direction in terms
15 of that.

16 I'd also like to respond to a point that Kate
17 referred to in one of her publications about geographic
18 variation in utilization rates for Part D medications, and
19 your group looked at all medications. We've done some work
20 that has looked at people that have specific diseases -- in
21 our case, it was diabetes and heart failure -- and we do
22 find evidence of geographic differences, and that people who

1 are in high -- or diabetics or heart failure patients who
2 are in high drug cost regions tend to have better measures
3 of drug adherence and exposure to evidence-based medication.
4 So it's an area that is still open, I think, to new work.

5 DR. HALL: Pending looking at some of these
6 stratification questions, is this another category of
7 opportunities of paying for the SGR fix if we could make
8 improvement here? The numbers are astonishingly large, I
9 think, if, in fact, there are some corrective measures that
10 could be taken.

11 DR. MARK MILLER: I think the answer to that
12 question works like this: First of all, I want to just re-
13 emphasize something that Karen said. The objective here
14 would always be to be sure that the beneficiary has,
15 current law, like under current law, a low-cost option, you
16 know, for choosing a drug. So a beneficiary wouldn't have
17 to experience an increase in cost sharing if they chose a
18 generic or they chose a preferred name brand -- a name brand
19 with a discount. Because, remember, what happens, a way to
20 think about it is there's a set of beneficiaries that
21 whichever drug they choose, the federal subsidy can be much
22 larger or smaller, their cost sharing stays constant. And

1 if you allowed a little distance in that cost sharing,
2 instead of \$1, \$5 and so the beneficiary chooses the generic
3 instead of the name brand or the discounted name brand
4 versus no discount, you may get a shift to the lower-cost
5 drug and the federal subsidy would fall. And that would
6 result in a savings.

7 The reason I did this in a little long-winded way
8 is I want to be clear. The objective of the policy would
9 not be to raise cost sharing overall. The beneficiary would
10 still have the opportunity of a current law low-cost-sharing
11 option and the exceptions process to appeal. But if they
12 chose the higher-cost drug, then that would be the
13 discouraging -- the price would be more discouraging.

14 So, yes, it would result in savings, and one of
15 the contemplated offsets in the discussion in SGR yesterday
16 was this kind of a policy.

17 DR. BERENSON: Just briefly, I think this is very
18 interesting data, and as you delve deeper into it, I guess
19 one of the policy issues that I'd be interested in pursuing
20 -- it comes out of a conversation I had with Bruce yesterday
21 -- is where there's systematic differences between stand-
22 alone PDP plans and MA-PD plans with the view that the MA-PD

1 plans have a better ability to integrate with clinical care,
2 and do we see, you know, fewer multiple -- less problems
3 with polypharmacy, I guess is what I would say, or -- as a
4 general question. But I think we could look through that
5 lens to learn about that difference.

6 MR. ARMSTRONG: I just wanted to acknowledge that
7 while I don't necessarily have more specific suggestions
8 beyond what the staff has recommended as future work, I do
9 think that this is a great example where payment policy can
10 be changed to reduce the costs, unnecessary costs that we're
11 currently incurring in the Medicare program, and that we
12 have within Medicare, but within systems all around the
13 country, medication therapy management programs, financial
14 incentives, and systems that allow us to run medical expense
15 trends that are far better than you are showing here. And
16 so I enthusiastically support going forward with the kind of
17 work that you laid out.

18 MS. UCCELLO: I think looking at things from the
19 payment side is appropriate, but in addition to that, one of
20 the news articles included in our packets talked about some
21 providers who were very reluctant to prescribe generics.
22 And I think we need to pursue policies that would help

1 change that.

2 DR. DEAN: A couple comments. First of all, I
3 raised the issue of the Alzheimer's drugs because that is
4 one that is just very difficult from a clinician's point of
5 view to know what to do with. These are expensive drugs.
6 They are almost impossible to evaluate the effect because at
7 least the way they're promoted is they slow the decline, and
8 how do we know? And even that, the science is pretty
9 skeptical, if even that is really true. And yet there's a
10 lot of pressure, once people get started on these, do we
11 dare stop them? I mean, they're just really tough drugs to
12 handle.

13 My experience, to move on, with -- well, I guess
14 to finish that, I don't know what the policy should be, but
15 whether it should be, you know, drug holidays or something
16 like that, I'm not quite sure. And maybe that's beyond the
17 scope of what this program can do. It's a more clinical
18 issue.

19 My experience with medication management -- and I
20 understand that it's generally directed between the program
21 and the beneficiary. You know, we do get things from
22 insurance companies, probably not so much for these

1 particular patients, but I have been struck with how
2 inaccurate they are. It seems like about half the time I
3 get things for patients that aren't my patients or they're
4 drugs that I didn't prescribed or it's just -- or else
5 they're just clinically inappropriate. I got one the other
6 day because a patient was on two different kinds of insulin,
7 and they thought they were getting duplication
8 prescriptions. Well, it's standard therapy to give people
9 two different kinds of insulin. So it's a process that
10 makes sense, but it's got a ways to go in terms of its
11 becoming clinically useful.

12 I was really struck by the comment that 58 percent
13 of high-cost beneficiaries were getting brand name
14 cholesterol drugs. You know, that is one that just really
15 there is -- in my view, I would guess in our practice we
16 might have 5, maybe 10 percent of people on brand name
17 lipid-lowering drugs, and it would seem to me that it would
18 be relatively easy to introduce a fairly simple
19 preauthorization plan that just says, "Has this patient been
20 tried on a generic? And has it been shown not to be
21 effective?" And then you can go -- there are a couple of
22 brand name ones that are more potent, but it's a very small

1 population that those are relevant for.

2 MR. HACKBARTH: Keep in mind, in this context the
3 insurer is a Part D plan, and so they're the ones deciding
4 what the best tools are to encourage appropriate use.

5 DR. DEAN: Okay.

6 MR. HACKBARTH: The step therapy approach is a
7 commonly used tool for some drugs.

8 DR. STUART: The data set that you had actually
9 does have information on whether the plan at the drug level
10 imposes either prior authorization or step therapy. And so
11 that might be interesting to look at plans that are
12 different in terms of whether Lipitor requires prior
13 authorization and Zocor doesn't.

14 DR. DEAN: It would like that clearly has not been
15 applied for whatever reason, and I don't understand all the
16 payment issues. And, finally, I would just echo what Karen
17 said about the -- she was being very diplomatic -- comment
18 about antipsychotics in the written material. That is just
19 a very difficult clinical situation, and everything that's
20 in there is true. On the other hand, as clinicians we get
21 put in a situation where these are not great drugs and they
22 do have risks. But we're faced with situations where we

1 don't have any other options. And it's true -- that's been
2 my gripe about the Beers list for a long time. Everything
3 that's on the Beers list is true. Those things are all
4 toxic drugs. But there are a few situations where we just
5 simply don't have other alternatives, and if you've got
6 nursing home residents that are abusive and disruptive and
7 injuring staff members, you know, we have to intervene, and
8 these drugs work.

9 So, I mean, there are other -- there's non-
10 pharmacological interventions that should be tried and that
11 do sometimes work. But I think we have to be careful just
12 because these drugs are dangerous drugs and they do have --
13 they were promoted initially as the solution to all our
14 problems. They were supposed to be risk free, and they were
15 supposed to be the solution. And it's clear that they're no
16 safer than the older drugs. They're much more expensive,
17 and -- well, enough.

18 MS. BEHROOZI: Well, here's no surprise. I loved
19 this. I thought the paper was really thorough and complete
20 and clear. It was really great. And no surprise because
21 this is so -- the recommendation to structure cost sharing
22 to encourage beneficiaries to use generics is very -- that's

1 what we do in our plan.

2 One thing that I want to emphasize -- and you
3 highlighted it in your presentation -- is that you want to
4 structure it that way, where generics are available. So the
5 flip side of that is where there are no generics available,
6 you don't want to say, you know, generics are cheap and
7 brand names are expensive, period. You want to say generics
8 are cheap and brand names are expensive where generics are
9 available. Brand names where no generic is available should
10 not be expensive. I just want to make sure that that's
11 stated, because you don't want to deter people from using
12 drugs when there's no generic available. You know, you
13 don't want to have a threshold that gets in the way of that.

14 On the topic of how to get people -- what's the
15 best motivator, what's the strongest encouragement, whether
16 it's for the beneficiaries or, as Cori raised, for the
17 prescribers, clearly, you know, education is a huge
18 component of it. We've just done sort of an analysis and
19 write-up of our program where mandatory, as we call it,
20 generics are a major component, and from 2009 to '10, I
21 think it was, or 2008 to '09, I'm sorry, we actually had a
22 negative drug trend. You know, the costs of our drug

1 program declined. And education is really highlighted. You
2 know, it has something to do with the fact that our union
3 was founded by pharmacists so people pay a lot of attention
4 to that. So we have to be very clear in our communications.
5 But we also have a lot of low-income members who, as you
6 have noted from your focus groups, carry some attitudes
7 about generics that reflect low health literacy or, you
8 know, they haven't been exposed to the concepts a lot.

9 So I know this sounds like, you know, whatever,
10 way out there, but a really good marketing tool is to say
11 generics are free because a dollar -- the difference between
12 a dollar and free to the payer really doesn't make that much
13 difference. To be able to use the word "free," generics are
14 free when they're available, overcomes as whole lot of
15 resistance. So I would just suggest you consider that as a
16 potential policy option. We have not found that the fact
17 that they are free means utilization in general ramps up.
18 People aren't going to just start taking drugs because
19 they're free, but they will take the generic because it's
20 free as opposed to the brand name drug.

21 So that's my two cents. Thank you.

22 DR. CHERNEW: I've very sympathetic to what Mitra

1 just said, so let me just start by saying I believe there's
2 a lot of inefficiency in the way the drugs are purchased,
3 and that's something that we should focus on. I think it's
4 important to think about what's meant by "when available"
5 because not all generics are the same as all branded, even
6 within class, and in some more than others. The cholesterol
7 one, as much as I understand that, that's going to go away
8 in a -- before we do anything, that's going to be less of an
9 issue.

10 DR. DEAN: Well, not necessarily. Crestor is
11 still around and they're pushing hard.

12 DR. CHERNEW: I understand. But in any case,
13 there are differences across the drugs in different ways,
14 and so we shouldn't think that just because there is -- we
15 shouldn't write as if just because there's a generic in
16 class that means they're perfect substitutes, because
17 they're not, although I do think the rates of use of branded
18 are probably higher than they need to be for many of the
19 reasons that Tom said.

20 But the thing I think is most complicated is it
21 turns out that I think the evidence suggests that when you
22 raise co-pays for individuals, you get many more people

1 dropping taking any medication at all as opposed to
2 switching even though you would think they would switch when
3 they're available. And so this incentive to switch comes
4 with a cost of people dropping out of taking the use of
5 appropriate drugs, and I think the problem is, particularly
6 in this population, that the population doesn't always
7 behave, as much as it pains me to say, the way economists
8 would predict. And so even if you have -- you know, you're
9 taking this drug that's branded, we have this co-pay
10 differential, but there's a generic you can go get or you
11 want an exception, you can go get an exception, you would
12 like to think that people would sort of thoughtfully think
13 through that and they would have that option. I think the
14 challenge is too often they don't and too often they won't.
15 And that shouldn't be used as sort of a blank check,
16 therefore, we can't do anything. We've identified this
17 problem but now we can't do anything. I think that's not
18 the message I'm trying to say. The message is really we
19 just have to be careful, particularly about what we mean by
20 what's available, particularly about what safeguards we use,
21 particularly when we focus on the plans and interventions
22 like have you done this as opposed to patient incentives.

1 So I think we need to think about what the costs
2 are, particularly recognizing that in many cases for some of
3 these classes there's a potential back end cost of not
4 managing the thing well. And while I understand the offset
5 literature geographically, it turns out that there's a
6 growing literature about Part D in general and the fact that
7 Part D increased used of prescription drugs and there was a
8 reduction in spending. This is the Joe Newhouse morning.
9 Joe has a paper on that. Mike McWilliams recently had a
10 paper on that. We have a paper on the use of
11 hospitalizations.

12 So there is a lot of good that's being done by a
13 lot of the drugs, and so we have to worry not only for
14 health reasons but also for other reasons about treating
15 them broadly as the whole pattern of care and be careful
16 with the interventions that we adopt. But that is not meant
17 to say we shouldn't adopt any.

18 MR. HACKBARTH: Thank you. Good job, Shinobu [off
19 microphone].

20 Our final topic is Medicare coverage of and
21 payment for home infusion.

22 So this is the first presentation we're going to

1 have on this topic, as I recall, and this is a mandated
2 report to Congress. Since it's the first time we're hearing
3 about this, what I propose we do is limit the questions to
4 one round of clarifying questions so we can finish
5 reasonably close to on time. Thank you, Kim.

6 MS. NEUMAN: Good morning. I'll try to move
7 quickly through the presentation so you'll have time for
8 questions. So we're going to talk about home infusion, and
9 we're going to look at a couple of things. We're going to
10 talk about what is home infusion, what issues Congress has
11 asked us to look at, and what work we have in progress.

12 We'll talk about what's currently happening in
13 Medicare on home infusion, what's covered, how much are we
14 spending, on what products, and for which beneficiaries.
15 And then we'll conclude with next steps. Before we start,
16 we'd like to thank Kelly Miller and Sinobu Suzuki for their
17 help on this work.

18 So what is home infusion? Home infusion typically
19 involves the infusion of an intravenous drug in a patient's
20 own home. It's most commonly used for IV drugs that require
21 frequent administration, daily or multiple times per day
22 such as IV antibiotics or drugs that have very long infusion

1 times.

2 There are several components of home infusion.
3 There's the drug. There's supplies like tubing and
4 catheters. There's equipment like pumps or poles. And then
5 there's oftentimes nursing involved. Typically, a nurse
6 visits for the first infusion or first several infusions to
7 train the patient or family in how to administer the drug
8 independently. And thereafter, the nurse just visits
9 periodically to check the infusion site, to do catheter
10 care, that kind of thing.

11 As we'll discuss again later, in some situations,
12 Medicare covers all components of home infusion; in other
13 situations, Medicare covers some components.

14 So this slide shows the issues that Congress has
15 asked us to look at. First we've been asked to look at the
16 literature on the relative costs associated with providing
17 infusions in the home compared with other settings with a
18 specific request that we assess whether or not broader home
19 infusion coverage under Medicare would yield savings through
20 shortened or avoided hospital stays or skilled nursing
21 facility stays.

22 We've also been asked to look at sources of data

1 on the cost of providing home infusion, how private plans
2 and Medicare Advantage plans cover and pay for home
3 infusion, and any potential issues related to fraud and
4 abuse. And recommendations are requested if the Commission
5 determines any changes to coverage or payment for home
6 infusion under Medicare are warranted.

7 So we've got a few efforts underway to look at
8 these issues. First we've contracted with NORC to interview
9 health plans, home infusion providers, and discharge
10 planners. We're also interviewing physicians and other
11 experts on home infusion.

12 We're in the process of doing a review of the
13 literature on the relative costs of providing infusions in
14 the home versus other settings. And finally, we've
15 contracted with Acumen to analyze Medicare data on current
16 expenditures on home infusion. And we'll talk about that
17 last part shortly.

18 First, though, this slide shows how Medicare
19 covers home infusion currently. Medicare's coverage of home
20 infusion is spread across several payment silos. Drugs are
21 covered under Part B or Part D. Under Part B, a small
22 number of drugs are covered. There's a small set of drugs

1 that CMS has determined require a durable medical equipment
2 pump. Those are covered under B.

3 There's also parental nutrition, IV nutrition, for
4 people with a non-functioning gastrointestinal tract.
5 That's covered under the B prosthetic benefit. And then
6 finally, B covers intravenous immunoglobulin, IVIG, for
7 people with a specific diagnosis.

8 And then Part D covers anything that Part B
9 doesn't cover that is on the plan's formulary and that meets
10 any medical necessity criteria that the plan may have. So
11 coverage of other aspects of home infusion, supplies,
12 equipment, and nursing, depend on two things generally. One
13 is whether the drug is covered under B or D. And the second
14 thing is, is the beneficiary homebound.

15 So this slide kind of summarizes the various
16 scenarios that can occur with coverage. With one exception,
17 if Part B covers the drug, then the supplies and equipment
18 are also covered. If the beneficiary is also homebound,
19 then nursing would be covered through the home health
20 benefit; otherwise, it's not.

21 If it's a Part D drug, then Part D will only cover
22 the drug, unless the beneficiary is homebound. If the

1 beneficiary is homebound, certain supplies and nursing are
2 covered through the home health benefit.

3 So what happens when a physician believes the
4 patient would benefit from home infusion, but only some
5 components of home infusion are covered through Medicare?
6 There's a couple of different scenarios. Some beneficiaries
7 receive coverage through other sources such as employer-
8 sponsored supplemental policies or Medicaid. Medigap,
9 though, does not cover this.

10 Some beneficiaries pay out of pocket and then some
11 choose to receive care in other settings like hospital
12 outpatient departments, skilled nursing facilities,
13 physician offices.

14 In terms of Medicare Advantage, Medicare Advantage
15 plans have the flexibility to provide home infusion coverage
16 that's broader than Medicare fee-for-service. And some
17 plans do offer broader coverage. MA plans have the option
18 of bundling Part D home infusion drugs with supplies,
19 equipment, and nursing as a Part C supplemental benefit with
20 no cost-sharing. And as of 2009, about 219 MA plans,
21 accounting for 15 percent of MA enrollment, did bundle home
22 infusion under Part C.

1 We know less about extent of home infusion
2 coverage among other MA plans. We've got data on their drug
3 use, but we don't have data on anything else.

4 So now, for a look at the data, this slide shows
5 some of the key statistics on current use of home infusion
6 under Medicare. So we've got 36,000 fee-for-service
7 beneficiaries using a Part B-covered home infusion drug as
8 of 2009, and a little over 100,000 Part D enrollees using a
9 Part D-covered infusion drug.

10 In terms of expenditures, Part B expenditures were
11 a little over \$600 million for Part B-covered drugs,
12 supplies, and equipment, and for Part D-covered drugs,
13 expenditures were about \$422 million.

14 So this next slide shows the top Part B and Part D
15 covered home infusion drugs. And it shows that spending is
16 generally concentrated on a small number of products. So if
17 you look at that second column, you can see that the top
18 three home infusion drugs, in terms of expenditures,
19 accounted for between two-thirds and three-quarters of
20 spending on all home infusion drugs in Part B and Part D.

21 And now if you look at these other highlighted
22 columns, what you see is that these products tend to have a

1 very small number of users and tend to have a very high cost
2 per user. And the one exception to that is the second line
3 from the bottom, antibiotics. There you can see that there
4 were over 50,000 Part D enrollees that got an IV antibiotic
5 under Part D, and the average cost was just a little over
6 \$1,000.

7 And we'll revisit numbers like these in future
8 presentations when we think about cost implications of home
9 infusion coverage.

10 So we also looked at home infusion use by
11 beneficiary in Part D plan characteristics. And what we saw
12 is that Part D home infusion use was higher among LIS
13 beneficiaries, similar to what Shinobu was talking about
14 earlier.

15 We also see higher use among PDP enrollees
16 compared for MA-PD enrollees, and certain beneficiary groups
17 such as minorities, beneficiaries age 85 and older, the
18 disabled, and those with ESRD. In terms of Part B home
19 infusion use, use was higher among the disabled and
20 beneficiaries with ESRD.

21 We also took a look at home health use among
22 beneficiaries receiving Part D-covered home infusion drugs

1 to get a sense of the extent to which Medicare is currently
2 providing nursing services. And what we found is that there
3 was a high rate of home health use among beneficiaries
4 receiving IV antibiotics.

5 Looking at the top two IV antibiotics, in terms of
6 expenditures, over 60 to 70 percent of the time there was a
7 home health visit within six days of the prescription being
8 filled. We saw much lower rates of home health use among
9 beneficiaries receiving other Part D-covered drugs.

10 So that brings us to our plan for upcoming
11 meetings and the report. In the future, Joan will be
12 presenting findings from our interviews of plans, providers,
13 and stakeholders, including how private plans and MA cover
14 and pay for home infusion, prior authorization and other
15 management tools they use, factors that providers and plans
16 consider in determining if a patient is a candidate for home
17 infusion, and what we've heard from discharge planners and
18 others about Medicare beneficiaries' access to home infusion
19 services.

20 We'll also talk about the cost implications of
21 home infusion versus infusion in other settings. We'll
22 discuss findings from our literature review on that topic,

1 and we've been asked to examine whether there are possible
2 savings when we reduce use of SNFs and hospitals if Medicare
3 broadened home infusion coverage. And we'll do our best to
4 consider that issue. But a lack of specific data on
5 infusions in inpatient hospitals and SNF settings will limit
6 our abilities there.

7 Then we'll also discuss fraud and abuse. We'll
8 consider potential vulnerabilities that Medicare might face
9 and what strategies might exist to combat them. And
10 finally, we could discuss policy options if the Commission
11 wishes to pursue them. So that concludes our presentation
12 and we look forward to your questions and discussion.

13 MR. HACKBARTH: Thanks. Well presented and
14 efficiently presented. Karen?

15 DR. BORMAN: You've indicated you're going to look
16 at bundled practices within MA, whether or not there might
17 be some bundled practices outside the Medicare system. I
18 mean, this just cries out for a bundle, I think, in a lot of
19 ways, particularly when we see how it's fragmented. So if
20 we can cast a wide net about how to provide this as a
21 bundled service, I think that would be very helpful.

22 I think appropriately used, home infusion is a

1 great thing for the right patient, for the right reasons.
2 And then my one other question would be, is the hospice
3 aspect of home infusion captured in one of these other --
4 does it come under one of these other categories of Medicare
5 coverage or would there be home infusion in hospice that's
6 covered separately only in the hospice benefit?

7 MS. NEUMAN: Home infusion and hospice is separate
8 from the home infusion in B and D. We actually did look at
9 data looking at crossover to see if there was sort of
10 crossover billing going on, and we did not see a lot of
11 that.

12 DR. CASTELLANOS: I agree with Karen. The silo
13 effect here is tremendous. In my practice, we do a lot of
14 antibiotics, but the silo effect really makes it a very
15 difficult walk through a lot of complicated paths.

16 The only other comment I have, and it's not a
17 negative comment, but I looked at your references and you
18 didn't reference the GAO report of June 2010. I'm sure
19 you're aware of it. I just wanted to make sure that you
20 were.

21 MS. NEUMAN: Yeah. One of the things that we need
22 to do in this study is to incorporate the GAO report in our

1 assessment. And so, we'll have a text box and discussion
2 and all of that. It just didn't get into the paper in this
3 round.

4 DR. CASTELLANOS: No problem.

5 DR. NAYLOR: Great work and two questions. Will
6 your study include actual interviews with beneficiaries and
7 family caregivers - I wasn't clear -- since it seems that's
8 an important perspective.

9 DR. SOKOLOVSKY: You're right and we feel like
10 we've interviewed the whole world, but we have not been able
11 to have the resources to find -- because the population is
12 so small --

13 DR. NAYLOR: Right.

14 DR. SOKOLOVSKY: -- being able to find them has
15 been beyond our ability in this.

16 DR. NAYLOR: Okay, okay. And the second is, in
17 your work going, can you explain a little bit about why home
18 health and its connection with Vancomycin and antibiotics is
19 -- there was much more home health use or nursing visits, I
20 should say, is that right, within six days relative to other
21 drugs? I think that would be helpful to know.

22 MS. NEUMAN: We'll be able to bring some more

1 information to that when we talk about what we've learned
2 from our discharge planner interviews. A lot of the folks
3 who are getting IV antibiotics are getting them after an
4 acute episode, and so the homebound criteria is likely to be
5 more relevant to them than to say another product that might
6 be a life-long condition that you're getting it for and not
7 sort of an acute situation.

8 DR. NAYLOR: I think that would be great to kind
9 of do a case on that.

10 MR. HACKBARTH: George?

11 MR. GEORGE MILLER: Very quickly, on Slide 7,
12 what's the definition of homebound? Is that definition
13 similar or the same as the definition for home care?

14 MS. NEUMAN: Yeah. We are meaning the homebound
15 definition under the Medicare home health benefit. That is
16 the mechanism by which they're getting the nursing services.

17 MR. GEORGE MILLER: Okay, very good. And then the
18 last part of that slide, do you know -- it says received
19 care in another setting. Do you know the cost for that
20 other setting versus them having it at home? Is there a
21 comparison? Do we have statistics to show what the savings
22 would be?

1 MS. NEUMAN: We are going to be able to do some
2 sort of conceptual work in that area. I'm looking at, say,
3 how much Medicare would pay in certain settings.

4 MR. GEORGE MILLER: Right.

5 MS. NEUMAN: You know, one of the gaps will be,
6 well, how much would Medicare pay for home infusion. So
7 you're going to sort of have to look at what the current
8 payment systems look like and then imagine what it might
9 look like for Medicare.

10 MR. GEORGE MILLER: Okay, thank you.

11 MR. KUHN: Kim, quick question. On Page 10, you
12 look at the top three Part B and top three Part D drugs. I
13 want to think maybe it's been three or four years now, but
14 there's been some reports that have come out talking about
15 migrating drugs that are in the Part B space over to Part D.

16 Would any of these drugs be in some of those
17 reports? Are you familiar with some of those reports and
18 would any of these drugs fall into that category of that
19 possible migration?

20 MS. NEUMAN: So the things where there's B/D
21 crossover issues?

22 MR. KUHN: Yeah, yeah.

1 MS. NEUMAN: I would say --

2 DR. SOKOLOVSKY: That's the one.

3 MS. NEUMAN: I mean, immunoglobulin is one where
4 there's a lot of crossover issues and sometimes it's under B
5 and sometimes it's under D. The other ones, I know there's
6 a little bit of B use of Alpha-1, but I haven't heard that
7 kind of discussion. So I think it's a mix.

8 DR. BERENSON: Yeah, I want to follow up to
9 George's question, the homebound definition, but
10 operationally, how does that happen? Is that part of the
11 physician's certification of an episode of home health or is
12 that how that determination is made?

13 DR. SOKOLOVSKY: I don't think we'll be fully able
14 to answer this, but what we're hearing from hospital
15 discharge planners is that if somebody is being discharged
16 from the hospital with need for an infused IV, they tend to
17 consider them homebound, and the physician who's writing the
18 order tends to consider them homebound. The main exception
19 they talk about is if the person is also getting outpatient
20 therapy, in which case they couldn't be homebound.

21 DR. BERENSON: But, I mean, if the patient is
22 homebound and qualifies for skilled nursing, then I'm

1 assuming there's a payment category in the home health
2 payment system that is for this specific activity,
3 essentially skilled nursing for supervising infusion
4 therapy, is that right?

5 DR. SOKOLOVSKY: I think Evan --

6 MS. NEUMAN: I don't think there's a --

7 DR. BERENSON: So it's a separate payment system,
8 you think. It just needs to be a certification of
9 homebound, but we don't pay for it as a home health service?

10 MS. NEUMAN: It's just part of the services that
11 are covered under the home health bundle.

12 DR. BERENSON: I see. So it is part of the home
13 health bundle?

14 MS. NEUMAN: Yes.

15 DR. BERENSON: So there's a case -- there is a
16 part of the whole case-mix adjuster?

17 MS. NEUMAN: Exactly.

18 DR. BERENSON: Yeah, that's what I'm assuming.

19 DR. MARK MILLER: I mean, I think -- I don't know
20 why this microphone won't go on. I mean, I think the
21 concern here is, is that if somebody's classified as
22 homebound, then basically they just roll into the episode

1 payment and that's -- that's how home health begins to pay
2 for this.

3 MR. GEORGE MILLER: There has to be a
4 certification.

5 DR. MARK MILLER: Oh, no, absolutely. If they get
6 the certification, but the reason I'm saying this, Bob, is
7 it sounded like, Well, they must go to a special category
8 and a special payment in home health, and I don't think
9 that's the case.

10 DR. BERENSON: I don't mean that. I mean, there's
11 -- I mean, we have an elaborate case-mix payment episode,
12 case-mix adjuster where we were concerned that it over-
13 emphasizes therapy and not -- and I'm just assuming that
14 somewhere in that scheme there is payment for home infusion
15 and that it has an appropriately lower payment level than a
16 complex patient would be or a therapy patient would be.

17 DR. MARK MILLER: And we'll get with Evan. We'll
18 answer this question for you. I suspect it's not as precise
19 as that. You'll have, you know, some sets of categories. A
20 patient will end up in one of those categories, but it will
21 not be peculiar to this infusion payment.

22 DR. BERENSON: Okay. I'd be interested in

1 following up.

2 MR. ARMSTRONG: Okay. Just, I think the comment I
3 wanted to make builds off of Bob's, but first, I just wanted
4 to ask, so why has Congress asked us to review this?

5 DR. MARK MILLER: Okay. All I wanted to say is
6 Kim will answer this question.

7 MR. ARMSTRONG: Okay.

8 DR. MARK MILLER: I think some of the issue works
9 like this, and this is kind of inferring from things we
10 heard. We get a letter and, you know, exactly the dynamics
11 behind it we're not always privy to. I think there is some
12 sensation on the part of Congress that this goes on in MA,
13 this goes on in the private sector.

14 As Kim showed you, there are gaps in the way it's
15 paid in Medicare, and so would this be a good change in
16 benefit design or expansion that we should pursue? But I
17 think you can also tell from some of the other questions
18 that they've asked us is, What are the cost implications of
19 this? Does this, in fact, have trade-offs that make it
20 worthwhile? What are the fraud and abuse opportunities
21 here?

22 So my sense, and Kim, feel free to modify any of

1 this is, is they were looking at this. They hear people
2 saying, This can be an efficient and good way of doing
3 certain types of therapies, but could see some of the --

4 MR. ARMSTRONG: Problems.

5 DR. MARK MILLER: -- problems that it might
6 represent. Yes?

7 MR. ARMSTRONG: So the reason why I asked that
8 question was just from my point of view, this exemplifies a
9 trend that we need to anticipate of more and more care being
10 provided in our patients' homes, and that the kind of
11 sophistication around the coding or payment structure, I
12 think, is going to become more and more of an issue for us
13 on down the road.

14 In fact, I think what we're doing in the home
15 today is only a small percentage of what we will be doing in
16 patients' homes as technologies change and so forth not long
17 down the road. And so, my hope would be that we're doing
18 this not just because Congress told us to, but that we have
19 the opportunity to sort of think about how this starts to
20 add to the development of an agenda in the next couple of
21 years around, you know, What do we really think about how
22 hard we want to push through payment policy the expansion of

1 these kind of home care programs.

2 DR. DEAN: I was just curious. One place in the
3 written material they mention insulin. When would insulin
4 be used in this kind of a setting?

5 MS. NEUMAN: So the insulin is continuous insulin
6 infusion through a subcutaneous method and there's a strict
7 policy that they have about the clinical criteria that you
8 would meet to get this continuous insulin infusion.

9 DR. CASTELLANOS: But there are insulin pumps that
10 we use quite a bit today.

11 DR. DEAN: I know. I mean, I understand that, but
12 they wouldn't be managed under this kind of a program, would
13 they? I mean, I don't know. I was just curious. It's not
14 a big thing.

15 MS. BEHROOZI: So it seems implicit that there's a
16 question about whether this is a better or most cost-
17 effective way of delivering services, you know, that Scott
18 was talking about. So what do we -- so a billion dollars,
19 approximately, is spent on home infusion by Medicare under B
20 and D. Do we know out of a total of what that's spent on
21 infusion and do we know how we would even attribute costs to
22 infusion not dealt with in the home?

1 Like do we attribute the whole cost of a SNF stay
2 that maybe somebody is staying there just because of the
3 infusion and they, for whatever reason, are not getting it
4 at home? You know, what's the bigger picture within which
5 that billion dollars fits?

6 MS. NEUMAN: Yeah, you've hit on sort of the crux
7 of the issue. We don't, first of all, know what the
8 universe is of all people who would be getting infusions in
9 the home if Medicare had broader coverage. And if we tried
10 to assess, you know, what SNF stays might not exist if, you
11 know, home infusion was more broadly covered, we wouldn't be
12 able to tell which beneficiaries are in the SNF for home
13 infusion versus they're in there because they also need
14 wound care and they have a whole bunch of needs.

15 So the best we're going to be able to do is to
16 sort of develop a conceptual framework of scenarios where we
17 think it might be more -- might be cost-effective versus
18 might cost more. And then it's really a judgment about how
19 many people you think fall in the various scenarios to make
20 a sort of assessment of what you think in that this would
21 do.

22 So we'll do our best to bring that to you, but at

1 the end of the day, I don't think you're going to have a
2 satisfying, rigorous, it saves or it costs this amount. We
3 won't be able to tell you that, unfortunately.

4 MR. HACKBARTH: Coverage policy, deciding which
5 services to cover, abstracted from specific patient
6 situations and needs is a very weak tool for assuring
7 appropriate use, most effective use, most efficient use of
8 services. You really need clinical management of the care
9 of the sort that's not provided through a fee-for-service
10 benefit structure or coverage sort of change.

11 That's one of the things that an organization like
12 Scott's can do. They've got total financial responsibility.
13 Their clinicians are actively involved in the care of the
14 patients. It's their home health people going out to the
15 patient's home. They've got all of the facts that you need
16 to know whether this is right clinically, let alone more
17 cost-effective. Doing it from Baltimore or Washington, it's
18 a real hard thing to do. Mike? Peter

19 MR. BUTLER: So I would echo Scott's question and
20 also it relates back to our Medicare risk discussion, that
21 is, what problem are we trying to solve? I'm still not
22 exactly clear despite Mark's excellent answer. But let me

1 zero in on one --

2 DR. MARK MILLER: [Off microphone.]

3 [Laughter.]

4 MR. BUTLER: Careful. My red light is still on.
5 Now you've distracted me.

6 Getting back to, the chapter says fraud and abuse
7 as one of the issues. So these are big money up here for
8 these kinds of drugs. So who in the chain is the potential
9 guilty party here that we're looking at in terms of fraud
10 and abuse?

11 MS. NEUMAN: I don't know if guilty party is sort
12 of the focus of what we're trying to look at. We're trying
13 to think about where there might be possibilities for
14 inappropriate use or use where there might be alternatives
15 that might be more cost-effective, and sort of if there are,
16 approaches that others use that sort of try to zero this in
17 on patients that it is most -- you know, sort of medically
18 appropriate for and, you know, makes sense.

19 So that's kind of what -- we're not sort of
20 pointing at actors, more at processes, what kind of
21 processes could exist to sort of, if you were to do this, to
22 do it as appropriately and effectively as possible

1 MR. BUTLER: Okay. But perverse incentives that
2 encourage to do too much or too little is one thing. Fraud
3 and abuse is a different kind of category, to me. It means
4 you're doing something --

5 MR. HACKBARTH: The two often go hand in hand. So
6 if you have a payment system that encourages more of
7 whatever it is, and there's an opportunity for people in an
8 unsupervised setting to say, Oh, I'm providing a lot of
9 this, when, in fact, they're not actually doing it, that's a
10 right fraud and abuse opportunity, to get lots of payment
11 for lots of things that they didn't do

12 MR. BUTLER: But fraud feels like you're going to
13 jail. Abuse is maybe a little bit -- you know what I mean?

14 MR. HACKBARTH: Yes

15 MR. BUTLER: There's something illegal,
16 fundamentally illegal about the activity is very different
17 from, I think, just kind of being incentivized to do
18 something because of the payment system.

19 MR. HACKBARTH: Well--

20 MR. BUTLER: I was just trying to wonder if
21 there's something there that I was missing.

22 MR. HACKBARTH: Yeah, and I think that's an

1 important point. Fraud and abuse, the two words are fused
2 together, but, in fact, they can be very different things.
3 Obviously there's a lot of concern in Medicare about overt
4 fraud, you know, just billing for things that never were
5 delivered.

6 MR. BUTLER: I just had one other. We don't
7 suspect there are crooked deals, whether they're kickbacks
8 or whatever, things like they looked at in southern Florida
9 in terms of home health and some of those? That's not what
10 we're talking about here, to the best we know about it? Is
11 that true? Or there are contractual arrangements that may
12 exist, but, in fact, if it's scrutinized by the OIG or
13 somebody would say, Oh, this is a real problem? That's what
14 I'm trying to understand.

15 DR. SOKOLOVSKY: I can't say exactly what was in
16 Congress's head, but when you think of what's been in the
17 news from the IG and the Justice Department, the sectors
18 where fraud has been easiest to develop, you would think
19 about DME and you would think about home health and you
20 would think about infusion centers. That's what in the
21 news.

22 So the fact that these are things that tend to

1 need low capital start-up costs, so it's kind of easier to
2 get in. So if you expand something, there's more potential
3 there. That may be part of why they want us to think about
4 this.

5 DR. MARK MILLER: The other thing I would say, to
6 be really quick here, I mean, some places that you could
7 take your mind to where -- first of all, I think you're
8 right. There's payment, there's abuse, and then there's
9 outright fraud. And in payment, it's trying to get the
10 payment right.

11 In the abuse, it's, I think, what Kim was trying
12 to say, it's processes. So imagine in home health --
13 remember, in home health, we were saying things like, Well,
14 we were looking at home health agencies and looking at
15 people in the distribution with very high rates of live
16 discharges or extremely long lengths of stay. And that
17 could reflect abuse or, you know, kind of bending the rules
18 on the benefit.

19 So you could imagine things like that and how
20 involved the provider is in ordering something and extending
21 something, as opposed to just one order and then the
22 provider who has the financial interest just keeps it going.

1 It's the processes that sort of focus in on abuse.

2 Then you cross the line into, I stole a bunch of
3 IDs, I'm running them through the system, and I'm not really
4 doing anything. And that's where -- or perhaps some of your
5 kickback arrangements. We can point out potential, but, you
6 know, the notion of identifying and saying, This much fraud,
7 that's where I think we kind of step off the cliff and I'm
8 not sure we're going to be able to identify those things,
9 but only identify the potential for something occurring.

10 Does that help at all?

11 So it's really more the remittal abuse issue that
12 I could imagine us speaking to processes that might help
13 focus CMS in on areas where abuse may be occurring.

14 MR. HACKBARTH: Thanks, Kim. Thanks, Joan.
15 That's it for home infusion. We'll now have our public
16 comment period.

17 Seeing nobody stepping to the microphone, we are
18 adjourned.

19 MR. MAGNUSON: Excuse me.

20 MR. HACKBARTH: Oh, I'm sorry.

21 MR. MAGNUSON: My name is John Magnuson with the
22 National Home Infusion Association, and I just wanted to say

1 thank you for taking the time to look at the issues of home
2 infusion and just wanted to add two comments to the thorough
3 look at home infusion that you added.

4 Just a little clarification on the fraud and
5 abuse, and it was asked about the headlines out of Florida.
6 None of those headlines were home infusion providers. Those
7 were infusion practices that were -- there was a definite
8 distinction drawn between someone who is just providing
9 infusion services in the field of home infusion. I wanted
10 to make that one point.

11 And then two, under the services, you were
12 recognizing the services of nursing, but there are also the
13 specialty pharmacy services that we wanted to just make sure
14 that you're aware of that go into the process of home
15 infusion.

16 But thank you for the look at this and we
17 appreciate your time.

18 MR. HACKBARTH: Okay. We are adjourned.

19 [Whereupon, at 11:21 a.m., the meeting was
20 adjourned.]

21

22