MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 3, 2011
9:03 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
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

AGENDA PAGE

P R O C E E D I N G S [9:03 a.m.]

MR. HACKBARTH: Okay. It's time for us to get started. Welcome to our guests. At this month's meeting, we will be voting only on one set of recommendations, those having to do with the PACE Program, and that will occur this afternoon right after lunch.

We begin this morning with a discussion of reforming Medicare's benefit design, a topic that we've been discussing now for quite some time, and I think coming to the point where we're nearing some conclusions. So Julie, are you leading off?

DR. LEE: Good morning. In today's presentation, we continue our discussion of potential changes in Medicare's benefit design that we began last month. The Commission has been considering ways to reform the traditional benefit package to give beneficiaries better protection against the high out-of-pocket spending and to create the incentives for beneficiaries to make informed decisions about their use of care.

The Commission has been also particularly concerned about the potential impact of such changes on low-income beneficiaries and those in poor health. There's a

basic tension between these goals. We want to protect and insure beneficiaries from financial risk, but if we provide too much insurance, then there's little reason for them to think carefully about what and how many services to use. And since people respond differently to risks and incentives, that adds another layer of complexity.

In last month's presentation, we discussed the current fee-for-service benefit design. The key components were that current benefit leaves a small group of people owing most of the cost-sharing, and most people get supplemental insurance to cover their liability, but it's often expensive and not always available.

Taking these issues into account, we presented three alternative benefit packages for you to consider. In today's presentation, we shift the focus to the role of the supplemental coverage, specifically we used the MA-neutral package, which is highlighted on the slide, to illustrate alternative policies related to supplemental coverage.

If benefit design is about what the Medicare program pays for, then supplemental coverage is about beneficiaries pay for what the program does not. Beneficiaries currently have different ways of covering

their share of Medicare spending and their choices have consequences for the Medicare program. Because the most common supplementary insurance that fills in all of Medicare's cost-sharing, it hides the prices and leads to higher use of the services, both the necessary and not necessary.

Today's presentation is in three parts. First, we review the role of supplemental coverage. Second, we overview our basic analytical framework. And third, we present preliminary results illustrating the effects of the three alternative options related to supplemental coverage.

We begin with a very quick review of why supplemental coverage matters. The classic results on the effects of cost-sharing come from the RAND health insurance experiment. Among its most important conclusions are, cost-sharing decreases the use of both the effective and ineffective services, but increased cost-sharing had no adverse affect on most participants, although there were exceptions among the poorest and sickest.

Once people decided to get care, however, cost-sharing had only a small effect on the intensity of cost of an episode of care. A recent review of the literature since

RAND found that the key results are still valid. Focusing specifically on the Medicare population, most research has found that those with the supplemental coverage tend to have a higher service use and spending.

As we go through our analysis, it might be helpful to organize things into three buckets. They are intimately intertwined so we will just start from the top with the benefit design elements. There are various design parameters including, but not limited to, out-of-pocket cap, deductible, co-payments, et cetera. They are the levers you have to change the shape of the benefit package, and we can include the policies related to supplemental coverage in this bucket, also.

Following the arrow to the value of the benefit, the combination of design elements will determine the overall value of the benefit package, and there are different ways to measure or benchmark its value. For example, it can be done with respect to how much the Medicare program spends or, in contrast, to how much the beneficiary is responsible for.

And moving to the left of the slide, what the Medicare program spends on the benefit package will also

determine the budgetary impact. To illustrate how these three things are related to each other, suppose we start with a budget constraint that whatever benefit package that you create must be budget neutral. In other words, zero budgetary impact. If we set the out-of-pocket cap at $5,000 with a deductible at $1,200, along with the various co-payments included in the alternative packages from last month and keeping beneficiaries' supplemental coverage unchanged, then the program spending under this package will be approximately equal to current law.

Now, suppose that you want to try a different combination of design elements and limit supplemental coverage to fill in only half of the co-payments while holding other elements the same. Then the program spending would be lower and there will be a substantial budgetary impact. This was an example to show the mechanics of the feedback loop, as shown on the slide. For the modeling analysis presented today, we used one of the benefit packages from last month as an illustrative example.

Before we turn to the results, there are a few basic assumptions in the model that you should keep in mind as we look at the numbers. First, we used two sets of

estimates on how beneficiaries respond to changes in cost sharing. They are discussed in more detail in your mailing materials. For convenience, we used the results based on the elasticity assumptions throughout the presentation.

Second, we made some simplifying assumptions related to supplemental coverage. We assumed the average annual premiums of $2,100 for Medigap and $1,000 for employer-sponsored retiree plans. These are, of course, a highly stylized at best since premiums do vary widely. We also assumed that beneficiaries keep the supplemental coverage that they have and do not switch in response to any benefit or premium changes.

As we previewed at the beginning of the presentation, our general strategy for today's analysis is to take one specific benefit package as an illustrative example and then show three alternative options on supplemental coverage. The benefit package used in the analysis is the MA-neutral package from last month. If you'll recall, it was labeled MA-neutral because it had the co-payment structure more common under Medicare Advantage, and it had approximately the same average cost-sharing liability as the current fee-for-service.

The package has a $5,000 out-of-pocket cap and a combined deductible of $750. It also has a $600 per-stay on hospital, a $25 co-payment on physician, and $100 on outpatient visits, and a $100 co-payment on per-day on skilled nursing facilities. It also has a 20 percent co-insurance on DME and 5 percent co-insurance on Home Health. The overall cost-sharing liability under this package was roughly equal to current law.

In today's presentation, we considered three alternative options related to supplemental coverage. They vary in the degree to which Medicare's cost-sharing can be filled in by supplemental insurance. Under the first option, supplemental coverage remains unchanged and it continues to fill in Medicare's cost-sharing as it does now.

Under the second option, it is not allowed to fill in any of the cost-sharing at all. And finally, under the third option, it can't fill in any of the deductible, but it can fill in half of the co-payments.

This slide presents the preliminary results of simulating changes in out-of-pocket spending and premiums for 2009 if the alternative benefit package had been in effect and was combined with the three options on

supplemental coverage. The three bars correspond to the three options, so let's look at some results.

Under the option that leaves supplemental coverage unchanged, that's the first bar, 11 percent, that's 7 percent and 4 percent at the bottom of the stacked bars, 11 percent of beneficiaries would see their out-of-pocket spending go down by $250 or more, and about one-quarter of beneficiaries would see their out-of-pocket spending go up by at least $250.

Now, let's look at the third bar. Under this option, when supplemental coverage is allowed to fill in half of co-payments but none of the deductible, 36 percent of beneficiaries would see their total out-of-pocket spending go down by $250 or more, and 29 percent would see it go up by $250 or more. This is because while their supplemental premiums go down, they now have to pay the $750 deductible out-of-pocket first.

The impact will vary, of course, based on individual circumstances. Overall, that change in total out-of-pocket spending will vary by the beneficiary's level in mix of service use and his supplemental coverage. For example, people who might see their total out-of-pocket

spending go down tend to be those with very high spending above the catastrophic cap or with the hospitalization if they don't have supplemental coverage.

Or if they have supplemental coverage, then those with a pretty small cost-sharing liability compared to their premiums would also see their total out-of-pocket spending go down. In contrast, people who might see their total out-of-pocket spending go up tend to be those with the high Part B spending, but no hospitalization if they have Medicare only, and those with the high spending but below the catastrophic cap if they have supplemental insurance.

We also calculated the relative change in annual Medicare program spending under the three supplemental coverage options. For example, using the first set of behavior assumptions, program spending would increase by about 2 percent under the alternative benefit package if there's no change in supplemental coverage.

In comparison, under the third option in which supplemental coverage fills in half of co-payments, program spending would decrease by about 1 percent. Although these are not budget scores, per se, they do indicate the relative budgetary effect of the alternative benefit package under

different options related to supplemental coverage.

We want to reiterate several caveats and limitations of our modeling results. First, as the previous slide points out, our results are sensitive to the assumptions underlying the model, especially the behavioral assumptions. In addition, the model contains some important simplifying assumptions. For example, regarding supplemental coverage, we assumed the average premiums and we also did not model any switching in the choice of supplemental coverage.

The scope of our modeling excludes dual eligible beneficiaries because we assumed that Medicaid would fill in any changes under the alternative benefit package and would keep the cost-sharing the same for those beneficiaries. We also applied the consistent supplemental coverage policy to both Medigap and employer-sponsored plans.

And finally, we want to point out that through our analysis, none of our numbers captures the value of the insurance that risk-averse people get when they insure against undesirable outcomes. This value of the insurance is real and important for many beneficiaries.

All three alternatives we presented today have

focused on restructuring what supplemental insurance can and cannot do. In contrast to this regulatory approach, there's an alternative of imposing an excise tax on supplemental insurance plans. That tax can be applied to all sources of supplemental coverage, both in Medigap and employer-sponsored plans, and it can be based on the generosity of that coverage.

To wrap up, here are some questions that the Commission may wish to discuss. What should be the basic structure of the benefit package? Are some design elements more important than the others? And what trade-offs would you consider among them? In addition, how is supplemental coverage going to interact with the benefit package? Would it be allowed to wrap around the benefit or would it be restricted in what it can do? Would it be through a regulatory approach or through an excise tax?

As we discussed in the beginning of the presentation, your choices on the shape of the benefit and the role of supplemental coverage would affect the overall value of the benefit package and, consequently, the budgetary impact. There are many moving parts here that are interconnected and they would require much balancing as you

consider and weigh various aspects of the benefit design. We look forward to your discussion.

MR. HACKBARTH: Okay, thank you, Julie. So let's have Round 1 clarifying questions. We'll begin with Karen. Any clarifying questions? Bill. And then Bruce.

MR. GRADISON: Thank you for your excellent presentation. In it you said, as a key overriding concern, that we would be mindful of the effects of low-income beneficiaries and those in poor health. I'm unclear as to what the impact of these alternatives would be in those two categories, and more specifically, to those whose incomes are just above the dual eligible thresholds.

And to be more specific, when you talk about here the percentage that have higher or lower than the 200 -- anyway, those who would experience higher or lower payments, do we know anything about how -- the relationship of the 23 percent, or whatever, to the income level of the people in those categories?

DR. HARRISON: We have some limited ability from the data we have. We were able to find people who had the low-income subsidy for Part D and were not duals, so they were, you know, in that, I guess you could say, near poor

category, and we found that they tended to have slightly higher losses than what was projected for the average person.

MR. GRADISON: Let me just make sure I understand you. Slightly higher losses than the current loss situation?

DR. HARRISON: Now, we haven't --

MR. GRADISON: Than the current benefit structure?

DR. HARRISON: Yes.

MR. GRADISON: Thank you.

DR. MARK MILLER: And this conversation has also been going on inside among the staff. You know, we're trying to see where the Commission kind of wants to center itself and get it, and then we'll have some limited ability to tell you about what the distributional impacts are, and it will be indirect indicators like dual eligibility, LIS, that type of thing. The dataset does not organize itself by income, unfortunately.

DR. STUART: I have a question, but just an observation based upon what Bill was talking about, and it strikes me that some analysis within MCBS where you do have income data would be useful here to address that specific

question, and obviously you don't have the same detail in terms of the large numbers that you have with the A and B claims.

My question relates to the application of these design elements to both people who have Medigap policy and who have ESI employer-sponsored plans, and it strikes me that it's pretty straight-forward when you're doing Medigap because we have these stylized options that are available, but the employer retiree market is really heterogeneous. I'm wondering if you could just give us a little idea about how you approach that heterogeneity when you come up with these estimates.

DR. HARRISON: We really don't have any way to address the heterogeneity of the employer packages. And we don't know -- there's a lot of things we don't know. We don't know what part of the premium the current retirees are paying. We don't know what would happen if the rules changed, whether the employer would pick up more or less. So for these people, it's very difficult to project.

DR. STUART: Very quick follow on. Would that argue then for having kind of two panels, if you will, one set of analyses for the Medigap market and the other set of

analyses for ESI, and just make it clear that you don't have that information and so there's more uncertainty, I think, in that area than in the other area.

DR. HARRISON: Yeah, we hope to do that for the future.

MR. HACKBARTH: Just picking up on Bruce's question for a second, we talk about the supplemental options, excise tax, et cetera. Does this envision that the excise tax would apply only to Medigap or would apply to employer-sponsored coverage as well?

DR. LEE: I think that that is one of the policy decisions. In terms of our modeling for today, we have applied a consistent policy to any supplemental coverage, but the implementation with respect to Medigap and ESI, employer-sponsored to retiree plans, would actually require different changes so that operationalizing that would require different approaches.

MR. HACKBARTH: Okay. George.

MR. GEORGE MILLER: Yes. I also want to echo the track Bill was taking, particularly on Slide Number 5. The question dealing with the sickest and poorest, is that mutually inclusive or exclusive? Do you have a group that's

sickest and poorest, or are you saying both sick and poor together? Sick people that may choose this that have high income. So I'm just curious just from a technical standpoint, is that mutually inclusive or exclusive, the term in the second bullet point?

DR. LEE: If I recall, those would tend to be correlative with each other.

MR. GEORGE MILLER: Correlated.

DR. LEE: So I don't think they separate it independently, the income and health status, but they kind of -- those two aspects were correlated.

DR. CHERNEW: I think I would read that as inclusive, like you had to be "and."

MR. GEORGE MILLER: And?

DR. CHERNEW: Yeah.

DR. BAICKER: It was low-income people --

DR. CHERNEW: With illness.

MR. GEORGE MILLER: With illness. Yeah, okay, good. That certainly helps me. And then I'll go back to my previous concern, and it may be a Round 2 question. I'll come back. That may be a Round 2 question. And on Slide 6, next slide, could you tell me or do you know that the

increase in deductibility and co-pays, is there a correlation between that and increase or potential increase to providers, both physicians and hospitals? Or did you do that type of analysis to see if you increase both the co-pay and the deductibles, is there a corresponding increase in bad debts?

DR. LEE: We have not looked at that.

MR. GEORGE MILLER: All right. Thank you.

DR. MARK MILLER: For this model, the way you think about it is you're kind of modeling an individual beneficiary's liability and spend. It is reasonable to assume that if you have more of this, the provider is at greater risk for, you know, having to change.

MR. GEORGE MILLER: But we have to measure that impact to see.

DR. MARK MILLER: Not in this. In here we're trying to measure the budget impact and the impact on the beneficiaries. Those are the two actors.

MR. GEORGE MILLER: Right.

DR. MARK MILLER: That policy question, in a sense, gets enjoined when we are talking about provider issues. But it's reasonable to assume that --

MR. GEORGE MILLER: I got you. Thank you.

DR. CASTELLANOS: Thank you for your presentation. We appreciate it. Slide 1 just makes a statement that I really -- I think we all agree to -- that we want to encourage people to use high valued care and discourage them -- I guess it's Slide 2 -- I'm sorry -- requires some cost-sharing to discourage the use of low valued services. I think that's really a good statement.

But in the material that you sent, you also said you're going to use it to increase usage of high valued services. But on Page 9 of the material that you sent, you said, Cost-sharing could be structured in ways to encourage beneficiaries to choose high valued services. For example, you could differential co-payments between primary and specialty care, and you're saying you're going to encourage them to use primary care because it has higher value.

I don't understand that statement and maybe you could clarify it. That's what you say here. I'm just asking you to clarify it. It's the top paragraph of Page 9 in the material that you sent.

MR. HACKBARTH: The paper.

DR. CASTELLANOS: The material that was sent to

the Commissioners. I'm sorry. It's not on this other slide. It's the last sentence.

MR. HACKBARTH: So that's a common feature now in private insurance plans, that they have differential payment for primary care services.

DR. CASTELLANOS: Well, I agree with that, but not based on value of service. That's what she's saying here.

MR. HACKBARTH: Well, you can argue the point, whether they're right or wrong, but, in fact, they justify it based on -- they want to encourage primary care as a high value service.

DR. CASTELLANOS: Okay. I want to understand, would you clarify what you mean by high valued service? That's the question I'm asking. I think what you're -- from a physician's viewpoint, I find that somewhat troubling because it, again, divides us instead of puts us all together.

DR. MARK MILLER: Okay. We'll revisit the language in the paper. I think the motivation in laying out the structure and raising that as a possible issue is whether the Commission wants to think about differentials, either emergency room/non-emergency room, primary care/

specialists. I understand, as a physician and a surgeon, you have issues about the value statement and we'll re-look at that.

DR. NAYLOR: Just to make sure that I understand, on Slide 10 it looks, just looking at these two graphs, that the proposed changes around not allowed to fill in cost sharing and, three, not allowed to fill in deductible have essentially the same kind of overall impact. There's not much difference in the two. So I'm just wondering: Is that right? Am I reading that correctly overall?

MR. HACKBARTH: So you are saying comparing the last two columns.

DR. NAYLOR: Comparing the last two, that those two options don't seem to have -- I mean, 30 to 36, 34 to 36 -- major differences between the two options. Is that...

DR. LEE: So comparing the second and third --

DR. NAYLOR: Second and third options. In other words, we're modeling three different -- keeping something the same and looking at differences in deductibles and cost sharing, and those two latter don't seem to be major -- but I just wanted to make sure that I was interpreting that correctly.

DR. MARK MILLER: What I would say, if I'm following your question -- so let me start, and if it's not the question, redirect. I do see something of a difference here. If you sum up the bottom two blocks, that's the group of people who have out-of-pocket lower by $250 -- or $250 or more, and that's about 64 percent in the middle and 36 percent in the last one. And then you could also just make the same point at the top of the distribution, but just to focus you at the bottom, I do see a difference between those two. Was that your question or were you asking something else?

DR. NAYLOR: That was my question. I just wanted to make sure. When I looked at it, the two recommended changes did not, based on this graph, seem to make much difference overall, and I just --

DR. MARK MILLER: Let me just check my fact. What I just said is correct, right?

DR. LEE: That is correct. So the underlying benefit package with the deductibles, the co-payments, and all that, that is staying the same across all three bars. And it's just to what extent that supplemental coverage can fill in the cost sharing under that package. And the middle

bar, the second bar, is where there's supplemental coverage that cannot fill in any of it. So the beneficiary is responsible for the entire liability under that example, the benefit package.

So if I guess the -- I kind of see the 34 plus 30 in the second bar, 64, versus 31 plus 5, that's 36, as a noticeable difference. But I might not be understanding your question.

DR. MARK MILLER: I am going to say now that we have established the numbers, one thing that was helpful for me as we thought through this, and it might help some of you or hopefully it won't at least confuse you, is part of the reason that you see an effect where you get these large -- or at the bottom of the decision lower out-of-pocket, everyone though you are talking about options that say, well, you cannot have any supplemental, this is because, remember, what comes in here is the premium that the person has to pay for the supplement begins to go down, and that's where you get -- when you count that as out-of-pocket, that's where you get people getting lower out-of-pocket. So the supplemental policy in the middle would no longer be purchasing, and so that premium comes back to the

beneficiary, and that explains the bottom of that bar.

Is that helpful or did that confuse you?

DR. NAYLOR: Very helpful.

MS. BEHROOZI: So the value at the lower -- the spending being lower by more than $1,000, that's because the premium will be more than $1,000 less or because you're measuring the spending without respect to the beneficiaries' actual out-of-pocket? Is it the actual cost of the premium that's reflected in that more than $1,000 savings?

DR. LEE: It's both. For the second bar, where, you know, basically supplemental coverage is not doing anything, in that particular example we subtracted the average premium to get the sum of basically the change in out-of-pocket spending and then subtracted the premiums. So it's the premiums in the middle case that actually is quite big.

MS. BEHROOZI: Again, for the light blue, it says the person will be spending, the beneficiary will be spending more than $1,000 less across all of them, right? That's what the light blue refers to. So what is that more than $1,000 comprised of? Is it the premium in all cases?

MR. HACKBARTH: A big hunk of it is coming from

lower premiums. These people are folks who are low users of services who are -- forgive me for saying it this way -- overpaying for their Medigap policy. They're paying a lot for premiums that they're not getting value in return.

DR. LEE: Suppose that I have a Medigap --

MR. HACKBARTH: Forgive me.

DR. MARK MILLER: Exactly. We have to have a quick commercial here.

[Laughter.]

DR. MARK MILLER: Kate regularly points out that when you use the term "value," you have to understand it both in a dollar term and a value to the beneficiary. A beneficiary may pay that premium and find high value in it because it provides peace of mind, and so these terms are --

[Laughter.]

DR. MARK MILLER: Did I not do a good -- all right. So we'd like to apologize to Kate on behalf of...

MS. BEHROOZI: I understand the point about premiums would be lower if the insurance company didn't have to pay but Medicare was paying at the high end. I get that. It's just that sometimes when we look at spending, we call it the beneficiaries' exposure, whether or not they have the

coverage, you know, to see what the spending above the cap would be. And if Medicare is covering it, nobody's going to be paying it. But you are talking about the savings in premiums. That's what --

DR. MARK MILLER: That's right. An important concept to carry around in your head -- and, again, I'm hoping to clarify. You can talk about a beneficiary's liability. I'm liable to pay, you know, $1,000. And then you can talk about the beneficiary's out-of-pocket, and the out-of-pocket may be different than your liability depending on how you have supplemental insurance. But it's important to bear in mind to get that insurance you have to pay a premium, and so we're putting in utilization effects what they have to potentially pay and the premium that they're paying to get that coverage, or the lack of a premium, particularly in the middle, and a lower premium in the third bar.

Is that all roughly right?

MR. HACKBARTH: Okay, so I want to get back on track here.

DR. HALL: Julie, back on Slide 5 about the sickest and poorest, I had two questions about that. One,

the original RAND data is a little old now, right? It's about 12 years old, something like that, 10 or 12 years old? Even before that? All right. So a lot may have changed in that period of time, and I think if we're going to go into this, we ought to have the most recent data that we possibly can have about these sickest and poorest, particularly if there's an age differential within the Medicare range of 65 to whenever. So that was one point that I had on that.

The other is going up to the first dot point then, it really would be quite important, I think, to have a little better handle on whether the adverse effect has to do because for some reason or other really the effective services are being underutilized. Is there any reason to think that there would be any differential there? I think that first point is one of the really attractive points, that, wow, cost sharing reduces both effective and ineffective services. Obviously, the corollary to that is let's get rid of all the choices on ineffective services.

So I think we need a little more fleshing out on the sickest and the poorest.

MR. HACKBARTH: I just wanted to mention that, as you know, the paper does talk about more recent studies on

the effect of cost sharing.

DR. HALL: Right

MR. HACKBARTH: A reason that we keep going back to the RAND experiment is that it is the only study that had a randomized design and, thus, is able to deal with some of the methodological problems that more recent studies struggle with in terms of different characteristics of patients and the like. And so for that reason, even though the data are 30 years old, I think it bears a role in the discussion.

DR. HALL: Of course. Right.

MR. HACKBARTH: But as I say, we do discuss more recent studies as well.

DR. BERENSON: I want to ask about the behavioral assumption. In looking at the literature you've cited, you've got a body of literature that seems to find the insurance effect is somewhere in the vicinity of 25 percent; some other studies that say but when you do control for severity and selection, selection bias, that pretty much disappears. But then we do a special study by Hogan for the Commission which seems to try to adjust for health status and all the other socioeconomic factors and finds a 33-

percent difference in what seems to be insurance effect. In the end, on Slide 12 it looks like we're in the low single digits of a difference between having unchanged Medigap and not allowing Medigap. It sounds like you've used conservative assumptions, or what did I get wrong here in sort of thinking that Hogan may be an outlier and that you're using much more conservative assumptions about behavior effect? Is that what -- is my inference correct?

DR. LEE: There are two sets of assumptions that we've used. They are kind of on the conservative side. They both come from the data from the RAND health insurance experiment.

Now, we have not actually converted Hogan's results into kind of an apple-to-apple comparison of elasticities. So that's on our list, but we have not actually made that kind of a comparison.

His study was set up so that the estimate is if you have Medigap insurance, then what would be the difference, but we will have to calculate the implied estimate as a response to changes in out-of-pocket spending, what would be the response. But we have not done that.

DR. BERENSON: But at least the initial view would

be you'd come up with a much greater savings, right?

DR. LEE: It will be a larger response, but I don't know in terms of elasticities how much larger.

DR. BERENSON: So that is on your agenda to do that.

DR. LEE: Yes.

DR. BERENSON: Because this is obviously, as you said, very sensitive to these assumptions, and I think we need a little more work in that area.

MR. HACKBARTH: At the end of the day, the assumptions that matter are CBO's assumptions in that they will be the arbiter of how this is scored. So explain this table in the context of CBO's established methodology.

DR. LEE: So the assumptions that are titled "Elasticity Assumptions," those are the actual behavioral assumptions that CBO uses. So for their model -- I'm not saying that our model is the same as CBO's. It's just that we use the same behavioral assumptions in the two models.

MR. HACKBARTH: Yes.

DR. MARK MILLER: Just to put that slightly differently, what we're trying -- this is not a CBO estimate, just for the Commissioners to be really clear.

This is not what CBO would necessarily estimate. To the best of our ability and what we understand about their models, we're trying to track to them in that column. And then the other column is some other assumptions that are commonly used by other types of modelers.

MR. HACKBARTH: In fact, while we're talking about this slide, Julie, it may be worthwhile for the audience to explain the difference between the elasticity assumptions and the induction assumptions.

DR. LEE: So they both measure how people's use of services change as their out-of-pocket spending changes. The elasticity assumptions, that response is measured as a percent change in spending in response to a percentage change in out-of-pocket spending. In contrast, induction factors measure in terms of dollar change in spending in response to a dollar change in out-of-pocket spending. So they both are measures of how people respond, but they are just measured in different units.

DR. MARK MILLER: Is there any difference in the effect along a curve, or are they both constant?

DR. LEE: The measures they used, they are constant numbers, but because one is elasticity is a measure

in terms of percent change, that when it's proportional to the level of spending. So if you have a higher level of spending, even though it's the same elasticity response, you are going to get in terms of a dollar response, it will end up being higher.

DR. MARK MILLER: And I think this is what's more significant in driving the difference, because you could obviously convert numbers to percentages, but it's really the response effect as you move up and down a curve of spending. That's what really drives the differences here.

DR. LEE: That's correct.

MR. HACKBARTH: I will nod my head like I understand that and ask Mike --

[Laughter.]

DR. CHERNEW: I just want to confirm a few things and ask a question.

The first thing I want to confirm is this is only A, B; there's no D in here. So all the out-of-pocket stuff is -- right? And the duals aren't affected by this because the duals still get whatever filling in of the duals. And the part that I was less sure on was this -- how does the employer-provided supplemental coverage play in slides like

Slide 8 where the premiums go down? Is that just the Medigap and it doesn't have the employer in it? Or is it -- this only applies to Medigap. It doesn't apply to the employers? Maybe not Slide 8. The one with the -- 10, the one with the -- yeah. So when the premiums go down, the reason why this goes back to the person is because this is only Medigap where the person is assumed to be paying the entire Medigap premium as opposed to anything going on for...

DR. HARRISON: For the middle bar, the beneficiary is going to get $1,000 back because they're not paying an employer premium. But --

DR. CHERNEW: But what if the employer was paying your premium for you?

DR. HARRISON: Like I said, we can't distinguish between that. Now, the other thing is what do we think the baseline is. The baseline is we think that the employer plans cover half of your current out-of-pocket.

DR. CHERNEW: I guess what you're saying is the employers are in here, and you have made assumptions about how much of the -- when the premium goes down because there's no cost sharing, you've made assumptions about how

much of that is going to the person and how much of that is going to the employer.

DR. HARRISON: Right, but in the third bar, it doesn't -- it tends to wash out mostly for the employers, just the way the things go up and down. We didn't make a big change in premium, and the policy ends up about the same what the employers are doing now. So the people covered by employer policies probably don't figure in much on the right-hand bar.

DR. MARK MILLER: But his point is correct. You're just saying the arithmetic runs out that way.

DR. HARRISON: Right.

DR. CHERNEW: Right.

DR. MARK MILLER: But his point about what's happening in the bars is correct.

DR. CHERNEW: So the people that get these reductions of 30 and 34, that assumes that they were paying the premium through their employer as opposed to having the employer covering that premium, for example.

DR. HARRISON: Right, and the assumption was probably that they're paying about half of the premium.

DR. CHERNEW: Okay. So that was the assumption in

here, so that's how they decided. Okay.

And then my last question, which was actually on 8, where you said people don't switch in response to benefit changes -- I think that was the bottom point there. Beneficiaries don't switch in response to changes in benefits. Is that changes in benefits or changes in premiums or both? In other words, they don't respond to changes --

DR. LEE: We did not model any switch in behavior in their plans.

DR. CHERNEW: So they stayed --

DR. LEE: They are assigned their supplemental coverage, and they stay under that.

DR. CHERNEW: Right, but you did take into account when you were looking at their out-of-pocket on Slide 10 that their utilization was changing.

DR. LEE: That's correct.

DR. CHERNEW: And so their out-of-pocket is a combination of paying more, or less, or whatever it is, and using a different volume of service.

DR. LEE: Mm-hmm.

MS. BEHROOZI: And so on 10, for I guess both 1

and 3, you started with the average Medigap premium of $2,100 and assumed the employer $1,000, and so then how did you calculate -- how did you come up with the changes in those premiums for bars 1 and 3?

DR. HARRISON: Those are the easy ones. The first one we just left it the way it was.

MS. BEHROOZI: Doesn't that assume the change in the design, the --

DR. HARRISON: Yeah, but we didn't change the premium for that, because the design is about neutral, and so it should be close to leaving the benefit the way it was. So there's no change in the first bar. In the third bar, there's no filling in, and so you don't pay any of the premium.

DR. LEE: The second bar.

DR. HARRISON: I'm sorry. The second bar. The third bar is more complicated where we rebated about half of the premium for the Medigap and a small rebate for the employer.

MS. BEHROOZI: You did, but would the insurance companies do that? Is there any regulation of Medigap rate setting or anything?

DR. HARRISON: Yeah, there's medical loss ratios stuff, and, in fact -- I mean, frankly, it might make it harder for the Medigap plans to offer a skinnier benefit.

MS. BEHROOZI: One other question on Slide 12. This is the models. I'm not asking, you know, what you assumed, but in the models, the only differences among beneficiaries that it reflects -- and I guess that's in the elasticity assumptions, or the other one? Whichever one is the rate of spending, right? I mean, it doesn't assume health status -- I mean, it doesn't incorporate in any way health status except to the extent that that's reflected in spending or income levels, right?

DR. LEE: That's correct.

DR. HARRISON: Except that the duals are not in here.

MR. BUTLER: So, Glenn, you said you nodded that you understood, so I'll take one for the team and look dumb and see if I understand it.

[Laughter.]

MR. BUTLER: On Slide 12, if you do not allow cost sharing, which is what this option is, either the deductible or the co-pays, is the 2.5 percent aggregate Medicare Part A

and Part B spending? That's the estimate of the impact on bending the cost curve, so to speak, in terms of the spending impact, downstream spending impact of having no co-pays or deductibles permitted --

MR. HACKBARTH: This is program spending. This is not total spending program beneficiary. This is --

MR. BUTLER: It's what the government is paying for Part A and Part B.

MR. HACKBARTH: Correct.

MR. BUTLER: That's a big number, and it's not CBO. I know that. It's just MedPAC.

DR. MARK MILLER: [off microphone] not a dumb statement. You got it right.

MR. BUTLER: Okay. I'm just trying to dumb it down.

DR. MARK MILLER: I just want everybody to know you got it right. And just to be clear, it's not an estimate, but these are directionally in magnitude, the impact on spend here. And A, B, you know, given Mike's question, not D. A, B.

DR. BAICKER: So I very much appreciate the shout-out and the presentation and the Q&A to the insurance value

of insurance, and I'll have a little more in my tiresome way to say on that in the next round. But I did have a clarifying question that will help inform that.

We talked a little bit last time -- and I'm not sure what the current state of the data is -- about evidence on the persistence of spending. So do we know for these people, you know, not only what their spending is, but what their odds of falling into different spending bins are? And in a big-picture way, that's very hard to know, of course, but there are proxies for it, like the correlation of year 1, 2, 3 spending, something like that.

DR. LEE: Actually it is on our list. We do not have the numbers, but we should be able to get some longitudinal patterns of their spending, or at least the main uses like hospitalization.

DR. MARK MILLER: But I also don't want to raise expectations too much. The development of this data set was fairly complicated in getting spend and supplemental coverage characteristics into the same data set, and we can add additional years, but, I mean, I don't know what time frame you were thinking about probabilities, but if she's thinking very long time frames, are we going to be able to

do that, like the probability over somebody's life and that type of thing?

DR. LEE: Actually, I understood your comment as more of a descriptive, you know, kind of historical pattern rather than actually modeling that and incorporating that into the model, which we are not.

DR. BAICKER: And my understanding of the complexity of assembling this data set is that it's the different pieces about who has what kind of coverage and all of that. The question about persistence of spending could be gleaned from a more stripped down data set where you just say, okay, 30 percent of next year's spending is explainable by this year's spending or 80 percent is explainable.

MS. UCCELLO: Can we go to Slide 7? And I just want to clarify here that this is just an example. The deductible here is listed as $1,200, and this is budget neutral. And that $1,200 is much different than the $750 we're using, so I just want to clarify that that's just a number that's put in there.

DR. LEE: That was, if you recall, when we modeled in the June 2011 report some budget-neutral trade-offs, just with out-of-pocket gap and deductible. That would be budget

neutral. And so that's kind of the general levels that we got, and this is just an example to kind of illustrate the dynamics.

MR. HACKBARTH: So, Julie, put up 12 for a second. This table is based on the newer benefit package with the $750 deductible and all of the features that are on Slide -- whatever the number is -- 9, right?

DR. LEE: That's correct.

MR. HACKBARTH: And as I interpret the table on 12, this benefit package with the $750 deductible would increase Medicare spending by 2 percent, assuming supplemental coverage is left unchanged.

DR. LEE: That's correct. So all the --

MR. HACKBARTH: So my next question is: If we wanted the number in that cell of the table to be zero, how high would the deductible need to be? Would it be the $1,200 number, roughly?

DR. LEE: Yes, roughly.

MR. HACKBARTH: So that's how these dots connect, Cori.

MS. UCCELLO: Thank you. In Slide 10, one of the issues we're facing is if we do change the plan design, what

do we do with the supplemental? Do we do an excise tax or do we mandate some changes? And I'm wondering here if the third column can be thought of -- and I'm just thinking out loud here. If that can be used to think about an excise tax on, say, the C and F plans and this could be the impact of people moving to a less generous Medigap plan because of the excise tax. I'm not sure the baseline of that is right, but I'm wondering if...

DR. MARK MILLER: Well, I had to answer that question, and I'm happy for someone else to do it. I would caution you and not commit to saying, yeah, maybe that's a proxy for it. I think if the Commission sort of shifts and says -- or not shifts, but sort of settles and say, you know, I'd rather think of tax policy instead of regulating the Medigap, I think we have got to take a couple steps back, look hard at this model and figure out how we can trace things through. So I wouldn't necessarily -- I get it. In a sense you're saying, But it's like a dollar, and a dollar is like -- you know, and that's like a premium change. And maybe in the end we come back to you and say, Yeah, you could roughly approximate it. But I'd want at least ten minutes to think about it.

MS. UCCELLO: And I don't disagree. So now I'm turning into round two here, but I think in order for me to address this question of which way is best to go, tax or regulatory, I need to flesh out a little more the impact of the tax side.

MR. ARMSTRONG: My list of dumb questions has already been asked. Special thanks to Peter, I want to shout out.

[Laughter.]

MR. HACKBARTH: Speaking of round two, round two questions or comments?

DR. BORMAN: I'm reminded, I think it was Mark Twain that said that you could keep your mouth shut and have everybody think you're stupid and open your mouth and prove it, so I just sort of offer that I was silent in round one. However, unfortunately, there is round two.

[Laughter.]

DR. BORMAN: Just a general comment. I think appropriately we shed a lot of concerned light on issues that would concern the lower-income and perhaps what we know now as economically vulnerable populations in addition to their medical burden. I think we do need to be open to the

consideration that we have this very challenging economic environment to which there appears to be not a lot of end in sight. And so we have a lot of people whose concepts about their retirement and their health care in retirement and how they are going to pay for it are certainly shifting sands at best. And I would like to see at some point a notion about modeling to the beneficiary who pays the highest tiered premium, if that makes sense, because we do a lot of focus and I think we assume the average premium paid or the lowest premium paid, but we don't ever consider this from the point of someone whose income at least currently mandates they pay the highest Medicare premium, because one could certainly envision that income threshold changing as part of the issues to deal with it, and --

MR. HACKBARTH: So you are talking now about the Part B premium or Part D premium with the new income --

DR. BORMAN: Right, right. And does that, as we think about that and the directions that may go, does that sort of change how you look at things for what will likely be an increasing share of the population that becomes subject to that and yet whose resources and ability to use them may have changed and who may be a group that is more

likely to want to purchase a variety of Medigap plans not to necessarily totally fill in, but because they are subject to higher risk because of the -- or higher expenses because they're paying that higher Part B premium to start with, if that kind of makes sense. It's a little fuzzy.

If you go to Slide 15, I will try to kind of at least give you my thoughts as you go kind of down here.

With regard to the basic structure of the benefit package, I think one thing that we can all conclude probably is that the value -- and kudos to Kate for reminding us regularly -- for the beneficiary's dynamic is maybe the best way for me to think about this across these things. At different points in my life, each of these things may shift in their relative value to me. When I'm a young elderly, maybe my biggest concern is, you know, what I pay today because I'm not envisioning all these services that I'm going to use, and so the cumulative co-payments maybe don't bother me, or I think I'm unlikely to have a catastrophe so I don't worry so much about a catastrophic cap. But as I age and I see what happens to me, my values shift.

So I think when we're trying to look at the population as a whole, we'll never get it perfect for

everybody, so in my view at least, the trade-off should be to some reasonable middle ground that tries to help all those considerations a bit but cannot fix them all for everybody, would be my personal take on that. And that to me makes the secondary argument that there probably will continue to be a place for some supplemental coverage because of that dynamic for people across time.

Now, should it be totally fill in supplemental is a second question, but in terms of the eliminate supplemental option, I think that would be wrong because it takes away part of the ability for people to customize a little bit as their dynamic and value changes.

In terms of budget neutrality, if I understand kind of what we're talking about a little bit, in my view, given all the fiscal considerations, I would be hard pressed to think myself being prudent as a Commissioner if we did not look at budget neutrality. I think that has to be our baseline and that we go away from that only with the gravest and deepest considerations and compelling evidence that it's the right thing to do. I just think in light of how we consider all our other actions, to do anything to her than that would be irresponsible.

I would ask do we know about for people that do purchase Medigap -- not get their Medigap through Medicaid, but for people who purchase it, what is the churning in that market or what is the turnover? Is it pretty much that you buy a supplement and you kind of stick with Plan N or P or Q, or whatever it is, over your lifetime? Or is it that people use that as a way to address their shifting needs as they age? I think just sort of some general sense about if that's just I buy it once and I forget about it, then that's very different than if it's a way for me to tailor my spending as I go forward.

And then on the supplemental coverage part, obviously I think we should allow it. We may need -- maybe we want to restrict it from being a total fill-in, but I do think we need to continue to allow it in terms of Medigap and employer-sponsored, particularly, you know, to Bruce's point that the employer-sponsored are all over the map and it's hard for us to consolidate them into something we can work with. I also think they're clearly becoming a dinosaur and a vanishing thing, and I'm not sure that the amount of time it would take us to model all that is worth the effort for what I think just economics are going to drive away.

Then, finally, in terms of restructuring the supplemental and applying an excise, again, in order to offer people options, I think the excise tax probably more directly supports that behavior and would opt probably to go that direction a bit more than regulatory. I think if we do regulatory, maybe it's just to try and limit that complete fill-in, and other than that, kind of stay out of trying to micromanage that. So trying to address this question.

MR. HACKBARTH: Thank you, Karen, for responding to the questions on this last slide. To the extent possible, I'd ask other Commissioners to try to do the same because it's really important in terms of trying to advance the work to the next step.

MR. GRADISON: I want to build on Karen's comments and some in the first round of Mike's with regard to switching. My recollection is the original choice of Medigap policies, once they were structured under law, was A through J and additional ones were added. I think it would be really interesting -- and maybe somebody has already done this -- to take a look at what kind of switching took place when these additional options were offered as well as what I understand your point to be, what kind of switches take

place in a fixed environment where the number of options has not changed. I'm not sure what light it would shed on this, but it might, and that's the only reason I mention it.

Thank you.

MR. HACKBARTH: Is there a database that allows us to look at switching behavior among plans? Or do we just have access to raw aggregate figures on how many people are in each of the options?

DR. HARRISON: Aggregate at the state level.

DR. CHERNEW: You might be able to get data from United, which has the AARP data, to enable you to do that. But they're pretty big.

DR. STUART: Well, I don't know about the rest of you, but I personally hope that Karen is wrong about the demise of retiree coverage.

The point I'd like to make, I'm going to put another oar in the water on this issue of elasticity estimates, and if we could put up Slide 2, it really focuses on that middle bullet point. When we talk about lower- and higher-value services in the context of the Commission's debate, we have tended to take a technocratic approach to that in the sense that, you know, reasonable analysts would

say these services are worth more than those services. But when it comes down to the question of behavior, it's really how the beneficiary values those services that matters.

One other thing that makes it very difficult to estimate what would happen if you reduced the value of insurance to people that currently have it is that we tend to focus on the objective factors that generate the demand for services. So Hogan controls for health status, and we have all these other things that we're controlling for, but the one thing that's almost impossible to control for is how the individuals value those services. And you could make the argument that individuals who purchase insurance actually place a higher value on the services they use. Whether they're objectively worth more or not, we don't know. If that's the case, then it would suggest that if you were to remove the insurance from these people, they would still -- I mean, they value those services so that they would still be relatively price insensitive to that change.

And so it may well be that the kick that we would get if we were to implement one of these services that adds cost sharing may be much less than we really think that it is if we do not consider those individual valuations.

MR. GEORGE MILLER: Just to follow up on what Bruce said, because my second-round question had to deal with Slide 5, but along the same lines, and that is the question about what is the effective or ineffective services and the value put on it and who determines that value, because bullet point two here -- I want to follow up on my first-round question, particularly with the sickest and the poorest individuals. And my question and my concern -- more a question than a concern -- is this still the population that has the largest segment of disparities in that population? And how can we from a policy standpoint impact that group of individuals in a positive way? And is there a way to carve out this group if it is, in fact, that way to incentivize them through policy to use more effective services versus ineffective services? But, again, it goes back to what Bruce just said and Kate has mentioned about the value of that service.

I'm not sure what's the most effective policy way to do that, but if there is an agreement on effective services from a policy standpoint, can we incentivize those folks to use that and using cost as a lever to do that?

MR. HACKBARTH: Ron, could I just jump in here for

a second? Put up Slide 2 for a second. The second bullet here I want to just focus on for a second.

Early on in our conversations about the Medicare benefit package, we talked some about value-based insurance design, where you would ideally structure the benefit so that there would be more coverage for high-value things and less coverage for low-value things in a very, to use Bruce's term, technocratic sort of way, its value as seen through the eyes of an analyst who looks at the costs and benefits of different services.

There really isn't much -- there isn't any of that in this package. You know, we have paid lip service to that as an ideal, but in the options that we're looking at, we really haven't incorporated that into the design because it's hard to do.

To me, the second bullet is not talking about a technocratic assessment of value but, rather, saying now if the patient sees more of the cost, they will do their own judgment about the value of the service and whether they want to have it given that they see a little bit more of the costs. So this is a patient-centric statement here, not the technocratic statement.

Now, there are, you know, open issues about disproportionate effect on people who are ill or people from different ethnic or racial groups, and I don't mean to minimize any of that. But the point here is let's reveal a little bit more of the cost to the patient at the point of service, allow them to make judgments. Broadly speaking, the evidence suggests that if they see a little bit more of the cost, people will use fewer services that they value less.

DR. CASTELLANOS: Glenn, I really like your comments because that's the real-world experience. This is what I see in my practice. If the patient has some exposure to his or her costs, they usually make pretty good decisions. The real problem that I see is what's happening is it's a moving target. As Karen said, most of us are very healthy right at this time, but as we get older and more mature, we're going to see bumps in the road. And it's very, very, very difficult in my opinion to be able to automatically from a health policy viewpoint dictate what's going to happen ten years from now.

I think we have a moral obligation -- let's go back to some of the questions you said. I think we as

society have a moral obligation to provide some kind of a basic structure, and I think we really need to do that. I think supplemental coverage should be allowed, but with today's economy people can't afford it today. It's a significant issue in what people -- how they're going to spend their money. And, unfortunately, value of services -- and you gave a good example. Most people who don't have insurance, they have coverage because they go to the emergency room.

I mean, I'm telling you right now. It is a mixed bag in the real world, and we need to be extremely careful on some of the recommendations we make.

DR. NAYLOR: So I support the objectives for Medicare benefit redesign, and I think I was way ahead of Peter in acknowledging what I know and don't know. But it seems to me that the opportunities to both achieve changes in redesign and to achieve savings for the program are pretty substantial, and it looks as if the second model that was talked about, the opportunity to not allow to fill in cost sharing, creates an avenue that also seems to affect -- seems to have less of a negative effect on a larger group of people than currently, if I'm interpreting that correctly.

So I think we should really pursue this. I mean, I think that this is -- I absolutely agree with earlier comments around this is a continuum, and we operate on a trajectory, and people, to the extent that there can be changes in the kind of regulation -- and certainly we should model excise taxing and see what that does and what might be trade-offs in both of those options. But I do think that we know through behavioral economics that the way that we structure these programs can have a major impact on the way people make decisions. And I think that this is a really important part of a formula to get there.

That said, I do think also the issue of sickest and poorest are not an "and," meaning I don't see them as inclusive. We know for years about a population that use more resources than others, and some of them are poor and some of them are really sick. And even Hogan's work showed that people who had a severe illness or were poor were less sensitive to cost sharing.

So I think that we have to really figure that out, but that said, I think this is an extraordinarily important part of a toolkit getting to benefit redesign that creates the right set of incentives and at the same time promotes

access to higher-value and less use of lower-value services.

MR. HACKBARTH: Let me just build on Mary's comment for a second and use it to ask a very specific question that I'd like to invite reaction to.

If you put up Slide 12, the questions for -- actually, put up 15 first, the questions for discussion, the second bullet here, the overall value of the benefit package and budget neutrality. This is one of the important policy variables here that I want people to react to.

Now put up 12, please, Julie. As we pointed out earlier, the benefit design that we're talking about actually by itself would increase Medicare expenditures by about 2 percent, and it turns into a net saver for the Medicare program only if coupled with a supplemental insurance policy. This analysis was done using a regulatory approach, but it could be done either through a regulatory mechanism or through a tax. Let's set that choice aside for a second. I'd really like people to react to the go up by 2 percent and then I offset that and a little bit more through the supplemental insurance policy, however we choose to effectuate that change, because you could well say, well, we shouldn't have a plus 2 at all, we should have a Medicare

budget-neutral redesign of the benefit package, in which case if you coupled it with a supplemental policy, the savings would be larger than the minus 2.5 or minus 1. And, obviously, our thought is we work through what that would entail the very high deductible, the $1,200 that we talked about seemed daunting to us, and thus, we went for a combination that had a lower deductible and achieved net savings through the combination of Medicare redesign and supplemental policy. But there are different ways to address that, and I'd really like people to reflect on that specific choice.

DR. HALL: I guess the only point I would make at this point is that when we talk about choice and using cost sharing as a way to incentivize people to make wise choices, I think it's well to keep in mind that in terms of health insurance, particularly for Medicare, this is not like ordering Chinese in that there is some present value from fried rice one night and maybe dim sum the next night. Generally, value is perceived at the point when there's immediate need for it -- a sudden change in health status, a death of someone in the family, whatever it is. And if that is going to give people incentive to make right choices, we

have to make sure that there are not some unintended consequences. For example, are there some underwriting considerations as one starts to skip around from these plans? I don't know whether ACA will take care of that or not, but I could see some nightmare situations where decisions have to be made very rapidly.

Now, that's a little bit off the central point here, but let's make sure that what we put together is going to have some health care value as well as a financial value.

MR. HACKBARTH: So, Bill, is your question about the ability of Medicare beneficiaries to switch and buy supplemental insurance policies?

DR. HALL: Right, without any implication -- I'm not even worried about the cost implications, but just whether they're going to run into underwriting --

MR. HACKBARTH: Yeah, what are the rules, Scott, on switching?

DR. HARRISON: My sense is what happens is you get a policy and you generally stick with it.

DR. HALL: Right.

DR. HARRISON: But your insurer might often let you step down to a lower-value policy, but they're unlikely

to let you get a richer benefit unless they underwrite you.

MR. HACKBARTH: And there's no restriction in terms of guaranteed issue, no regulatory rules --

DR. HARRISON: There are some states that have guarantee issue, and they let you change year to year.

MR. HACKBARTH: But it's a matter of state law.

DR. HARRISON: New York is one of them, actually.

MR. HACKBARTH: Yes. It's a matter of state law. There are no federal protections.

DR. HARRISON: Correct.

MR. HACKBARTH: Even after ACA there are no federal protections.

DR. HARRISON: Correct.

MR. KUHN: As I looked at this paper and listened to the presentation this morning, I kind of reflected a little bit kind of more of an environmental assessment before I kind of get into more details here, and that is, at the September meeting we looked at kind of the initial chapter for the March report, and it kind of sets the environmental framework for where Medicare's going. And I don't remember the number specifically, and I might be off here a little bit, but I think what that report told us is

that over the next decade, we're going to see the Medicare population be decidedly younger. Basically one-third of them are going to be between age 65 and 69 because of those that are aging into the program.

What we're also probably going to see is those aging into the program are going to have less resources, one, because their retirement plans have taken a hit as a result of what has gone on in the market, some have taken in relatives to live with them because of the state of the economy. But this group that is coming in will be younger but probably will have less resources.

But also I think the third thing that paper reflected on for us was the fact that over the next decade, this population is probably going to be more used to seeing designs that we're talking about here in terms of their private coverage, and so the seamless nature of them moving from what they have now into the Medicare program with these kind of changes probably won't be as dramatic perhaps -- that could be argued -- as we might think others.

So as I think about that, as the environmental notion in my head and trying to think about, as Glenn mentioned earlier, the value-based insurance design, if you

looked at that second bullet point or dot point that you talked about in terms of the overall value of the benefit package and the budget neutrality, you know, if you think -- and then one other kind of fact on this environmental assessment. If you even go back to the letter that we did on the SGR where we talked about the growth in the Medicare program -- and well over 50 percent will be from aging into the program -- I'm just kind of struck by the need to really think pretty hard about the benefit package in at least a budget-neutral or some kind of manner there, just with these growth factors in some of these environmental assessments that are out there.

So those would be my initial thoughts coming into this right now.

MR. HACKBARTH: You're saying not go 2 percent up but start with a budget-neutral redesign?

MR. KUHN: [off microphone] Correct.

DR. BERENSON: First I'll start with a round one question, actually, which I didn't ask, but as I'm formulating my answer in round two. Do you make any assumptions about behavioral effects of purchasing supplemental if Medicare has a catastrophic benefit that

there will be lower purchase of Medigap insurance? Okay.

DR. MARK MILLER: The only thing implied in the model is that the premium would go down. You make no assumptions about people saying I am, therefore, not going to purchase the plan. We assume they stick with the plan, but the premium comes down.

DR. BERENSON: But conceivably there would be some behavioral effect there, and that would help us in a sense, meaning we have -- well, where I'm going to come is I'm not sure we -- I wouldn't go the regulatory route. First let me just say I would do this only budget neutral. I would not have an increased cost to the program. And so we need to address, given what I've seen about what might happen to the deductible there, I think we want to address supplemental. I'm less attracted -- I'm unattracted to a regulatory route, and in a way it's the obverse of all the controversy about the individual mandate saying people have to buy insurance when we come along and say you can't buy insurance, we're going to prevent you from doing that.

I think the market is starting to work. Plan N, as I understand it, which from pure dollars and cents is a much better deal. Lower premium, higher cost sharing is

starting to sell, as I understand it. It's being marketed. It's starting to sell. So, in general, I think there is a market that works reasonably, but I wouldn't want to tell people they can't buy peace of mind for having first-dollar coverage if they want to use their money to do that.

I think we have an alternative, and that is the excise tax approach, which I think is ripe because of the induced spending in Medicare. I think it's probably reasonable to have such a policy. So I would want you to do the staff work on that model of affecting supplemental.

I guess my final point is to go back to what I was talking about in the first round, if we think the Hogan work was pretty good work, I would like to see us follow through on developing elasticities and modeling where that would take us. I understand CBO ultimately is the scorekeeper here, but I assume they would be interested in new information. And it seems to me, not knowing anything about this, that those elasticities would be very different from what the current assumptions are from the RAND study, and I think would generate probably much greater savings, but I'd be -- I mean, if the work can be done relatively straightforwardly, I would encourage us to do that and see

if that affects the analysis.

[Pause.]

DR. CHERNEW: So first let me say I agree completely with Bob for the reasons that Bob said about the excise tax versus the regulatory approach, and I think that that is the right way to go. I have a mild problem with the term excise tax, in part because I think it's important to remember what we're doing, is we're not taxing a product really. What we're doing is making sure that people pay the full cost of the product, because right now they're getting a subsidy. So really removing a subsidy.

I understand it has this tax, it's going to look like it's a tax, but what we're really doing is saying if you want to buy the full dollar coverage, you have to pay the full cost of that to the entire program, not just for the little subsidized part. And that will come off like a tax, but I think that that is right pricing, or something like that. Anyway, so that's my first point.

My second point is that I see two things the benefit design packages that were discussed. The first one is, this desire to integrate A/B, because there's these separate deductibles and crazy things, and I think that's

really important just to maintain this beneficiary centric as opposed to site of care centric design, so I'm very supportive of everything that goes into integrating A and B. And I basically like these designs.

I think what one has to be careful of when one does this is that what I imagine would happen is, for the 750 deductible, people -- even if we aren't saying it in this document, people will start giving you value-based insurances on kind of arguments. But we don't want to discourage colonoscopy and we don't want to discourage all these other various things, and I would be supportive of that statement in a value-based insurance design way.

And likewise, I worry about the out-of-pocket max, not because I dispute at all the insurance value of having out-of-pocket max. I think that's very important. I worry that there could be a lot of waste above the out-of-pocket cap for certain types of patients and certain types of treatments, and we're basically precluding using any cost-sharing component no matter how crazy the service is that people want to buy.

So if you happen to have a serious illness, as tragic as that is, for example, there's some services which

we're saying, You just -- you won't have to pay for a whole bunch of things, and I can envision the system just running there to provide those types of services. So I'm much less worried about that in an MA or even an ACO kind of world. But in the world that we seem to be talking about here, I'm worried that there could be a lot of wasteful services marketed to sick people in various ways.

And I also, frankly, worry that there are some high value services and pharmaceuticals that are over that that we don't even touch in various ways, and there's some low value pharmaceuticals over there that I think we should touch.

So the point is, I think that this is a fine and focused design. I think in practice, we'd have to worry about exactly what the incentives are, and I'm not so sure I'm as supportive -- I would be supportive of a deductible, assuming that policy had some value-based waivers, and we don't have to talk about that, and I'm supportive of the out-of-pocket cap, but I'd like to see some mechanism through coverage or some other way to try and at least provide some financial incentives to discourage things that might be wasteful going forward.

MR. HACKBARTH: Let me just pursue that for a second. So I think your points make sense, and so the question is how do we pursue them. One approach would be to say, Well, this is the basic benefit design. We think a feature of it should be to grant discretion to the Secretary to modify the cost-sharing for some particular services, either a high or low value, and for it to be able to apply across the full range, including people who have exceeded the catastrophic cap.

DR. CHERNEW: Right.

MR. HACKBARTH: Or we could -- another approach would be to say, Well, let's take this in steps and this is step one, and MedPAC will come back and try to delve more specifically into these value-based design elements that may be added on at a later point, so a sequential process.

DR. CHERNEW: I'd prefer [off microphone].

MR. HACKBARTH: Well, the third one was going to be, we don't move forward with this until we can work out all of the value-based insurance.

DR. CHERNEW: That's my least preferred --

MR. HACKBARTH: Yes. Me, too.

DR. CHERNEW: -- of them. I like the first one,

but I think the first and the second one aren't mutually exclusive.

MR. HACKBARTH: Right.

DR. CHERNEW: I think our recommendation should recognize it. If there's a service, the Secretary should have authority to charge you even if you've exceeded the out-of-pocket cap for those services and not have it just be a blanket whatever it is. I don't know if they have to work through the MedPAC or coverage kind of thing and they may never do it, but then I think we can simultaneously think about that.

MR. HACKBARTH: Am I right there's some precedent for this in current law? Isn't the Secretary granted authority about adding coverage for preventive services?

DR. CHERNEW: Oh, yeah.

MR. HACKBARTH: So it would be not a totally novel thing to say the Secretary ought to be granted some discretion.

DR. CHERNEW: On the deductible side. The deductible side, it's already there actually. I don't think you'd be able to change it in that way. I think it's the out-of-pocket max side that you worry about, the financial

consequences, not what people are spending now, but in the future, imagine you were going to develop something and it was like, oh, and any patient who has had a serious illness, heart attack or cancer, all the services, because they would hit -- they're the people that would hit the out-of-pocket max. All the services that they buy at the margin are free to them.

MR. HACKBARTH: Okay. Mitra.

DR. MARK MILLER: Can I just -- real conscious of time because we're over time. I mean, the other way to think about your second point, the catastrophic cap, is not to have total, you know -- you could continue some small set of cost-sharing even after you pass the catastrophic cap. That's the way D is designed.

The reason I'm stepping through this carefully is I'm afraid these two are going to explode. Are we able to look at anything like that? And we can also just discuss this offline, and maybe we'll just leave it at that. I see what you're saying about that. I'm going to put some thought into that with these guys.

MS. BEHROOZI: So, I think to go down some of your questions, so the redesign, I think, is really two parts.

Right? It's the out-of-pocket cap and it's loading some more costs onto the front end, and then separately, there's the whole issue of limits on supplemental coverage.

So the out-of-pocket cap issue, as I understand it, is really only about 10 percent of the Medicare population, right? Because everybody else, other than that 10 percent -- 90 percent of people have supplemental coverage through Medigap, employers, or they're dual eligibles, right?

So I'm not feeling real great about dealing with a 10 percent problem by loading costs up front. I think that's really the wrong direction to go. If you want to achieve coverage for that 10 percent, maybe it is about, as Bob said, new kinds of Medigap coverage that will be more attractive and affordable ways of funding an out-of-pocket cap that doesn't just take the burden off the insurance companies or off the employers or off the state Medicaid programs, and then load it onto Medicare beneficiaries across the board at the front end.

And in particular, I really don't understand the value-based concept of deductibles which, you know, you aren't distinguishing between types of service, you're not

distinguishing between high and low, and it goes somewhat to the issue of the value of insurance coverage, as Kate would say, that it's for somebody to pay 190 bucks a month or whatever for their Medigap insurance policy is something predictable and knowable, but having to pay $300 or $450 or whatever for a procedure might be a hurdle that they can't surmount at that point, not just because they are poor, as in duel eligible, but something came up. They had to pay for something else unexpected or expected or whatever.

I think that that kind of thing, as Bruce said, value is in the eye of the beholder. It's not -- it's a whole bunch of different circumstances that go into someone making a judgment about the value of a service for them. And, you know, Glenn, you referred to VBID as being technocratically driven, but I think of it as being clinically driven actually. Right?

Whereas a person who makes their choice, the patient centric, as you say, or the beneficiary centric, is not always the best person to be making the clinical judgment. Economically rational choices for individuals given all their circumstances may be health care irrational choices.

And I think that we see some evidence about that. We see, in Part D, people have been taking their medications when they are covered, and then they get to the donut hole and they stop taking them. Now, how much more evidence do they need for themselves that they should be taking that drug? But somehow, they can't come up with the $58 for that month's worth of medications, or the $120.

If they can't do that, why do we think they're going to avail themselves of all the health care they need if they have to pay $750 out-of-pocket before they get to any level of coverage.

I was disappointed, I think, the way the paper laid out the findings in the 2010 Chandra paper about the California Medicare Advantage program findings where there was a hospital offset associated with higher co-pays for outpatient and drug benefits, where it said hospital spending increased significantly for chronically ill patients as patient visits and drug use decreased.

Overall, however, the size of this offset was not large enough to overcome the effects of co-payment changes on physician visits and prescription drugs. So it sounds to me like we're just looking at the dollars. Right? The

dollars saved on people not going to the doctor and not taking drugs was about equal to what those people ended up spending in the hospital.

But if you're this person who was here, who was taking drugs, who was going to the doctor, and that's like on Slide 11 at the bottom, the people who would see an increase in their out-of-pocket spending, they're the people who are spending money on going to the doctor. Right?

The people who are going to so-called save money are the ones who are now going to the hospital, but you're going to see people shift out of that bottom category and into the top category. They're going to not, you know, as Chandra found, those people, those individuals, those humans are going to reduce their drug and doctor spending and end up in the hospital, and that I don't think is consistent with the kind of value that we want to drive here.

I think that also in the paper, there was a hundred dollar threshold to see. On this slide, it was changes less than 100 was the middle band and changes above -- you know, spending more than $100 more or spending less than $100 -- less -- whatever. You know what I'm trying to say here. I think that showed more people would be spending

more and the impact of that spending more, they might not be spending it. That's really the problem.

Bruce suggested that people would continue spending it if it was of value to them. My bigger concern is the people who wouldn't spend it because of that greater change. So I think -- and, you know, I just feel like it's not the future. It's not the enlightened way to go with benefit design, is to load more up-front costs. We're looking at eliminating co-payments for generics among LIS patients, I mean, LIS beneficiaries.

I understand that that's a very targeted thing, but the point is we recognize that you don't always have to apply a co-payment. I think it's in the footnotes to the paper. Only 5 percent of Medicare Advantage plans impose a co-payment for home care. Scott has told us about the high value of home care in a sort of integrated delivery design.

So this notion of across-the-board first dollar cuts being the way we should be designing the Medicare program of the future I just think is absolutely not the way to go.

Now, okay, I also recognize that there are higher program costs associated with everything being filled in

indiscriminately. But that doesn't mean the reaction to it is to impose -- or the right response, rather, is to impose costs indiscriminately. So, Glenn, you and I have had this conversation, that in the absence of other management tools, all you've got is the dollars.

And Medigap plans tend not to manage. That doesn't mean they can't. They're insurance companies. They can require a prior authorization or they can, you know, impose various kinds of management tools, whether it's through limited cost-sharing or whether it's through other rules.

So it does seem to me that it's about the nature of the plan and the costs, you know, how well those plans control costs, and if they don't, then -- I like the way Mike put it -- then they should -- then people should pay the true cost of that plan, whether you call it an excise tax or whatever. But that's spreading it.

That's in a way that people are more able to bear it, are more able to make a broader judgment about the value of what they're buying, rather than at the moment they need care or should be getting care to prevent them from having to be hospitalized later, that that would be, I think, the

more progressive way to go and one that's more consistent with the things we've been doing.

MR. HACKBARTH: So, Mitra, you've made a bunch of really good and important points. The choice we have right now, though, is not between a comprehensive first-dollar plan and one that has more front end cost-sharing. We have an existing Medicare program that has a lot of front end cost-sharing and no catastrophic cap.

So we wouldn't be moving from what you and I might consider to be a better place to one that's embracing cost-sharing philosophy. There's a lot of cost-sharing in the existing plan.

MS. BEHROOZI: But not when people have Medigap coverage. That's that second part, and so I'm addressing --

MR. HACKBARTH: Well, that's, in fact, where I was going to go. So what happens now is that people cope with that high degree of cost-sharing, both at the front end and the back end, by saying, Well, I want to buy supplemental coverage. And that's a reasonable response to what is a relatively limited benefit package.

But the problem, though, is that that does increase Medicare expenditures, and so to use Mike's term,

it's not right pricing what people see for that supplemental coverage. It's an understatement of the true cost of what they're buying.

So, you know, the option that I see is, for better or for worse, we have a Medicare benefit package that has lots of patient cost-sharing. Can we rationalize that cost-sharing a bit and then couple that with a supplemental policy that says, Well, people can buy insurance, additional insurance if they wish, but they really ought to see the full price of that and it not be borne by the taxpayers.

And because I share some of your concerns about loading up too much front end cost-sharing, that's why we did the 2 percent thing with the 750 deductible as opposed to the $1,200 deductible. But, you know, there are constraints here.

And sort of the big policy choice here that we've not focused on but is increasingly part of the debate is, more and more you hear provider associations say, You can't use cutting payment rates per unit of service as your only mechanism to control Medicare costs. We need to figure out how sensibly to share this burden across taxpayers, providers, and beneficiaries.

And this is an effort to say, Here's a contribution that we can make in terms of the benefit structure. It's not coming out of provider payment rates. It yields a net savings to Medicare, if you combine the coverage with the supplemental policy, and it rationalizes the Medicare benefit package somewhat. Is it perfect? Is it what you or I would design as the ideal insurance plan? Probably not.

MS. BEHROOZI: But really my point was that I get that we shouldn't continue increasing the cost of the program by what some call overly-generous coverage, but I would agree to do that only in a fashion that spread it, a fashion that didn't burden the choice of whether or not to seek appropriate care at the point of care.

I would support something like an excise tax or, as Mike says, right pricing. I'm not saying don't address anything, leave it all the way it is, but I don't agree with the path of prohibiting Medigap coverage from covering up-front costs.

DR. CHERNEW: She's agreeing.

MR. HACKBARTH: I agree with that as well. I prefer the excise tax approach for all the reasons that Bob

--

DR. MARK MILLER: But there is one wrinkle, I think, in what she's saying, and since you're right here, let's see if this is right. What I also heard you saying is that in this -- you know, you could have -- let's just use the $750 deductible as the example. You'd have a $750 deductible. That would be one way, but you have a problem with the point of service, you know, barrier from a beneficiary getting a service.

And what I heard Mitra saying is I would rather have a plan that allows the deductible to be filled in and to bear a larger tax on such a plan. That's what I heard her saying. Is that correct?

MS. BEHROOZI: Exactly, so that it's spread.

DR. MARK MILLER: You guys were all saying, I'd prefer the tax approach. She's saying, I prefer the tax approach and I want to be clear that I would let people fill all the way in on the deductible or some number less than 800.

MS. BEHROOZI: Right, right. And not that everybody would have to and that everybody would have to bear that tax, but that you could have that option available

at the right price.

MR. HACKBARTH: So I'm not sure what the significance of that is. So you're saying there's a graduated tax with a higher tax on the one that has zero cost-sharing at the point of service and a lower tax on the one, the supplemental?

MS. BEHROOZI: Exactly. And I think that's what Mike said, right? The right price for each thing, not the right price for Medigap in general, and it's somewhat consistent with what ended up happening in PPACA about the Cadillac tax. There's a threshold, you know. So I think that's more the direction that things are going.

MR. HACKBARTH: Yeah. And I don't want to -- haven't thought about the feasibility of that exactly, how you would do it, but in principal, that makes sense to me as well. Peter.

MR. BUTLER: Phew. I'll try to be smarter rather than dumber. Okay, just a couple of quick points. One is, I would want to reinforce Herb's point about the incoming consumers being younger and maybe poorer, and also a different generation of purchasers. I'm reminded of the movie network, you know, I'm mad as hell and I'm not going

to take it anymore.

They are, I think, more price sensitive people, at least at the premium -- at the time they're picking their premium. I'm not talking about the fragile elderly, and I wouldn't under-estimate the, you know, the opportunity to use that purchaser's sophistication.

Second, I'm still troubled a little bit about looking at this Part A and B in isolation, and Part D as well as all of the other discretionary spending on health care that elders are facing, because they are linked. And so, we're kind of carving out just the A/B piece and making judgments on that.

Having said that, I agree with not only going to budget neutrality, but I would think beyond that. I think this is an issue we probably should have addressed earlier on rather than later, and you've made the point, Glenn, on we tried to work so hard on the provider side, or the health plan side to -- and with almost no engagement on the insurance side when it really comes down to it. It's such a huge part of the equation. So I'd go as low as 2-1/2 percent.

And then finally on the -- I would also agree with

an excise tax for the reasons noted, and also agree with the most recent comment. If you really want first dollar coverage, and I think a lot of people would pay even an actuarial value -- above the actuarial value for the peace of mind, but, you know, they should pay a big price for that.

Now, the dumber part of my last comment is, is there any carrots to actually even reduce maybe even Part B premiums or something in a way that is even -- I know that cuts into another part of the budget neutrality issue, but is there -- it's not a penalty, but a full value on that side of the equation, on the excise tax, or is there something that is still overpaid for somebody that says, I'm just going to take pure old Medicare?

MR. HACKBARTH: To go back a couple or three sentences, you know, as I said at the last meeting, I'd thought about what might be a carrot in this, and if you look at this through the lens of total beneficiary financial responsibility, out-of-pocket payments at the point of service plus premiums, including any excise tax added onto the premium, what are other ways that we can make this more attractive to beneficiaries and minimize the financial

burden.

The one that I came up with is have the Government offer a supplemental policy with lower administrative costs than the individually-marketed supplements. And that's a way to reduce the total out-of-pocket costs to beneficiaries without increasing Federal spending. It basically comes out of the pocket of the supplemental insurance industry.

And then the question is, well, is that a good policy or a bad policy, and as I said at the last meeting, my view is that Medicare Advantage plans that assume full responsibility, clinical and financial, have the potential to do things that traditional Medicare cannot do. I don't see value added in paying deductibles and co-insurance.

That is not private industry doing things that traditional Medicare cannot do for itself. It's a simple administrative function that the Government can do for less. And so, let's try to keep the total increase in beneficiary cost to a minimum. That would be one thing that I would consider, you know, as part of the package. Kate.

MS. BEHROOZI: Guess what I want to talk about? I think the whole motivation for this discussion is great in recognizing that the basic Medicare benefit is not a very

good insurance package, that it doesn't offer people the protection against catastrophic costs that we think is a fundamental function of insurance, and that's why we're in this box where everybody has -- where most people have supplemental coverage, because we're not providing this basic insurance function.

So moving to a world in which we do and then fewer people end up taking out supplemental coverage, I think of that whole thing -- I'd want to price that whole thing as budget neutral as one of the options to think about. We're taking over a function that the supplemental plans are providing now as part of the basic benefit, and then allow people to top that out using right pricing or an excise tax that incorporates the effects on the program overall, so the pricing would have to depend on how much of an extra now I think we thought the plans imposed on the basic Medicare program and price that in.

All of that makes a lot of sense to me as a direction to go, but I don't feel like it's completely interwoven into our discussion and in the chapter in a way that I think highlights the main purpose of what we're trying to do, which is improve insurance value.

Even talking about the number of people whose costs would go up and the number of people whose costs would go down suggests that there are readily identifiable winners and losers and that we're redistributing money from some people to other people. If the average costs stay exactly the same and the variance went down, we would have improved the value of the program. We would have made things better without changing the amount of money spent by reducing the exposure to risk.

And so, I would love to weave that into our whole discussion, that it's not about whether your costs will go up. It's about the risk you face of very high costs going down.

MR. HACKBARTH: And that's the reason for your earlier inquiry about whether we can look at costs over time for a given beneficiary.

MS. BEHROOZI: So the simplest way to do that would be to assume -- to just look at the distribution of costs and figure you could be anywhere in there next year, and instead of saying the number of people whose spending goes up, you would say the odds of people -- of the odds of you facing higher spending. Doing that translation sort of

depends on a certain amount of independence of spending that probably isn't there.

I am not advocating doing a sophisticated micro-simulation of people spending over time. But I think drawing on evidence from the existing literature or some basic aggregate correlations we could say some things about, you know, say half of spending is predictable and half of spending is uncertain, or whatever number the literature supports, to then say, even for people whose spending doesn't change, there are odds of having this really bad thing happen has now gone down, and that could be done without a lot of detailed micro-simulation.

You would also then, I think, want to think about if possible, including some order of magnitude on the value of insurance delivered, again without doing a micro-simulation, but drawing on some of the literature on the insurance, value of insurance. What I worry about is that the only numbers that we talk about are things like, you know, if spending -- if your spending was exactly the same under this other program, 23 people would have this level of spending and 73 people would have that level of spending. Oh, and there's insurance value.

We could put an order of magnitude on that by using estimates from the literature, risk-aversion, and saying, you know, this creates X billion dollars of value for people, you know, with all appropriate caveats, and not a detailed model, but at least some sense of scope that the protection against high out-of-pocket costs is a real value to people.

And we know it's a real value by looking at how many people buy Medigap insurance, that clearly people want to avoid those bad states of the world, so the program would be delivering this value, that if at least tried to quantify a little bit would give people a sense that it's important.

MR. HACKBARTH: Kate, going back to one of your first statements, what I heard you say, and I want to check this, is that your preferred approach would be to go with a design that is budget neutral relative to the current benefit package?

MS. BEHROOZI: Well, I guess --

MR. HACKBARTH: A higher deductible, for example?

MS. BEHROOZI: I guess I was being a little more flexible than that in saying that I don't think that the basic Medicare package has to -- that we use as a benchmark

has to be budget neutral. Comparing the basic package we have now to the modification of the package is a little bit apples and oranges in calling that budget neutral in that under our model, the new benefit would be taking on some of the function of the previous Medigap policy.

So if I were going to have a budget neutral benchmark, I would have it be the basic package plus Medigap coverage. So total spending -- so that's not budget neutral. That's spending neutral.

MR. HACKBARTH: Well, if we put up Slide 12, so if you look at this slide, what we're saying is we're looking for a benefit package that is slightly better than budget neutral when you take the two policies combined, the restructuring.

MS. BEHROOZI: Yes. I think we're saying the same thing.

MR. HACKBARTH: Cori.

MS. UCCELLO: In terms of budget neutrality, I think -- is your question then, should it be budget neutral from like the get-go with just the design without the other changes? And, I mean, just overall, we need to be, I think, better than budget neutral incorporating the other items.

And I think a $1,200 deductible is too high to have that do it alone.

And I have jumbled comments here, but in terms of thinking about the excise tax versus the regulatory approach, I think Bob and Mike made some compelling arguments that I'm leaning toward, but I still want to see some more modeling to see how some of this shapes out.

And in terms of the elasticities, I wonder if we need to think more about this and taking into account what Bob was saying, too, that maybe we can help influence how CBO was thinking about this, is if we think that it's really the first encounters that are the most sensitive to cost-sharing and high spenders may be less sensitive, to incorporate those kinds of things into those assumptions.

And I also like the idea of including some kind of cost-sharing, nominal co-pays or something, above the cost-sharing cap makes sense. And I wonder, Glenn, you talked about thinking about having Medicare itself offer some kind of supplemental coverage. This would be further down the road, but I think it might also be useful to think of this in combination with some potential premium support types of approaches that kind of ties that stuff in together.

And in terms of the issues, too, I think we can't simply keep the same plan design, add a cost-sharing cap, and then expect the excise tax or whatever to carry the load for making it budget neutral, because I think doing so -- the concern there that Mitra has is that you're increasing the cost at point of service too much for some people.

But my concern would be then the people who might still want that first dollar coverage, with the extra excise tax to make that all budget neutral, those plans now are going to be priced so high that they're going to be even less affordable. So I'm not sure how that addresses the concerns about people facing cost-sharing at the point of service.

MR. HACKBARTH: [Off microphone].

MR. ARMSTRONG: Most of the points I want to make have been made so I'll march through this pretty quickly. First, I support the objectives that we're trying to achieve. I thought Kate did a nice job of making the point I wanted to make, and that is that, you know, this proliferation of these Medigap plans is, to me, symptomatic of a flawed basic benefit for the Medicare beneficiaries themselves.

I also think this is important. Someone made this point, but I would amplify it again, that at MedPAC, this is an enormous opportunity for us to complement all the work we do on provider payment with work on the benefit design, and to be thinking about how these are two different, but also, frankly, complementary and powerful levers for us to be using. And I think it's time for us to be pushing this lever a whole lot more than we have been in the past, and so I think this is really an important agenda for us.

I also really appreciate the point about how this gives us a chance to modernize the Medicare benefit as a whole new wave of beneficiaries start relying on these benefits, beneficiaries who have different experiences and expectations. I support the cap. I think it's overdue. And I think that all of this actually -- and I really appreciate the points made about a concern about a small percentage of beneficiaries who will go through that cap quickly.

We really do need to think about how in the design of the benefits, there is still -- maybe it's like Part D, but there's still some kind of financial incentive to the individuals for certain kind of benefits, and I don't really

know what that design looks like, but I think it's really worth further consideration.

In terms of cost neutrality or budget neutrality, again I would take this point of view that you're looking at the total out-of-pocket cost for the beneficiaries. I think there's a cost to this $5,000 cap, but I think it should be more than neutralized. I think it can be, frankly, overwhelmed through the projected reductions in medical expense trends that come from some of the other benefit designs that we're talking about.

I would also just add that there is tremendous value, and I don't know what micro -- whatever the term is that you use -- modeling means, but what I do know is that the vast majority of health insurance in our country relies on evidence-driven adjustments to incentivize valuable services, that improve health, and at lower expense trends, and they ask patients to pay more out-of-pocket for those things that don't.

And it's about time that we started applying the same standard. And, frankly, I think we're going way too slow in terms of trying to over-analyze and figure this all out, and that there's plenty of evidence in Medicare

Advantage plans and in other insurance plans that we should also be looking to. And I think that's all I have to say.

MR. HACKBARTH: Okay. Thank you, Julie and Scott.

Our next item is Part D, and we'll have two component there, our annual status report on Part D and then a more focused discussion on beneficiaries with high drug spending.

Shinobu, you can start whenever you are ready.

[Pause.]

MS. SUZUKI: Good morning.

Today I'm going to give you a quick update on how the Part D program is working for Medicare beneficiaries, and continue our discussion from the September presentation on beneficiaries with high drug spending and discuss ways to reduce spending growth.

In general, Medicare beneficiaries seem to have good access to prescription drugs. All individuals have access to dozens of Part D plan options, and many continue to receive drug coverage through former employers.

Prescription drug coverage for Medicare beneficiaries haven't changed very much since the program started. In 2011, about 60 percent of beneficiaries are

enrolled in Part D plans, an additional 13 percent get their coverage through employer plans that receive Medicare's retiree drug subsidy. Some beneficiaries receive their drug coverage through other sources of creditable coverage, such as VA, TRICARE, and FEHBP.

Although 2011 data are not available, last year, about 10 percent had no drug coverage or had coverage less generous than Part D's benefit.

Surveys indicate that beneficiaries enrolled in Part D are generally satisfied with the Part D program and with their plans.

There hasn't been a dramatic shift in enrollment patterns from year to year. In 2011, about two-thirds of the beneficiaries are in stand-alone prescription drug plans and the remaining one-third are in Medicare Advantage prescription drug plans. Most LIS enrollees are in PDPs. A larger share of MA-PD enrollees have enhanced benefits that provides, for example, coverage in the gap. In 2012, about the same number of plans will be available.

The national average bid for 2012 came in a lower than for 2011. That means the plans are expecting the average benefit costs for basic benefits to go down by about

4 percent between 2011 and 2012.

The chart shows the year to year changes in the average bids from plan sponsors. As you can see, the bids have fluctuated over the years.

The drop in expected costs for 2012 is likely due, at least in part, to the expiration of patents for some of the top selling brand-name drugs. For example, Lipitor, a popular drug used to treat high cholesterol, is expected to face competition from a generic market entry later this month.

The base beneficiary premium will be $31 in 2012, which is a decrease from $32 this year. That's not going to be the average of the premiums beneficiaries will pay in 2012. The actual average premium will depend on how the enrollment changes after the annual open enrollment period ends on December 7th.

Higher income beneficiaries pay a surcharge calculated based on their income, similar to income-related premiums under Part B of Medicare.

The average plan bid we just saw reflects plans' expectations about what it would cost to provide basic coverage for a beneficiary with average health. You saw

this chart in September. There are two things I want to call your attention to: the low-income subsidy, which is the white bar, and individual reinsurance, which is the red bar. These are two of the fastest growing components of Part D spending.

Payments for low-income subsidy continues to be the largest component of Part D spending. The subsidy has grown by 34 percent cumulatively over this period. Payments for individual reinsurance has grown the fastest between 2007 and 2011, with a cumulative growth of 60 percent. This is the subsidy that covers most of the catastrophic costs for beneficiaries who have very high spending.

We are focused on these two components because the growth of these magnitudes will soon make the program unaffordable, particularly in the current budget environment. In the second half of the presentation, we'll talk about a policy that may help slow the growth in payments for low-income subsidy and individual reinsurance.

In September, we discussed the characteristics of beneficiaries who have spending high enough to reach the catastrophic phase of the benefit. Before we go into the policy discussion, I'd like to recap some of the key

findings from our analysis of the high-cost beneficiaries.

Using 2009 Part D data, we found that over 80 percent of high-cost beneficiaries received Part D's low-income subsidy. They had high drug spending because they filled many prescriptions, and the average cost of prescriptions filled were more than twice as high as those filled by other Part D enrollees. Although high-cost beneficiaries are using many drugs in classes with generic alternatives, they tended to use more brand-name medications compared to other Part D enrollees.

What this analysis showed is that most of the payments for individual reinsurance are made on behalf of low-income subsidy enrollees. And it also suggests that encouraging the use of generic drugs could potentially reduce program spending by slowing the growth in payments for both low-income subsidy and individual reinsurance without affecting access to needed medications.

Here is a quick background on how the low-income cost-sharing subsidy works. The cost-sharing amounts for low-income subsidy beneficiaries are set by law. This is different from how things work for other Part D enrollees, where cost-sharing amounts are set by their plans.

For about 80 percent of LIS beneficiaries the law sets nominal copays. For example, an LIS enrollee who is a dual eligible with an income under 100 percent of poverty would pay a little over $1 for generic drugs and $3.30 for brand-name drugs.

So, I have here an example of a hypothetical plan with four tiers. The plan charges $7 for generics. That's the top row. An individual who does not receive the low-income subsidy would pay $7 at the pharmacy for generic drugs. An individual who received the low-income subsidy would pay $1.10, while the LIS program picks up the difference, which in this case is $5.90.

If an individual receiving the LIS, instead, filled a brand-name medication, the subsidy amounts would be much higher. In this example, about $37 for preferred brand-name drugs on tier 2, and about $77 for brand-name drugs on tier 3. If we could encourage this individual to take a generic version of the drug, the subsidy payments would be $30 less for each drug switched from tier 2, and $70 less for each drug switched from tier 3.

Here are some aggregate spending and utilization information that compares LIS enrollees to non-LIS

enrollees. The key things to note here are that LIS enrollees fill more prescriptions and the cost of each prescription is higher, on average, compared to non-LIS enrollees.

In 2009 they filled, on average, five prescriptions per month compared with 3.6 for non-LIS enrollees. The average cost per prescription was about 50 percent more expensive as non-LIS enrollees, costing $68, on average, compared with $45 for non-LIS enrollees.

Although some of the difference likely reflects the difference in the health status and medication needs between the two groups, as you'll see in the next slide, part of the reason the cost per prescription is much higher for LIS enrollees is because they tend to take more brand-name drugs compared to non-LIS enrollees.

Plan sponsors have generally been more successful at encouraging generic substitution among non-LIS enrollees than among LIS enrollees. In 2009, non-LIS enrollees had an overall average generic dispensing rate, or GDR, of 72 percent compared to 68 percent for LIS enrollees. The difference in GDRs between LIS and non-LIS enrollees varies by class, but in general, LIS enrollees tend to have a lower

GDR compared to non-LIS enrollees. For example, for antihyperlipidemics used to lower high cholesterol, GDR for LIS enrollees was 7 percentage points lower compared to non-LIS enrollees.

Given that generic drugs cost significantly less in most cases -- and typically require much lower cost sharing -- a policy that encourages beneficiaries to use generics when available has the potential to lower program spending without affecting access to medications.

One way to encourage more generic use is to use financial incentives. A cost differential that makes generic prescriptions relatively more attractive can have a strong impact on the use of generics. But a policy based on financial incentives must be carefully constructed, particularly for this population, to ensure access to medications they need. It also needs to take into account variations in plan formulary structures so that it can be applied uniformly across all LIS enrollees.

We would not expect the cost sharing policy to apply to dual-eligible beneficiaries residing in institutions.

To provide stronger incentives to plans, in the

future, CMS may want to rate plan performance based, in part, on generic dispensing rates for selected drug classes.

Here is an example of a policy that would make generic drugs relatively more attractive. Under the alternative cost-sharing structure, the copays would depend on whether the drug class has generic substitutes or not. The table shows how this example would work for drugs in a class with generic substitutes.

The top portion of the table shows the current cost-sharing amounts for dual eligibles under 100 percent of poverty. The bottom half shows what happens to the copay amounts under a policy that eliminates cost sharing for generic drugs and increases copays for brand-name drugs when generic substitutes are available. In this example, we have set the copay amount for brand-name drugs at $6.

For brand-name drugs in classes with no generic substitutes, cost-sharing amounts would stay the same so that beneficiary would have the same access to those drugs as under current law.

Although the extent to which generic substitutions are possible varies by therapeutic class, higher generic use, when possible, can mean significant savings. For

example, in 2009, spending for antihyperlipidemics by LIS enrollees who were subject to copays totaled $2.2 billion. That's about 90 percent of the total that was spent for this class of drugs by all LIS enrollees.

Of that $2.2 billion, $1.8 billion was for brand-name drugs. If the generic use rate among these beneficiaries were increased to 63 percent, which is the average generic use rate across all non-LIS enrollees, the low-income cost-sharing subsidy payments would be reduced by more than 10 percent, or by more than $100 million. Plan costs would also go down by about the same amount.

For the seven classes that we looked at a few slides ago, which accounts for about 40 percent of spending for drugs taken by this population, spending on these drugs could have been reduced by over $1.3 billion if the generic use rates were similar to those of non-LIS enrollees.

Lower Part D spending for this population would have effects beyond just reducing spending for low-income cost-sharing subsidy. Lower plan bids would reduce direct subsidy payments Part D makes to plans, and it would also lower premiums that non-LIS enrollees pay. And if fewer beneficiaries reach the catastrophic phase of the benefit,

it would also reduce Part D's payments for individual reinsurance.

Here are some issues you may want to discuss: What cost-sharing amounts are appropriate for this population with limited incomes? In our example, we changed the cost-sharing from $1.10 for generics and $3.30 for brands to $0 and $6. For LIS enrollees with income above 100 percent of poverty, the current cost-sharing amounts are at $2.50 for generics and $6.30 for brand-name drugs. What are the appropriate amount for this group of beneficiaries? Are there other, non-financial, ways to encourage the use of generic drugs?

In the next draft, we will have additional information on plan formularies, drug prices, and quality ratings of Part D plans.

Finally, I will put this slide up for the discussion session. This re-states the example of the policy option that we just talked about. The two key features of the policy are first, the policy would modify Part D copay amounts specified in law for Medicare beneficiaries with incomes at or below 135 percent of poverty to further encourage the use of generic drugs when

available in a given class.

Second, there should be Secretarial review of the therapeutic classes periodically to determine an appropriate classification for implementing the policy.

That concludes my presentation.

MR. HACKBARTH: Okay, thank you, Shinobu.

Could I ask a clarifying question on slide 11?

A common structure among Part D plans is to distinguish between preferred brands and non-preferred brands, and you didn't address that in the way this particular table is set up. So if we're talking about a plan that distinguishes between preferred and non-preferred, is there an opportunity to have different copays for LIS beneficiaries for preferred versus non-preferred brands?

MS. SUZUKI: I think that could be done. I guess it might be something the Secretary may have to approve on a case-by-case basis, given the variation in plan formulary structures across different plans. Not all plans have preferred/non-preferred.

MR. HACKBARTH: Right.

MS. SUZUKI: If we do implement this type of policy, you may have to consider how this type of policy

interacts with the differentiation between preferred and non-preferred brand-name drugs.

DR. MARK MILLER: And just to follow up on the plan-by-plan approval, CMS reviews plans each year. The Secretary establishes therapeutic categories and then the plans submit their tiering structures and then CMS sort of reviews that.

So in some sense, that review occurs now.

MS. SUZUKI: Right. So there is a guideline for classification. Plans can have their own classification that the Secretary reviews. But the review is conducted every year to make sure the formulary doesn't discriminate, for example, against some type of disease.

DR. MARK MILLER: The reason that I'm saying that, just to conclude this thought -- I'm sorry, I didn't necessarily anticipate that we would have this conversation right here, but here we are. Sorry, that probably just made it worse.

So if that review had occurred and the policy was in law or regulation, whichever way this is executed, you are allowed to charge up to this price on the non-preferred therapeutics, the review process would have occurred and

then the law could say in that circumstance the plan could raise the cost-sharing accordingly.

MS. SUZUKI: I think –

DR. MARK MILLER: Your lawyer seems to indicate that it's okay for you to say yes here.

MR. HACKBARTH: Which lawyer is she going to choose?

[Laughter.]

DR. MARK MILLER: I'm just trying to say that if we made this policy, there is kind of an underlying review process that might enable it to go forward, if we were to choose something like that.

MS. SUZUKI: Yes.

DR. MARK MILLER: I'm not asserting that we should. And there may be other issues that I'm not focusing on right at the moment.

MR. HACKBARTH: Scott, clarifying question?

MR. ARMSTRONG: Actually, that slide and I think the comments you were making were speaking to this. It's not a big deal, but I just want to confirm that we're really distinguishing between these different categories purely on the basis of whether there's a generic alternative or not.

And that -- now, we spend a lot of time arguing that there are actually some non-preferred generics where there's more than one generic alternative.

And so I assume we really didn't try modeling, to a more sophisticated degree, those different categories than just generic versus non-generic.

MS. SUZUKI: Right, I mean, I think class-by-class -- I mean, this is going to vary by class. And that's sort of beyond our knowledge. And it's something that maybe the Secretary -- this is why we're sort of saying the Secretary should conduct a review of the classification to make sure that the policy can be implemented.

MR. ARMSTRONG: But in every drug class, all generics are created equal and all brand names are created equal, according to our analysis? That was a question.

DR. SOKOLOVSKY: That's the way it was modeled.

MS. SUZUKI: That's the way we're modeling; right.

MR. ARMSTRONG: Okay.

MS. UCCELLO: Two related questions. First is why are there so few LIS beneficiaries in MA-PD, as opposed to stand-alone plans?

And two, do MA-PD plans do a better job of

controlling costs among the LIS population?

MS. SUZUKI: So a lot of the duals, at the beginning of the program, got assigned to PDP and so they're already in PDPs, the majority of them. A lot of them also sort of get facilitated enrollment to PDPs if they don't choose a plan on their own and those are two specific PDPs.

I think that's probably the reason that they're almost all in PDPs. But 20 percent of them are in MA-PDs.

MS. UCCELLO: Do the MA-PD plans do a better job? Do they have fewer high cost?

MS. SUZUKI: We haven't done a close look at how they compare. We have looked at risk scores in the past and compared low-income subsidy enrollees in PDPs versus MA-PDs, and it seems like MA-PD enrollees had a lower risk score. And so there may be health-status related issues, as well.

MR. BUTLER: So what do we know, if anything, about the 10 percent of the beneficiaries that either choose not to have Part D or drug benefits that are less than what Part D offer?

MS. SUZUKI: I don't -

DR. SOKOLOVSKY: The early analysis -- and I don't think there's been very much going forward -- they were

people who tended not to take many drugs and didn't think that the penalty was worth it for them at this point.

MS. BEHROOZI: So in the paper -- this isn't directly relevant to what the presentation is on, but just on the issue of people's behavior and response to costs.

In the paper, you say that 30 percent of enrollees make it to the coverage gap, make it to the donut hole; right? And then 8 percent make it through the donut hole to the catastrophic coverage phase.

So I wonder -- you might have done this before and told us before -- or can you do this? Can you look at the rate of spending of people who are approaching -- you know, that the 30 percent, to see whether they should have come out the other end or whether they just stopped spending? I don't know if you've done that.

MS. SUZUKI: I have not looked at that. There are papers where I think they've looked at a subset of people who saw some reduction in use when they entered the coverage gap. It's something that we can certainly look into.

DR. CHERNEW: When you did some of the estimates, there are some drugs that are going to go off patent soon, some big ones certainly, anti-cholesterol drugs and stuff --

did you take into account what would happen in the future or just what would have happened in the past?

MS. SUZUKI: This is just a snapshot from 2009 PDE data.

DR. CHERNEW: So it's before some of the ones that were big went off.

DR. MARK MILLER: The only thing I would add to that is I think there's two phenomenon. One, more generics and do they have a signal to move to them?

DR. CHERNEW: Right, the reason I said that is it is -- I agree very much, again, with what Scott said. Having a generic in class doesn't imply some sort of perfect substitution in a whole number of ways, particularly since this population is a little bit different. So knowing when they're switching molecules versus they're just using the branded drug and the generic exists for that exact thing -- they're just very different.

And in many of these classes, you're going to get a lot more, the current brand of drugs are going to become generic going forward. And getting them to make sure they switch to the generic version of that is really important to avoid some of the problems.

DR. BERENSON: On slide 11, you may have said this but I missed it. Is the alternative cost-sharing package budget neutral to the initial one?

MS. SUZUKI: It is not budget neutral the way it's constructed because we've made generic drugs free in this example. But I don't think we've figured out how many of the brand name drugs would be switched.

DR. BERENSON: Assuming no change in patterns, about two-thirds currently are generic, so you've brought that down by $1.10 and you've raised the others by $2.70. It almost looks like it's budget neutral with current utilization patterns, but you didn't intend to do that.

DR. SOKOLOVSKY: But you did estimate savings, taking into account -

MS. SUZUKI: Right. The savings that I discussed were taking into account -

DR. BERENSON: Okay, I did miss something then.

MR. HACKBARTH: Can you say that again, Shinobu, just the last sentence?

MS. SUZUKI: So the savings that I estimated did account for the fact that the generics are free. In which case, long-term subsidy is picking up more of the cost

sharing for generic drugs.

MR. HACKBARTH: Yes. So in the offset package that we discussed last time as part of the SGR discussion, there was an option related to LIS cost-sharing and -- I can't remember off the top of my head -- the estimated 10-year savings from that. They were how much?

MS. SUZUKI: I believe it was $16 or $17 billion over -

MR. HACKBARTH: Over 10 years. Yes, that sounds right. And that was based on this cost-sharing structure or a similar cost-sharing structure?

DR. MARK MILLER: Her lawyer is not going to allow her to answer that question.

[Laughter.]

DR. MARK MILLER: What we did there is we put together that estimate using some aggregate numbers working out of a CBO 2010 report and looking at some of our own data. And what I think -- the way we would characterize this is we had some general policy parameters in mind, but we didn't model specific policy parameters. Now what we're trying to do is fill in behind that, and we put a conservative placeholder in there and shaved off how much

savings in the hope that we could design something that would fill in that savings estimate.

Is that fair enough?

DR. BERENSON: This is going to -- I'm not sure you'll have an answer to this, and I'm not sure I can ask the question right. But I'm interested in -- do we know whether the LIS patients -- we have a 4 percent difference in aggregate in the generic prescribing. Do they see the same clinicians writing prescriptions and the clinicians are somehow writing different prescriptions for this population? Or are they seeing a different class of prescribing clinicians? In which case, cost-sharing policy may be less helpful.

Do we have any idea? Or is it a mixture? Which is what I would assume, both things are probably going on.

MS. SUZUKI: I don't have the answer for that, but we do have prescriber information on the PDE. So it's something that we could look at.

DR. BERENSON: I mean, I guess the point I'm making here is if they're seeing just the different profile clinicians, it may be that cost-sharing policy isn't going to directly change that prescribing behavior. And it might

be helpful, if this doesn't take a lot of work, to sort of get some sense of that.

MS. SUZUKI: One of the things we were trying to add to the policy discussion is to say that maybe we should add more incentives to the plans to increase the generic use among this population, for example, using ratings based on these generic use rates.

MR. KUHN: Just a quick question on this notion that Mark mentioned a moment ago, the signal to move, but kind of take it up from the generic substitution from the brand name up to kind of the health plan level. Every year there is a certain number of switchers within the LIS population. Some are moved by CMS because of changes in the plan bids. Some will move because they might just want to select another plan.

What is kind of that number of switchers we're seeing every year? And how many of them are being moved by CMS and how many move on their own accord? Do we know?

MS. SUZUKI: I don't have the numbers, but I believe last year it was less than the million who was reassigned by CMS. I'm not sure that we -- we don't track the, what we call choosers, on a regular basis, but there

are some people who did choose their own plans. CMS won't reassign those people. But it's not something that we've tracked in close detail.

DR. HALL: On Slide No. 9, I've been puzzling why -- what are some of the reasons why generic use would be lower for LIS, and at least some things that come forward would be that they are sicker and older. You alluded to that a little bit, and that would make sense. The other is that there is something going on in the PDP programs that allows this to happen. Or, third, there's some great conspiracy here that we haven't unearthed yet. Can you help with that a little bit?

MS. SUZUKI: I think we've also thought that there are multiple reasons, one of them being that maybe they don't have as much incentive to choose the incentives when the financial incentives they face is very different from the financial incentives non-LIS beneficiaries face. That could be one of the reasons. But I agree that health status probably has something to do with it. The fact that they're also almost all in PDPs may also affect their prescribers' behavior.

DR. HALL: Right. Just as a follow-up point, this

is generally not a decision point where consumers are very informed on this. Their physician or their health provider gives them a prescription for something. I mean, I can't remember a situation where somebody would just quiz themselves and go to the literature to see whether a generic would be equivalent. So some governments, like New York State, for example, really won't allow us to write non-generic prescriptions. I mean, basically, you have to make a conscious decision -- well, it used to be on paper, but now it's electronic -- that you are going to be willing to accept the generic if a generic exists. So I'm very puzzled by that, why this difference occurs. But, obviously, it needs to be looked at.

DR. SOKOLOVSKY: One of the things that I want to say is we've been doing focus groups with beneficiaries on the drug benefits since before the drug benefit began --

DR. HALL: Mm-hmm.

DR. SOKOLOVSKY: -- and in the first year, 2005, all the beneficiaries we spoke to were very suspicious of generic drugs -- a majority of them were. In years going forward, we've heard consistently from the non-LIS population, particularly those that were hitting the

coverage gap, that they were going to their physicians and saying, is there anything you can do to lower my costs? Are there any generics available? And you hear them talking about it like we would be doing it here. It's quite amazing, the difference.

DR. HALL: Hmm.

DR. SOKOLOVSKY: And you don't hear quite that level of change in the LIS.

MR. HACKBARTH: So there are multiple potential hypotheses --

DR. HALL: Right.

MR. HACKBARTH: -- why this differential exists. Our policy option focuses on one, that there's economic incentive at work. Is there any way to explore through data the other hypotheses, so not being research? I'm not much help here, but is there any movement of people from the LIS population to non-LIS status where you could actually track people and see if their behavior changes as they move? My hunch is that there probably aren't a lot of people who graduate from LIS status, given that we're talking about the population we're talking about. But is there any way that we can try to shed light on these other hypotheses?

MS. UCCELLO: Can we look the other way?

DR. NAYLOR: [Off microphone.] Non-LIS --

MR. HACKBARTH: Or when they move in, yes. Yes, that's probably the more plausible possibility.

MS. SUZUKI: That's definitely a possibility, something we can look into.

MR. HACKBARTH: Yes.

DR. MARK MILLER: And this doesn't mean we don't look into it, but would you expect the bias there to be if I'm on a generic because I was non-LIS and more sensitive to it and then I moved to LIS, you would be less likely to immediately go to a name brand than the average person who started out on LIS --

MR. HACKBARTH: Right. That would be your hypothesis to test --

DR. MARK MILLER: So you would have a little bit of a bias in what direction you expect to -- but it doesn't mean we can't.

MR. HACKBARTH: Okay. Mary.

DR. NAYLOR: Very briefly. I think I know the answer, but the PPACA changes that will be going into effect in 2012 that you mention in this terrific report, you can't

model what effect -- I mean, so you won't know the added value of this recommendation in terms of cost sharing on top of the ones that will be implemented going forward?

MS. SUZUKI: You're talking about phasing in and the gap, or -- I'm sorry, what --

DR. NAYLOR: [Off microphone.] I understood that you were already -- so I may be wrong in the assumption that there are already efforts to reduce cost sharing in 2012, 2013, and I'm still wondering about the added value of this recommendation on already expected implementation efforts.

MS. SUZUKI: So right now, we're talking about LIS enrollees. They don't face the coverage gap. The phasing in of the coverage gap affects the non-LIS population.

DR. NAYLOR: [Off microphone.] I'm wrong. There are other cost sharing reductions that have been recommended as part of -- thank you.

DR. CASTELLANOS: As a physician, I was reading the material that was sent to us and I really was intrigued by a statement that beneficiaries who do not enroll in Part D have a lower drug spending, as you would expect, but they have better health and lower risk scores. Now, I know you referred to an article in Health Affairs. I didn't have

time to look at that, but that's intriguing, because the best way to save money is to get them out of Part D so they don't have to be there. We have very little emphasis on well care that I've noticed, at least mentioned on the Commission, and I'm just curious if you had any comments why these people -- what's the difference between those people -- something what Peter asked, a similar question.

DR. SOKOLOVSKY: I think the arrow points the other way. At least, the literature that is available suggests that the people who didn't enroll in Part D were the people who already were pretty healthy and not taking many drugs.

DR. CASTELLANOS: But why were they healthier and why do they have better risk? Do we ever look at that population and try to say, hey, what are they doing that we should be doing?

MS. SUZUKI: And part of the problem trying to look at their utilization is we have no utilization information for them on the prescription drug side.

DR. CASTELLANOS: Just an interesting comment. Thank you.

MR. HACKBARTH: George.

MR. GEORGE MILLER: Yes. I'm kind of intrigued by the information Joan said for the focus group meetings, why there is suspicion about generic drugs. Did you dwell any deeper and try to understand why?

DR. SOKOLOVSKY: We have in the past. This isn't something we've explored recently, but in the past when it was more widespread, we would hear things like generics are fine for other people but I'm more sensitive. We also heard other people talking more like it's like a store brand is never as good as a name brand.

MR. GEORGE MILLER: Okay. All right. Well, with that said, from a policy standpoint in that those are the reasons, and with all due respect to people's perceptions about that, from a policy standpoint, why don't we -- I think it was just mentioned in New York -- is make a policy that generics would be the drugs unless the provider specifically had an indication that it should not be a generic drug, just from a policy standpoint to flip this, because if there's not a logical reason, I don't understand Slide No. 9.

MR. HACKBARTH: This is actually something that Cori and I talked about.

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: There was a piece in one of -- I think it was Tab A from the last meeting that talked about this issue of resistance to generics. As I understand it, this is currently a matter of State law and varies from State to State on whether a physician can, must substitute generics in certain circumstances. So for the Federal Government to legislate in that area would be potentially problematic. It would be intervening in a matter that's well established as a State law issue.

MR. GEORGE MILLER: Okay. Thank you.

MR. HACKBARTH: Bruce.

DR. STUART: If we could go back to Slide 11. The copays that you see there are for essentially the duals, and there are LIS beneficiaries who have higher incomes and they have slightly higher copays. I guess my question is, in a way, that's kind of a natural experiment, and I wonder if we're trying to understand what would happen to LIS beneficiaries if you change the copay structure, if you compare these two groups. They're not strictly comparable, but they're both poor. Have you looked into that?

MS. SUZUKI: I have looked at them and compared

them for a couple of therapeutic classes. In most cases, there is no difference in the generic use rate. We are talking 250 versus 630, roughly, this year, compared to 110 versus 330. We didn't see any difference.

DR. STUART: Well, just a suggestion, and then another thing here that's important in terms of understanding the copay structure for LIS, and I think I'm right here, is that these copays are per prescription regardless of the days' supply, is that correct?

MS. SUZUKI: Mm-hmm.

DR. STUART: So if you think about it, if an LIS beneficiary fills either a generic or a brand, it's the same whether it's 30 days or 60 days or 90 days, and so that would be interesting to look at when you're comparing the LIS to non-LIS in terms of whether some of this difference is due to differences in days' supply.

MS. SUZUKI: I guess, in the aggregate, I think non-LIS enrollees are more likely to take drugs that have more days of supply, on average, than LIS enrollees.

DR. STUART: Actually, I would expect that to be true, because the duals came from Medicaid and most State Medicaid rules basically mandate a 30-day supply. But if

that's the case, we're looking at moving from dual to non-dual, that difference of days' supply is also something I think we would want to consider.

MR. GRADISON: This seems important to me, that there be an opportunity for physician override. I had been assuming as a layman that a generic was either therapeutically equivalent or chemically equivalent and that's just the end of it. I don't think it is in every instance. I've been struck in the literature, for example, with regard to thyroid supplements, that there is some evidence that the generic isn't equivalent in terms of the stated strength of the bottle. I don't know any better way to say it as a layman. So I just think we have to be careful about this. I'm not in any way objecting to the way in which we approach it, but circumstances differ.

DR. BORMAN: Could you just refresh me, because maybe I have missed it and I am just not into it, why we wouldn't apply something to encourage the use of generics more in the institutional LIS group? We say we exclude that, and it's 13 percent of the group.

DR. SOKOLOVSKY: I think the reason is because there is no cost sharing at all of institutional and we

don't think there could be because, first of all, they're not making a decision, generally speaking. They're getting what they're being given. And also, to the extent that these are duals, they don't have much -- once they're institutionalized, they really don't have the cash.

DR. BORMAN: I mean, I understand that they aren't making decisions, but someone is making a choice for them. So the entity that gets the payment for them, are we motivating their behaviors in other ways to use the drug money wisely, or is there -- it just doesn't apply?

MS. SUZUKI: I think some of the things we could consider are, you know, are there things plans could do to work with the long-term care facilities to increase generic use. But as far as cost sharing policy goes, there's not much we can do there for this population.

DR. BORMAN: I would just hope that -- 13 percent is a non-trivial chunk when, if my gut feeling is correct, they would be likely to have pretty high drug use by virtue of the conditions that cause them to be where they are, and so I just wouldn't want that group to get lost in the shuffle, whether or not it belongs under this initiative or this investigation.

MR. HACKBARTH: So let me play with this for just a second, because I really don't understand how it works. So most of the Medicare beneficiaries who are institutionalized are going to be duals and also covered, therefore, by Medicaid. So Medicaid is actually providing their drug -- well, with the switchover in Part D, so Medicare is paying. So how do the dollars flow? If the nursing home is buying and distributing the drugs, how do they get paid now for those drugs?

MS. SUZUKI: Once they're -- you know, for the people who are outside of the SNF-covered days, it's just like what Medicaid used to do. They pick up the cost of the drugs. But now Part D plans pay for those drugs --

MR. HACKBARTH: Yes --

MS. SUZUKI: -- on whatever pre-negotiated payment terms with the pharmacy --

MR. HACKBARTH: So they pay directly to the nursing home. Yes. Okay.

Round two. Scott.

MR. ARMSTRONG: So to the issues for discussion, I don't know exactly what the dollar amounts are for different levels, but I believe and strongly support a direction that

you've laid out to model zero out-of-pocket costs for generics. I just want to acknowledge, too, the point I made earlier. I think it's kind of a blunt tool and it's, I think, a good step, particularly given we have a fairly narrow goal here, and that is to increase the generic use rate for this population of beneficiaries because we know their expenses are higher because they don't use generics at the same rate. So I really support that.

We talk about next steps, getting more involved in formularies and some other things, and I think there, there is additional opportunity for us to have an impact on the drug expense trends for our beneficiaries by being a little bit more focused in on not all generics are the same. And, frankly, there's great value in some brand name drugs that maybe should also have zero copays, but that's beyond what we're trying to do here. I realize that.

And the way that the policy statements or policy options are laid out, I think that language is good and look forward to continuing to work on this.

MS. UCCELLO: Yes. I, too, agree with the policy options, and in terms of the cost sharing amounts, I definitely agree with the zero for the generic, and I'm

guessing that the zero is a bigger driver for shifting to generics than the difference between the generic and the brand. So I'm comfortable enough with six. You know, maybe it could stay at three or whatever, but that range seems appropriate to me.

I would go further with respect to plans and include a measure of GDR in the quality measures. I think it is important to get some way to get the providers in on this, and since we can't do, because it is more of a State policy of the generic-only dispensing, that kind of thing, that the lever that we do have is including something like this as a quality measure.

MR. HACKBARTH: Plans are highly motivated to do generic substitution. It's not like their incentives are in a different direction and so they need some additional push. Presumably, they are pursuing every angle they can think of.

Kate.

MS. BLONIARZ: I agree, as well, that I think this is a great down payment towards a more value-based design and that in the future we could think about more differentiation based on values to individual patients and also think about non-price levers that promote. You know,

we know that having to renew more often leads to less adherence than getting more at once or automatic refills promoted here. There are other levers that could be promoted, and the plans have some incentive to do that and we could encourage that, but this seems like a nice first step.

MR. BUTLER: So I don't have a clue what the price elasticity -- I do remember a little of my economics -- would be on these, but I understand the concept and support it. I am reminded of when the State of Illinois said, let's do a $100 copay for the first day of admission for Medicaid, as if that was going to be anything but just a flat-out budget cut. It had nothing to do with affecting demand.

So having said that, the only thing -- and maybe it's just too hard to do -- there are not only differences between generic and brand, but there's a difference in the value of the drugs and how much you need them to stay alive versus they're somewhat discretionary. If you could differentiate, too, and say, okay, it's zero for the ones you've absolutely got to have, but if there's some discretionary, is there a second tier that would say, for those that there is some copay - I realize which would be

grouped into that which would not is a very difficult decision, but I wish you could do that.

MS. BEHROOZI: Yes. This is the kind of first dollar coverage policy I like, because it's not just about the zero on the generic drug, but it's about raising the cost on the brand name drug where there's a generic available. So I really want to make that clear, going back to the earlier discussion. It's not that I think there should never be up-front costs, but it should be -- there should not be barriers to people being able to access care, and this way everybody can get the drugs that they need.

Just on what motivates people, yes, in New York State, there was no limitation with respect to generics versus brands as long as the pharmaceutical companies were successful in keeping up the pressure, convincing people that it would be second-class health care to require people to take generic drugs, and frankly, our fund covers people who there but for the grace. I mean, a lot of them are very low income and sometimes are on Medicaid and we have been doing what we call mandatory generics, but it's free generics, high-priced brands is really a better way to characterize it, for a number of years, and our generic

substitution rate is close to 99 percent, I think it is. So that means wherever a generic is available, people are taking it almost all the time because it's free, despite that there has been for all this time all this pressure. And I can get for you what the change was, if we can truly find it, before to the after.

But certainly in our focus groups, and I think we've talked about this, I might have even mentioned it here, that we found, particularly among more recent immigrants and certain ethnic groups, more resistance and more distrust and we have to do a little more education with them. But again, the fact that it's free helps a lot.

And whether it's different providers, Bob, I think there are providers who, yes, fall into patterns because they've got lots of patients for whom there's no cost. I mean, we find that with our own plan, right. And so then, yes, you do have to pay attention to the providers and what their patterns are. But when they see what's free for their patients, that's one of the things that's also going to drive their behavior, because they're going to want their patients to be happy. They don't want their patients to say, hey, how come last month I was paying, whatever, $1.10

and now I'm paying $6 or whatever.

So I think those are all the points, but I think the direction is really great and I love this work.

DR. CHERNEW: My comments were said.

DR. BERENSON: Briefly, I support the policy. I would be interested in pursuing some of the discussion we had around hypotheses here, not as much -- I don't think the four percent is a huge differential. I think our policy will partly address that. It's learning more about the 28 percent who don't -- where there is no generic writing, and it might include some of Bill's ideas, that at least when I was practicing, there were some particular drugs I was told, you can't use generic for those, and I didn't know at the time how much of that was just urban legend and how much of it was based on science. So that might be there.

I mean, Mitra has got a very plausible theory as to that providers who have a large population of people with little cost sharing can get into one pattern. I would be interested in knowing whether there's also a pattern of some clinicians just ignoring the cost sharing and that's their pattern.

So, in any case, I think this is worth pursuing if

it helps us in the bigger sort of picture of understanding Part D. I think in terms of the LIS specific problem, I think we've got a policy here that I can endorse.

MR. KUHN: I'm very supportive of continuing this work and I think it's going to help us. As Kate, I think, indicated earlier, in terms of a downpayment on value-based design, I think is good work. Thanks.

DR. HALL: I agree this is very important work and I guess we ought to be worried at least about one thing, and that is sort of the law of unintended consequences. I would hate to see us trash Part D. It's made an enormous sea change in the availability of pharmaceuticals to a large percentage of our older population.

But I think from a 30,000-foot level, I think the goal here ultimately should be to link prescribing patterns with clinical outcomes. Call me crazy, but I think that's kind of why we use drugs. When physicians are dealing with PDP plans, they may be dispensing medication to maybe ten or 12 plans in the same community, all of which change their formularies on a year-to-year basis. It's just -- if you were an alien coming down to earth and looking at dysfunctional systems, you would say, well, of course, it is

not going to work. Now, that's somewhere in the future, but I think the more we can link this -- and that may be -- may be -- why the MA plans seem to be a little more rational, because they may be incentivized to keep track of the health of their populations. Maybe or maybe not.

MR. HACKBARTH: Could I ask you to go back to your initial comment about unintended consequences and trashing Part D. Could you be more specific about the risk that you see.

DR. HALL: Well, I mean, sound bites, I guess. MedPAC looked at prescribing in Part D and found that it's a mess, that somehow, despite the equivalency of generics, they're not being used. Well, that's true, but five years ago, it was a very different scene, and not a pretty one in terms of availability of drugs based on people's financial needs.

DR. MARK MILLER: Yes. I agree that the tone, I think, here should be, whether it's coming across or not, is that D had a lot of impacts in terms of access, but also general movement to generics, and in a sense, all we're trying to do --

DR. HALL: Right.

DR. MARK MILLER: -- is bring that LIS along behind that. That's really the tone that I think is in our heads, anyway.

DR. NAYLOR: I also support the general direction and your work, and with all the caveats about making sure we know the health status and how they might be different, the LIS population, and also about efforts that are continuing to really make sure we understand when generics and brands -- when brands should be used, et cetera.

I think the notion of other ways to encourage use of generic drugs that you also outlined are really important, that they should be simultaneous, so the work around beneficiary education, particularly in the context of growing public understanding about the shortages of generic medications that are frequently and increasingly occurring, I think that this is going to be a really important issue.

I also think provider -- I mean, your earlier work showed that some providers just don't believe that brands are better than generics, so the kind of provider education and rating both plans and providers in terms of use of generics when appropriate for the right population, et cetera.

I also think this annual exam that we now have -- I don't know if it now includes a kind of annual review of medications, because it's one thing to look at these individually, but many of these older adults, frail older adults, are on way too many that negatively interact with each other. So an incentive that would help somebody to take a look at the big picture would be great.

DR. CASTELLANOS: I had two questions. One, I just don't get it. Insurance companies and plans prefer generics from a cost saving viewpoint. The patient from a cost sharing viewpoint, unless he or she has some peculiar idiosyncratic response to the drugs, I would assume if they're clinically indicated, would prefer it. The pharmacy, not the drug company manufacture but the pharmacists, make more money dispensing generics than proprietary drugs. I'm a physician, but I've learned something on this Commission. Follow the money.

[Laughter.]

DR. CASTELLANOS: What's happening here? I mean, there's got to be something happening here.

MR. HACKBARTH: The disconnect that we're focused on is at the patient level for this particular population,

the LIS population. So I agree with your basic analysis, but the tool that the plans use to encourage people, the patients, to switch to generics, one of their principal tools is the cost sharing lever, and they've, as Bill says, they've used that tool very effectively to greatly increase the use of generics under the Part D program, but there are regulatory limits, statutory limits on their ability to use that tool for this population. And basically what we're trying to do is propose a way that they can use that tool without impeding access to needed drugs for LIS beneficiaries.

DR. CASTELLANOS: I understand what you're doing. Let me just give you a real world experience. I live in Florida, where they have to sell by generic. I get maybe one phone call a year from a pharmacy saying, hey, we have got to change this because they can't do it. A lot of plans do a lot of different things, but I don't think that's -- have we looked at the State level to see if there's problems with, like in Florida, where you have to fill with a generic by law?

DR. SOKOLOVSKY: We haven't looked at it. There are a number of States that have that same kind of law, but

there are also quite a few States that don't.

DR. CASTELLANOS: [Off microphone.] Are there any problems with --

MR. HACKBARTH: Ron, could you turn on the microphone?

DR. CASTELLANOS: Are there any problems with the States that have that law?

DR. SOKOLOVSKY: We have not looked at that.

MR. HACKBARTH: Are there States that go the other way, that they impede substitution as opposed to encourage it? In other words, by impede, I mean there are higher hurdles that --

DR. STUART: I think you're going to find that that was the way it was back in the 1960s and 1970s but not so much now, and my guess is that most States, in fact, do what Florida does, but it's certainly something that you'd want to take a look at, because, again, it gives you some kind of natural experiment here.

MR. GEORGE MILLER: Yes. I'm going to follow up Ron. His last comment hit where I was. In fact, after you had passed on to me, I thought about that, that for the States that do, we should take a look at it and see if that

has a significant impact. I've heard two on this panel, which is New York and Florida, at least, that allows the physician or other provider to write for generics, and if there is a significant number, that is a savings. And then we can use the other non-financial levers for the rest of the population where the State will not allow that. And Mitra mentioned that zero worked pretty well for her beneficiary group. Ninety-nine percent is pretty good.

DR. CASTELLANOS: Pretty close.

MR. GEORGE MILLER: Pretty close, yes. So we could use that as the lever, too. So I support the recommendations, but my caveat is to look at those States that allow the providers to write generic and make that a policy issue -- for those States that allow it -- and for those who don't, use the other financial levers, and again, I like the term zero, Mitra's example.

DR. STUART: I can just see the title of that: The Power of Zero. We can -- it's got a real appeal.

I'd like to pick up on something Scott mentioned in the first round, which was he was distinguishing between preferred generics and non-preferred generics, and again, it may be the power of zero, but if you look at most plan

formularies for non-LIS beneficiaries, what you see is that the difference -- this would apply to therapeutic classes in which there are multiple branded products -- but in those circumstances, you will find frequently that the difference between the generic copay and the preferred brand copay is actually less than the difference between the preferred brand and the non-preferred brand.

And so the question is, and maybe you are already planning on doing this when you get into the formularies, is to look at the percent of LIS beneficiaries who are using what turn out to be non-preferred brands within the plan that they happen to be enrolled in because the structure of the cost sharing that they face makes no distinction between preferred or non-preferred brand, and I have no idea what the potential savings would be, but I think the policy implications would be, what if you raised -- what if you took account of the plan's distinction between preferred and non-preferred and applied that at some lower level to the LIS population.

MR. GRADISON: [Off microphone.] I support what you are doing --

MS. BEHROOZI: I support the policy direction that

you are going and would agree with the power of zero.

MR. HACKBARTH: Okay. Thank you very much. Well done.

We will now have our public comment period before breaking for lunch.

[No response.]

MR. HACKBARTH: Seeing nobody rising to the microphone, we will adjourn until -- oh, we are right on time -- 1:15.

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

AFTERNOON SESSION [1:19 p.m.]

MR. HACKBARTH: Okay. It's time to begin our afternoon session, and the first topic is coordinating care for dual eligibles in the PACE program.

MS. AGUIAR: Today we will continue our discussion on the Program of All-Inclusive Care for the Elderly, also known as PACE. As you know, PACE is a provider-based integrated care program that enrolls nursing home-certifiable beneficiaries age 55 and older with the goal of keeping them in the community. During the September meeting, we discussed the findings of our research on PACE, and in October I presented draft recommendations for your consideration. Today I will review the findings from our research and the draft recommendations. Because PACE providers are paid on the Medicare Advantage payment system, Carlos is sitting with me to address your questions on MA.

Before we begin, I will address the Commissioner questions from the October meeting. Scott asked about the context of this work within our future work on dual-eligible beneficiaries. In the spring, we anticipate discussing flexibilities that are characteristic of PACE that could be extended to managed care=based integrated care programs. We

also anticipate discussing broader issues on dual eligibles, such as strategies to increase enrollment into integrated care programs and the structure of federal and state financing for integrated care programs. However, today we will wrap up our discussion of PACE.

Karen also raised a question on the rationale for providing pro-rated payments and outlier protection to PACE providers and not to MA plans, and I will address those questions during the discussion of those draft recommendations.

Now I will move on to reviewing the findings from our research on PACE.

As you remember from the previous meetings, we concluded from our site visits with PACE providers that the PACE model does provide a fully integrated model of care. We identified key characteristics of the program which are listed on this slide. We also identified three areas for improvement and developed draft recommendations to address each area. For the remainder of the presentation, I will review the draft recommendations and our findings that led to these recommendations. These are the same draft recommendations that I presented during the October meeting.

As a reminder, the goals of these recommendations are to more accurately pay PACE providers for the beneficiaries they enroll, to support the growth of the PACE program by improving the payment system and expanding enrollment, and to pay all integrated care programs for dual-eligible beneficiaries through the same payment system.

The first draft recommendation is: The Congress should direct the Secretary to improve the Medicare Advantage risk adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay PACE providers based on the MA payment system for setting benchmarks and quality bonuses. These changes should occur no later than 2015.

The purpose of the first part of this recommendation is to improve the accuracy of the MA risk adjustment system. We found that the risk adjustment system underpredicts costs for very complex patients, which are the types of patients that PACE providers enroll, and this recommendation would address this issue. When the system is revised, the amount of the frailty adjuster should be revised because improvements to the risk adjustment system

may result in the need for a reduction in the size of the frailty adjuster.

The second part of this recommendation addresses the county benchmarks and quality bonus program. We found that because Medicare payments to PACE are based on the pre-PPACA county benchmarks, Medicare spending increases when beneficiaries move from fee-for-service into PACE in the majority of counties PACE sites operate in. We estimated that for 2012 Medicare will spend about 17 percent more on behalf of PACE enrollees than it would spend on these beneficiaries if they were to remain in fee-for-service. Under this recommendation, payments to PACE providers would be based on the PPACA-revised county benchmarks which are the benchmarks used for MA plans. This change would reduce Medicare spending on PACE and better align it with fee-for-service spending levels. Finally, PACE providers were exempted from the MA quality bonus program and therefore are not able to receive bonus payments. This recommendation would permit PACE providers to participate in the quality bonus program. These changes would also make the payment system for PACE more consistent with the SNP-based integrated care programs.

We estimate that this recommendation would have no effect on federal spending on PACE relative to current law in the first year and would decrease spending by less than $1 billion over five years. This is the smallest bucket we use for the five-year impacts; however, we expect the financial impact to be much less than $1 billion because of the small size of the PACE program and because the improved risk adjustment system and quality bonuses would mitigate some of the payment reductions from moving to the MA benchmarks. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries' access to care. Paying PACE providers on the PPACA-revised benchmarks would lower payments to PACE; however, the improvements to the risk adjustment system -- I'm sorry, would mitigate, as I said before, these payment reductions. In total, we do not expect these changes to reduce PACE providers' willingness and ability to care for Medicare beneficiaries.

The second draft recommendation is: After the changes in draft recommendation 1 take effect, the Congress should change the age eligibility criteria for PACE to allow nursing home-certifiable Medicare beneficiaries under the age of 55 to enroll.

This recommendation addresses enrollment in PACE, which is our second area for improvement. We found that PACE programs are generally small and enrollment is slow; however, reaching enrollment targets can help sites operate at or above breakeven. Our research also indicates that the PACE model could serve the nursing home-certifiable beneficiaries that are younger than 55. This draft recommendation would allow, but not permit, PACE providers to enroll beneficiaries that are not currently eligible for PACE, and doing so would also help providers increase enrollment to achieve economies of scale faster.

We do not expect a large enrollment increase into PACE due to this recommendation, and, therefore, we expect that the cost to the Medicare program from beneficiaries under 55 enrolling into PACE would be offset by the savings achieved from paying PACE providers on the PPACA-revised benchmarks. Therefore, we do not expect this recommendation to increase federal spending on PACE relative to current law. We do expect this recommendation to increase access to PACE services for nursing home-certifiable Medicare beneficiaries under the age of 55. This recommendation may also help PACE providers to increase their program

enrollment.

The third draft recommendation for your consideration is: After the changes in draft recommendation 1 take effect, the Secretary should provide pro-rated Medicare capitation payments to PACE providers for partial-month enrollees.

This draft recommendation also addresses enrollment. One barrier to enrollment is that PACE providers do not receive retrospective payments for beneficiaries enrolled after the first of the month, and because of this sites have not been able to enroll some beneficiaries that are in immediate need of services. This recommendation would also address this issue by enabling PACE providers to receive Medicare payments for partial-month new enrollees.

With respect to Karen's question of why this recommendation would apply to PACE and not MA plans, MA plans can enroll beneficiaries after the first of the month, and the beneficiaries can receive their Medicare services through fee-for-service until the MA plan receives the full capitated payment. However, PACE providers furnish services that are not covered under Medicare fee-for-service. And

because of this, PACE providers, unlike MA plans, cannot enroll beneficiaries after the first of the month. In addition, some potential PACE enrollees are in immediate need of services, and if they cannot enroll in PACE, they may instead be admitted to nursing facilities or home- and community-based services. PACE providers would then miss the opportunity to enroll these individuals.

We do not expect a large enrollment increase from this recommendation, and, therefore, we expect that the cost to the Medicare program from this recommendation would be offset by the savings achieved from paying PACE providers on the PPACA-revised benchmarks. Therefore, we do not expect this recommendation to increase federal spending on PACE relative to current law. We do expect this recommendation to increase access to PACE services for some nursing home-certifiable Medicare beneficiaries. This recommendation may also help PACE providers to increase their program enrollment.

The fourth draft recommendation is: After the changes in draft recommendation 1 take effect, the Secretary should establish an outlier protection policy for new PACE sites to use during the first three years of their programs

to help defray the exceptionally high acute-care costs for Medicare beneficiaries.

The Secretary should establish the outlier payment caps so that the costs of all draft recommendations do not exceed the savings achieved by the changes in draft recommendation 1.

This recommendation addresses outlier protection. We were told by PACE staff that although most of the rural sites did not use the outlier protection that was available through the rural PACE grant, having it available was an incentive to their sponsoring organization to open the site. The outlier protection under this recommendation could help PACE programs and prevent insolvency due to extremely high costs incurred before a provider reaches a breakeven point. A mechanism that helps to ensure financial stability during start-up would provide an incentive for sponsors to open PACE programs. As under the rural PACE demonstration, the outlier protection would be available for the first three years of the program and could only be used on high acute-care expenditures for Medicare beneficiaries. CMS could structure the outlier protection similar to the one available to the rural PACE sites. In order to not increase

total Medicare spending, the Secretary should determine the size and structure of the outlier pool and the per enrollee and per provider outlier payment caps so that the outlier protection, the expansion to enroll beneficiaries under the age of 55, and pro-rating capitation payments for partial-month enrollees can all be completely financed from the changes in the PACE county benchmarks.

Karen, to address your question from the October meeting, the reason the outlier protection would only apply to PACE is that, unlike MA plans, even a few enrollees who incur exceptionally high costs during the first few years of operation can jeopardize a PACE program's fiscal solvency because of the very small scale of the programs, and this financial risk may be significant enough to dissuade sponsors from opening a PACE program.

With respect to implications, this recommendation would not increase federal spending on PACE relative to current law because the outlier protection would be funded by the reduction in Medicare spending from basing PACE payments on the PPACA-revised benchmarks. In addition, we do not expect this recommendation to have adverse impacts on Medicare beneficiaries' access to care. This recommendation

may be an incentive for sponsors to open new PACE sites.

The final draft recommendation for your consideration is: The Congress should direct the Secretary to publish select quality measures on PACE providers and develop appropriate quality measures to enable PACE providers to participate in the MA quality bonus program by 2015.

This recommendation addresses our final area for improvement which is quality data. As you recall, CMS requires PACE sites to report outcome measures; however, those measures are not yet publicly reported. Publishing quality measures would permit the policy community to evaluate PACE and would help beneficiaries and their families make more informed decisions about joining PACE. In addition, CMS needs to identify which measures will be used to evaluate PACE providers so that they can participate in the quality bonus program.

We estimate that this recommendation would not impact federal spending on PACE relative to current law, and this recommendation should not have adverse impacts on PACE providers. We do not expect this recommendation to adversely impact Medicare beneficiaries' access to PACE

services, and it could enhance beneficiaries' ability to choose a program that meets their needs.

This concludes the presentation, and this slide summarizes the five draft recommendations to facilitate your discussion. Thank you.

MR. HACKBARTH: Thank you, Christine.

So this is at least our third session on PACE and maybe even the fourth. So what I propose we do is limit ourselves to just one round of comments on the recommendations. Everybody saw these recommendations in draft form at the last meeting, had an opportunity to provide input at that point and, in addition, between the last meeting and this one. So I think we can get right to round two, and, Karen, I think it is your turn to lead off.

DR. BORMAN: Just one quick question, because I support the substance of the recommendations. We are tying the implementation of 2, 3, and 4 to number 1, correct, but not number 5?

MS. AGUIAR: Yes, that's correct.

DR. BORMAN: I just wanted to make sure I was clear.

MR. GRADISON: I just wanted to indicate my

support of all the recommendations and my appreciation for the fine job that has been done by the staff. Thank you.

DR. STUART: I also support the recommendations. I just have one question regarding nursing home certifiable, what that means, and in a sense how PACE providers recruit enrollees or, in fact, do they recruit? Who searches whom here? I'm assuming that we don't have people that have signs on their back that say, "I'm nursing home certifiable," so I'm wondering how this process actually works in practice.

MS. AGUIAR: So we've heard from, again, the PACE sites that we visited, who their referral sources are, and they really do differ. In some of the sites it really is word of mouth. Once they are able -- you know, they went into the business of opening a PACE site because they felt there was a need in the community, and then they get referrals from word of mouth of other PACE enrollees. In other instances, they get referrals from hospitals, and that actually was what tied into the pro-rated recommendation. So it really sort of very much differs. They could get from -- physicians could, you know -- they could get referrals from physicians, from hospital systems, from family members,

from word of mouth, from other participants. It really does vary.

DR. STUART: Is the certification done at the time of enrollment into the PACE program?

MS. AGUIAR: Yes, it is. The way that it works is they'll get a referral, and then the PACE staff have to do a very comprehensive assessment of that person. But then the certification is done by the state, and so, again, there is a lag there, which we have heard from PACE providers that there is a lag sometimes.

DR. STUART: I'm not going to take much more time. A very quick one. Is it possible for a PACE program to actually enroll somebody who is currently in a nursing home?

MS. AGUIAR: You know, I'm not 100 percent sure. I think -- and I'll have to check on that. I don't think there's anything either in statute or regulation that would say that they couldn't do that. I think the issue is the people that enroll in PACE have to be able to live safely in the community, and so if you do have someone who has been in a nursing home, perhaps they have lost their housing, and so it would be -- they would have to make sure that if they were to take the person out of the nursing home that they

could safely treat them in the community.

DR. STUART: This is something you might want to look at because there is a program in -- I believe it's Minnesota that is designed to identify nursing home residents who wish to return to the community and to facilitate that. And if you were to tie that into a PACE program, that would be obviously one way to do that.

MR. GEORGE MILLER: Yes, thank you. I also want to say that I support the recommendations, and I certainly want to thank the staff for doing an excellent job of pulling all this together and then summarizing it. I think this is very good work.

Also, I appreciate when the staff answers Commissioners' questions as you did today, I think that is also very helpful and reminds us of what has taken place, for those of us who have slept since the last meeting.

I do want to challenge the staff to do one thing, and that is, although you said that the cost for PACE is approximately 17 percent more than fee-for-service spending, I don't know if you've had the time to look at the analysis. If those patients were in the PACE program, what would have been the spend on that population of patients so that we

could determine if it may have been greater than the fee-for-service spend because there's no coordination of care like the PACE program does. And I thought I had alluded to that a little bit last time. I may not have been very articulate -- I may not have articulated it appropriately, but I think I've slept since then and got it straight.

MR. ZARABOZO: Well, that 17-percent figure is supposed to be a comparison between what enrollees in PACE are paid compared to what they would have cost in fee-for-service Medicare. That's what that is.

MR. GEORGE MILLER: Okay. So that includes if they had been hospitalized or used other --

MR. ZARABOZO: Right, anything that would have occurred in fee-for-service for that particular kind of person.

MR. GEORGE MILLER: Thank you.

DR. CASTELLANOS: I wholeheartedly support this. Just one clarification. If draft recommendation 1 is implemented or a delay in implementation or whatever happens, we are still going to go ahead and push for the quality reporting irrespective of what happens. Is that right?

MS. AGUIAR: Yes. The fifth draft recommendation is not tied into the first draft recommendation having to happen first.

DR. CASTELLANOS: Right, but there may be a delay in Congress on doing draft recommendation 1.

MS. AGUIAR: Right

DR. CASTELLANOS: But we're still going to push for the quality reporting.

MS. AGUIAR: Right, exactly.

DR. CASTELLANOS: Good job. Thank you.

MS. AGUIAR: Thank you.

DR. NAYLOR: So I also support the recommendations and want to really congratulate the staff on their efforts, both through their site visit work and evidence review to really capture the critical essence of a program that has been demonstrated consistently over multiple studies to do better, to improve quality of life, reduce hospitalizations, improve mortality.

I really in recommendation 1 also appreciate the attention first to getting to the risk adjustment and then to the payment change, and so I really appreciate the language that talks about using the revised system to move

toward implementation of the payment system.

And I also would say that, like all of our recommendations, I hope we will continue to monitor the impact of what happens here on a program that I think serves an important need, albeit to a small community but that can teach us many lessons for care of dual eligibles across this country. So thank you.

DR. HALL: I also support this very strongly. I think this takes this very important program and really mainstreams it now for the emerging number of older people we're going to be seeing over the next 20 years. I think it's a great step forward.

MR. KUHN: I'd just like to add my comments to Christine and the staff for a nice job on this project, and I strongly support the recommendations.

DR. BERENSON: Could you just remind me what the original purpose was of excluding people under 55?

MS. AGUIAR: So that is in the statute, and I actually don't -- I don't know. I can only speculate that when that statute to make PACE permanent, it really was based off of the demos that had gone on before, you know, from On Lock Program, and I don't know if the under 55 was

included in that, but I don't actually know why that cut-off was made.

DR. BERENSON: We haven't heard anybody out there saying there's some reason to keep that, right, all the people you've talked with?

MS. AGUIAR: No, no. And, again, we asked the PACE providers whether or not they thought that this would be -- they would be able to appropriately manage and care for that population. We didn't ask beyond the precedent providers.

DR. BERENSON: Okay.

MS. AGUIAR: So we didn't hear any pushback from the PACE providers on that.

DR. BERENSON: That makes sense to me. I was just curious. In any case, I support these well-thought-out recommendations, and I concur with everybody else about the good work that has been done here. Thanks.

DR. CHERNEW: I also support the recommendations.

MS. BEHROOZI: Yeah, same here. Great work. Like Mary, I appreciate the attention paid to the order of the risk adjustment and the payment change. But with respect to recommendation 5 on quality, I would have a similar concern,

that it be clear that people would be using that data not to compare PACE to some MA plan with a lot less frail people and, you know, younger people or whatever, but that somehow the quality measures would be reflective of what that particular population would otherwise be experiencing, you know, some way of risk-adjusting the quality measures to make it fair.

MR. BUTLER: Just a process question. Most of our recommendations that we vote on get ultimately housed in the March or June report. Last month, we had the letter on SGR. Is this another one-off where we vote, or does this ultimately get housed into a formal report? I know obviously we vote on it publicly.

MR. HACKBARTH: The June report will include a broader look at dual eligibles in these recommendations.

MR. BUTLER: So we're just way ahead of ourselves for once. Okay.

DR. MARK MILLER: And just so you know, the other thing that happens routinely is whenever there's a vote taken and some action is taken, Ariel and Kahlie make sure that the committee staff know that the action is taken. And even though it doesn't get housed and printed until the June

report, you can be assured that the staff know what's going on there. They've been briefed over the last few days and each month before this, and so we'll just send something up to them that says, "By the way, those recommendations you saw? Those were voted on," or whatever the outcome is here. But then it will all be formally written up and put in June.

DR. BAICKER: I support the recommendations.

MS. UCCELLO: Just a quick question first. Does this have any negative impact on state Medicaid programs at all?

MS. AGUIAR: I don't think so, no. This has come up a lot and also in our conversations with some of the other interested groups, the PACE interest groups, that, you know, we're really trying to clean up the Medicare side of the house. There are lots of areas on the Medicaid side that we can't say anything about, so we are only saying on the Medicare side. So none of these would require states to have to also do pro-rated payments or also expand to under 55 or anything like that.

MS. UCCELLO: Okay. Thank you. I'm very supportive of these recommendations and have one suggestion. In draft 4 when we talk about this outlier fund, I would

characterize it more as removing a barrier rather than providing an incentive. It's a subtle difference there, but I think it's somewhat important.

Also, you know, we talk about -- we've spent several meetings now talking about PACE, and sometimes people may wonder, myself included, you know, why we spend so much time talking about a program that covers such a small share of the Medicare population. But I think it's really important that we spend more time on this population and other duals and populations like this because these are some potentially very high spenders. And so they really do deserve our focus, and I think it's appropriate that we've done so.

MR. ARMSTRONG: You could say that our PACE conversations have been well paced, right?

I do want to say I support these recommendations as well. I like the evolution of this program into a more standard application of the MA risk adjustment system, the requirement of the quality reporting, and those changes are terrific.

To Cori's point and points others have made, this is a fairly small slice in a much bigger issue, and in

particular, as we frame this in the broader context, I think we need to remind ourselves, if I have this correct, that we're actually expecting that we are going to be investing in a program that costs the Medicare program more money, 17 percent more than the expenses the Medicare program would have incurred otherwise. And we're believing that there's a good investment on this -- or a good return on this investment, but we're not exactly sure. And as you start expanding this to more and more patients, beneficiaries, we have to really understand how investments in programs like this will actually be part of a solution to a cost problem for dual eligibles. And we haven't really solved that one yet. We think it's good, and obviously these are arguments we make with MA plans more broadly and elsewhere. But I just think there's going to be an opportunity for us as we go toward this June report to continue to reflect on that question.

MS. AGUIAR: The only thing I would say about that -- and I completely agree with you. That's the reason why we tied the expansion to the under 55, the pro-rated, the policies that would cost to the first draft recommendation to reduce the county benchmarks. So it wouldn't be really

an investment from a Medicare financial perspective.

MR. HACKBARTH: So the 17-percent figure is the current where they don't have the MA benchmarks applied to them. They have the old benchmarks, not the new ones. And so we're proposing that they be brought down in conjunction with better risk adjustment.

MR. ARMSTRONG: So maybe I misunderstood, but my sense is whether it's 17 percent or not, this is a richer program, and that the beneficiaries are getting -- we're spending money on this group of beneficiaries, more money than we would if they were not in the PACE program.

MS. AGUIAR: Right, exactly. So now we spend more because of the county benchmarks. That's the issue, because they're not on the MA benchmarks.

MR. ARMSTRONG: Oh.

MS. AGUIAR: So this recommendation would move them to the MA payment system in terms of the benchmarks and the quality bonus, and so that added investment gets into more of the MA versus fee-for-service, which is more Carlos' realm. But that was what precipitated some of -- the first recommendation.

MR. ARMSTRONG: Well, it's a good thing you're a

lot smarter about this than I am.

[Laughter.]

MR. ARMSTRONG: But I still think that there is this whole idea of if we believe a solution to the big issues we have around managing care for and the expense trends for dual eligibles comes from investing in these more holistic programs, at some point we really have to understand where really is the return on that investment and how do we think about that as we go forward with this. And we want to believe. We like this. I really like this. But I just think that's a question we're going to have to keep in front of us as we go forward.

DR. STUART: I think you can still look at this in a return-on-investment perspective if you include Medicaid because, after all, these are nursing home-certifiable enrollees, and to the extent that you're reducing nursing home admissions among these individuals, they're not going to be Medicare nursing home admissions but Medicaid nursing home admissions. So, overall, there could be some savings, and I know there have been some studies that have looked at that. So that might be just something that you'd want to add to the report.

MR. HACKBARTH: Okay. I think it's time to vote. So, Christine, would you put up recommendation 1? All in favor of recommendation 1, please raise your hand. Opposed? Abstentions?

Okay. Recommendation 2? All in favor of number 2 -- do you want to put that one up, Christine, in case somebody wants to read it? Okay. Opposed to recommendation 2? Abstentions?

Number 3, all in favor? Opposed? Abstentions?

Okay. Number 4, all in favor? Opposed? Abstentions?

And number 5, all in favor? No one is opposed and no abstentions.

Thank you. Well done. I appreciate your work on this.

Let's see. So next is Medicare's payment system for skilled nursing facilities.

[Pause.]

DR. CARTER: Okay. The payment system Medicare uses to pay skilled nursing facilities needs to be reformed. The program's payments to SNFs have been consistently high relative to facility costs for 10 years, and in this past

year's update, the Commission stated that it would examine whether Medicare's payments need to be rebased. The first reform we'll talk about is about that need to rebase payments. Aside from the level of payments, the Commission already recommended changes to the prospective payment system that would affect the distribution of payments. Those changes would address the shortcomings of the PPS that result in widely varying financial performance based in part on the mix of patients a facility treats. Rebasing would address the level of payments.

Another possible reform would address the lack of an incentive to avoid unnecessary hospitalizations, which raise program spending and expose beneficiaries to care transitions that can result in poor patient outcomes. The Commission discussed the need to align incentives between hospitals and SNFs to discourage unnecessary hospitalizations from SNFs.

There are three reasons to consider rebasing payments. First, Medicare margins are high and have been since 2000. Second, there is a large variation in cost per day that is not related to wages, case mix, or beneficiary characteristics. And, last, some providers manage to have

relatively low costs and furnish relatively high quality, suggesting that payments could be lowered.

In this chart, we're looking at the trends in costs and payments between 1999 and 2009, and you can see that the cumulative increase in payments increased 68 percent while costs rose 40 percent. Increases in payments have far exceeded the updates facilities have received during this period. The GAO and the OIG found that the original PPS rates were relatively generous because they were based on costs incurred during a period when only routine costs had limits on them. The mix of facilities was also different in the base year, with a much higher share of high-cost hospital-based facilities than the current mix of facilities.

SNF margins have remained above 10 percent since 2000. In red is the median, with the 25th and 75th percentiles also shown. Margins rose quickly after payments were added by the BBRA and BIPA and then declined when some of the additions expired. The revised case mix groups implemented in 2006 have led to higher Medicare margins. Since 2006, average profits have risen from $49 a day to $79 a day in 2009. To understand this increasing profitability,

we looked separately at trends in costs and payments.

After adjusting for wages and case mix, costs for freestanding SNFs with the largest increases -- those are the ones in the top 25th percentile of cost growth -- grew an average of 66 percent, while standardized costs declined for SNFs with the smallest growth. These differences in cost growth are not explained by the amount of intensive therapy or medically complex days or their patient demographics -- that is, the shares of dual-eligible, very old, or minority beneficiaries that they serve. In fact, facilities with the lowest cost growth had a higher case mix than the high-growth group.

Facilities managed their costs per day by increasing their length of stay (which spreads their fixed costs), having higher census, and providing therapy to more than one beneficiary at once. Since 2002, the average length of stay has increased 11 percent. Facilities with the highest cost growth still had Medicare margins over 14 percent in 2009, indicating that the PPS exerts little fiscal pressure on facilities.

Looking at 2009, the costs per day in freestanding SNFs varied 30 percent between the 25th and 75th percentiles

after adjusting for wages and case mix. This variation was the same for SNFs by ownership group and their shares of dual-eligible beneficiaries, minority, and very old beneficiaries. These findings suggest that the variation is not related to location, case mix, ownership, or beneficiary demographics.

Turning to revenues, we found that SNFs with the highest growth in revenues had almost double the share of intensive therapy days compared to SNFs with low revenue growth, even though their patient mixes were similar in terms of average case mix and shares of dual-eligible beneficiaries, minority, and very old. Facilities in this high-growth group had median Medicare margins of 23 percent compared to 14 percent for the low-growth group. While patient frailty has increased over time, those changes were nowhere near the changes in the amount of therapy provided. Between 2006 and 2009, at admission, patients' ability to perform activities of daily living (as measured by the Barthel score) declined 5 percent, and their cognitive function declined 3 percent, while intensive therapy days during this period increased 36 percent. Beneficiary age and diagnoses are virtually unchanged. While shorter

hospital stays would shift some therapy provision to the SNF sector, the growth in the therapy days far outpaced this shift. Facilities paid more attention to furnishing just enough therapy to qualify patients into the next highest case mix group. And because of the way assessment periods work for establishing payment rates, facilities would continue to get paid for one level of therapy care even after that level was no longer being provided.

Another piece of evidence that payment levels are too high is the work we have done on the efficient provider. We identify a group of facilities that have consistently relatively low costs and relatively high quality for three years in a row and then look at that group's performance in subsequent years. Compared to the average, these relatively efficient SNFs had community discharge rates that were 29 percent higher and rehospitalization rates that were 16 percent lower. On the cost side, relatively efficient SNFs had costs per day (after adjusting for differences in wages and case mix) that were 10 percent lower than other SNFs.

Before we look at some rebasing options, I wanted to make a couple of points about the current Medicare environment. You may be aware that CMS lowered payment

rates to SNFs by 11 percent this fiscal year. This reduction represented a correction to overpayments that had resulted when CMS implemented the new case mix groups the year before. When any new classification system is implemented, payments should be the same under the new system as they would have been under the old one. However, the changes to the case mix system generated almost $4.5 billion in spending. To re-establish budget neutrality, payment rates were lowered, but they were lowered from the level that had been set too high. Even after the reduction, payments are higher than they were two years ago -- before the increase and then decrease in rates.

By lowering payments, rebasing will put some SNFs that are now profitable in the red and those that are already losing on Medicare further away from breaking even. We looked at the characteristics of SNFs with negative margins and found that their costs were 30 percent higher than other SNFs' after adjusting for wages and case mix. To the extent that their losses are due to higher costs, rebasing the PPS will further erode their Medicare margins. If these SNFs could not lower their costs under fiscal pressure, some facilities might cede market share to more

efficient SNFs. However, some SNFs with negative Medicare margins tended to furnish less intensive therapy than other SNFs. This is consistent with our findings that the PPS systematically disadvantages SNFs that do not furnish a lot of therapy. To the extent that the financial performance of SNFs with negative margins is rooted in their mix of patients, a revised PPS that would base payments on patient and stay characteristics would redistribute payments more equitably across SNFs and narrow the disparities in financial performance.

To give a sense of the impacts of rebasing, we modeled margins in 2009 if payments had been lowered under three options: a 5-percent reduction in payments, and setting payments at the 75th and 70th percentiles of the distribution of the cost per day. Looking down the rows, you can see the margins that would result with each level of rebasing. I should point out that these estimated margins are higher than what we would see in 2013 because by then there will have been two years of productivity adjustments that will lower their payments, and those are applied against the updates. We will also need to consider how the industry responds to the productivity adjustments, which may

slow their cost growth. For December, we plan to model margins in 2013 under various cost growth and rebasing assumptions. While rebasing would lower payments, we wanted to remind you that a revised PPS would redistribute payments across SNFs.

Here you can see the estimates of the impact a revised PPS would have payments. We compared payments under current policy with payments under a revised PPS. These results are consistent with the results we reported in 2008. I should point out that, on net, aggregate payments would not change; they only get redistributed. A revised PPS would lower payments to SNFs with high shares of rehabilitation patients. For example, we estimate that payments would be 5 percent lower for SNFs that treat high shares of rehabilitation cases -- those are in the top 10th percentile of cases -- and raise payments to SNFs with low shares by 13 percent. There are even larger differences for SNFs with the highest and lowest shares of intensive therapy cases -- those in the ultra high and very high case mix groups. Payments would shift from SNFs that don't treat many medically complex cases to SNFs that do. Here I've shown SNFs that treat high and low shares of special care

cases, but the trends were similar for clinically complex cases. The impacts illustrate how a revised PPS could redistribute payments across SNFs based on the mix of patients they treat. As such, we think that rebasing should be accompanied by revising the PPS. We will come back to you in December with estimates of rebased options in combination with the revised PPS.

The goal of rebasing is to set the level of payments that balances the desire to increase the fiscal pressure on facilities while maintaining beneficiary access without rewarding inefficiency. The option is to rebase SNF payments that would better align payments with costs. Because this would not correct the known shortcomings in the PPS, the option would also revise the PPS to base therapy payments on patient and stay characteristics, establish a separate non-therapy ancillary component, and implement an outlier policy. The Commission will continue to assess the financial performance and access to care and may make future recommendations if needed.

Now let's turn to our second possible --

DR. MARK MILLER: Can I just add one thing?

DR. CARTER: Sure.

DR. MARK MILLER: For those of you who have been on the Commission a little bit longer, this second -- the therapy, the NTA component, and the outlier -- these are the recommendations we made a few years ago, so we're saying the rebasing would be done in the presence of those recommendations. So the Commission has already worked through the second half of this.

DR. CARTER: Yes, you made those recommendations back in 2008.

So the second possible reform has to do with a rehospitalization policy. Last year, the Commission stated that it would examine a rehospitalization policy for SNFs as one way to improve care for beneficiaries and to lower Medicare spending. Avoidable rehospitalizations of SNF patients expose beneficiaries to hospital-acquired infections and poor care transitions. Under current policy, SNFs have a financial incentive to transfer high-cost patients to a hospital, even those with conditions that typically can be managed in a SNF. The variation in risk-adjusted rates suggests that lower rates are possible. A rehospitalization policy for SNFs would align hospital and SNF policies to improve the transitions between the two

settings.

MedPAC reports the rate of risk-adjusted potentially avoidable rehospitalizations for five conditions, and those are respiratory infections, congestive heart failure, kidney and urinary tract infections, electrolyte imbalance/dehydration, and sepsis. Those five conditions make up about three-quarters of the rehospitalizations from SNFs.

These rates vary 60 percent between the 25th and 75th percentiles, and there is an almost three-fold difference between the 10th and 90th percentiles. The median rate for hospital-based facilities was almost half that of freestandings. Hospital-based facilities have lower rates in part because they have ready access to ancillary services, without the need to readmit patients. Compared to other SNFs, those with the highest rehospitalization rates had similar shares of medically complex days. They also had higher shares of dual-eligible beneficiaries. This is consistent with another study's finding that all-cause rehospitalization rates were more than a third higher for nursing home residents compared to those who had resided in the community. We also found that facilities with the

highest rates were disproportionately for-profit. On average, for-profit facilities had rates that were 25 percent higher than nonprofit facilities.

We also found that some facilities have consistently high and low risk-adjusted rates. For example, we found over 900 facilities that were in the worst quartile of rates three years in a row, and 200 of those were in the worst 10th percentile three years in a row.

Many factors that influence rehospitalization rates are within a SNF's control, and these are listed on the slide. They include transition care, drug mismanagement, the use of hospice and advance directives, staffing and physician presence, the financial incentive to rehospitalize, and local practice patterns. Family, patient, and staff preferences also play a role in the decision to rehospitalize.

A rehospitalization policy could prompt facilities to ensure good care transitions, improve their medication management, ensure adequate staffing especially at night and on weekends, and ensure families and patients are aware of their options regarding advance directives and hospice.

Consistent with the Commission's past

recommendations for a hospital readmission policy, a rehospitalization for SNFs would include potentially avoidable conditions. By being focused on select conditions, the measure would give direction to providers about which care processes need improvement.

The time period should start with a measure that covers the entire length of the SNF stay. This would hold the SNF accountable for care throughout the beneficiary's stay and does not encourage SNFs to delay rehospitalizations until after the measure's time period is over. Starting with this measure would allow a policy to be implemented relatively quickly because CMS and MedPAC have both have risk-adjusted models for the SNF portion of the stay. In the future, the measure could be expanded to include 30 days after discharge from the SNF to encourage facilities to ensure effective care transitions for patients going home. This phased approach would allow CMS to move forward with a policy and begin to lower rates while a risk-adjusted measure that includes 30 days post discharge is developed. CMS will need to monitor provider behavior after the measurement window to ensure providers are not shifting care to beyond the window.

In terms of the penalty, the penalty would target facilities with above average rates over three years. Relative performance has the key advantage of not assuming every hospitalization is avoidable. Basing a penalty on a pattern of performance avoids penalizing providers for one bad year.

For consistency with the hospital policy, a penalty could range up to 3 percent. And, last, these rates should be publicly reported so that providers can gauge their relative performance and beneficiaries may use this information in selecting a post acute-care provider.

This policy option would reduce payments to SNFs with relatively high rehospitalization rates for select conditions. An initial measure would include risk-adjusted rates of potentially avoidable rehospitalizations during the SNF stay. The measure could be expanded to include 30 days after discharge from the SNF once a risk-adjusted measure is available.

With that, I'll end my presentation, and we've posed three questions:

The first is: Do you have any questions about the rebasing or rehospitalization policies?

The second: Is there additional information you would need to further develop these policies?

And, third, what level of rebasing should we be thinking about?

MR. HACKBARTH: Thank you, Carol [off microphone]. Karen, I think you were up for clarifying -- oh, no. Scott's champing at the bit to ask a clarifying question.

MR. ARMSTRONG: Just one. The recent changes in payment for -- or nonpayment to hospitals for readmissions, do we have a sense for -- I mean, how does that interact with the second policy proposal here? Would that potentially mitigate some of the impact of what we would be trying to do in payment policy change for the SNFs? Do we have a sense for how that would interact?

DR. CARTER: Well, right now a hospital obviously gets penalized for the readmission, but right now the SNF is not held accountable for that. So if the patient does come from the SNF, the SNF is not being held accountable for that. So this is trying to align those.

MR. ARMSTRONG: That I get. I just was wondering -- and maybe it's really beyond the scope of this analysis, and I think actually part of what we're acknowledging is

that we are the global payer, but we deal with payment policy within these different silos. And so maybe that's just the reality of this. But it just seems to me that there is an incentive that didn't exist a couple of years ago for hospitals to manage the readmission rate, and it may have some impact which could mitigate the impact of this second policy here. But I just didn't know if we had tried to take any of that into account, and it sounds like we really haven't.

DR. CARTER: We haven't. I mean, we've thought a little bit about how the windows overlap or don't overlap, but we haven't looked at kind of the relative -- what's going on with each of those sectors.

MR. ARMSTRONG: Okay. Thanks.

MR. HACKBARTH: There are a couple different ways to look at this readmission policy. One is strictly in terms of this silo and its impact on payments for skilled nursing facility care. The way I'm more inclined to look at it, though, is that when, say, Peter is trying to figure out how to reduce hospital readmissions, I want to make sure he's got eager partners out there in the post acute-care community who are aligned with that goal, and lining up

these policies is important in that regard.

MR. ARMSTRONG: So, in fact, that's more important than making sure our estimated impact of this new policy is really accurate within the SNF payment.

MR. HACKBARTH: Yeah.

DR. MARK MILLER: Also, the way I take Scott's comment is if the baseline on SNF readmissions before the hospital policy was up here and the hospital policy pulled it down a bit, then putting this policy in place may not have quite the effect. And, you know, that will end up getting estimated under new baselines at CBO and all that in the presence of the hospital policy, and from a program perspective, you get the benefit one way or the other. Either the hospitalization doesn't occur or the penalty applies. But it probably means the baseline been affected a bit, and that's the way I took your initial comment, and I think you're probably right about that. But I don't think it's zero left out there.

MS. UCCELLO: On Slide 6, it says that SNFs can manage their costs by increasing the length of stay. But then when we compare the relatively efficient SNFs versus others, the efficient ones have lower lengths of stay. So I

was just wondering how that jibed.

DR. CARTER: Well, one's an average for the whole industry, and the efficient providers is a discrete subset. It's only 9 percent of the facilities, so you're right in the sense that they seem to have different patterns. But --

MS. UCCELLO: That's just the way it is.

DR. CARTER: That's just the way it is.

DR. BAICKER: I was interested to learn that the case mix doesn't go very far in explaining a lot of variation that we see, and I wondered if you had a sense of how big a role patient risk adjusters play in the probability of readmission and whether we're able to adjust -- whether you think that having adequate risk adjusters is within our grasp, and if it's not, how much of a problem do you think that will pose in terms of penalizing those who enroll the sickest.

DR. CARTER: These are risk-adjusted rates. We have worked with the contractor to develop a risk-adjusted rate, and we've revised them once. I think they're pretty good in terms of the risk adjustment model. It has 17 co-morbidities, and it includes things like presence of catheters and tube-feeding and pressure sores and DNR. I

think it's pretty robust.

DR. BAICKER: Those end up being good predictors of future readmission?

DR. CARTER: Yes, they're pretty good.

MR. BUTLER: Sorry for the audience, but Table 5 in the text is not in front of us in this presentation, but it has important data, I think. You separate the SNFs with negative margins from those with positive margins, and the ones with negative margins are 10-percent loss on Medicare, and the ones with positive margins are 20-percent profit.

So what's not synching up for me, in the hospital world we looked at these and we say if you're financially -- the financially stressed organizations have found a way to make money on Medicare; therefore, the efficient -- you know, we could maybe do something with the rates. Here I'm sitting there, and you say if you have a 10-percent negative margin on Medicare, how are you even staying in business? Because the payer mix isn't different between the -- you've still got 60 percent Medicaid. How are these places staying afloat? If they have a 10-percent loss on the Medicare side alone, I think that they'd be in deep trouble overall. I know it's a little bit of a round two, but it doesn't add up

to me.

DR. CARTER: I wish that we had sort of the private payer rates. We don't have that, and the cost report doesn't -- it only has Medicare and non-Medicare. We cannot sort of tease out, because, you're right, the Medicaid shares are similar. And so I'm wondering about kind of what's happening with the private pay rate.

MR. BUTLER: But at least 69 percent here is Medicare/Medicaid, and I don't know if dual eligibles is in addition to that or are they part of the Medicare -- anyway, you don't have a lot of private pay to draw upon, that's for sure, any way you look at it. Okay. That's one question.

Then the other is the cost differences. My impression is in skilled nursing care there's probably as a percentage of costs, there's less variable costs maybe than, say, in hospitals because you don't have all the supplies and other things. So you've got the cost of the plant, and then you've got the cost of the staff. Do we have any idea in these cost differences what might be due to kind of the fixed versus the variable -- and maybe that's, again, a round two, something to kind of understand how some are more efficient than others. And is it realistic, therefore, if

they strap things down and become more productive from a staffing standpoint, they might be able to make it, is different from, you know, having a fixed plant and other costs that are kind of not too hard to adjust.

MR. HACKBARTH: Go ahead, Carol. I'll let you go first.

DR. CARTER: I haven't looked at fixed and variable. I did compare sort of the routine versus ancillary, but that's still a different question than what you're asking. I haven't looked at that. I'm looking a little bit at Craig, because we could look at sort of the overhead shares, which I know vary considerably across facilities, but it's still different than fixed and variable. I'm not sure I can get a good read on that from the cost reports.

MR. BUTLER: You should be able to separate the overhead from the --

DR. CARTER: Yes, I can certainly separate the overhead.

MR. ARMSTRONG: It's different from routine versus ancillary --

DR. CARTER: Right.

MR. ARMSTRONG: -- because both have overhead in them.

DR. CARTER: Right.

MR. HACKBARTH: So related to both of your points, Carol, do we know what percentage -- going back to Table 5 -- what percentage of those SNFs in the negative margin column are hospital-based SNFs?

DR. CARTER: This is only data for the freestanding.

MR. HACKBARTH: Okay.

DR. CARTER: So hospital-based in general is about six percent of the industry. This column is the 13 percent of facilities that lose money for the freestanding facilities.

MR. HACKBARTH: Okay.

DR. MARK MILLER: And then the only thing I can think of for Peter's initial question, the other thing you can have is this is a one-year snapshot, right, so perhaps it's not minus-ten the next year, because if it's consistently year over year, it's really hard to see how they stay in business, but whether there's some variability. And then the other side of it is the private pay, which we

have a hard time seeing.

MR. ARMSTRONG: So what I'm obviously trying to get at, how much, with the right management, the right systems, the right staffing, you know, they can stay in business, the access won't be an issue, versus they're structurally never going to get from here to there.

MS. BEHROOZI: I think my question is related and I hope it hasn't already been answered. Carol, the average costs for those low-margin or money losing SNFs was 30 percent higher, you said, right? Do you know what the variation in that range of costs is? I mean, is their negative margin really all about their costs or is it about -- is there something about the payment system, because also, the bigger -- the biggest differentiation is in the intensive therapy mix of days, right?

DR. CARTER: Right. I mean, I think it's both a cost structure and a revenue difference, but I haven't looked at the variation in costs for the SNFs that lose money and I can do that.

DR. CHERNEW: I have a very basic question about risk adjustment. When you do risk adjustment, you could have a lot of things on the left-hand side. You could have

spending, or you could have probability of readmission, or you could have a whole bunch of things. It seems like we have the word risk adjustment here and coming throughout, but sometimes we say these are the same patients risk-wise and we are talking about spending, and other times we are saying these are the same patients risk-wise and we are talking about readmissions.

So my question is, are there different risk models for predicting the risk of different outcomes, or is there basically one risk model and we just talk about that like risk is for all, and if the latter, what's on the left-hand side of that risk model?

DR. CARTER: Okay. So these are different risk models. When I standardize for costs, I using the nursing component of the case mix. The SNF payment system doesn't have one neat CMI like in the hospital world. It has one for the nursing and one for the therapy, and I don't use the therapy because providers can control that. And so we're really -- they do tend to vary with nursing, but the nursing component is separate and it's based on nursing time. So that's what we use to standardize for cost. On the --

DR. CHERNEW: So risk adjust -- by standard the

cost, you mean to risk adjust. When you say the spending is the same risk adjusted, you mean you're using a model of risk adjustment that's based on the, I think you call it NTA, or the nursing --

DR. CARTER: Just the nursing.

DR. CHERNEW: Just -- okay --

DR. CARTER: Right. It's based on the nursing components, the CMI.

DR. CHERNEW: All right.

DR. CARTER: Right. The hospital, rehospitalization risk adjustment model is what I was talking about before, and it has -- it's comorbidities, sort of the presence of catheters and tube feeding and pressure ulcers and stuff like that.

DR. CHERNEW: And the dependent variable is did you get sent back to the hospital, so --

DR. CARTER: Yes.

DR. CHERNEW: Okay.

DR. MARK MILLER: We built that one ourselves with a contractor, whereas the standardization of costs is using the payment system.

DR. CARTER: Right.

MR. HACKBARTH: So in the same vein, when you were talking with Kate, I think I heard you say patient characteristics don't explain variation in cost very well, but then later say that the risk adjustment does work pretty well for readmission to the hospital. Did I hear that correctly?

DR. CARTER: Yes, you did.

MR. HACKBARTH: And so just to put this in Mike's framework, so using patient characteristics, which is to me a layman risk adjustment, is not very good at predicting variation in cost per day for a skilled nursing facility, but we do have a risk adjustment model which is pretty good at predicting the risk of readmission to the hospital. Did I follow that correctly?

DR. CARTER: You did, and when I was talking about how we can't explain cost differences, I tried to separate out that the case mix index doesn't explain those costs because we've standardized for that. But we also looked at the cost differences between dual and sort of for facilities that have lots of duals, that have lots of old, really old benes and minority benes, and we still didn't see that those cost differences. So when I said patient characteristics, I

was talking about some of those demographic characteristics but also the CMI.

MR. HACKBARTH: Yes. Kate.

MS. BLONIARZ: And I was trying to distinguish -- not sure that I did so effectively -- between being able to predict at an individual level which patients are more likely to get rehospitalized versus explaining variation across SNFs in the rate of rehospitalization. So what I understood is that we can do a reasonably good job at predicting who is going to be rehospitalized, which is important because then those risk adjustors are going to inoculate SNFs against being penalized for taking patients that are just worse off, but then it doesn't -- there is still a lot of variation in rehospitalization left, meaning SNFs are then performing differently conditional on that mix of patients they happen to grab.

DR. MARK MILLER: I think that's right, and -- oh, Carol.

DR. CARTER: No. I think the R-squared on the rehospitalization is about 0.6 or 0.7, so it's pretty good. I mean, I took that as pretty good. Yes.

DR. MARK MILLER: And to the extent, though, that

there is still unexplained variation, remember, the rest of the policy is, okay, we're going to look at rates over time for the SNF, not case by case, and so you kind of build in some cushion that way.

DR. BERENSON: Yes. I'm back at a basic question, also. I get confused about sort of the terminology of a skilled nursing facility, basically. The Table 5 in the handout and the paper is the finances of an institution that is a nursing home that includes patients who have SNF benefits from Medicare, right? I mean, that is what we're referring to as a skilled nursing facility?

DR. CARTER: Yes.

DR. BERENSON: Okay.

DR. CARTER: So I would say 95 percent of facilities also are a SNF and a nursing home, but there's a small share of facilities that are only Medicaid and a small share that are only Medicaid.

DR. BERENSON: Okay. So I got that far. So then when we have Medicare days are only about nine or 12 percent, or about ten percent, and Medicaid is about 50 percent, and duals are about a third, it's telling me that the duals are mostly being covered for their residential

stays by Medicaid and some portion of that ten percent Medicare is for duals, right? Is that basically right?

DR. CARTER: Yes, but we're only looking at the Part A benefit side of things. So this is while they're in a Part A covered stay.

DR. BERENSON: All right. What percentage are Medicare only, not duals? Do we know that, in terms of the payer mix -- beneficiary mix? Is it small, very small, or -

DR. CARTER: It's small.

DR. BERENSON: Okay.

DR. CARTER: Yes.

DR. BERENSON: And I guess where I'm ultimately going with that background is do we know on the readmission or -- yes, the readmissions, the rehospitalization policy, where people go after a SNF stay, what percentage stay in that same facility, versus going to their home, versus going to a residential community?

DR. CARTER: I don't have that with me, but I have it. I can get back to you on that, yes.

DR. BERENSON: I think that would be important for the few -- I mean, I'm all for aligning the incentives -- well, this is around two things. I'll come back to that.

I'll explain why I'm asking this in the second round.

DR. CARTER: Okay.

MR. KUHN: We're real excited about hearing round two, Bob.

[Laughter.]

MR. KUHN: Two quick questions, Carol. One, kind of picking up where Scott was going a little bit, he was talking about the hospital readmission activity that was part of PPACA. I'm curious about ACOs and the final rule that CMS put out there. Do we know or did they estimate -- the Office of the Actuary estimate how much they thought how much ACOs would help curb rehospitalizations from SNFs?

DR. CARTER: The straight answer is I don't know -

MR. KUHN: Okay.

DR. CARTER: -- and so --

MR. KUHN: And then the second question, on Slide 9 where you were talking about the payment reductions that were in this final SNF rule, the 11 percent, you had -- we'd also had in the paper where we talked about -- where it was talked about where CMS has tried to curb therapy services in the past and has met with uneven success in that. So 11 percent is what CBO scored or where OAC scored where they

think they are. Do we have any estimates or is there any kind of conversation of what folks think the actual real savings might be as a result of that? I mean, are people already thinking about work-arounds to get around these new changes that are out there?

DR. CARTER: I haven't talked to a lot of people about that. I have heard that the estimated impacts will be smaller, but I haven't really looked into that.

DR. HALL: We've used the word "variation" quite a bit as we've gone around the room, but what about regional variation?

DR. CARTER: In rehospitalization?

DR. HALL: And just in rates, for example, or margins, I should say. How do we know this isn't being differentially skewed because of some large urban areas that have --

DR. CARTER: Well, these are standardized for wages, so at least the differences in wage rates have been taken out --

DR. HALL: Mm-hmm.

DR. CARTER: -- in terms of the variation in cost. We do see considerable variation in the rehospitalization

rates --

DR. HALL: Right.

DR. CARTER: -- with much lower rates in sort of the Dakotas, Montana, Wyomings of the world, and that, in part, is because they have a higher share of their SNFs are hospital-based and so those facilities have much lower rehospitalization rates and so it pulls down their State average. I think there's about a two-fold variation in the State rehospitalization rates.

DR. HALL: Because every time we've looked at almost any sort of medical phenomenon, whether it's hospital admissions, operative procedures, there's just incredible regional variation that -- I guess the one thing we don't want to do is compromise areas that are doing a good job and have sort of a different economic model that they have to face, but --

DR. CARTER: Well, I do think if you implement a policy where you're targeting folks with above average, then you won't be disadvantaging facilities that are already doing a good job.

DR. HALL: Okay.

MR. HACKBARTH: Carol, do we know anything about

variation in use of therapy across regions?

DR. CARTER: I haven't looked at that.

MR. HACKBARTH: Okay.

DR. CARTER: So no.

MR. HACKBARTH: All right. Mary.

DR. NAYLOR: So the readmission rate for skilled nursing facility Medicare beneficiaries hasn't -- in the five conditions that you followed, as I understand it, hasn't changed much in ten years. It's somewhere between 13 and 14 percent for those five. What's the all-cause -- in 30 days -- all-cause readmission rate for those beneficiaries?

DR. CARTER: I don't know, and if I reported it to you, I would be using other folks' studies.

DR. NAYLOR: I mean, I --

DR. CARTER: We don't calculate that.

DR. NAYLOR: Because I'm trying to put the perspective of --

DR. CARTER: I mean, it would be higher, obviously, right, because it's including any reason somebody goes back to the hospital.

DR. NAYLOR: So it would obviously be higher than

13, but we know all cause for all Medicare beneficiaries is somewhere between 19 and 20.

DR. CARTER: Mm-hmm.

DR. NAYLOR: So I'm trying to put where -- how big a problem is this for -- in terms of readmission rates.

The other thing is, do you have any sense, in the notion of rebasing, if -- a lot of the recommendations around how we could get to better care and outcomes for this group, at least evidence-based, such as EverCare, use nurse practitioners or physicians assistants, et cetera. So the question is would rebasing position us -- I mean, how would it affect our ability to address and implement some of the kinds of solutions that we know can result in avoiding rehospitalization and improve care outcomes?

DR. CARTER: We look at sort of whether facilities with low costs are also able to have relatively good quality and we do find facilities that manage both of those. And so I guess I think of it as does rebasing have to affect quality, and I guess I don't necessarily get there, because we can identify providers that manage to maintain -- to manage their costs and maintain good quality.

DR. NAYLOR: So I will get back to that. And the

last thing, in terms of tracking, I think it would be great if, and you may already know this, the idea of what's happening at State levels to transition people from nursing homes back to the community and what has that done in terms of the population, and the only reason I say that is I think it's about 70 percent of the people in skilled nursing facilities are going to long-term care. I don't know if they're going back to the same long-term care facility, but a very high proportion of this population. So to know what's happening in terms of the long-term care population might have some bearing on policies related to skilled nursing facilities.

DR. CARTER: States obviously vary in terms of how aggressive they've tried to move their long-term care residential population into the community, so there's sort of the States have done differing kind of strategies and really effort to rebalance their long-term care dollar in terms of the in-facilities versus home and community-based services. We know that nursing homes with bed hold policies, I mean, States that have bed hold policies, that really affects their hospitalization rates, but that's still different than what we're looking at, which is when somebody

-- let's say it's a long-term care patient and they get hospitalized. Now they may be in a Part A stay. That's what we're looking at now, is the Part A stay and how likely are they to be rehospitalized. And even if they're sicker, we're risk adjusting for that, and so I don't know that it would necessarily affect the rates of rehospitalization that we're looking at, because we are trying to control for the complexity of the patient.

MR. HACKBARTH: If a patient is a long-term resident in, say, a nursing home, they have a hospitalization and they receive SNF care, would the probability of rehospitalization be affected by the fact that rather than going home where they may have very little in the way of supports, their home is a nursing home? Without really knowing anything, it seems like it may even reduce the risk of rehospitalization if they live in a place where they've got supports beyond what most people have at home. Just a thought.

DR. CARTER: Mm-hmm.

DR. NAYLOR: Another alternative is that the people who are remaining in the long-term care -- so it's counterintuitive to me, but the patient characteristics

don't matter. I mean, are, in fact, sicker, higher cognitive impairment. But you are saying they --

MR. HACKBARTH: [Off microphone.] I didn't say they don't matter, but that we adjust for differences in patient characteristics.

DR. CARTER: Mm-hmm. Mm-hmm.

MR. HACKBARTH: Ron.

DR. CASTELLANOS: Confusing subject. Just for clarification, go to Slide 6 for a second. What I'm seeing, and I keep saying the real world experiences, and I think Peter will agree and George will agree that patients in the hospital today are getting out of the hospital into a lower-cost setting, case managers, et cetera, and a lot of these patients, especially the orthopedic and joint replacement patients, used to go into a rehab hospital, but now because of the 75 percent rule they're going into other low-cost settings. What I'm seeing is that -- you mentioned the cost growth. You adjusted this for patient mix and for risk adjustment also?

DR. CARTER: No, these have been adjusted by the nursing component of the -- you know, the case mix index associated with the nursing component, and we looked at

differences in duals and minority and --

DR. CASTELLANOS: Okay --

DR. CARTER: -- but it's not risk adjusted in the same way that I was talking about before.

DR. CASTELLANOS: Okay. It's not risk adjusted --

DR. CARTER: Right.

DR. CASTELLANOS: Okay. That explains that. I think we all agree that the patients going into a SNF today or into some post-acute setting are a little sicker now than they have been in the past --

DR. CARTER: Well, we actually looked at that, and when I look at the Barthel scores for incoming patients, they are a little sicker, but they're not -- that doesn't explain the increases in therapy and stuff that we're seeing. So it's true they have -- they are a little sicker. They have fewer abilities to perform ADLs and their cognitive function is a little worse, but it's not commensurate with what we're seeing on the payment side.

DR. CASTELLANOS: I think on the next slide, 7, you kind of answered that by saying that it was not commensurate with increased therapy, but these people are requiring that. I know the orthopedic guys are because

they're increasing the level of therapy. I just see a disconnect with what you're saying and perhaps maybe what I'm saying in the real world. I'm just saying that, Carol. I'm not criticizing you, but I'm just saying --

DR. CARTER: I don't feel criticized.

DR. CASTELLANOS: -- I'm saying this in the real world.

DR. CARTER: Yes. I mean, and also, the other thing when we look at the DRGs for, like, hip replacement, those -- the biggest impact was on the home health as opposed to SNFs. Actually, they really had much more of an increase in those patients than the SNFs did.

DR. CASTELLANOS: That's what I said. Any of the post-acute settings --

DR. CARTER: Yes.

DR. CASTELLANOS: -- I'm sure there's going to be increased settings. But I just thought it would be reflected here, also.

MR. HACKBARTH: So, Ron, just let me pick up on one thing that you said. So I don't think there's any question that, in fact, the patients are getting more therapy. In fact, what the data seem to indicate, that they

are getting more therapy, in part because it's very profitable.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: And so the reason I think it's related to profitability is that you see how quickly people respond to differences in the thresholds and how you qualify for higher payment levels. They are acutely sensitive in terms of the amount of therapy provided to where they get more money or less money.

DR. CASTELLANOS: I guess I'm saying that they're getting more therapy appropriately, not because of --

MR. HACKBARTH: And what I'm saying is that you wouldn't expect to see this pattern of the amount of therapy changing dramatically in response to payment changes if this was all clinically driven.

DR. CASTELLANOS: I think you -- I understand that. Thank you.

MR. GEORGE MILLER: Yes. You just said what I started to say, because this is an example, at least in my opinion, of looking at silos versus looking at where service is given. And since we saw the same issue, or the same type of response to payment in the home care business, especially

around the intensity of therapy, would lead us -- at least lead me in my mind to think that we need to look at more than just silos. We took the SNF, we did the home care, but dealing with this across silos so that we can have that impact and probably be ahead of the curve on policy changes.

But just to respond to Ron, my question has to do with Slide No. 12. Do we have -- and that's the definition that was very well done in the paper of efficient provider. But do we know demographically what that efficient provider looks like? Do we have a model of that, and are they located in rural areas or urban areas or suburban areas and what their case mix would be in their patient population? I should look at Carol.

DR. CARTER: I can get back to you on that. So sort of who's in that circle?

MR. GEORGE MILLER: Yes, who's in that circle, and is there something that we can learn from them? Are they all for-profits? Are they all not-for-profits, although the data --

DR. CARTER: I don't have that in front of me.

MR. GEORGE MILLER: Yes. The data wouldn't say they're not-for-profit.

DR. CARTER: Mm-hmm.

MR. GEORGE MILLER: That would be interesting to know. And the follow-up, is there something we could learn from them? And it seems, if I remember the data correctly, they did not use a high level of therapy disproportionately than the numbers we saw on the previous slide, if I remember correctly from the efficiency --

DR. CARTER: I will have to get back to you on that.

MR. GEORGE MILLER: Yes. That would be interesting to find out. I could be wrong. Thank you.

MR. GRADISON: Is it fair to say that the changes you were recommending would at least maintain the access to care that we have today and maybe even improve it, or do you think it might have an impact in perhaps affecting the amount of certain therapies that are made available and the intensity of the care that's actually given?

DR. CARTER: I don't think it would affect -- for those providers that are furnishing therapy that's not related to patient characteristics, you could see a reduction in the services that are being provided and that would save the program money and I don't think access would

be affected.

MR. GRADISON: Okay.

DR. CARTER: And that's what we're striving for, and that's why I think we've tried to pair the rebasing policy with a redistribution based on the revising the payment system, so you don't have the sort of systematic biases that are there now.

MR. GRADISON: About a dozen years ago, I did some work with the for-profit nursing homes. I haven't done this for eight or nine years, so it's nothing recent. But I was struck at the time, coming back to, I think it was -- it may have been Peter's comment -- by the way in which many of these companies, the few that were able to stay in the black at that time, were able to have sufficiently high margins on their private pay and their Medicare to overcome the very low margins on Medicaid.

While it probably is not directly relevant to what we're talking about here, I'm sure I'm not the only one in the room that kind of wonders what the impact of what is going on in the States in Medicaid reimbursement might mean to Medicare beneficiaries, which is -- I've always thought just as an outsider and now a newcomer to this organization

that the principal justification for knowingly providing higher margins on Medicare business was to help to preserve the availability of the nursing homes, which, if Medicare reimbursed them along the lines of Medicaid, might lead to something like we saw back in that period. At that time, five of the seven largest for-profit nursing home chains went through Chapter 11. This wasn't one of those theoretical concerns or crying wolf. It actually happened.

One thing that struck me there, and this is more specific, had to do with the ones that didn't get in that difficulty. There were some. My sense was part of it was I don't think the government had a darn thing to do with it. That was my view at the time. But I think part of it was that the debt level, the debt service was a real challenge which couldn't be overcome by the ones that went under. But also, I think it had to do with location, and that's really the main point I want to make.

I don't know how you would get these data, and I understand why you have urban and rural, but it seemed to me at the time that one of the principal explanations for why some of the nursing home organizations were able to sustain themselves was locations in areas where they would be able

to -- by their location, not manage with policy, by their location -- manage the proportion of Medicaid patients. In other words, they would be in areas where they were more likely to get a larger than normal percentage of Medicare patients and private pay.

I appreciate the difficulty in getting private pay information. To me, this is a real important element of this and I wish -- I don't know how you do it, but I wish we knew how more about how that interacts with what we are talking about. But I accept your statement about the difficulty of obtaining that data.

DR. CARTER: Well, we don't have Medicaid revenue, but we have Medicaid days, and so I can make sure to look at that when I compare sort of the profitability on the Medicare side of whether facilities look different in terms of their Medicaid share days.

MR. GRADISON: I think that would be helpful to know.

DR. CARTER: I do know that when we last year looked at who was in the top quartile and bottom quartile of Medicare margins, they did differ in their Medicare share with facilities that had higher shares of Medicare doing

better.

I think for sort of the cross-subsidization, I think Glenn wants to talk about that.

MR. HACKBARTH: So, Bill, this is an issue that actually we've spent a fair amount of time discussing over the years, and let's start by stipulating that we all have a strong interest in making sure Medicare beneficiaries have access to needed nursing facility care.

The problem with using higher Medicare rates and margins to cross-subsidize for Medicaid is this: first of all, it doesn't get the money to the right institutions. So if the premise is correct that Medicaid is a losing proposition, Medicare is a profitable one, the ones who most need the money are the ones that are going to have small Medicare shares and large Medicaid shares. The ones who most benefit, however, from using Medicare to cross-subsidize Medicaid are the reverse, the ones with big Medicare shares and lower Medicaid shares. So the money is very, very poorly targeted if what we want to accomplish is to make sure that Medicaid payment does not drive organizations under.

MR. GRADISON: Sure.

MR. HACKBARTH: The second problem that we face if we use Medicare to cross-subsidize Medicaid is if the Federal Government says, oh, we will assume responsibility for the bottom lines of nursing facilities, it is not just a license, it's an invitation for the States to keep cutting Medicaid reimbursement because the Feds will make up the difference and that simply isn't a sustainable policy.

The third problem is that the further you drive these rates apart, Medicare and Medicaid rates, it starts to affect business plans and it creates a very strong incentive to build your organizational plan and your investment around getting the really profitable Medicare patients and spending as little as possible on Medicaid.

So I understand the allure of saying, well, we will just cross-subsidize, but it creates all sorts of bad incentives and it's not an inherently stable system.

MR. GRADISON: Well, I agree with everything you said. What I'm trying to figure out is why, in the face of that powerful logic, for years we have knowingly had a system which does what you advise against. That's all.

MR. HACKBARTH: Politics. You know more about that than I do.

[Laughter.]

MR. ARMSTRONG: So, first of all, I support the direction that we're heading in with both of these different sets of policies around rebasing the payments. I think we're overpaying, and we're not paying -- our payments are not distributed the way they need to be, and so I think that the kind of analysis you're doing is right on. We should continue with that.

I also support the work around creating incentives to address the high variation in rehospitalization rates. Our approach here has been to create penalties where they're high. I would love it if we could imagine some upside opportunities for SNFs that have really great rehospitalization rates or are considered to be quality institutions by whatever measures we have, to give them some flexibility, perhaps, around three-day prior hospitalization requirements or some other benefits to create, you know, parallel incentives for reducing rehospitalization rates or for other goals that we might have.

The last point I would make is just this -- I know you're expecting me to make this -- is that this whole conversation just feels so constrained by the fact that

we're trying to deal with skilled nursing facility payment rates within the context of this artificial barrier between the different parts of our care delivery system. I think we have to do that, and we've really tried to be as attentive as we can to aligning incentives for skilled nursing facility payment with hospital payments and others.

But the world I live in may not be the real world that Ron lives in, but the world I live in is one where there could be patients who have very high SNF costs but whose overall costs are low and this approach doesn't give us any opportunity to really think about that. And so I'm going to be much more interested as we go forward with our MedPAC agenda in bundling payments and other ways of trying to be smarter about the fact that Medicare is a global payer for all of these things and I think we could do a better job.

MR. HACKBARTH: Cori, can I just jump in here for a second? I meant to do this before Scott started. I want to get folks to react to one of Carol's discussion questions, so Carol, could you put up your last slide. The third one. We've talked abstractly about rebasing the rates and rebasing the rates doesn't have a specific meaning in

terms of, oh, it's this percentage or this many dollars. So that would be a question that we would need to answer.

And let me just offer a couple thoughts for people to react to, not that these are answers, but they're sort of benchmarks to take into account. One is that, in the past, when Medicare has established new prospective payment systems, what it does is establish the initial rates based on average cost that exists at that time. So that's sort of one tradition, if you will, for how we establish rates. So one approach here would be to bring the payment rates down to the level of the existing costs.

Another potential benchmark is to look at the cost level of efficient providers. In fact, our charge from the Congress in the statute governing MedPAC is that we are to make recommendations on rates that are consistent with the efficient provision of the services in question. So that's another potential benchmark.

Now, just to be clear, I'm not suggesting that we choose one or the other, but I'm trying to define some potential boundaries in how we think about how much rebasing would be appropriate here and I invite Commissioners to offer any additional thoughts on that topic.

Scott, is there anything you want to say on that?

MR. ARMSTRONG: Well, just generally, I would say I think there's opportunity for a lot of rebasing here in that if our standard in other sections of our payment policy has been to rebase toward efficient providers, then I would apply the same standard to this area, as well.

MS. UCCELLO: Yes, I agree with Scott. I really like the direction of this entire package, but I am attracted to using the efficient provider as kind of the base.

DR. BAICKER: I think this is a great direction, as well, and I thought you made a very strong case that avoidable rehospitalizations were a nice marker for other -- to target for this, and I just wonder, going forward, it would be interesting to know more about how well that maps to the other components of care. If it doesn't, that's okay because it's an important outcome in and of itself. But sometimes we worry when you target particular outcomes that you can actually worsen other outcomes if you divert resources and attention, you know, teaching to the test or people targeting just the things that are in the limited set that goes into the payments.

Now, naively, this seems like a good one in that I would imagine that all the things that go into avoiding avoidable rehospitalizations are positively correlated with lots of other things we all care about, but that would be something good to think about in possibly incorporating other measures in addition to avoidable rehospitalizations or thinking about the repercussions of targeting just this one but not other ones. Do we think that it is complementary to other things we care about or substituting for other things we care about?

MR. BUTLER: I'll answer your question first, and that is like most successful transitions, it's a combination. First in the rebasing, you need to have probably something like three years, and then you need to take into consideration some aspect of cost. In this case, it may be not more than 105 percent or 108, whatever it is, and then a component of either a mean or efficient provider, whatever the standard is you're shooting for. So if you take multiple years, the cost that you're at now as well as whether it's mean or efficient provider, you can blend those together and have a graceful but rigorous transition. Something like that is what I'd do. And I just thought that

in the last two minutes, so I do know if that's helpful.

MR. HACKBARTH: [Off microphone.] -- pretty consistent with what's been the practice in the past in moving to new payment systems --

MR. BUTLER: I think it, generally, has worked. When one system has done that, it gives you some chance to make the adjustments. Okay.

I'm very supportive -- I remember well about two years ago or maybe three years ago when I said, okay, hospitals should get dinged for readmission rates, and maybe they're the first ones even though they may not be most responsible, they should show some leadership. If I were to say, what party is the most important other party, it is the skilled nursing homes, and sometimes they say, well, they don't have the data, they don't have the sophistication. I think most of these nursing homes do understand pretty darn clearly the criteria they use to send somebody to the hospital, when they call on an ambulance. It's usually one nurse and the medical director in combination kind of have protocols that say, we don't want any more of this, whatever the reason. And so I think it is quite doable, even in places that are relatively small or perceived to be

unsophisticated.

I did want to put one other kind of -- I don't know what to do about it, but the worst cases are where you still have, hopefully not very often, the medical director of one or more nursing homes that has 20 patients in the hospital with long lengths of stay which is an economic incentive for that medical director -- the medical director is conflicted on multiple fronts, and I've seen this in many hospitals where they take them right out of the nursing home, which helps the nursing home and the medical director's role there, and then helps their own income as they have extra long lengths of stay in the hospital, as well. And that's terrible abuse when that -- and if it still occurs, but the system kind of does not actually align for sometimes with the medical director who is coordinating care on behalf of the nursing home and the hospital, and that's still -- you know, you have to be attuned to that as you're trying to align two organizational financial incentives, the hospital -- and it's still a physician that admits and discharges patients, and how that person is positioned in this equation is not irrelevant.

MS. BEHROOZI: This is -- it's really great to see

the development of the work, Carol. I'm trying to get at what I think of as the revenue maximization that's going on. I mean, you know, I think you said this, Glenn, there are people with a business model that it's a natural thing in business to maximize the revenue, and unfortunately, the payment system here is somewhat easier than some to figure out, to game, frankly, in some cases, and maybe achieve that cross-subsidization that you have clarified why it's a bad thing to do.

I guess I feel like the revising of the PPS really gets at the revenue maximization stuff as does the rehospitalization, you know, looking at policies to address that. The rebasing is -- just because the revenue maximization has been so effective by so many people, but maybe not by everybody. So I am concerned that there are some providers who are suffering negative margins -- I don't know this, I don't have any facts on this -- but it's because they're not, whatever, treating two people at a time and only providing that one extra day of therapy to cross the line and that kind of thing.

So I do really think it's important, similarly to what we said with PACE, putting the risk adjustment first

and then the change to the payment, you know, basing it on the current MA policy. I would just want to make sure that we -- on Slide 12, it says rebase and do the revision to the PPS. I know we've recommended it before, but it might be very important to revise the PPS first, like I said, even though we recommended it before, and then see how that will shake out, whether there's anybody who will suffer incorrectly from that. I think that will make it better. And then you can rebase from there.

MR. HACKBARTH: That's a good point, and also this was an issue with home health rebasing, where we also wanted to synchronize improvement in the payment system with the rebasing for just that reason.

DR. MARK MILLER: Working with that thought, or maybe the way to think about it is to make it clear in the language that rebasing, then using -- or, sorry, the recalibration or reforming the underlying system, then using that, you engage in rebasing. But in order to not let the recalibration process go on forever, set a date certain for both of those steps to be done, because that's the catch. If you just say, don't do it until, then it may never happen. So you put a backstop on it, and that's kind of the

construct we put in the PACE arrangement.

DR. CHERNEW: This isn't an area that I have a lot of experience in, so I may be a bit off base, but I have a few general thoughts. My first comment is I'm a little skeptical of necessarily how good the case mix of the quality-type measures are because some of the things that are going on here, it's hard to measure well, like the right quality measures, something to do with is the therapy working or preventing you from getting worse, and I'm not sure we have all those right outcomes. So we're kind of doing, I think, a reasonable job, and I guess I'm basically convinced of the arguments, but I guess the data is not so overwhelming that it's clear.

And that wouldn't bother me quite so much except my bigger concern is that imagine we wanted to do something like reduce the rates to the level of an efficient provider. That doesn't mean that the inefficient providers are just now going to become inefficient. Bad things could happen in a whole series of ways that we need to think about if we were to do that. And I worry about that. And if we had good quality measures or I thought it would all work out, that would be one thing.

So I guess in the end, I am supportive of some level of rebasing, or some other payment reform, and I could think of a bunch of things besides rebasing. I could think of some sort of mix payment, like we lower the rates but give them some cost amounts, so some novel thing of doing that. I could think of -- maybe the problem is just we're paying too much for therapy and the right thing to do is not to make a big change and just lower the amount we pay for therapy. There's some discussion in the materials where they're providing -- this might not be the right word -- group or double therapy instead of single therapy, but they're still getting paid because they do each one, so it's cheaper, and they found this -- now, I have no idea if that's better or worse quality, for example, but maybe the challenge is we could just solve this problem in a much more straightforward way of lowering the therapy rates.

DR. CARTER: Well, CMS has made a number of corrections pointing at that, but our contention is still you have a payment system that has a basic incentive to do therapy, and at least the amount of therapy that was being provided concurrently or in groups was 25, 30 percent. So mostly it was still individual therapy that was going on -

DR. CHERNEW: I'm not advocating any of these because I said I don't know, but I am sure of one thing. You could lower the payment for therapy enough so there would be no incentive to do the therapy. We just may have not gotten there yet. And I am not advocating that, just to be clear when people start calling me. My only point was it's not clear how to compare that.

Another thing you could do is you could pay a certain amount for therapy and have some -- we've talked about copays and consumer incentives. Maybe there's people that want more therapy and people that want less therapy, they think it's going to work well for them and not work for others, and you let consumers decide one way or another in doing therapy. And again, I'm not advocating that.

My only comment is that my general concern about trying to do this all through rebasing is we end up pulling down things which clearly hit some people we want it to hit and likely hit some people we don't want it to hit and we always have this problem in every heterogeneous service category. We're going to do this all through December and January. There's going to be some big margin. Our instinct when we see the big margin is to cut the rate and we're

going to worry that the people on the one side -- we could get into the situation we're driving out the good and protecting the bad because you can only survive if you're doing, you know, doubles therapy or whatever it happens to be.

And so I guess the only thing I would add, because I simply don't know which of these many options are right for what I do believe is a problem you identified, is to make sure that we're as strong as we possibly can be in monitoring the very outcome -- the outcomes that are going on, and I very much agree with Peter that we kind of go a little slowly into this in a blended or other way so we don't end up causing a disaster and then after the fact having to jump back in and say, oh, this didn't work out the way we thought.

MR. HACKBARTH: Carol, could you put up the table that has the redistribution that occurs from -- yes. So moving to the sort of revised payment system that we've recommended in the past move substantial amounts of money around. And isn't there also, or is it just in the paper, a table that has it by -- well, I guess all the breakdowns are here. I guess this is the one I was thinking of.

So if you reduce the rates, you know, by five percent due to rebasing, there are some -- concurrent with a redistribution of the payments, there are going to be some people who are still much better off even after the rebasing than they are today, and I just wanted to make sure that that was clear.

DR. CHERNEW: [Off microphone.] Within each of these categories, there's heterogeneity --

MR. HACKBARTH: There's heterogeneity. Fair enough.

On the issue of how confident are we in our quality measures, you say you're inexpert on this. I'm even less expert than you are on that subject. To me, I think that that really does go to how quickly you want to move towards any new level of rates, and that would be your policy variable. You might say, well, we want to ramp down more slowly as we monitor what happens to access, et cetera, given that uncertainty. And if you're very confident in your measures of quality, then you have a short transition. Do you see that similarly? Bob.

DR. BERENSON: Yes, most -- well, the first part of what I wanted to say has just been sort of dealt with. I

agree with the way Peter laid out the factors related to where we get to. I would be relative aggressive on where we want to get to. But I think we need to think pretty carefully about a transition. Peter said maybe three years is typical. In this case, it might be longer. I guess Medicare Advantage is five or six or something is their transition to a new rate, so we're not always doing three.

I was around at the latter part of the last century when all those bankruptcies happened. I was at CMS, and it wasn't a pretty sight. I think one of the issues there would be related to a transition to a rebased amount, but I think we need to do pretty aggressive rebasing and Peter laid out the kinds of factors we typically consider and I think that's how we would do it, average costs, efficient costs, et cetera.

The point I was going to make, will now make, one, is I think it's real important to proceed with the rehospitalization policy that you're laying out, the 30-day rehospitalization. I know there's an attraction to bundling payments and having larger units and CMS -- ACA set that up. CMS has now announced four models of bundled payments that they're going to test. I think it's not going to be so easy

to bundle the nursing homes' money in with the hospital's money into a single bundled payment, and I very much like the idea that we will align payments, have them having consistent incentives to work together, and I do take the point that if the hospital incentive system works there may be less savings uniquely from what we would be doing with SNFs, but we would be aligning incentives and so I think that's real important.

And the final thing is looking to the future work. The reason I asked about where people go to after discharge is that I think it's -- I can conceive of it much more in the control of a nursing home for their residents who were in a SNF stay and are staying in the nursing home and to try to provide incentives to reduce rehospitalizations, and indeed to reduce hospitalizations for that population. I think there's less than in the case of the hospital, less control that a nursing home has over a patient who's discharged to their home with multiple chronic conditions, and so I'm not so sure I want to jump into that one. But I think I'd start by understanding where they are being discharged to with the emphasis on the patients who are staying in a facility, presumably their own.

MR. KUHN: Thanks. Let me start with the rehospitalization. I would just say, Carol, you did a very good job, I think, of capturing both the key methodological and the decision points and I can't think of anything else to add in this area.

The only thing I would add is some conversation here, I think in round one, about the distribution of kind of what was going on in different parts of the State, and in the paper that we looked at, there was twice there was references to States that had low rates of rehospitalization and States that had high rates of rehospitalization. So I think a chart that kind of showed us kind of the array of States and where they are would be very helpful on a go-forward basis.

On the issue of rebasing, I liked the work that's done so far. I'd like us to continue this work. And I think anything we can do to more closely align payments with costs makes sense to me.

What would be helpful, I think, in future conversations, whether it's charting or more explanations of how it goes forward, is mechanically how all of that would occur, I think would just help in terms of understanding how

robust it is. It would deal with things that Peter is talking about as well as Bob in terms of a transition. So I think a mechanical way of thinking about kind of how that works would be helpful.

The other thing I wanted to raise here, and I know it's not on the discussion points, but if we could revisit this policy, I would just ask if it would be for consideration. In 2008, you made the policy recommendations for both NTA and outlier. If we do rebasing, I guess I would say, is it a policy consideration that we still need both of those or would one do?

And so I ask that for two reasons. One, again, if you do the rebasing, do you still need outlier? Do you still need NTA? And the second thing is we all know that CMS is stressed out. I mean, they're putting together the ACA, and if we can think of anything around this table that could reduce the workload on CMS and create less work for them but still achieve policy objectives, is this one thing where we can say, you know, in 2008, this made sense to do both of those, but if we're going to do rebasing, one of those would make sense on a go-forward basis. We don't have to do both.

So, again, this was a policy in 2008, but in the combination with the rebasing, is that just something we would want to revisit? I just ask that question.

MR. HACKBARTH: Let me ask another question back. So to this point, the conversation led by Mitra has been if you're going to rebase, it's even more important to distribute the dollars accurately, because you run the risk of doing real harm if the dollars are maldistributed. So each of those policies that you mentioned were focused on trying to make sure that the payment system is as fair as possible. So if you coupled them with -- if you do rebasing the need is even greater for them, not less. So what am I missing?

MR. KUHN: I hear what you are saying, Glenn, but I am kind of looking at it in a different way, is that, you know, is there a need for both of them? And I want to go back and reread the 2008 recommendations. Is this a layering on or are these all stand-alone that need to be out there as we go forward? That just is a question I'm asking, if we could, you know, maybe the next time, at least just kind of look at that and see if that still makes sense.

And, I think, not only for workload for CMS, but

also for an industry, a SNF industry that's going through a lot of changes, as well. You know, how many new things can they absorb at the same time?

MR. HACKBARTH: Bill.

DR. HALL: Not to say what's already been said, but I'm very worried that we should not go too fast in this arena. We say the nursing home industry. It's really not a single industry. It is so much more heterogeneous than the hospital enterprise throughout the country. Some of these nursing homes, freestanding, are mom-and-pop operations. Some are run by religious orders. Some are run by very shrewd businessmen. Some have very close relationships with hospitals. It is bereft with legitimate conflict of interest on the part of all parties, and the ACA in some sense increases that tension, particularly around the whole subject of readmissions.

So whatever we do in every phase, and particularly if it's going to be rebasing, I think let's do this in a very programmed and conditioned manner so that we don't run the risk of what we already know happened once before that caused tremendous disruption in the industry, which is going to really, really affect the hospital industry, as well. So

I think that we're on the right principle, but I think we have to be very careful in the implementation.

DR. NAYLOR: So I echo the need to be cautious. I think on the issues, I would really like to be more confident that we did have the quality measures. Some of the ones that have been talked about in the paper are pretty gross measures and don't necessarily reflect the two communities that are served by skilled nursing facilities which have been articulated, those that are coming post-acute and going home, and those that are coming from a nursing home, going in and back, and I think are measures.

I do think that we have opportunities here. I mean, if we create the right set of incentives to prevent that index hospitalization through the use of a skilled nursing facility, we could have really created a better quality environment, particularly for the nursing home residents, to prevent those kinds of issues that unnecessarily result in hospitalization and all the things that are associated with that.

If we go readmission, and particularly ambulatory care sensitive readmission, targeted ones are not necessarily the right ones, so I think all-cause readmission

becomes really important for this population as a measure.

And I finally think that not all readmissions, as exemplified by Moore's summary [phonetic], are in the control of either the skilled nursing facility or the nursing home. I mean, this issue around transitions and early hospital discharge to get into, you know, that maybe should have been a day later or something like that, those kinds of things are not all within the control. So I think we need to be really looking at the kind of incentives that create the blending of hospital post-acute care. I'm sorry to hear that bundled payments aren't going to help us get there. I think that for Medicare, it could help us get there. But I am concerned that we rely too much on one setting when they don't control all the factors that contribute to rehospitalization.

DR. CASTELLANOS: You know, you asked the question about, do you have any questions on rebasing and rehospitalization. I'm looking forward to the next hour's discussion about the hospital capacity. But I don't know if we've ever looked at the SNF capacity, and I know getting a skilled nursing bed for some patients are virtually impossible. The pulmonary assist patients, you can't find a

nursing home that will take that patient.

Nursing homes have the ability to say yes or no, and so when we start looking, we need to really think risk adjustment and we really need to look at -- and I agree with what's been said. We need to do this very slowly or otherwise we're going to have a lot of -- we can't find nursing home beds now, and the reason you're seeing the hospital-based SNFs half the readmission rate is because they're in the hospital and they're being taken care of appropriately. But I don't know if that's really available throughout. So I would also like to maybe look at the capacity of, in general, of the nursing homes.

MR. HACKBARTH: Yes. I think Carol can help me out here, but, in fact, we have looked at the capacity of nursing homes in the context of our annual update recommendations and one of our findings has been consistent with what you say, that getting access to SNF care for some types of patients is problematic. And what we've attributed that to is the payment system, where some types of patients are much more profitable than others and it's the complex non-therapy patients that are having difficulty finding appropriate placements. And so the redistribution of the

payments that we've recommended is very important on that access issue.

Carol --

DR. CARTER: Well, I mean, one of the things I was particularly wanting to update this analysis to reflect the new case mix groups because they do a better job on the medically complex cases. They really expanded the case mix groups for those patients, and so I wanted to see whether we still were seeing whether current policy compared to a revised PPS would still be moving money around, and I was a little surprised, actually, to see that we have still very consistent findings.

And so part of what Herb was asking before, about, well, so maybe you don't need to kind of target this NTA stuff, well, the relative weights still only vary five-fold, but NTA costs vary 18-fold. And so you can't move enough money through getting people in the right case mix group. Now, that's just for drug and respiratory care, but that's going to affect the SNF's willingness to admit a patient, or that's our concern.

MR. GEORGE MILLER: Yes. Much has been said already, so I won't repeat that, but let me see if I can

highlight a few things that I think is important, which is I think we should go slow. This is a very vulnerable population, especially the dual eligibles and what Ron just mentioned about some patients not being able to be placed. I think this is an important consideration and we want to be careful. Deliberate, careful rebasing, but do it in such a way that we not do more harm than is currently being done. I think that's an important issue.

And then also on Slide 12, this may be part of round one's question, but I would be interested in knowing what the outlier policy will be. Historically, we've had some outlier policies that other organizations will take full advantage of and have done very well with that, so we have to be very deliberate about that outlier policy since that reflects dealing with an issue that is outside their control and they can help mitigate that versus being in an open-ended situation.

DR. STUART: I support the general direction here. I particularly support the idea of looking at synergies between reducing rehospitalization rates in the nursing home and what the impact is on hospitals and vice-versa.

I would also like, if we could move back to 11, I

think one of the points that has been raised around the table is you start moving around money and you're going to have unintended consequences, and one of the things that we might do with a table like this is just simply look at -- start by looking at the number of nursing facilities that are going to be affected by each of these. I mean, we start with an industry that in some parts of the country is virtually all for-profit. In other parts of the country, it is mostly not-for-profit, and so some of that would come out here. But I also would like to see some of the regional implications. When we talk about other forms of institutional post-acute care, we know that that's regionally distributed and so it would be interesting to see if there are any implications on rebasing in the nursing homes for areas that have long-term care hospitals and have more ERFs and other kinds of alternatives for long-term care, or alternatively, don't have alternatives where this might be even more serious in terms of its short-term impacts.

MR. GRADISON: If we had started at this end of the table, I probably would have been the first to use the word "caution" or "go slow." Others have already used it,

and I support that view. I definitely think we should continue to explore this, but I think we've got to move ahead with great care -- great care.

DR. BORMAN: I guess I get to be a little bit contrarian. No big surprise. And part of it is we've had, as you've noted, Glenn and Mark, some of these pieces of conversation over a period of several years and I guess I'm having a little trouble discerning out what we will potentially address in our update process versus this particular aspect of it that we've sort of deemed policy. It's sort of like one of those Venn diagrams, if I have the term right, where there's an overlapping area here.

While I think this is a huge area and a very important one to me personally and professionally, we need to do with all deliberate speed and caution. I also think we've spent a fair amount of time identifying that there's a problem in this area. I don't pretend to know what the ideal fix is, but I also think we are in some danger of -- it's so difficult to wrap our arms around, despite Carol's wonderful job at helping us to get there, that we perhaps disable ourselves from starting to act. And I would rather not see us get into inertia about this based on our concerns

about making a mistake. And maybe the correct answer is to take our initial action in terms of the update and continue to do that as we've made some recommendations in that area over the past several years.

But I worry a little bit about wanting to be all, know all, be at the sort of Holy Grail end point before we're confident in saying anything, and perhaps there will be some middle ground in being able to make some recommendations, perhaps at -- even if we say we think we could be at this percentage, maybe cut that by half to give ourselves wiggle room, or just make some -- perhaps, ultimately, at the end of the day, we may have to come to some empiric conclusions as a means to moving forward. And so I would just not want to see us put this in such a long-term queue that we lose our power to move forward.

MR. HACKBARTH: So can I just respond to that? So here would be my approach, is that based on this conversation, we will put together a draft recommendation for discussion at the December meeting to be considered as part of the update process. And then where we go past December will depend on how people react to the draft recommendation. But this isn't something that I envision

we're going to put on the back burner. We're going to try to move it ahead and get more concrete, obviously, in the next conversation and see how people react to it.

Mark.

DR. MARK MILLER: And I haven't discussed this with Glenn, so -- I mean, as you think about putting that together, if you try and square the thoughts of, well, what about the update? There does seem to be a lot of evidence, but I'm concerned about how fast we move, you know, if you try and thread these things, you could imagine a recommendation that says, okay, we're not going from here to here in one step. We'll start taking, as you move through some time frame, and precede it with the recalibration and reform, notwithstanding your comments, but precede it with that and then start a step-down so that you get on this road, and then if there is some adjust that's needed, remember, we look at this every year. We come back if this transition isn't working for some reason. We can make recommendations at that point on it.

So as I was listening to it and thinking about having to come back in December with a recommendation, that's what I was starting to frame up in my mind without

having discussed it.

MR. HACKBARTH: That's quite consistent with what I --

DR. BORMAN: I would just like to make sure that in order to get the beneficiaries in the system to a better place, that we just move in a, you know, like I said, with deliberate speed, maybe -- I like that term --

MR. HACKBARTH: Yes.

DR. BORMAN: -- and, you know, too much --

MR. HACKBARTH: Yes. A question, Carol. Have SNF rates been reduced in recent history? My recollection is that there have been some times when, for various reasons, the rates have been reduced.

DR. CARTER: Yes, and I'm trying to -- I think they were reduced because of the parity adjustment when they implemented the 2009 RUGs -

MR. HACKBARTH: Yes.

DR. CARTER: -- back in 2006. They took a parity adjustment, I think, in 2010, if I'm remembering. So that lowered payments by, I think, three percent, but then that was offset with an update. But I think that --

MR. HACKBARTH: Okay. I forgot about the offset

with the update --

DR. CARTER: Yes. I think it's really just been through kind of the parity adjustments.

MR. HACKBARTH: What I was trying to remember is whether we have any prior experience of how SNFs respond to reductions in payment --

DR. CARTER: Well, if the rates were lowered 3.3 percent with the parity adjustment and spending still went up in the subsequent years, I guess that's some evidence that --

MR. HACKBARTH: Yes, and what about margins?

DR. CARTER: They've been steadily increasing.

MR. HACKBARTH: Increasing, yes. So I can't recall the numbers on SNF, but my recollection is on home health, in the face of reductions, the margins have been not only maintained, but actually increased, even though the rates are going down, and even though every time the rates are cut, there is a prediction that this is going to be the end of the world as we know it. And so I think -- I'm a cautious person by nature, and so I resonate with the words about caution. On the other hand, there's such a thing as being too cautious. Money is scarce, and if we're

overpaying SNFs, that means there's less to pay other providers adequately and we have to be cognizant of that, as well.

MR. BUTLER: One very quick question. What is our total spend in Medicare on SNF?

DR. CARTER: About $27 billion.

MR. BUTLER: Okay.

MR. HACKBARTH: Scott.

MR. ARMSTRONG: Yes. All I wanted to do -- this is sort of the problem of being first in the second round -- was make the point you made. I appreciate that all of us here care deeply about the vulnerability of these patients and the variation from one skilled nursing facility to another, but these margins are spectacular, and the difference between the cost and the revenues is spectacular, and that we really, I think, have to move forward with steps to start dealing with a mismatch between what we're paying and what we're getting from the sector. I just hope that as we go forward -- today's not a decision day, but as we go forward, we need to put this in the context of $330 billion, ten-year trend sort of proposals that we've got responsible for making these decisions in that context.

MR. HACKBARTH: One last question, Carol. I think Bruce -- I guess he stepped out for a second -- made a point that really rang a bell with me. In talking about other post-acute providers like long-term care facilities and ERFs and the like, we've often noted that they are not spread evenly across the map. And in the course of making that observation, we've said that, well, one of the reasons that, say, long-term care hospitals don't exist in some parts of the country, including my State of Oregon, is that SNFs play that role, or at least part of that role, in those communities.

And I think it was Bill Scanlon who made the observation, which struck me as an astute one, that these categories are not fixed and the capabilities that a SNF has is in part dependent on what other resources exist in the community. So if there are lots of other different types of post-acute providers available, you may have a SNF with a narrow range of capabilities. But if there aren't any long-term care hospitals or ERFs or others, they may have a richer range of capabilities because they're expected to play a broader role in the local health care system.

So it would be interesting, as Bruce suggested, to

look at SNF profitability, performance in different types of markets. Are they performing less well in areas where they have to carry a broader responsibility in that local health care system? So just -- it just strikes me as an interesting hypothesis. I don't know where it will lead us.

Okay. Thank you, Carol.

The last topic today is an installment on the hospital update discussion which we will engage in in more depth in December. As you know, one of the factors that we consider in our payment adequacy analysis is what's happening to the supply of given service, in this case hospital services. And Zach, lead us through it.

MR. GAUMER: Thank you. Good afternoon. First I'd like to thank Jeff Stensland and David Glass and Matlin Gilman for their assistance with the material you're about to hear and the material that you read in the chapter earlier this week. In this presentation, I'm going to walk you through a variety of measures that we look at each year to collectively assess Medicare beneficiaries' access to hospital services and hospitals' access to capital.

Specifically, you'll see measures pertaining to hospital utilization, capacity, the scope of services

hospitals offer, and the financial stability of the industry as it relates to capacity growth.

Each year, the Commission deliberates and makes a judgment as to the adequacy of hospital payments. MedPAC's standard payment adequacy framework includes four basic components, which are listed on the slide above here. Today we will cover the first two components of the framework, and next month we'll present data on hospital quality metrics as well as payment and cost information, the last two bullets on the slide. That will include margin data as well.

At the conclusion of my presentation today, I'll ask you if you have questions about the material I've presented, ask for general feedback on the measures you've seen, and ask for any enhancements that you'd like to see. Then in December, after you have seen all the data related to the four components of the framework, you'll discuss the overall adequacy of hospital payments.

Based on our evaluation, we conclude that Medicare beneficiaries' access to hospital services remains good and hospitals maintain access to capacity -- excuse me -- access to capital. In addition, it appears that capacity at facilities is growing and as that is occurring, an industry-

wide shift is taking place in the site of service from the inpatient setting to the outpatient setting.

Contributing to these conclusions are a variety of facts. First, inpatient utilization and hospital occupancy rates continue to trend downwards as outpatient utilization continues to trend upwards. Combining the next two facts on the slide above, we see that we observed the number of acute care hospitals increasing and bed capacity remaining relatively flat.

Next, the scope of services hospitals offered in 2009 increased from the previous year. Hospital consolidation continued to increase in 2010. Next we observed hospitals adding staff faster in the last year than in the previous two years. And finally, the industry demonstrated continued investment in capacity as borrowing and construction spending moderated in 2010, but remained at high levels.

Between 2004 and 2010, Medicare inpatient hospital discharges per fee-for-service Part A beneficiaries declined 6 percent. At the same time, Medicare outpatient utilization increased 23 percent. In conjunction with these utilization trends, we observed a decrease of 1.9 percent in

the all-payer hospital bed occupancy rate, and that was from 2004 to 2009.

These three trends suggest that the model of hospital care is changing in the United States and the site of hospital services shifting from the inpatient to the outpatient setting. The decline in occupancy is consistent with two other pieces of data that we've looked at.

First, we observed a decline in the share of Medicare beneficiaries using inpatient hospital services in a given year, falling from 23 percent of beneficiaries in 2004 to 21 percent of beneficiaries in 2010. Therefore, beneficiaries used the inpatient benefit less often in 2010 than 2004.

Second, we continue to see an increase in outpatient observation claims, and a corresponding decline in one-day inpatient stays. From 2006 to 2010, the number of outpatient observation claims increased by 16 claims per 1,000 beneficiaries. In contrast, we observed a decrease in the number of one-day inpatient stays of five stays per 1,000 beneficiaries. Therefore, cases that had previously been a short inpatient stay are now more likely to be treated on an outpatient basis.

The number of acute care hospitals entering the Medicare program exceeded the number of hospitals exiting the program in 2010. Specifically, you can see on the chart above that 30 hospitals entered the program while seven exited the program, and this was the ninth consecutive year in which hospital openings exceeded closings. In addition, while the number of openings was on par with the volume of openings we've seen in recent years, the seven closures in 2010 were, by far, the lowest volume of closures we have seen throughout the last decade.

Those seven closures tended to be slightly larger than those that opened. Excuse me. The hospitals that make up those seven closures tended to be slightly larger than those that opened. They're in a mix of urban and rural areas. They had lower occupancy rates than their nearest competitors, and most were non-profit.

We also know that most of these facilities closed as inpatient facilities and reopened as outpatient-only facilities. In contrast, the 30 hospitals that entered the program in 2010 were relatively small. They were primarily located in urban areas and tended to be for-profit entities.

In addition, many of these 30 facilities appear to

specialize in one or a few clinical areas. The last thing I'll say here is that the characteristics of the closed and open hospitals that we observed this year more or less match those characteristics that we observed in 2009.

As facility level capacity grew, inpatient bed capacity remained relatively flat. AHA survey data reveal that the raw number of hospital beds increased slightly from 2006 to 2009, but our own analysis of bed capacity on a per capita basis display that bed capacity declined slightly from 2.75 beds per 1,000 people to about 2.67 beds per 1,000 people.

Scott, at one point last year, you inquired about the geographic variation in bed capacity. And as was the case last year, the story this year is that we observed wide variation in capacity on the state level. For example, in North Dakota, South Dakota, and the District of Columbia, bed capacity exceeded about five beds per 1,000 people. And in Oregon, Washington, and California, bed capacity was less than two beds per 1,000 people.

Hospitals and their affiliated providers expanded the scope of services they offered in 2009. Over 94 percent of the nearly 50 clinical hospital services we track each

year were offered by a larger share of hospitals in 2009 than in 2005. The most pronounced expansion of services during this time period was for robotic surgery, translation services, PET scanners, bariatric weight control services, and indigent care clinic services.

For example, robotic surgical services were offered by 11 percent of hospitals in 2005. In 2009, 24 percent of hospitals offer this service, and that was a 13 percentage point difference between those two years. Many of the services that grew most rapidly, as you can see here, were either relatively new or very specialized services.

By contrast, on the bottom of the chart here, you can see that about 6 percent of services were offered by a smaller share of hospitals in 2009 than in 2005, and all of these services were facility-based, post-acute care services. Assisted living, Home Health, and skilled nursing services were those that saw the biggest decline.

In addition, the majority of services grew more rapidly at urban hospitals compared to rural hospitals. We view this as a consequence of the relative complexity of a given service rather than declining access in the rural setting.

Hospital industry consolidation has increased in recent years. The trend in hospital mergers and acquisitions suggest that owning and operating hospitals remains an attractive use of capital. In 2010, the hospital sector saw 72 separate merger and acquisition transactions in which 125 individual hospitals were acquired.

The red bars on the chart above illustrate the number of hospital transactions which increased above what had been a relatively steady trend in transactions over the last few years. The textured bars or the pink bars, as they appear, suggest the number of hospitals involved in these transactions also increased in 2010.

As was the case in 2009, in 2010 regional hospital systems were more active than either national systems or individual free-standing hospitals in making hospital acquisitions. In addition, a disproportionate share of acquires were for-profit entities.

A variety of sources have also recently observed that physician group practices are a growing piece of the trend in hospital consolidation. A report released by the Center for Studying Health Systems Change in August of 2011 concluded that the pace of hospital employment of physicians

has quickened in many communities.

Bureau of Labor Statistics employment data reveals that the number of individuals employed by hospitals increased 5 percent over the last four years. That's from October of 2007 to September of 2011. During this time, hospitals added about 220,000 jobs, and as of September 2011, the hospital industry employed about 4.8 million employees.

Just as a reminder, the reason we look at employment trends each year is not as a measure of general efficiency. Instead, we view employment as an indicator of financial well-being.

The rate of employment growth has varied over the last four years, and as you can see on the figure above, in the first year of this period on the far left hospital employment increased about 2.3 percent. In the second and third years, the growth rate was more flat.

Following the decline in the economy, employment growth during this period slowed to less than half a percent per year, or slightly 1 percent over the period. However, in the most recent year, hospital employment accelerated again, increasing more than 1.7 percent.

In the context of other health care providers and the rest of the economy, hospital employment has been positive. As hospital employment increased 5 percent overall, employment for other sectors in the health care sector collectively increased 10.5 percent and employment for the rest of the economy declined 6.1 percent.

Two somewhat related measures of hospital investment and capacity display similar trends over the last decade. Taken together, we believe hospital borrowing and construction spending indicates that overall the hospital industry maintains access to capital markets and continues to build capacity.

However, we also believe that capacity growth is occurring differently now than in prior years. In 2010, hospital tax exempt municipal bond offerings amounted to $28 billion. The value of hospital construction spending in the same year amounted to $27 billion.

In the context of the ten-year trend, we view the 2010 levels of borrowing and construction to have moderated from the historically high levels of 2008. Both borrowing and construction grew steadily from 1999 to 2004. Then starting in 2005, both grew rapidly for five years. During

this period, hospital capacity surged. Borrowing and construction crested in 2008 at approximately $51 billion in borrowing and $34 billion in construction.

Since 2008, both measures have moderated to levels that remain high and are similar to levels observed prior to the surge that began in 2005. Several factors have contributed to the moderation of capital investment and capacity growth. These include the trend in the decline of inpatient utilization and the economic downturn.

As a result, over the last two years, we have observed that hospital construction projects now tend more toward outpatient services, such as emergency departments, imaging, and surgical services. Inpatient services are currently considered a somewhat secondary focus within construction projects. In addition, hospitals are now more likely to choose to renovate existing capacity than to build new facilities.

In summary, we conclude that Medicare beneficiaries' access to hospital services remains good and that hospitals maintain access to capital. However, it is also apparent that an industry-wide shift is occurring and the site of service from the inpatient setting to the

outpatient setting. Inpatient utilization is declining as outpatient utilization is increasing.

Similarly, occupation rates and the share of beneficiaries using inpatient services are down. The number of facilities is expanding, and yet, bed capacity remains flat. In addition, hospitals are expanding service offerings, consolidating, adding staff, and increasing capacity through borrowing and construction. But they're doing these things with a deference towards outpatient capacity.

At this point, I welcome any questions and feedback you might have. I also welcome any suggestions you might have for other measures that we're looking to add to the payment update. However, I'll remind you that in December, Jeff Stensland and others on the hospital team will be presenting the second installment of hospital updates, update measures to you, and those will include quality and margin data.

Finally, we're particularly interested in hearing your thoughts about the implications of the site of service shift from the inpatient to the outpatient sector. Thanks for your time.

MR. HACKBARTH: Round 1 clarifying questions.

MR. GRADISON: On Chart 5 where you have the openings and closings, do you have any information with regard to closings that might be related to action that CMS has taken, basically to remove the certification, if that's the right word, where the hospitals haven't met the requirements to be readmitted to the program?

MR. GAUMER: I haven't looked specifically into that. I haven't seen anything about that in the trade press, but I can take a look.

MR. GRADISON: Thank you. And one final question with regard to the inpatient/outpatient, I'm aware there's a fair amount of data with regard to hospital-based -- I know sarcomial infections, which I assume are from hospital stays, but I don't remember seeing any data if there are any, which relate to infections related to outpatient care? It's not directly on point, but if you come across anything along that line, I'd just be interested in learning about it.

MR. GAUMER: Okay.

MR. GRADISON: Thank you very much.

DR. STUART: Thank you. I have two quick

questions, one on Slide 4. Do we have any sense of how much of that increase in outpatient hospital utilization is due to purchase of physician practices? In other words, is it possible for hospitals to essentially take a large physician practice and say, Oh, well, now you're an outpatient department?

MR. GAUMER: I think that might be a subject that comes up tomorrow in Jeff's presentation. Do you want to hold off until then?

DR. STUART: I can wait.

MR. GAUMER: Okay.

DR. STUART: And my second question is regarding Slide 7. And I've seen this each year since I've been on the Commission and every time I have the same question. I mean, this tells you what happens in an individual year. And what I really want to know is, what does it look like cumulatively?

So if we have all of these things happening every year and these numbers are a whole lot bigger than the net increase in the number of hospitals, so clearly we know there's consolidation going on. But if there's some cumulative way to show us what that looks like, I think it

would be helpful in terms of making these decisions.

MR. GAUMER: Okay. We can look into doing that.

MR. GEORGE MILLER: Yes, thank you. We just finished the 2010 census and there's been significant population shifts. Some states and communities congressionally have lost -- my home state of Ohio has lost three Congress persons in that state alone. So I'm curious, back on Slide 5, at least in my mind, there should have been probably -- with huge population shifts, that should have been greater new hospitals, at least in theory, in some places in the south. I notice in the text, Texas picked up quite a few. I can't remember the other state.

But it would seem to me just longitudinally, we should have seen more hospitals, particularly in the south. I remember several years ago the big boom in Las Vegas, although I don't think that's the case anymore. Do you know why there wasn't more of a distribution around the country because of population shifts?

MR. GAUMER: Well, what we do see is that among the openings, nine of them were in Texas, so among the nine were in Texas.

MR. GEORGE MILLER: Right, I saw that.

MR. GAUMER: Three were in Pennsylvania. And there was kind of a distribution, I would say, away from the upper Midwest.

MR. GEORGE MILLER: Right. But you had growth in those other states and I don't see that reflected, because if nine were in Texas, the other states in the south seemed to have picked up a huge population shift.

MR. HACKBARTH: So you used what happened to congressional seats --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- as a result of the census. So it's a ten-year census. This is a ten-year period.

MR. GEORGE MILLER: Oh, yeah.

MR. HACKBARTH: And in that ten-year period, you've got --

MR. GEORGE MILLER: Got you.

MR. HACKBARTH: -- just eyeballing the yellow lines, several hundred new hospitals opened.

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: In a ten-year period.

MR. GEORGE MILLER: Yeah.

MR. HACKBARTH: And we've got how many hospitals

nationwide, 3,000?

MR. GAUMER: Maybe 3,500 PPS hospitals.

MR. HACKBARTH: So a significant number have opened. Now, as Zach pointed out in his presentation, these vary a lot in size. You know, some of these could be relatively small specialty hospitals. I knew you were going to say that, George.

MR. GEORGE MILLER: Yeah, I was getting there.

MR. HACKBARTH: Yeah.

MR. GEORGE MILLER: Right. That's where I want to concentrate on. All right. Now that we've got the number out there, what type of hospitals are we talking about? And I think I asked the last two years. Do we also do analysis of the number of beds available? You know, a hospital could open, but another hospital could still be open, but have closed beds or not staffed beds. So the actual bed capacity, and I think that was indicated by the -- indicated a little bit by the decrease in inpatient utilization.

MR. HACKBARTH: Let me ask a related question to George's. In the New York Times yesterday, there was an article about three brand new hospitals opening in New Jersey in the relatively new future. Now, in each of those

cases, it's a full replacement facility for an older hospital. In this, how is that counted?

MR. GAUMER: Okay. Those will not be reflected in here because the provider numbers are not changing, and if they were double-counted in some way, you know, we're going through some effort to make sure they don't get double-counted.

MR. HACKBARTH: Yeah, so we can net it out and there will no addition to the hospital count.

MR. GEORGE MILLER: Well, that's a question. In Springfield, we had two hospitals. We're closing two and we've built one replacement for the two because the two merged. And before we built the new hospital, we merged the two provider numbers, so that would have been counted last year, I guess. Okay. I got it.

MR. GAUMER: I'll add one thing, though, and that is, those hospitals that are new facilities on the same site or under the same provider number would be reflected in the construction data that we look at and they would be reflected in the bed capacity analysis that we do. So if in the case they added more beds, we're going to pick it up in the bed capacity analysis.

MR. GEORGE MILLER: In my case, we went from 600 beds down to 254 beds, two hospitals with a capacity of 600 beds down to one hospital with 254 beds.

MR. GAUMER: Okay.

MR. HACKBARTH: Okay.

DR. HALL: As you go through these data, there are lots of different metrics that are being used here and I think some are more reflective of hospital capacity for a Medicare patient than others. And I think at some point, we probably need to kind of agree on which are the metrics that are going to have the most sustainability.

For example, on Slide Number 4, occupancy rates, I think those data are very useful; whereas, when we look upon services somewhere along the line, I guess that's Number 6, it doesn't resonate with me as a very good marker of anything. In fact, robotic surgery has a lot more to do with acquisition of technology than anything else.

The translation is usually something that is mandated by various states or communities, depending on dominant ethnic populations, and ditto with PET scanners. That's just trying to catch up with the other folks in town. And bariatric surgery has a little bit to do with Medicare,

but it's largely a non-Medicare based service.

And I don't really -- can't suggest what are the right metrics, but I think probably access to capital, occupancy rates, shifts to outpatient are probably where we're going to get the most bang for the buck.

MR. GAUMER: Okay, thank you.

MR. KUHN: Maybe picking up a little bit where George was probing a little bit, of these 30 or so hospitals that we had open up, do we know the types of hospitals they are? Are they behavioral health? Are they -- because I know right now we have a moratorium for long-term care hospitals, and I can't remember where we are with physician-owned specialty hospitals. Is there a moratorium there?

MR. GAUMER: I think it's about to come upon us or it might be happening right now, but the data that we have now have not captured the moratorium.

MR. KUHN: So within that 30, do we know what kind of -- are they just general acute care or are these all types of hospitals?

MR. GAUMER: What we tried to do here is to weed out the LTACs or the ERFs that sometimes land on the list of PPS hospitals for a year before they convert into LTACs or

ERFs technically. So the list of hospitals or the chart that you're looking at here reflect PPS hospitals mainly, and then when we try to determine whether or not they appear to be specialty hospitals or have some other specific focus, you know, that's kind of a judgment call based upon -- since we don't have data for them really yet, because they're brand new facilities, you know, looking at their Web presence and also trying to determine how they're marketing themselves, and it turns out that maybe -- I think the number was about 40 percent of these 30 hospitals were pretty clearly single or double specialty hospitals.

And then there was another 30 percent that appeared to be focusing on a handful of things as opposed to a very large general hospital, and that handful of things was often ER, imaging, surgical --

MR. KUHN: Cardiac, orthopedic, those?

MR. GAUMER: Yes, sir.

MR. BUTLER: And a third are in Texas with no CON and a lot of entrepreneurial spirit.

MR. KUHN: And then on the closures and the openings, do we look at like the number -- I mean, obviously this is the numbers of facilities, but do we also look at

the number of beds and what kind of beds those are? Because I know in the paper, we talked about -- and we are -- at the last meeting, we talked about the loss of psych beds or behavioral health beds and concerns about certain lines of business. You looked at those one lines of business, but also there are certain beds that take care of these really critical type patients. Are we looking at that as well?

MR. GAUMER: We don't actually, but I can try to take a look. Right now it's just very generally staffed beds, but I can look at that.

DR. BERENSON: On Slide 10, I'm trying to relate the borrowing and borrowing and construction spending to sort of this major economic downturn we've had. Do you have any rules of thumb for typical lags between a decision to construct, when the bond is offered, and when the actual spending occurs?

MR. GAUMER: I don't actually. I might look to my colleagues on that.

MR. BUTLER: Say the question again. When the --

DR. BERENSON: A decision to have a major construction project, the bond offering to get the capital, and the actual construction spending. What's sort of the

lag?

MR. BUTLER: It depends on the size of the hospital, but you could look at a six-year cycle kind of between the time you decide you're going to build something, and it would be a couple of years later that you'd be breaking ground and you wouldn't be borrowing until you start spending that money. So it could be as long as two or three years after you've made the decision that the borrowing would occur.

DR. BERENSON: So the construction lag would be going on before you actually secure the funding, the financing?

MR. BUTLER: You can't really get and use the money until you start your construction. So you would -- yeah.

DR. BERENSON: So I guess the point I'm making here is --

MR. GRADISON: I've wondered whether some of this, particularly in those three years, was actually refinancing at lower rates rather than for new construction. So I think you'd have to find out what they were raising the money for. It isn't necessarily for construction, I don't think.

MR. GAUMER: We did look into the refinancing issue, and specifically, I think we showed in the paper that the share that is new financing, you do see kind of a lot of refinancing taking place between 2005 and 2009, but that the general trend in borrowing is still there, the same flow or the same wave.

DR. BERENSON: Yeah. The other one, do we have any information about this new phenomenon of free-standing emergency departments? That wouldn't be in this data, I assume, and how prevalent is that?

MR. GAUMER: I've been looking through some of that stuff. I don't think the analysis is really complete yet, but we do see a bunch of that taking place. I've looked recently at some shops like that opening in the Houston area. There's a bunch associated with Swedish Hospital up in Washington State. And so, I can look into that more.

DR. BERENSON: And again, picking up on Bill Hall's comment, I'm not sure how I would use that for making a judgment about Medicare spending, but it's interesting information as to what's going on. So I wouldn't spend a lot of time.

MR. GEORGE MILLER: If I could just follow up on Bob's point, because I think it's a good one, particularly if some of this in the red line is refinancing versus new hospital construction, especially with the interest rates coming down. I know my system refinanced to get us a lower rate to build, and Peter is correct. There's about a three to six-year time frame as far as when the funds are available and then you actually start construction. In fact, we even changed architects, so it took us a little longer.

MR. HACKBARTH: So there are two distinct issues. One is the refinancing question and the other is whether there are lags in the data, the implication, I think, being that this decline may continue out into the future. The effect of the 2008 crisis may still be resonating through the system.

DR. BERENSON: Yeah, no, I mean that's the implication. I do see that the employment has turned back up again, which would seem to suggest maybe it's bottomed already, but it could well be that there's a continuing decline here that we would be seeing.

MR. HACKBARTH: Mike.

DR. CHERNEW: I have a question about Slide 3, which is, I think, the main indicators you used. So on the bed capacity one, you do it per capita, and I think you mean per beneficiary.

MR. GAUMER: Actually, no, it's per capita.

DR. CHERNEW: Because it's for everybody?

MR. GAUMER: Yeah. We look at everybody and -- yeah.

DR. CHERNEW: I understand. But you could think of all the other ones, also, being per capita. In other words, if there was an expansion of the number of hospitals, you would want a general expansion. So if you do the number of beds not per capita, you might find a slight increase. You do it per capita and then it looks flat, and the same is true for a lot of these ones.

So I guess there's a general question of what the right scale is. Certainly, employees, again, is going to go with the general flow of things. So I think my -- I realize there's this complexity because for the capacity ones they're serving the entire population, and then for some of the utilization ones, you care a lot about Medicare per se.

But in any case, I guess I would -- I understand

now what you're doing and my recommendation would be to just think about which ones really make sense to think about per capita and which ones don't. Certainly I agree that that's true for bed capacity. I'm not so sure some of the other ones you might also want to make a similar adjustment.

MR. GAUMER: Okay, thanks.

MS. BEHROOZI: This might just be one that I missed. On Slide 6, the specialized services, you know, so where do you get this data from, I wonder?

MR. GAUMER: This is AHA survey data, and the way it works is that the hospitals centrally -- I'll probably offend our friends at AHA in simplifying this -- but the way I understand it is in these surveys, the hospital is checking essentially whether or not they provide translation services or not and they check it at that hospital or within their network or within their system.

MS. BEHROOZI: Self-reported. But also, like translation isn't something that enhances a code or anything? It's not really -- it's not billable. It doesn't generate revenue, right?

MR. GAUMER: Right.

MS. BEHROOZI: But like adding PET scanners means

that you would be able to generate revenue in an indigent care clinic I don't think is a big money maker. I'm just wondering in terms of the analytical construct why we have those all on the same chart. I don't mean to be challenging it. I feel like I'm missing it. I keep seeing those as very different.

MR. GAUMER: Sure. Yeah, this wasn't intended to be a DRG-like comparison to see, you know, which volume of which service is going up or down. This was just what types of departments or what types of services in general are hospitals adding or subtracting. And, you know, if we saw five services that 100 or maybe 1,000 hospitals were dropping in the Midwest, that would raise a red flag and we'd want to talk about it, I think.

MR. HACKBARTH: So one way to think about looking at these data is, are there services that we're particularly concerned about? And I think this is where Bill was going. Because of the financial situation of hospitals, are burn units closing or psych units closing or indigent care clinics?

There's certain services that we may want to really have advance warning, as much advance warning as

possible if a negative trend is developing, as opposed to just sort of giving us the long list or giving us the top five increasers and the top three decreasers, maybe it would make sense to try to identify some sort of sentinel services that we really want to track. Is that --

MS. BEHROOZI: Also, just distinguishing the revenue-generators from the cost, you know, the cost drivers or whatever the things that might drag them down. If there's more of a need for indigent care services -- I mean, there's other things measuring that, obviously, or more of a need for translation services that they're not going to get reimbursed for, is that a harbinger of further stress, you know, to come later rather than the things, you know, imaging and whatever where they can arguably make a buck or something.

MR. BUTLER: Just to slide that shows the split between the outpatient and the inpatient decline, just a clarification there. So is this just hospital inpatient and outpatient spending? So it wouldn't say Part B, fee-for-service Part B beneficiary outpatient services? It's just the hospital part of Part B?

MR. GAUMER: It's volume and not spending and it's

-- yeah, it's just the hospital part of Part B, that's correct.

MR. BUTLER: But you say the volume --

DR. MARK MILLER: Charges in service. Yeah, claims goes to dollars. So it's like how many discharges and then how many --

MR. BUTLER: Well, services, and how do you count the number of services on the outpatient side?

MR. GAUMER: How do we count the number of --

MR. BUTLER: Sort of like you said before, if you have an employee position that wasn't -- every visit would be a part of that. So you've got a lot of different things in there anyway.

DR. MARK MILLER: On the outpatient bills, there is an indication of how many units of whatever the bill is, along with the dollars. So we can count the units that are provided.

MR. HACKBARTH: So is there any --

DR. MARK MILLER: I'm sorry. So if I did two X-rays, we count two X-rays as services, as opposed to how much spending on X-rays. That's what the outpatient per-service is.

MR. GAUMER: That's correct.

DR. MARK MILLER: Right?

MR. BUTLER: It's hard for me because they're not weighted and everything. You've got observation stage, you've got all kinds of stuff in those numbers, and no question they're going up faster than the inpatient is going down, but it's hard to draw too many conclusions from an aggregate number like that.

MR. HACKBARTH: They are not intensity-weighted in any way.

MR. GAUMER: They're not, no. It's raw volume of services.

DR. MARK MILLER: And I think, rightly or wrongly, what drove it in this instance is that we were looking at discharges per bene going down, which is a unit, an item, a widget -- sorry -- and then we wanted to try and say, Okay, on the outpatient side, then I don't want to count dollars and compare it to discharges. We were trying to put it on a comparable basis, which may not have worked for you, but that was the thinking.

DR. BAICKER: Just a very quick thing following up on that. If I had in mind a model where every discharge

translated to four services, you know, that things are getting broken up and so the same stuff is being done, but it's being counted differently, that would also be consistent with a quicker growth rate and also they're off of different bases and whatnot, but I would be interested to know if there were just a way to calculate a summary statistic of the typical stuff that's done in a discharge would show up as X services.

Obviously there are going to be a lot -- there's a lot of variation there, but should I have in mind that it's kind of one for three or one for one or trying to think about rough apples and apples.

MR. GEORGE MILLER: Excuse me. Kate raised an interesting question on that very issue and that is, would the discharge bill that's dropped, that would include X-rays and lab and all outpatient procedures, but you're counting it once versus all those things were done, and then comparing that to an outpatient procedure where there would be multiple ones.

MR. GAUMER: That's correct.

MR. GEORGE MILLER: Okay. Thank you.

MR. ARMSTRONG: I think this is a Round 1

question. I don't really have a specific question about your analysis, which actually I think is really excellent, but more it's around what we're trying of the accomplish with this analysis, and generally speaking, I want to make sure I'm thinking about this right.

We're trying to evaluate payment adequacy as a function of whether capacity is meeting demand in hospital-based services, right? Are there enough hospitals out there to take care of our beneficiaries, generally speaking?

MR. GAUMER: Yeah, I think that's fair.

MR. ARMSTRONG: And so, on Slide 2, we have a series of indicators that we look at for that. And I guess what I'm saying is that this is all good, but I'm not sure it's doing a great job of helping us to answer that question, because I think capacity matched to demand, the things I worry about more would be, first, I'm far more worried that we have too much capacity and that actually it creates demand, and that there's nowhere in here that we consider that or talk about that.

Second, I worry about huge variation in utilization because demand is actually a function of the number of beneficiaries times day per thousand, or something

like that? And so, we're worried that there's going to be a big growth in beneficiaries covered by the program, and the way we think about it is the only way to match that growth is to build more hospitals, but we never really talk about, well, what about days per thousand? Shouldn't we be actually more consistently monitoring some kind of utilization statistic like that?

And so, you tell me if that's kind of beyond what we're really trying to deal with here, but it just seems that, at least when I think about this, those are the things I worry a lot more about than, you know, some of the indicators that we're measuring right here. To me, that was a Round 2 comment.

Are we limited to looking at these indicators in this chapter, maybe is the really the more specific question that I have.

MR. HACKBARTH: The answer to that is no. Not limited in any way. And I agree with looking at some other indicators like, say, days per thousand and trends in that. Any of these indicators is not going to be hard-wired to a particular update number. Although this is part of the payment adequacy analysis, it doesn't lead through some

formula to a conclusion that the update numbers should be higher or lower, at least I've never thought of it that way.

I think of it more as sort of scanning the environment in a consistent way to see if there are things that leap out at us as potential significant signs that there's a change afoot in the care delivery system that we should be aware of. But having said that, again I think we could well add some other indicators to this. It may be subtract some that we currently have to better do that job.

MR. ARMSTRONG: So I just made my Round 2 comments then. I mean, I think --

MR. HACKBARTH: It was a good job.

MR. ARMSTRONG: That's the kind of information, as we go forward, I'd really like to know much more about, you know, how are we -- what kind of patterns are we seeing, what is our theory about how days per thousand or other statistics like that are influenced by whether it's our payment policy or it's other things going on in the marketplace.

MR. HACKBARTH: Yes. So when we get to the December discussion, we will be looking at some other indicators still like access to capital. Bill mentioned

that as something that he thinks would be meaningful to look at and that's part of what we'll talk about in December. So I'll shut up. Let's go to Round 2. Karen.

DR. BORMAN: In terms of looking at some of the questions that Zach brought to us, one thing in getting to maybe in the same ballpark as Bob Berenson's question about free-standing emergency centers, I know in the past sometimes we've looked at provision of trauma services, and I think that that may, in fact, be something of a proxy for the ability to deliver acute care services, because in order to sustain some sort of trauma system, you probably need to have a number of services that you can provide acutely.

And so, I know in the past we've looked at that, and it sounds in the chapter like you may have looked up some things that you didn't put either in the draft chapter or on the slides, and if you do have that number, if we do consider it, maybe as an index or a proxy for emergency care, that might be helpful to add back to the list.

The one thing I would say about the bariatric service is that it may be something that exemplifies the service line approach to hospital services because it does take a fairly broad multi-disciplinary team to do properly,

and most -- because I see it from the surgical side and I've listened to a number of presentations by the bariatric general surgeons who do the bulk of this.

It sounds as though that is the organization. So if we were trying to maybe get a little bit of a handle on service lines, that's one. But I guess one in my mind that maybe matches up a little better to Medicare beneficiary needs might be oncology, specialized oncology services, because I think that is a disease that we do see, you know, prostrate cancer, breast cancer, lung cancer certainly we see more in the Medicare population, and if we wanted a service line proxy, that might be a better one. I don't know that that's why you picked bariatric, but I just throw that out there as a conversation piece.

In terms of the implications of the site of service shift from the inpatient to outpatient setting, this so interdigitates with the payments cross-settings, the conversation that we're going to have tomorrow, and I think the two, at least for me the draft chapters really reinforced each other a lot in the sense of, as Ron Castellanos said earlier, following the money in terms of, as we've looked at the growth in various Betos categories,

as we've looked at just different kinds of service growth, looking at observations services, imaging services, dah, dah, dah, these are where the building is going.

Now, it seems to be maybe on a little bit of a time lag and that's explained by the capital funding. But I don't know that I exactly understand where the shift in the site of service will necessarily impact how much money it takes to deliver.

I mean, what's changing here is the mix of services that is being delivered under the hospital umbrella. And so, the question still remains, I would think, and maybe I'm not understanding this correctly, for the update, is the update adequate to support the mix of services that are being delivered using, as a filter, are these the right ones for Medicare beneficiaries. So if I have that wrong, I need correction.

But it seems to me it's more important -- the part about the shift is more important as we think about the payments across the settings than maybe it is specifically about the hospital update. I freely admit I might be missing something there, but that strikes me.

MR. HACKBARTH: Bill.

MR. GRADISON: This is an annual exercise. The rural study, in-depth rural study is not, but it seems to me that there is some very good information already developed there that could permit us to have a much more expanded report on access to rural hospitals than the other factors that you're looking into without doing any additional work and hopefully without committing us to make such a deep dive into rural issues every year.

DR. STUART: I'd like to pick up on a point I made in Round 1 on Slide 7. Zach, what I'd really like to know is, how many years is it going to take before we have a single national hospital chain?

DR. MARK MILLER: We'll --

DR. STUART: And I ask that in the context of this tradition of having long-term Medicare projections.

MR. GEORGE MILLER: Well, following Bruce, let me be provocative in a different way and that is, along with Scott's concern or things he's worried about, about bed per thousands, it just occurred to me that maybe, especially with the critical access program, maybe every hospital isn't a hospital and the fact that we have specialty hospitals, maybe we need to think about -- to look at a different

payment mechanism for a different class of hospital.

Again, I'll be very kind. Nothing against specialty hospitals at this point and for-profit hospitals. But if that's what they are, then maybe we ought to put them in a different category, different payment, because they're not providing the full service, and create a different payment mechanism so that the thrust of the payment -- excuse me -- beds per thousand isn't impacted by that group because they do a specialty and not a full service hospital.

I don't know if that has traction at this point in time or if it makes sense when we're doing a payment update, but that may be something to consider down the road, create a whole new category for that type of hospital that doesn't offer the full services and doesn't have all the complexities that is required by regulation and law for full-service hospitals, create a whole new category, and then we would decrease that bed per thousand to your point. Something to think about and just throw it out for discussion or not.

DR. CASTELLANOS: Could you turn to Slide 3, please? Mike brought up a point about the bed capacity and that's per capita. I can understand why they do that. And

per capita, it looks like we're okay. Nancy Kane, last year, I remember, and myself had some issues. I think the national study shows that, but there's certainly regional changes.

In my community, we have two times the normal national average of people over 65. We have a 30 percent fluctuation. With the aging of the Medicare population and the fastest generation growth is between 80 and 90, that capacity may be interesting to see bed capacity per Medicare population. It may be an important thing to look at. We are a Medicare payment advisory commission, so maybe that would be an interesting statistic.

Can you go to, I guess it's Slide 6? Bill kind of pointed out some issues there and I'd like to kind of point out some issues, and I think Scott said it, also. The services that you're listing here, I'm not quite sure what the value to the Medicare system really is.

I understand if I comment on robotic surgery, my other urology colleagues are going to probably lynch me on it, but the real value isn't known yet. It's much more costly and really the statistics are really unknown whether it is of value. I really think we have such an increase of

robotic surgery, we do robotic surgery in our community, and the only reason we're doing it is because it's a marketing tool. I'm sorry, but is that a value to the Medicare system or is it a value to the surgeons doing it and perhaps the hospitals?

And, Bill, you mentioned the PET scanning, the reason we have an increase there is you want to keep up with what's happening in the community. So I think we really need to look at what the value to the Medicare system is.

MR. HACKBARTH: So two points. One is, as I said earlier, it seems to me that we may want to go down the path of identifying some select services that we think have some particular importance. I'm not sure exactly where that path leads, but that makes sense to me and that's a comment that both Bill and Ron have made.

The second thing I would say, though, is for people in the back of the room who can't read the fine print at the bottom, this is not a normative statement at all. Zach did not choose these particular services. There's a list of 50 services on the AHA survey. He is simply reporting the five at the top and the three at the bottom.

And so, he didn't select bariatric surgery as

something particularly important to highlight. It's just that it was one of the five on the top of the list. So I just wanted to make that clear to people who can't read the small print.

DR. MARK MILLER: And actually, just because there have been so many comments on this table, let me give you some different ways to think about this, not -- you know, we can narrow it down and say there are certain things we want to track, sentinel services, if you will. But just to give you some sense of where this comes from.

One way to think about all of these measures is -- and I think Glenn was saying this a few minutes ago. It's like if you saw large numbers of hospitals closing and occupancy rates going up extremely rapidly and lines of services being dropped, you know, huge movements in the data, you might say something is up and we need to be paying attention to it.

In the past, some of what drove this table is people would say, Well, you're counting hospitals and you're counting beds, but you could have a hospital and you could have beds, but lines of services could be discontinued and we'd like to know about that. So that drove some of this.

And the reverse, which is, you might say robotic surgery, it's just a loss leader or, you know, a CT scanner that was put in, you know, to keep up with the Joneses or for revenue, whatever the case may be, that's also indirectly telling you what the circumstances of hospitals are, where they're putting their efforts and whether they have the revenue to do those types of things.

And so, I get the sentinel important service idea and we can certainly organize this data much differently, but in the past, people have asked those questions -- these questions about this data for those reasons as well. You would see lots of additions of imaging services, and then people would say, What are we doing? Why is this happening and should we start focusing on that? So it kind of cuts a lot of different directions in what this data can be used for. Sorry. I didn't mean to go on.

DR. CASTELLANOS: One more point. I know we're seeing that construction is down or slightly down. I just would like to know the capital spending that hospitals do. Is it down because construction is down or is it down because EMR costs are so high now and hospitals are putting so much money into EMR, et cetera, maybe that's where the

money is going in the capital spending rather than construction.

MR. GRADISON: Maybe they all have their atriums.

DR. NAYLOR: So this was an excellent report and under the quality, I think one factor to highlight that really stood out for me was not just the growth in employment, but the growth in recruitment of people with advanced training and skills relative to less training and skills.

So there's investment in physician assistants, pharmacists, more nurses, fewer licensed practical nurses. I think that that's a really important statement to highlight in terms of, you know, Medicare's capacity within the hospital system.

DR. HALL: I'll pass.

DR. CHERNEW: I really do like looking at this work. My one concern would be, in the spirit of what Ron was saying earlier, this is going to be local, and so it's useful to look at these numbers, but I'd also like to know, how much variation is there? Are there areas that have what seems to be a shortage and other areas that seem to have a big surplus in capacity?

Because I think we could get these numbers and they could look perfectly fine for whatever reason and we could be completely missing out about access in some areas than others.

MS. BEHROOZI: Mary, I actually had a different reaction when I saw what you were looking at. I mean, I think the fact that it's not all at the doctor and all -- that the hospitals are relying on physician assistants and RNs and higher skilled people within certain classifications is good, except that we also know that lower skilled people cost less.

And so, I think in other contexts we've talked about moving toward having people work at the top of their licensed or non-licensed position, or whatever, in order to make for a more efficient, whether it's a hospital or a nursing home or whatever institution that's separate from the numbers of them and the relative numbers of them. And I'll have more to say offline to you guys about the way you characterize hospital employment. That's offline.

DR. MARK MILLER: Oh, it's on.

MR. BUTLER: Okay. So speaking of on the transcript, George, you know, after you say specialty, you

have that little laugh. How can you capture that on the transcript? That kind of says it all.

[Laughter.]

MR. BUTLER: Then we know what you're really thinking. So next time you do that, okay.

MR. GEORGE MILLER: We could [off microphone].

MR. BUTLER: Okay. Here's the positive thing and then I'll have some constructive suggestions. It is trying to capture, give us guidance in any of the pricing update, and it basically says, Do we have reasonable access to not just hospitals, but to hospital services. Is there anything in the baseline that would suggest, that would help give us guidance on the update?

And I think overall, you've captured it. It's a relatively stable set of services. You can argue it up a little, down a little, but it's about the same number and about the same places with about the same range of services and there's nothing that pops up that says that the supply has gone one direction or another dramatically in a way that you ought to take that into account in pricing. So that's -- and so, if you didn't change a word in the chapter as it is, I think you've kind of captured that.

So now most of mine could be, I think, how do you make it better maybe next year even rather than this year? So on the services, I won't pile on, on the AHA survey, but I would suggest it would be interesting to have such things as how many are meaningful users? How about, do they have Medical Homes? How about tracking the number of employed primary care physicians? How about, are they in an ACO or not?

I mean, some of those would be interesting because they're what we're trying to encourage. And then when you look at the financial health, you could also kind of say, And by the way, are those things merited? Are the same people that are financially healthier, are they having the kinds of services that we're looking to have occurred? And then you'd have a little richer analysis in terms of kind of the services we're trying to create that are new as well as the correlation with the financial health.

On the financial health side, I don't like employment, so I'm in your camp on that. I don't think it's a very -- if you were to look at the financial health and if Wall Street were to look at it, they would never look at the number of FTEs in an organization.

I think it's pretty simple. I think you look at operating income, you look at day's cash on hand, because that tells you how much cash they've got in the bank, and those two things by themselves capture a tremendous amount of information about the financial health of an organization. You may have a lot more employees because you've merged with two lousy places that are weak, together you have more employees, but it doesn't -- you know, so those are the two big indicators that rating agencies look at, operating income and day's cash on hand.

I think it would be very helpful to know if day's cash on hand are trending dramatically down, and so you have a bunch of places that are just on the brink, and if they're also not making operating income, they're in trouble.

And then the third one, on the capital spending, I think we're also kind of beating around the bush and looking at ability to borrow and things like that. I would look at the total capital spending as a percentage of depreciation, and that you do put in here and you do say it's gone from 1.6 in 2006, or Citigroup or whoever -- Moody's -- said it's gone from 1.6 to 1.1. It's kind of systematically ratcheted down.

So right now, the total capital investment is just barely over depreciation, and if you -- that means, if you could replace everything at the price you bought it for, you'd be about even. But we know things cost more than they do. So over time, if that thing is at that level, you're going to see that, you know, you're not keeping up with things.

And as Ron pointed out, even if you looked at the mix of spending now, you would say -- and by the way, that's a median number so that means half the places now are not replacing what they've already got. And if you looked at the mix, you'd see IT has gone probably from, say, 5 percent to 25 percent of that capital spending in the last four -- I don't know, but whatever it is, it's gone up 14 percent a year while others have not.

So I would look at those three things, operating income, day's cash on hand, and capital spending as a percentage of depreciation. Finally, I think the private equity presence, that is something -- I'm glad you put that in there. It's something to kind of follow because it's having an impact in markets, whether it's in Boston or even places like Duke that is pairing with an organization or the

big Catholic chain.

It's a different kind of newer source that may have good or bad consequences, I don't know, but it is. And so, I think it's good that you put it in there because I think people are thinking about, okay, I've tried every other route. Maybe I'll do that. And so, I'm glad it's highlighted.

DR. BAICKER: I share the feeling that we might tweak the measures or come up with slightly different metrics, but that the picture seems fairly consistent that we don't see evidence of an access problem. I also, as you know, I'm not a huge fan of the employment metric, although it's an indicator of industry.

I don't know if it's for the same reason as metrics or not, but I want to avoid thinking that we want to evaluate our policies based on their affects on employment so the causality can sometimes get muddy.

With that said, I think the overall picture seems fairly clear and I think Mike's suggestion of getting a little more nuance on variation within the average would be helpful. With that said, these metrics seem very informative.

MR. HACKBARTH: Okay. All right. Thank you, Zach. We are finished for today. We'll now have our public comment period.

[No response.]

MR. HACKBARTH: Okay. It looks like we are done for today and we will reconvene at 8:30 tomorrow morning. Thank you.

[Whereupon, at 4:43 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, November 4, 2011.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 4, 2011
8:32 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
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

AGENDA PAGE

P R O C E E D I N G S [8:32 a.m.]

MR. HACKBARTH: Okay. Good morning. We have two sessions today, the first on payment rate differences across ambulatory sectors. And who among this distinguished group is going to first? Jeff.

DR. STENSLAND: All right. Good morning. Before we start, I want thank Matlin, Carlos Zarabozo, and Kevin Hayes for their help in examining differences in payment rates across sectors.

The reason we're discussing payment differences across settings is that we're seeing a shift of Medicare patients to settings where Medicare pays higher rates. Hospitals have been acquiring practices for a long time, but the pace of practice acquisitions is accelerating, so the effect of discrepancies in payment rates across settings is increasing in importance.

Many factors have been cited as contributing to this trend such as the desire of new physicians to have stable, predictable working hours, increased difficulty and cost of running a private practice, preparing for accountable care organizations, and the potential for increased reimbursements from both Medicare and private

insurers.

Regardless of the cause of this trend, it will shift billing of services from free-standing practices to outpatient departments. The result of such a shift would be to increase program spending, increase beneficiary cost sharing, and potentially create an increase in providers' coding and billing expenses, even if the care received by the patient does not change at all.

Let's see. I'm missing something.

Today we're going to talk about -- there's two different types of practice acquisitions, and the purpose of this slide is to show that we are not concerned about all different types of practice acquisitions. There's only a specific type of acquisition that causes concern.

Specifically, we are concerned about the first type of acquisition on this slide. In this case, a hospital acquires a practice and starts billing for the services as if the practice is an outpatient department. As I said before, it's possible that care does not change at all, but Medicare prices could increase substantially.

A second concern is that inefficiencies could develop. When the physician office becomes an outpatient

department, there are some overhead cost increases that may not have anything to do with patient care. For example, the hospital would now generate two bills, one coded for the physician service and a second bill coded for the hospital's facility fee. The patients are often confused when they start getting two bills for a service that they used to receive one bill for. Hospitals may pursue this less efficient method of delivering outpatient visits purely because Medicare and private payers set up financial incentives to declare a physician's office part of the outpatient department.

As I said, we're not saying all practice acquisitions create concerns. The second type of acquisition shown in this slide is where a hospital acquires a physician practice and continues to bill for services as a freestanding physician's office. Hospital ownership of the practice and integration of care is not dependent on the hospital calling the physician office an outpatient department. Under this second type of acquisition, the change in ownership by itself does not result in a change in Medicare payments. Changes in Medicare payments will depend on changes in the services provided and the quality of those

services. And today's discussion would not affect this second type of acquisition in any way.

And now Dan will talk about some of the trends in physician hospital.

DR. ZABINSKI: Okay. To determine the extent to which hospital acquisition of physician practices has caused a shift from free-standing physician practices to OPDs, we examined Medicare claims. From this analysis, we found that among all office visits provided to Medicare beneficiaries, the percentage that were provided in OPDs increased from 5.9 percent in 2008 to 7.3 percent in 2010. And although this chart also indicates that the OPD share of office visits increased from 2004 to 2008, the rate of increase has been higher in more recent years. Other ambulatory services have also shown a steady increase in the percentage being performed in OPDs.

For example, we examined the ambulatory services provided by cardiologists from 2008 to 2010. We found that among ambulatory echocardiography services, the percentage that are provided in OPDs increased from 22 percent in 2008 to 29 percent in 2010. Also, among nuclear medicine services provided in ambulatory settings, the percentage

provided in OPDs increased from 11 percent in 2008 to 16 percent in 2010.

This trend may be, at least in part, due to large differences in Medicare payment rates between sectors. For example, when Medicare payment for a commonly provided echocardiography service is provided in an OPD, it is 102 percent higher than when it is provided in a free-standing physician practice. And for a commonly provided nuclear medicine service, the Medicare payment rate is 75 percent higher if it is provided in an OPD.

As an example of how a shift of services from free-standing practices to OPDs would affect spending and beneficiary cost sharing, consider the case of a mid-level office visit indicated by CPT code 99213. I'd like to focus your attention on the last row of numbers on the table.

If this service is provided in a free-standing physician practice, total payment for the service would be the nonfacility rate in the physician fee schedule of $68.97, with the physician receiving the entire payment.

But if it is provided in an OPD, there would be a reimbursement for the physician's service at the facility rate in the physician fee schedule of $49.27. This is

obviously a lower rate than the $68.97 that is paid in the free-standing practice. However, I want to emphasize that this difference is due to lower reimbursement for physicians' practice expense when provide in an OPD, but reimbursement for physician work effort is the same in both settings.

Then in addition to the $49.27 paid to the physician when this service is provided in an OPD, the hospital would be reimbursed $75.13 under the outpatient PPS. Adding these reimbursements together results in a total payment of $124.40 if the service is provided in an OPD, which is 80 percent higher than when the service is provided in a free-standing practice.

What we see on this table is typical of most ambulatory services: that payments are much higher when provided in an OPD compared to a free-standing practice.

The data that we've presented so far, although they present a shift from free-standing practices to OPDs, the shift has not been large. But a large shift is still a concern because when you have a large shift from free-standing practices to OPDs, you have a potential to substantially increase aggregate program spending and

beneficiary cost sharing.

For example, in 2010, there were 220 million office visits provided in free-standing practices. But if 50 percent of them had been billed as provided in an OPD, program spending would have been higher by $5.4 billion and beneficiary cost sharing would have been higher by $ 1.3 billion.

Now I'll turn things over to Ariel who will present policy options for addressing these issues we discuss today.

MR. WINTER: I'm going to start off by proposing some principles for aligning payment rates across settings.

First, Medicare should strive to ensure that patients have access to settings that provide an appropriate level of care. If same service can be provided safely in different settings, it may be undesirable for the prudent purchaser to pay more for that service in one setting than another.

Further, payment variations across settings may encourage higher-paid settings to expand and attract more patients, thereby leading to higher Medicare spending. Therefore, Medicare could base payment its rates on the

resources needed to treat patients in the lowest-cost, clinically appropriate setting.

There are some important factors that we may want to consider in aligning payment rates across settings. First, there may be differences in patient severity across settings that could affect the cost of providing the service. Second, hospitals incur additional costs related to their unique mission and regulatory requirements. Many hospitals maintain standby capacity to handle emergencies, and they are also subject to regulations like EMTALA and Conditions of Participation which do not apply to physicians' offices.

Finally, there are differences in the level of packaging of services in the outpatient PPS and physician fee schedule. For example, the cost of ancillary services and supplies are more likely to be packaged with a primary service in the outpatient PPS than the fee schedule, and this can affect our ability to compare payment rates across settings.

We're going to talk about an option to equalize total Medicare payment rates across settings for E&M office and outpatient visits that are not provided in emergency

departments. And the rationale for selecting these services is as follows:

We noted on the prior slide that we need to be mindful of patient severity differences by setting. One way to look at patient severity is to compare average HCC risk scores for patients who are treated in different settings. And as you know, risk scores are used to adjust Medicare Advantage payments. They indicate the expected costliness of beneficiaries based on their age, gender, and diagnoses in the prior year.

We found that Medicare patients who receive E&M visits in outpatient departments have higher risk scores on average than patients who are treated in physician's offices. However, the coding structure for E&M visits accounts for variations in resources related to patient complexity.

For example, CPT code 99213, a mid-level visit, is used for visits that typically include 15 minutes of face-to-face time between the physician and patient, whereas CPT code 99214 is for visits that typically include 25 minutes of face-to-face time and also involve a more detailed history and examination. So if a sicker patient requires

more time and resources, this should be reflected in the code assigned for the E&M visit.

We also noted that hospitals incur additional costs related to their standby capacity and regulatory requirements. However, we should ask whether it makes sense for Medicare to cover these additional costs if the program can obtain E&M visits from a lower-cost setting.

Finally, very few ancillary services are packaged with the cost of these E&M visits in the outpatient PPS, which means that the unit of payment is similar across settings.

This table illustrates how this policy option would work using a mid-level visit as an example. The first column of numbers indicates payment if the service is provided in a free-standing physician's office. In 2011, Medicare pays the physician $68.97, which includes the work RVU, the professional liability insurance, and the nonfacility practice expense. There is no outpatient payment so the total payment is $68.97.

The second column of numbers indicates total payment if the service is provided in an outpatient department. The physician receives a payment of $49.27,

which is less than the payment for a visit provided in a physician's office because the practice expense amount is lower when the visit is provided in a facility. However, the physician work stays the same.

The hospital receives a payment of $75.13, and the total payment is $124.40, which is 80 percent higher than the payment in the first column.

Finally, the third column of numbers indicates the total payment amount if the service is provided in an outpatient department, but the outpatient rate is lower so that the total payment is equal to total payment when the service is provided in a physician's office.

To accomplish this, the outpatient rate is set equal to the difference between the physician fee schedule's nonfacility practice expense and the facility practice expense. And just as a reminder, the nonfacility practice expense is paid when the visit is performed in an office, while the facility practice expense is paid when the visit is performed in a hospital.

The physician still receives a payment of $49.27, just as they do under current rates. But the payment to the outpatient department drops to $19.70.

The rationale for reducing the outpatient rate is to equalize the total payment amount across settings. The option illustrated here appeared on the Commission's list of savings proposals for the purpose of assisting Congress in offsetting the cost of repealing the SGR. According to staff estimates, this would reduce Medicare spending by about $5 billion over five years and by about $10 billion over ten years. And this slide simply puts this policy option that we illustrated on the table before into words.

So there are some other issues we plan to examine in future work. We want to address payment differences for other services that are usually provided in physicians' offices. In doing so, we'll consider the same issues we considered in our analysis of E&M services, namely, patient severity differences across settings that could affect costs, hospitals' additional costs related to their unique mission and the cost of meeting additional regulatory requirements, and differences in the level of packaging across settings.

We also plan to explore options for increasing the level of packaging in the physician fee schedule so that it's more comparable to the outpatient PPS.

So we have a couple of questions for your discussion, ideas for your discussion. We would be interested in getting feedback on the policy option we discussed for equalizing total payment rates for E&M visits across settings. In addition, are there other issues you would like us to examine? And do you have additional questions or requests for additional research?

Thank you very much.

MR. HACKBARTH: Thank you. Could I ask you to put up Slide 12, the methodology for equalizing the rates? I understand why you did this, but all of this money is going to the hospital, right? To qualify under this, there aren't separate payments made to the physician and to the hospital. This has to be a hospital-owned unit to qualify for the payment. So does this really -- the important thing is the bottom row, not how you split out the dollars between the professional piece and the facility piece, correct?

MR. WINTER: To be eligible for the outpatient payment, the entity has to be owned by the hospital, and there are other requirements that have to be met as well under the provider basic rules.

MR. HACKBARTH: Right.

MR. WINTER: If the hospital employs the physician, then it's getting the entire payment at the bottom row. But in some cases, the hospital may own the entity but contract with the physician, in which case the physician could bill separately.

MR. HACKBARTH: I see.

MR. WINTER: Or the hospital could have some arrangement where they pay the physician a portion of the full physician fee. So it could vary depending on the arrangement.

MR. HACKBARTH: Okay. Round one clarifying questions.

DR. BORMAN: Do we know how this intersects with teaching hospital status and payments in that not based on data, based on some prior experience, and sort of a visceral sense, there might be disproportionate representation of academic practices in this model, and that might have some bearing as we consider policy options? So if we don't know that, it might be something worth pursuing before we get to some endpoint on this.

I think the other thing I would ask is just as we rightfully say that there are some less easily quantified

but, again, visceral feeling hospital mission costs, are there some things on the flip side that sort of we'd have to consider in fairness? That is, are there some things that when the service is provided in a physician's office -- and this doesn't hold so much for E&M because I agree with you that they're pretty much apples to apples. When you start to look at other things, do physician offices have the same contracting power? Do they not perhaps increase the skill level of their personnel in order to support the eventualities that are uncommon but could happen in their offices by virtue of doing some of these procedures?

So, you know, I start to be looking at intangibles versus intangibles, or at least things I don't know how to measure versus other, and so I'm a little less swayed by that as an argument for higher rates in the HOPD. So if you have anything that would help me think about putting a dollar value to that and what the dollar value might be on the physician side that's excess cost that they're shifting, then that would be helpful.

DR. ZABINSKI: Yeah, well, you talked about the disproportionate representation of the teaching hospitals. Running the numbers, one thing we did find is that as a

percent of total outpatient department volume, the major teaching hospitals have a higher share of these E&M visits than basically all other hospital groups. There's a pretty wide difference from one category to another, like proprietary hospitals have about 5 percent of their volume from office visits, while major teaching hospitals have about 25 percent. So there's quite a bit of difference from one hospital group to another.

MR. WINTER: If I can respond to the second part of Karen's question, which is if an office is acquired by a hospital and performs more intensive procedures, there's a need to increase its skill level and maybe acquire other resources. And so for the next set of services we want to focus on after we get past E&M would be services that are commonly provided in physician's offices, like more than 50 percent of the time, but may also be, you know, provided in an outpatient department, and the volume may be shifting to outpatient departments.

So it demonstrates that for many patients, at least, the office setting is an appropriate and safe setting for those services, so that might be the next level of services to focus on.

DR. BORMAN: Just to be clear, my point was that when it is delivered in the physician office, the physician office may, in fact, have some things that it has to account for, just as it would have to be accountable for in the HOPD to make it safe that are costs that are sort of picked up in that. So just as we say the hospital has a mission to do all these things and has to do EMTALA and all those other kinds of things, there may be things when the service is provided in the office that, in fact, increase the cost in the office so that this kind of increased cost kind of happens in both sites of services, I think, although I'm not sure what the differential between those two may be because they're kind of a bit ephemeral costs to pin down.

MR. GRADISON: Can we get any information with regard to how Medicare Advantage plans handle this same issue and through that perhaps gain some insights into alternatives that we should consider?

MR. WINTER: So we've talked to a couple of private insurers, one of which had a Medicare Advantage plan, and their policy really varies. Some insurers do pay the additional facility fee for these kinds of visits when they're performed in a hospital-based office or setting;

others do not. And so it does seem to really vary, but w have only spoken to a handful. We have not done a really broad survey. But we can try to expand our analysis in this area and try to focus specifically on Medicare Advantage plans.

DR. STUART: This is kind of a follow-up on that from a slightly different angle. As I understand this, it is simply where the service is provided, not who is providing the service. So that if you had a physician who had private offices but then also worked in an OPD and provided exactly the same service, it would be reimbursed at different rates, depending upon the setting. I know that's true because it has happened to me.

And so one of the questions here is whether you have looked at that in the data. In other words, if you had the physician ID, you would be able to determine whether this practice is common. And to the extent that it's common and it's the same patients that are being treated and the codes are the same, then that provides some pretty compelling basis for doing the kind of policy change that you're suggesting here.

MR. GEORGE MILLER: On this slide, can you tell me

if you've had the ability to determine if the $19.70 covers the cost based on what you talked about the unique mission? Or did you just figure out the difference and just put that number in?

The second part of the question is -- and I think I asked this yesterday, but have we been able to measure the impact of bad debt that may increase because of the current economy and the unemployment, and if this number would cover potential increase in bad debt because of the change in the economy and unemployment.

DR. STENSLAND: We didn't arrive at the $19.70 by trying to accommodate the costs. The $19.70 was arrived at by trying to equalize the end payment rates to keep the payments level. And so if indeed it does cost more to provide the service in the hospital-based setting but we don't appear to be getting anything additionally out of it to go to that more costly setting, by making this policy move we would be discouraging that movement toward the more costly setting and keeping it in the less costly setting.

In terms of bad debt, we didn't compute that into here. Of course, the bad debt -- in the physician's office, if there's bad debt, they don't get paid any of that. They

absorb it. In the OPD they do get some bad debt reimbursement. So, if anything, that makes the differential and rates even bigger than what we're showing here.

MR. HACKBARTH: Let me introduce an idea of Bob's, and then he can elaborate. One way to think about this is we ought to equalize the rates, not worry about what the costs are. As Jeff says, if they can cover their costs, maybe they'll get out of the business or reduce their activity.

Another way to think about it is that we really shouldn't price differently for the same service based on the type of provider. If we want to cover costs associated with the unique role of hospitals, we ought to increase payments where there are not clear, competitive substitutes. And so you would put the money in the inpatient rates as opposed to paying higher for E&M visits. Then, you know, it's a continuum. You can do somewhere in between those two and, you know, offset part of it in the inpatient rates. So, you know, there are policy alternatives here, different paths you can go down.

Anything you want to add on that, Bob?

DR. BERENSON: Yeah, that was the idea, is pay

outpatient rates comparable or have some narrow difference for something, but close to the same or the same. And then put those unique characteristics -- I mean, Glenn basically said it. As I was listening to Ariel's presentation of what those unique things are, they largely are not related to outpatient services. Outpatient services aren't open 24 hours for the most part. Having stand-by capacity means the OR is available, there's a trauma team on call, some of whom are getting paid to be on call.

So it actually seems to reflect where those costs actually are, is more in the inpatient capacity, the ER capacity, and so formalizing it in a way by just that's where the costs should be allocated to and we keep the outpatient rates comparable or the same has some appeal, I guess is what I'd say.

DR. CASTELLANOS: I'll have a lot of comments in round two, but a clarification. Two issues that came up. George, you just mentioned bad debt, and then you said "some." Well, in the Medicare age group in the hospital, 70 percent of bad debt is reimbursed. In a critical access hospital, as we found out, 100 percent of bad debt is reimbursed. So it's not some. It's a significant amount,

and the issue here, again, is not in -- it's just in the hospital setting, not in the doctor's office.

The other question just for clarification, Ariel, you mentioned EMTALA does not affect the physician. I think you may want to look into that and check with the AMA. They have done some surveys. General surgeons, affected about 50 percent of the time, according to their survey, and ER doctors, some ER doctors are private doctors working in the ER, and that's about 95 percent of the time they're affected. So I think EMTALA does affect the primary doctor also.

DR. HALL: I'll also have some comments in round two, but I just wanted to refer back to Slide 8, just the statistic here. There are some metrics that there were 122 million office visits in free-standing practices. What's the opposite number for hospital-based practices? Are we talking about a 2-percent problem or a 25-percent problem?

DR. ZABINSKI: It's in here, but it's not coming out.

[Laughter.]

DR. STENSLAND: It's about 7 percent.

DR. ZABINSKI: Right, 7 percent.

DR. HALL: It's sort of are we talking about angels dancing on the head of a pin here. I don't think so.

DR. ZABINSKI: No, it's somewhere in the 15 to 20 million range.

DR. HALL: Okay, so it is quite a bit smaller.

DR. ZABINSKI: Yeah, quite a bit smaller.

DR. HALL: Maybe 10 percent or less compared to--

DR. ZABINSKI: Yeah.

DR. HALL: Okay. Thank you.

MR. KUHN: Two good questions. One, if I remember right, what we're dealing with here is kind of the provider-based rules, so basically one of these physician clinics or offices has to be under provider-based in order to get the higher payment rate. Could you just recap for us a moment what are the criteria for provider-based? I think there's like a 30-mile radius, just so we have kind of a grounding of which facilities we're talking about and which ones we're not.

MR. WINTER: Sure. We have a text box in the mailing material that describes this in more detail, but I'll just give you the high-level summary. There are rules that apply to all hospital-based entities or provide-based

entities, whether they're on campus or off campus, and there are five main criteria. One is that they have to operate under the same license as the parent hospital. They have to be clinically integrated with the parent hospital. For example, the professional staff of the facility has to have privileges at the main hospital. There has to be financial integration, shared income and expenses. The entity has to be held out to the public as being part of the parent hospital, so if someone walks into the facility, they know this is part of the main hospital. And if it's an outpatient entity, it has to meet the general obligations of an outpatient Department, like EMTALA and anti-discrimination rules and some other things.

Then there are some additional requirements that apply to off-campus provider-based entities, and the one you referred to is that they have to be within 35 miles of the main hospital campus. There are exceptions, including one for rural health clinics that are part of a rural hospital. Two other main requirements are that they have to be under the ownership and control of the hospital. For example, they have to be 100 percent owned by the parent hospital; they cannot be a joint venture. And there also are

administration and supervision requirements, so the entity has to be under direct supervision of the parent hospital, and the administrative functions have to be integrated between the entity and the parent hospital.

MR. KUHN: Thank you. That's a great overview.

Then the second question, kind of following up on Bill's question when he was talking about the order of magnitude here, 15 to 20 million visits per year we're talking about. If you take the cohort that you're talking about now of the E&Ms, what percent of that 15 to 20 would be the E&Ms?

DR. ZABINSKI: Well, let's see. This is all E&M, this slide here. It's the office visits.

MR. KUHN: I guess to rephrase the question, I think you mentioned at the end that if the proposal that we're talking about here would save $5 billion over five, $10 billion over ten, you know, what's the total spend of hospital -- of these procedures going to the hospital? And which percent of that are we being impacted by the policy option you're talking about now? Is it half? Is it even half of what is going on in the outpatient department? Is it -- you know, you mentioned earlier that 25 percent in

teaching, maybe 5 percent in proprietary. What percent are we talking about here?

DR. ZABINSKI: It's about 12 percent, approximately.

DR. BERENSON: Another statistics question. You were sort of getting at this. What percentage of outpatient revenues are E&M? Is that a number you know? You said there was a range from 5 to 25, you gave earlier. Is it in the middle somewhere?

DR. ZABINSKI: That's one -- I don't know that. I want to know it, but I don't know it yet.

DR. BERENSON: Okay. The reason I ask is that I'm interested in the future work when we go beyond E&M, I'm sort of -- because I think some of what's going on in the market now is related not to E&M services, like cardiologist services, et cetera. So I'm just getting a sense of how much of this problem we're tackling with this policy.

DR. STENSLAND: And I just want to be clear. This 5 to 25 percent we're talking about, that's just a simple count of services. So it might be a $60 E&M service counts as one, and, you know, the $600 MRI counts as one. So on a dollar basis it's going to be much smaller.

DR. BERENSON: Right. It might be lower, so significantly lower. Okay. I think that will be important to help us decide how much we want to go into this area to know how small of the problem we're tackling here.

The other thing I had to follow up on the provider-based discussion has to do with how we're framing this discussion and the policy solutions. Jeff, you presented -- one of your slides, 4, was about acquisition and the provider-based discussion is about when is a medical practice part of an outpatient department and when is it not. But the broader trend, as the paper talked about, is just employment, regardless of how the employment occurred. And the policy we're recommending seems to be about employment, not about provider-based per se. Do we want to -- you can comment on that, but the question is: Is there a role for us to be also working on the provider-based definitions, the whole list that Ariel went through, until -- because I would anticipate getting this kind of thing in place will take long, you know, an equivalence of payment, then maybe some short-term fixes to the provider-based definition.

DR. STENSLAND: I think this really just addresses

provider-based. Getting back to the two types of acquisitions, sometimes the hospital will buy a physician practice and continue to operate it as a free-standing entity. So nothing changes in Medicare billing. All the stuff we're talking about, nothing changes. It's just if they decide to make it a provider-based outpatient department, then the billing changes and then some of these policies --

DR. BERENSON: What I'm suggesting is that there are fully integrated practices in a teaching hospital. We're not talking about -- they're on campus. They're in the office building next door to the hospital. Everybody agrees that they're provider-based. The policy we're considering would reduce reimbursement for those physicians. It's not like they're 10 miles away in their usual practice. The policy we're recommending isn't about sort of the nuances of the provider-based definition, right?

Mark, you wanted to --

DR. MARK MILLER: No, no, I'm just following the conversation along. It's true what you said, this policy would affect the reimbursement for that practice, too. What I'm not following in your line of questioning, are you

saying that we should not be focused on that, we should only be focused on the off-campus? Or were you asking --

DR. BERENSON: I'm asking whether we're, I guess, addressing the two problems separately or we think this problem solves the other problem?

DR. MARK MILLER: Here's what I would say. Follow this closely. And don't hit Dan, okay? Don't hit him. We got to stop all the hitting that's going on.

[Laughter.]

DR. MARK MILLER: This is what I would say: Once you've cleared out the first case where you have a situation where the hospital is involved but they just let it run as a free-standing -- that's out of this conversation -- then in a sense there's -- simplifying, there's two ways you can go from there. I'm employing the physician or I'm engaging in a contract. Okay? Sort of the exchange that we had at the beginning. It would definitely govern both of those situations because you just say the payment rate would be the same. And if I happened to have either of those arrangements, either on campus or off campus, it would govern those arrangements. And the only thing I was going to react to was you could kind of go into the provider-based

rules and say, okay, I want to start redefining them and clarifying them. In a sense, this is a more direct way to send a signal that says this is what we pay when something is done in this kind of arrangement, regardless of whether you're on campus, 20 miles away, whatever the case may be.

Did I get that roughly right?

MR. WINTER: Yeah, and just to point out, we can certainly think about playing with the definition of provider-based criteria, but we should keep in mind CMS' ability to enforce, you know, the existing criteria or even changes or more restrictive criteria. We've talked to the regional office staff who administer -- who enforce these criteria, and they don't have the resources to -- they tell us they don't have the resources to do it really effectively, and they have heard about abuses, and it's just hard for them to police all the variety of arrangements that exist.

DR. BERENSON: My only point -- and maybe this is a round two discussion, but my only point is we're dealing with E&M services here, and we do have all of those other services in which we're not dealing with it and which we still have major payment differentials. And whether there's

a -- we'll come back to that.

DR. MARK MILLER: And you are right about that. [off microphone]. This conversation so far is only about E&M, and we have some thinking on some of those other ones, but we're not down that road yet. And so if you want to give some direction, this is the right time.

DR. CHERNEW: So Bob and Herb's question are like understanding this Level 103. I'm still at 101, so I have some more basic questions about the stuff that's sort of outlined in the text box where you talk about these things. Let me just make sure I understand.

Our belief is that whatever's going on in this discussion we were just having, no one is actually moving. So when the hospital is buying the physician practice, we don't believe the physician practice is now moving to a new office building or doing anything that's physically different. So when you said it's the same services, it's more than just the same services. It's the same services, basically we think it's happening in the same location. So that's my first question.

DR. STENSLAND: They don't have to move. Sometimes they might, but they don't have to to get the

extra money.

DR. CHERNEW: So, again, I guess my question is: But generally do they? I know they don't have to, but should I be thinking about this like they had an office building wherever they had an office building, and then they happen to be within the 35 miles, then they got bought, and so we should worry about how many physicians are in- or outside of the 35 miles? Because that would limit this problem. In other words, if everyone within 35 miles already did this --

DR. STENSLAND: I think my general understanding is often they don't move, but I'd also caveat that to say that if we changed the policy so that if they do move they get the extra money, but if they don't move they don't get the extra money, then we might see a lot of moving going on.

DR. CHERNEW: But that's the way the policy is now. If they do move, they get the extra money, and if they don't -- if they're --

DR. MARK MILLER: No, no, no -- [off microphone].

DR. CHERNEW: No, I take that back. If you're outside the 35 miles you have to move.

MR. HACKBARTH: [off microphone] 35 miles.

DR. CHERNEW: Right, so that's what I was trying -- right, so the sense is that they don't move. And then my second question is: Are there places where there's the Bob practices that he was just talking about that are in the hospital that actually were set up not owned by the hospital in a particular way, or are all those ones owned by the hospital?

DR. MARK MILLER: [off microphone] So do you understand the question?

DR. STENSLAND: I don't know about in the hospital, but there's certainly practices like right next door, you know, the hospital owns the building here, and then there's the practice there, and they're not part of the -- they're not operating as a hospital-based practice.

DR. BERENSON: That's pretty common, to have practices in a medical office building very close to the hospital, and they are owned by the practices, not by the hospital.

MS. BEHROOZI: This is maybe just a hair on the tail of the dog here, but urgent care clinics, which we like to encourage people to go to rather than the emergency room, I guess they would be billing like an HOPD. Is that right?

Billing Medicare.

DR. ZABINSKI: I would think so, yes.

MS. BEHROOZI: We wouldn't be able to distinguish them -- I mean, you know, you were talking about the problems that CMS would have in sorting all of these things out. There's no particular distinction or add-on to the code or anything like that?

MR. WINTER: Only in they're an emergency department where they get -- can they bill for ED visits, I think.

MR. BUTLER: So this is a topic I know a fair amount about. I've lived in this world in various settings, but I'll comment on the academic medical centers in round two. But I share some of Karen's issues. I'm not sure we know where this is really residing and where the incremental change has been. I think these things have been around a long time, and they've quietly just kind of existed and not been a real issue until probably the last two or three years. That's what I sense. And I sense that the real growth is in the community settings, off campus, where practices may, in fact, be doing pretty much the same thing they were doing before they were converted to employment.

But I don't know if -- and so kind of moratoriums around that kind of thing makes a lot of sense. Now I'm getting into round two, but part of where to target this is kind of like just understanding the base a little bit better, because I am also told, but I don't know, that some critical access hospitals in rural areas also have been participants for some time in this kind of practice. But that's my question. Other than the comments that you had for Karen on the academic medical centers, is there any other area that you know of right now where this is more prevalent, disproportionately prevalent, like critical access hospitals in rural areas or something? So if we apply a blunt instrument we don't get unintended consequences.

DR. STENSLAND: So what we're talking about today would be just the PPS payments, and so critical access hospitals would be in a different bucket, and they do get cost-based reimbursement for whatever their costs are for the facility part of the E&M cost. So if somebody goes into the critical access hospital -- and it's often just one building, and there's a little wing there where they have their exam room -- they get to bill the costs of that exam

room and that time as a cost-based reimbursement. So that's separate from this.

MR. BUTLER: They'd be exempt no matter what then because they're getting cost-based reimbursement for all of their activity.

DR. STENSLAND: And there's a separate kind of rural health clinic which can be hospital-based, which also gets cost-based reimbursement for rural health clinics that can be off site, and that's a separate policy, too.

MR. BUTLER: Okay.

MR. WINTER: And, Peter, you had asked about to what extent is the growth occurring in community settings versus like on the main campus, and unfortunately, we don't have the data to be able to distinguish.

MR. BUTLER: I'm sorry. I had one other question, back on the slide that Glenn cited originally where he was looking for clarification on the --

MR. HACKBARTH: [off microphone] 12.

MR. BUTLER: Okay. So what really surprised me was when you said there are provider-based clinics where the hospital owns the -- it's a hospital department, but they're contracting for the physician piece and the physician isn't

even employed. But they're getting the provider-based -- that's a new one to me. I had not heard that. I guess that's permitted.

MR. WINTER: It's permitted, and we don't -- all we hear are anecdotes. We don't know to what extent that's a small minority of the models or not.

MR. BUTLER: I can't -- I'm trying to --

DR. MARK MILLER: There might be a misunderstanding here, and if I'm wrong I'm sorry. But you're saying under contract you think the physician can get the $75?

MR. BUTLER: No. I was back on Glenn's. If you imposed a policy, we recommended one rate, you know, the hospital is going to sit there and just charge the physician rate and not send out two bills. There's no reason to send out two bills and one gets paid at $19 and one at $49. And then they just abandon the -- they would abandon the split billing and just take your rate. And I think your answer was, well, not so fast, because in some cases there is a physician that is an independent contractor that would get the 49 bucks, and the hospital would get the 19, and that's really convoluted to me. I don't know of any example where

that exists. And maybe it does. It's a question.

MR. WINTER: A hypothetical. That doesn't actually exist in nature.

MR. BUTLER: If you talk about tightening up rules, I'm surprised that that would be permitted.

MR. WINTER: Right. On the -- there are -- when we've looked at the literature and articles about the recent trend, it talks more about hospital acquisition of practices and employing the physician. We don't hear about the second model, the one you were asking about where they just contract with -- so it may just be -- they may not exist may be a very small minority.

MS. UCCELLO: I'm going to ask a very basic question. The facility charge for the outpatient, can you just tell me what that includes?

DR. ZABINSKI: Well, it includes the cost of the hospital employees, the cost of the examining room, you know, any -- there's a small bit of packaging, say if there's a -- you know, the outpatient PPS has a fair amount of packaging of sort of low-cost drugs. If there's any low-cost drugs administered during that visit, that would be packaged in. But packaging is pretty minimal on these

things.

MS. UCCELLO: So how much of this is a fixed cost versus a variable cost?

DR. ZABINSKI: I don't want to venture a guess on that. I would think that fixed costs are fairly high, but I don't want to venture a guess.

MS. UCCELLO: Because thinking about, you know, whether we want to move that back more toward inpatient versus outpatient, I think that matters.

MR. HACKBARTH: Just say a little bit more [off microphone].

MS. UCCELLO: Well, if we're thinking we only want to apply some of these costs to the truly inpatient kinds of services, to the extent that any of these are true variable costs that do apply to the outpatient services, we don't want to completely take that away.

MR. HACKBARTH: I see your point now. This isn't going to come out very clearly, but there's two different reasons that you may want to pay more for the hospital, one that I think may have some validity and the other I question the validity.

One is that through regulatory requirements the

hospital needs to provide certain services that cost money, the path that Bob was describing, and most of those, I think Bob is right, are related to the inpatient mission of the institution.

The second thing is that they might have higher overhead costs because of, you know, their location, they're in downtown areas or, you know, they've got union contracts for nurses that, you know, independent physician practices may not have, and those increase their costs.

That I would be less inclined to say, oh, we ought to cover that if, in fact, Medicare can purchase the same services for a lower cost and alternatives. So I think it matters what the reason for the higher overhead costs might be.

MS. UCCELLO: I agree.

MR. ARMSTRONG: Actually, a couple of points.

First, I do work in a market where I am seeing a lot of this happen, and I have seen different structures for the employment of the physicians independent of the ownership for the practice itself. So I think there are variations on this salaried kind of theme.

Cori, I think actually your question is related to

the question that I would ask here, and that is, my point of view on this seems different than several of yours, and that is that one of the main arguments for this kind of consolidation and acquisition is actually to lower costs. There are economies of scale. There are ways of avoiding redundant investments and information technology, and that we're actually talking about how hospital outpatient departments may be more expensive as kind of an underlying presumption. And I actually think that it's good to pay equally for equal services, but, in fact, the Medicare program should be asking how does Medicare benefit from the argument that acquisitions like this, in fact, are lowering costs? And I just wonder if you've -- in your analysis you talk about many reasons why the acquisitions are taking place, but you never talk about the stated goal to, in fact, lower the operating costs or the medical expense trends. Is that something you're not hearing or should we pay more attention to that?

MR. WINTER: There was an article in the New England Journal in May by Robert Kocher and somebody else which argued that hospitals incur large additional costs when they acquire practices in terms of bringing them online

with their EMR and with their other systems and that the physicians are billing for fewer services. And so they argue that at least in the first couple of years there are up-front investment costs. They don't talk about -- I have not heard as much about, you know, the efficiencies. Jeff might want to comment on that. But even if there are lower costs and efficiencies, the point we're making is that Medicare is paying more regardless of any efficiency gains.

DR. STENSLAND: I guess I'm not so confident in either direction, and I think back to the 1990s when there was a lot of physician acquisitions by some of these private entities that were going to aggregate these things, and they all told the doctors, "We can run your practice more efficiently than you can. Sell out to us." And a lot of those places just went bankrupt. And maybe the hospital can do things more efficiently, maybe not, but I think the general idea is that if we pay equally, we're not distorting the incentives to do one way or the other, and people can gravitate toward the more efficient model of the two.

It is kind of the solution for those who aren't completely confident they know the answer.

MR. HACKBARTH: So I want to go back and just make

sure I understand points that I thought I heard Karen, Bob, and Peter make about distinguishing between sort of the old line, you know, academic practice, been in place for a long time as opposed to the newly acquired, previously independent practices. I thought I heard each of you indicate that you think that that might be a potential distinction for policy. I'm not sure that I understand why we would want to make that distinction. In fact, I would fear that if we made that distinction, we would start skewing how the delivery system develops in the future in ways that may not be intended.

So I think the environment that we see right now is that both hospitals and physicians see an interest in coming together in new ways, in integrated practice, salary practice, and the like. And some of those physicians are physicians that are currently in practice in independent practice. Some are physicians that are in training in thinking about their future career.

If what we start to say is that, oh, if you're part of an academic practice or you're part of a practice that's on the main campus as opposed to 10 miles away or 15 miles away, we're going to pay you differently given this

dynamic, this urge on both sides to come together, I think what we'll just do is we'll encourage them to come together in a particular way, in a particular location that may not be in the long-term interest of the health care system or Medicare beneficiaries or the most efficient model.

So I think that, you know, drawing distinctions among types of practices and, you know, whether this has been around for a long time or a short time could have unintended consequences. I do think it's better to focus on the principle, we pay the same for the same service regardless of the location, and then if we have concerns about, oh, hospitals have regulatory burdens and associated costs, let's figure out another mechanism to pay them that doesn't skew the delivery of, you know, basic E&M services.

So that's my round two comment.

DR. BORMAN: Well, first, my question was a little more -- not necessarily having a clear endpoint of saying that some sorts of practices should be treated differently, because at the end of the day I think I come to the same place you do about that we say that one of our goals is accurate pricing, and I think that one of the things we've tried is also to try and name some consistency of principle.

And so those two things would suggest that our default position is that same services are paid in the same way.

Now, there's a lot of room for nuance there in terms of is it really the same patient population or the same service or whatever, and those may have to be captured in different ways than we have traditionally captured them. The appeal of this in evaluation and management services, albeit Bob's point that it may be the tip of the iceberg is a very well taken one, is it as something that it is more of an apples-to-apples comparison and something that we could act with principle, I think, sooner than we may be able to act on some of the other pieces.

I share Bob's belief that the money is much more in the other services. That's part of the reason they're migrating as physicians and hospitals come together. These services are migrating to the HOPD, and there's an awful lot going on here that relates to a lot of other factors. The inclination of today's residency graduates to be employees rather than independent business people I think plays into this in a huge way that, you know, certainly we shouldn't account for in payment, but it's part of what is behind the availability of physicians to do this kind of thing more so

than there was in the past.

I think that the reality is that probably this double payment, if you will, is part of what's enabling at least starting out with physicians not losing income when they do this. And the reality is that if we change that, the attractiveness of the model may go down. But a corollary then is: Is this behavior of coming together something we want to encourage as a way toward systemness. And so we have a good goal and a perverse consequence sort of meeting up here that I'm not sure we know the resolution to. And I think that we have to be cognizant of what we're trying to encourage or not in the context of doing policy on this.

Another thing we have not talked about -- and I know certainly at least in my generational group of physicians a lot did this over the past five to ten years, and they did it to some degree, to large measure, motivated by economies of scale in their practice expenses and particularly their ability to get a lower professional liability rate by virtue of doing this. We haven't touched on that at all, and that's a huge difference here in higher-risk specialties -- OB, anesthesia, the surgical

disciplines, and in certain parts of the country. And so that's a factor behind all this that we would need to acknowledge, I think.

So we've got this big thing that I'm not sure we can get around all the nuances quickly. I am led to believe that if we look at this one small piece, E&M services that don't have a lot of ancillaries bundled around them, that do have a pretty much office visit to office visit, skills, supplies kind of thing, and there is the ability by virtue of levels within the service to capture or to generate a higher charge because of the intensity of the visit and resources consumed, that this is a reasonable place to act. But as Bob rightfully points out, it's not the biggest piece of the puzzle, and we need to dig some more on that to try and get that right.

And my last comment would be that we talk about patient selection, and you've appropriately mentioned several times the right side of service to be safe for the patient. I cannot emphasize too much how important it is that we protect that. Just as an example, I was at the American College of Surgeons meeting last week and went to a session that was "Nightmares in the Ambulatory Surgical

Center," and they circle around that patient selection is absolutely key. And that is a complex interchange of risk-adjusting for the patient, but also what's the nature of the procedure and what is the sedation or anesthesia or whatever that needs to be done there, and to some degree how far are attorney from a hospital? You know, this 35-mile thing is a little bit scary, what you might be doing there versus what you're doing if you're on the campus.

So I would say my bias would be let's move -- I think we could continue to move forward on the E&M side. I think there are some things we need to know on the bigger-picture side, but that our principle, as you outlined, Glenn, should be right pricing, accurate pricing, and consistency, taking into account those factors.

MR. HACKBARTH: As you know, Karen, I really agree strongly with your point about getting patients cared for in the proper location is key, and moving into areas like ambulatory surgery raises much more complicated issues, I think, than E&M services.

MR. GRADISON: I may be repeating some of the points which Karen just made so well, but to me personally, the part of this that I wish I knew a lot more about is why

are we seeing these acquisitions take place and to what extent is the issue we're discussing, the specific issue we're discussing right now an explanation.

Certainly, a lot of hospitals were badly burnt by their experience some years ago and are approaching this acquisition matter in a quite different manner today because of their experiences, which, as I understand them in talking with some of them, was a significant drop in the productivity of the physicians once their practices were acquired.

Now, this has implications for us because it means that there is, if anything, from the point of view of things we talk about here all the time, an encouragement to do more work, to do more procedures that is inherent in the hiring decision, because to try to correct for what went wrong the last time. That's just another piece of this.

But what I'm really suggesting is that it would be helpful to me to know how important this -- and I know it's a judgment call, but how important is this differential in explaining the rather dramatic change that's taking place? That's point one.

The other thing I want to mention is that I think

there are ways to deal with this in a more surgical manner without even changing those numbers, with keeping the present rate -- this is just a for-instance. You could have a blended rate phased in over three to five years where at the time for the first year when a doctor moves into doing E&M under the hospital license rather than under their own, they're paid four-fifths, of course, by the old rate and one-fifth by the hospital rate, and phase it in, which would take some of the juice out of this thing and not necessarily require a change across the board. Whether that makes sense in my mind would be determined, the way I would think about it, a lot by trying to understand how important is this differential in the decision, the strategic decision of the hospital.

I mean, there are a lot of advantages in having -- from a point of view of comprehensiveness of care, in terms of the patients, in terms of what you're trying to accomplish here. And I don't think we want to stifle that if we see benefit from it.

Those are the thoughts I have at this time.

MR. HACKBARTH: Peter and George, as people with experience in this business, do you want to try to address

Bill's first question about the motives and how institutions are approaching it differently this time than the '90s? You and I were talking about that yesterday at lunch, Peter.

MR. BUTLER: Well, you know, I can't speak for all hospitals, that's for sure. I think that the difference this time is, first of all, they're not paying money for good will. The most typical arrangement that is occurring is that physicians may be guaranteed a salary for two years that is comparable to what they're making now, and then they move to a productivity-based kind of arrangement that, you know, fluctuates up and down based on what they do and what they see. So that's quite a different thing.

I think some of the motivations are the same in the sense that I think the principal reason for employment is they don't want to be left out, and they want to keep their patients and be a part of something that's successful.

Another motivation that is more accelerated than last time is kind of the administrative hassle factor of running a practice has never been greater. So they're looking at, I'll never be a meaningful user in my practice the way I am now. I need help, and I need money to make that happen. And, furthermore, all of these value-based

purchasing arrangements, it was one thing just to be part of a contracting entity. Now I have to -- whether it's PQRI, you name the initiative, I need help in making that -- I want to be a part of something successful that can help me with that, and let me spend most of my time still being a doctor.

So I think a lot of the motivations are actually pretty good on both the hospital side and the doctor side, and, frankly, it is exactly what we want to see. I don't see that free-standing private practices that have paper charts and are doing things that they're just not in sync with the kind of care coordination that is going to have to occur.

So I think it is a different day, and unfortunately, there are some -- I think in this particular issue, in this particular case, I think we probably overstated in the document this issue as being why they're being employed. It's third or fourth on the list. It helps facilitate employment, but it's certainly not the reason for employment. They're the bigger issues that I just mentioned that I think really are getting physicians so, okay, I want to be part of something bigger, something that is going to

help me be successful and be a good doctor in the future.

MR. HACKBARTH: Peter, did you mention negotiating leverage with plans being part of a larger organization in your list? And if not, do you see that as a factor?

MR. BUTLER: Well, of course it's a factor. Anybody who wants to be part of something -- you know, if I'm out there on my own and I have got to negotiate on my own, how am I ever going to be successful? But I don't know that if a doctor themselves are thinking, I'm getting low rates, I got to be -- I don't know if they're thinking about it at the individual doctor level, no. Do hospitals think about that? Do big physician groups think about that? Sure.

MR. GEORGE MILLER: Yeah, very similar to Peter, I remember I was in Texas in the '90s and the difference then between now is that we were concerned about managed care and capitated rates, and that's why we bought physician practices. And as Peter indicated, we paid Goodwill or Blue Sky for those practices, and we paid salaries. And the concern then was productivity. They got the salary. I remember one physician immediately took his 30-day vacation back then.

Now the difference is, as Peter stated -- all of my neighbors surrounding me are cardiologists, and I see them in the driveway in the morning, and the hassle factor of the practice, the cost of the practice, the malpractice, all of the regulations they had to deal with with HR, with documentation, meaningful use of EMR, all of those issues now, they don't get the reimbursement issues, but all of the cost factors. And then as I talk with physicians coming out of medical school, they just don't want the hassle of starting a practice.

So, again, I agree with Peter. The reimbursement is not the issue. It's just the change. And the physicians that are coming out of medical school, they say they want a family, they want a lifestyle, they want predictability. They do not want to start a practice up, particularly in rural areas. They want to be employed. That is just a driving factor.

MR. ARMSTRONG: One comment. We're not hospital-based, but we're involved in acquisition and consolidation, and I just think that a lot of these are going to fail like they did in the mid-1990s. But I think that the ones -- this is partly based on my experience, and partly this is an

opinion. But in the context of an industry that sees the value of integration, that's promoting ACOs, that really is beginning to recognize that you can drive better quality and lower costs, better value, and, in fact, it's probably the best way to achieve those goals through the integration and consolidation of practices. Those organizations that are going into this with that mind-set I think are the ones that are going to succeed, which is the reason for my point before, that we're taking our payment policy into this arena, and it's a very small little sliver, what we're talking about today, and has little impact, but with the mind-set that we're trying to defend against overpayment. But, in fact, I think this is really just another opportunity for us to reinforce the ideals of integration and consolidation and that we shouldn't be silent on that.

DR. BERENSON: I'll just comment because I was a co-author of an issue brief that was cited in the paper for Health System Change and it was based on interviews with hospital executives and physician groups. And what you heard around the table are the multiple reasons why docs want to be employed. And George is exactly right. Lifestyle and predictability is all part of it. Some are

doing it for higher reimbursement. I mean, there's just a mixture. But I just wanted to pick up specifically on the point Bill Gradison was making, and it's absolutely correct.

Virtually without exception, every hospital who was talking to us said they had made a mistake in the 1990s. They took these hard-working, industrious docs, and they put them on salary, and they went on vacation, sort of figuratively if not literally. And so learning from that lesson, they are all not only productivity but work RVUs. The thing that gets published in the Federal Register, that is something that we care about, which is part of the Medicare fee schedule, is the tool that is used to determine productivity, and that's how docs are getting paid.

So to Scott's point, simultaneously the hospital folks would say we're aligning with docs so we can become ACOs, so we can be part of new efficiency models and higher quality, and then ten minutes later in the conversation, we're putting them on productivity metrics to make sure that we take advantage of the fee-for-service environment. And how they're going to sort of turn a switch and turn that off and turn on a new payment model is what I'm not so sure about. I think most of those organizations haven't sort of

thought that through very much, and you're right, there are some who have.

So I wanted to contribute that part.

MR. HACKBARTH: I need to get back into the queue, and, Bruce, I appreciate your patience here, but Karen and Bill I think were raising important issues, and we had some expertise around the table that can help ground our conversation in reality. So it seemed to make sense to take advantage of that.

Let's continue with round two, and Bruce is up.

MR. GEORGE MILLER: Yeah, and Bob just reminded me, the environment now, just to respond to what he said, the difference between then and now is the ACO model and bundled payments and trying to be more efficient, and certainly, using RVUs as an emphasis for the physicians to be much more productive.

I want to go back to Peter's question and ask it from a rural perspective, rural hospitals, and that is, how many of the outpatient departments in rural areas did you find? And isn't there a difference, if I remember correctly, that the payment -- outpatient departments in rural areas include the cost of the drugs, but the

physicians that were not part of that can then bill separately for the drugs. Am I correct about that? No? The bundled payments for the outpatient department includes the cost of the drugs, but the physician, if he's independent, can then bill -- he gets his professional fee, or she, and then can bill separately for the drugs, which is different from the rural outpatient department. Is that correct?

MR. WINTER: Okay. So, yes, the cost of drugs -- under what? Sixty dollars a day? It's probably higher than that now.

DR. ZABINSKI: It's like $80 a day.

MR. WINTER: Okay, $80 a day. So those are packaged with the associated service.

MR. GEORGE MILLER: Right.

MR. WINTER: Under the physician fee schedule, the cost of drugs is billed separately outside the fee -- I'm sorry. They're not paid under the physician fee schedule. If the physician is providing the drugs, they get a separate Part B payment.

MR. GEORGE MILLER: Right.

MR. WINTER: But I don't think that if the

physician is providing this service in an outpatient department that they can bill separately for the drugs if the outpatient department is submitting a claim. That would seem to me to be --

MR. GEORGE MILLER: No, that's my point. They can't do that, and so we don't have an apples-to-apples comparison, do we?

MR. WINTER: That would be a concern for services with a lot of packaged drugs, and we raised that as one of the issues we will be looking at in the future. For E&M, as Dan was saying, the cost of ancillaries is a very small part of the payment under the outpatient PPS for E&M services.

DR. ZABINSKI: I found that about 3 percent of the total costs of the E&M services in OPDs is for ancillaries, including separately paid drugs -- or the packaged drugs.

MR. GEORGE MILLER: So 3 percent of the $75 charge or 3 percent of the $19?

DR. ZABINSKI: It's 3 percent of the $75.

MR. GEORGE MILLER: But then that's going to be absorbed if you change the fee to $19.

DR. ZABINSKI: Correct.

MR. GEORGE MILLER: And then there's a limit on

the drug costs. The package price for the drugs is limited.

MR. WINTER: Right.

DR. ZABINSKI: Yes.

MR. WINTER: If they provide a drug that is above the threshold, they would still get paid separately for that as under the current system. So that would be in addition to the $19.70, or whatever the rate is set at.

DR. CASTELLANOS: Thank you. I was a little surprised that you asked all the hospitals why they're doing it, but you really haven't asked the physician community why they're doing it. And there's two sides to the equation. Bob said some of the issues. I think you really need to look at the root problem. Now, I joined a large group. I did not join a hospital. But there's a lot of reasons I did that, for some of the same reasons that Peter mentioned why doctors are doing things today.

It's a different world today. It's a different day. We do want to be part of something successful. We recognize that the independent physician working in a small office is very limited on his ability to negotiate. I think you all remember John from Humana, and he and I went around and around one time during a meeting where Humana was

offering me 85 percent of Medicare rates for a private contract. And since I joined a group, I was able to negotiate and got 120 percent. So it is a business model that we're doing. It's not dollars. It's a business model.

We're looking at lifestyle. There's no question about it. We're looking at less strain. We're looking at trying to get away from the burdens of administration.

It's very similar to when we saw the concierge practice. Why are doctors going into concierge practice? For a better lifestyle, for doing what they were trained to do, to be able to spend time with patients.

So it is a different day, and I think we really need to look at the root problem of why not just hospitals are doing it, and they're doing it to fill their panels, which you need. They're doing it for coverage. They're doing it also for financial reasons. And I think physicians are doing the same.

I remember Bob Reischauer, one of the most important point I remember him ever saying is it's not the site of service that's important, it's what's most appropriate for the patient. I'm switching to another side. So I really believe that it is more expensive to see a

higher-risk patient in the HOPD. We saw it, for example, in the material that was given to the Commission with colonoscopy. There's no question it takes more time, it takes more skill, it takes more appropriateness, but it's paid the same.

So I think sometimes we need to pay on a risk adjustment basis rather than a site-of-service basis, and there's just no question that as we go down this cycle, that when we get into outpatient facilities, et cetera, that we may want to consider that.

I have no problem with the present. I think there is some rationale for trying to make payments equal on the E&M side, but I do have some problems as we go further down in the cycle. And my suggestion is we go very slow on this and we try to get input from as many people as we can.

Again, I congratulate us for addressing this problem. It has been a problem that has been a difficult situation for physicians in the community and for the hospitals, but also for the clinics. There are a lot of large clinics or practices that do it. I would strongly suggest that we do this very, very slowly.

Thank you.

DR. NAYLOR: So others around the room appreciate the complexities of this much more than I, so I'm just going to reflect on the great report I read and this conversation.

I do think evaluation and management is a pretty predictable service. We know what we are looking for, and we actually have really good measures of -- we know when we get it. So if there's any opportunity to think about getting to equitable payment for the same service, I think this represents a really important starting point. And I think it is absolutely consistent with our efforts to get to thinking about the most efficient provider, so if we're going to be internally consistent in trying to work toward that.

I also appreciate that people are at different risk, and the E&M service allows for that. As Ariel and others, Jeff, said, you can lengthen the service and get paid for a longer service to accommodate people of different needs.

So in this case, I think that there's an urgency to capitalize and take advantage of this opportunity to, in some ways, to move a service or a payment for a service in a way that also capitalizes on our interest in moving toward

community-based care. And I think it promotes continuity, it promotes integration when it all can happen in the right way.

I do not think access to the Medicare beneficiaries will at all be affected by this change. And finally, I think the costs -- really, this slide, Slide 8, which says that if we were to increase by 50 percent where we sent these services to outpatient departments, the cost growth which could happen, not just to the program but to the beneficiaries, is dramatic. And here's an opportunity to really go the other way, $10 billion savings in ten years.

So to me, I would say, I think this is exactly where we need to be going because we know this service, and it's a great one to move on in terms of equalizing payment.

DR. HALL: I'm not going to repeat some of the arguments that have already been very well stated.

Look, I think what we're talking about here are E&M services -- just to sort of constrict this down, because part of our conversation is confused by we can't have the same conversation about a lot of technologically-based services and E&M, but let's just look at what we've been

looking at, the 222 million E&M office visits, ten percent or so of which are now in hospital-based practices.

So let's take the viewpoint of the patient. So I'm 75 or 80 years old or whatever and I get my primary care from Dr. X and his associates. It's not clear where I live. I might live in a large urban area or a rural area. But in either circumstance, I'm probably going to be best served if I can go to a practice that knows me, that has consistent physicians and health care providers, and in all probability in the vast majority of instances that's going to be in what we now think of as a freestanding ambulatory facility. It's not going to be in a larger hospital where the primary care geriatrics clinic is squeezed between the MRI machine and the lithotripsy machine. And we're also very concerned, as we were last month, about preserving primary care.

So if I'm that primary care doctor and I feel threatened by a hospital coming in and setting up something else, I think the principle is that for the same service, the same fee ought to be paid. Otherwise, I think, as Mary has alluded to, we're really sort of speaking out of both sides of our mouths in terms of our desire to promote a medical world that will have primary care services that are

efficient and amenable to our Medicare population. So I think that helps me in that situation.

But the flip side of this is that under Medicare rules, I am required, no matter where I work, to comply with certain requirements of Medicare. Let's just take a very recent one, as of today or that's coming up today, is that physicians are now under meaningful use supposed to have a certain percentage of their prescriptions submitted electronically. Now, I can tell you that any hospital-based practice is probably already at 100 percent because it's built into the infrastructure that presumably is paid for by these extra fees. But in many parts of the country, only about 25 percent of practices are going to be compliant, in which case presumably they're going to be penalized, then, in their Medicare reimbursement.

So, if you will, equal pay for equal work, but let's also remember that maybe the overhead involved in these practices may not be enough at this point to allow them to do the work. So there may have to be not just moving down to where the primary care fee schedule is, but some compromise somewhere along the way to allow them to continue to practice in that environment.

MR. KUHN: Thanks, Glenn. This has been a good discussion about a site-neutral payment system for the ambulatory side, and obviously we're talking just one part of that site-neutral and that is the E&M codes that are out there.

So when you look at Slide 15 where you ask the Commission discussions and you had those three dot points up there, I thought I would just talk about the latter two, about future issues to examine and additional questions and research, and I have kind of three general areas that I thought would be helpful for me as we continue to move forward.

The first would be kind of the rural impacts. As Ariel walked us through the discussion of provider-based, I'd like to kind of get a better understanding of how this might be impactful in rural areas, rural systems that are out there, critical access. Jeff, there might be some portability in terms of some of the work that you're doing on that report that we're looking at for Congress next year, so hopefully not a lot of new work, but maybe, again, there's some portability in the work out there. So that would be kind of one area of impacts that would be helpful.

The second area of impacts would be kind of what we've talked a little bit about here that both Karen and Bill and Bob have talked about, and that is kind of what's the order of magnitude that we're talking about here. You know, we've got this 220 million codes. What subset is the E&Ms? And then also stratify, if we can, by types of facilities that are out there. You know, Karen asked the question about teaching. You talked a little bit about proprietary, rurals, just community hospitals, so we can kind of get a sense of the order of magnitude.

And then the third issue a little bit came up, and, I guess, when Ariel was again walking through the issue of the provider based, when these facilities do become provider based, they then become under, as you kind of indicated, all the requirements that hospitals have, and you talked about EMTALA, but I assume also -- you didn't mention it, but I assume also the COPs as part of that. So I'd like to understand a little bit about the impact of the COPs, and from two areas specifically.

One is what might impact this beyond access? For example, under -- you know, we know physician offices have no COPs that are out there. But on the hospital side, if

you take Medicare, you're also required to take Medicaid, as well, and since E&Ms are largely the primary care codes that are out there, if we did this, would this create an access -- could this create an access barrier in the future for some folks who can't access a physician in Medicare or Medicaid, in a physician office, but if it's through a provider-based facility that's attached to a hospital, would that limit their access on a go-forward basis. If there's anything out there that can kind of help us understand that.

And then picking up on Bill's point when he was talking about EMRs, I think from what I've seen in Missouri is that those that have become provider-based tend to be ahead of the game in terms of not only the EMRs he mentioned, but also in the whole realm of care coordination. And so if we were to do this, does this slow down the care coordination effort or does it just -- would it continue with the other incentives out there? I'd just like to know the interaction of those two things together, I think would be helpful to understand better, too.

DR. BERENSON: Okay, just a few points. First, to address the point you made in your comments, I think some of us have distinguished the provider-based issue from the

overall payment because we're right now distinguishing the services we're considering policies to. If we were able to have a policy that extended across all services, then I think those distinctions should disappear because I basically agree with you that we wouldn't want to, by our rules, determine what these particular configurations of doctors and hospitals are going to be. So I see this only as a transition until we get to a full policy.

Second, I think we can move more quickly than Ron maybe suggested. You know, the Deficit Reduction Act acted overnight in saying that doctors wouldn't get imaging services in doctors' offices for MRIs, PET and CT would be the same as outpatient, without an awful lot of thought, and that's actually worked out pretty well as far as I know, that policy. I'm not saying we should do it exactly that way because I think we do need to do a little more evidence-based work.

I would very much like to move quickly to considering the whole universe of services that are provided both in an outpatient department and in the doctor's office, but I think we do need to understand more about whether there are systematic differences in severity of illness

which would be presumably manifested in different variable costs, which I would consider in that case a legitimate variable cost difference if it's reflecting more staff or something that you need for sicker patients.

I don't know how complicated that would be, but I think that would help me decide whether we want to go to a -- I said in my first remarks that we should either pay the same or small differences. Right now, we have differences, according to the table you provided in our handout, as much as 400 percent payment differences for removing actinic keratoses. I can't imagine you need a major severity illness adjustment for doing liquid nitrogen applications to the skin, but maybe you can justify five or ten percent on a systematic basis. If we had differences on that magnitude which reflected real differences in severity, we wouldn't be distorting the market. When we have differences of 200 percent, 300 percent, we are creating distortions.

So I don't know that it has to be the same payment, but I think if we have differences, they need to be -- there needs to be a basis for those differences other than what we've currently got.

And then, finally, I would, consistent with the

discussion earlier about applying the extra -- the hospitals into the unique hospital-provided services, I'd like to understand a little more about these particular obligations that hospitals have, as Herb says, including the COPs and seeing where those costs can be attributed, and know just a little bit more if there are any of these sort of special obligations that legitimately are attributable to outpatient services rather than as, I think, largely inpatient or emergency department services.

DR. CHERNEW: Thank you. This is a fascinating topic, and sometimes I think we get so caught in the details, we sort of miss the headline, and I think the headline here is that the fee-for-service system is loopy.

[Laughter.]

DR. CHERNEW: And I think that transcends just this discussion, but it goes through a whole series of discussions we have, that if you listen to the discussion, you're, like, really? We're really having this discussion?

[Laughter.]

DR. CHERNEW: So my general view is that, as a baseline, we should pay the same rate for the same service. There's a question about what that rate should be, and what

hasn't really been said here is part of the reason this may be going on is that the physician office rate was just too low for a bunch of reasons and so people wanted -- so we don't know what the right rate is. I think, in general, it should be the same rate.

I agree 100 percent with Bob that maybe it should be risk adjusted. Maybe we need a little difference of five or some percent. But the rates we have now just clearly are not right, and all the cost arguments you make are great in the level, but they can't explain what's going on in the same practice. They're switching from one to the other and they're doing the same thing because their costs weren't changing to justify what was going on.

I am worried in some ways, of course, because I believe that we have to move on to a better fee system, that some odd inadvertent aspect of this is encouraging integration, which is basically the way we want to go because integration encourages and facilitates different types of fee schedules. My general view is that, despite that, this shouldn't be the mechanism to encourage that level of integration. We need to find some other way to think about that as opposed to having the -- you don't want

a system where we've set the fees wrong just because it helps us get somewhere we want to go. I think you want to set the fees right and find some other way to get to where we want to go, and I think some of our other recommendations in other sessions have sort of led to that.

I will say that when we did our evaluation of this alternative quality contract in Massachusetts where they put physicians in a bundled payment, one of the things you saw was there wasn't huge changes in utilization, but the physicians shopped around and got better prices. They saved their money by finding cheaper settings to deliver the same services. And I think you would see that type of stuff going on.

I also agree with Bob that I am on the side of expanding and moving quicker to investigate this and doing so in the spirit of trying to get us to a reasonable fee-for-service system as we transition away from a fee-for-service system.

MR. HACKBARTH: Mike, can I ask a question about your evaluation of the alternative quality contract? I read your piece and heard you make that point before that, at least initially, the most significant savings were not from

reduction of utilization, but going to lower-cost providers of the services. When you looked at that in Massachusetts, were you able to distinguish between hospital-owned practices as opposed to practices that were part of an organization under the quality contract?

DR. CHERNEW: No. We weren't able to distinguish that, or the extent to which they were going from one outpatient facility that was just more -- had a more expensive rate to another one. One of the challenges in the private sector, of course, is there's huge variation in the rates that are different than just driven by the site. So they have variations that you could look exactly the same and there could be this variation of rates. So you could go from one hospital outpatient to another hospital outpatient if it's cheaper.

So you've seen anecdotally in Massachusetts, for example, large groups, some of which you have been affiliated with, suggesting that they're moving some referrals from one large center to another large center, those that have the exact same ownership if you tallied them up in our data, the same type of ownership -- they're both big academic centers -- it's just one had a lower rate than

the other. And so we don't have in our data the ability to do exactly what you asked and I think more of some of the other --

MR. HACKBARTH: So a Harvard Vanguard can respond to the alternative quality contract by moving services from the Brigham to the B.I. Deaconess system.

DR. CHERNEW: Right.

MR. HACKBARTH: But if it's a Brigham-owned practice, moving their services to the B.I. Deaconess is probably not an option for them.

DR. CHERNEW: Right. No, exactly, and we'll see. I mean, of course, the other thing they can do is they can send some services out, and one of the things we're looking at going forward is a very complicated, under the alternative quality contract or any bundled payment system more broadly, there's a complicated make or buy system, and you have to think about what the marginal cost of providing it versus what the actual fee is when you're doing it internally. So it's a complicated --

MS. BEHROOZI: So we're looking at it from the point of view of the payer wanting to pay the same thing across services, and I firmly believe in that. I think I

said last time that we don't pay the facility fee. We just pay the physician fee. We don't pay a split lower HOPD rate plus facility. What we often get is the bill for the physician services plus the facility fee, so looking for a real premium on both, even what the HOPD rate would have been, and we just say, no, we don't pay that facility fee.

But we also pay ER visits that are coded at levels, you know, where the diagnosis code is really worthy of an E&M visit, we pay an office visit rate to ERs. One of our more unique, I guess, situations is that we have employers, who happen to be hospitals who happen to have ERs who have, in many cases, eliminated their employee health services and so they're sending people to the ER when they have a stomachache or whatever, and so we've had to be very vigilant about that. So we pay ERs, urgent care centers, HOPD - well, leave the HOPD out for a minute, but just hospital-owned physician practices or hospital-contracted physician practices, we pay the same thing across the board.

But where Medicare is paying more for an ER visit for something that they would then pay an urgent care center less, then you may have -- because Medicare is such a large payer, obviously, we're not going to influence things no

matter how big we are in Europe, we're not big enough to influence -- you may have a disincentive for institutions, hospitals in particular, to set up urgent care centers, which are a better alternative than an ER for people who really don't need emergency services but can't get to a physician office because it's after 5:00 p.m., for example. And they do have a little bit higher overhead because they are operating longer hours and they are making -- they are trying to keep more services available.

So I have a little bit of a concern looking at it from that direction of trying to keep available or make more available less than emergency-level services but more than what a regular physician office can provide. As Mike says, maybe the physician office visit isn't the right price or maybe there's different gradations to make sure that you don't eliminate some middle swath of services that you otherwise need and drive things to the high and low ends.

MR. BUTLER: Several comments. I can't resist to go back to Bob's comment on RVUs being counter to the -- I go back to my Henry Ford Health System days when we felt you couldn't get a private practice doctor into a meeting and you couldn't get a group practice doctor out of a meeting --

[Laughter.]

MR. BUTLER: -- and we struggled, whether they were flat salaries, we had all this capitation, but you still wanted to get work effort out of them and you had to -- so, you know, how do you do that? And so percentage of time to get an appointment, all kinds of other things. How do you get it down at the ground level, you know, a sense of energy and work effort, and RVUs isn't.

So in our contracting, we do have a lot of pay-for-performance in our contracts that does reward the kind of things that this Commission would like to see rewarded and disproportionately favors the primary care. I think we're getting there, but these are complicated -- as you know, these are very complicated when you start having all these measures in there to create behavior and you're only putting, say, ten percent of salary at risk. You just kind of throw up your arms sometimes and say, is this all worth it? So that's just a comment.

A second comment, generally, Scott's about we should be looking at lowering costs for Medicare and not maybe justifying higher costs. I agree. I would say, though, that the ambulatory sites, I think, are going to be

more expensive than they are now. Forget about this one particular issue. When we employ somebody, we put in the EMR. We sometimes upgrade the staff. We try to create greater participation in coordinating care. We put extenders. And, you know what? It is usually more expensive on a per unit basis, but it's where the care is being coordinated, so that it's worth it because all of the rest of the system can benefit from that because we put more effort into the site that really is instrumental to making other things happen. So it's kind of hard to look at the costs on just site by site. If the goal is lowering the widget cost per unit of service in an ambulatory site, I'm not sure that's going to be the right answer, necessarily.

Now I'll get to more substantive -- those are substantive, but not specific to the proposal on the table.

So one comment now on the academic medical centers. Here's where I really get great angst, and I will say that I can support the principle. I think it's how can you not really kind of support the principle? It's just what are the consequences, how do you do it, and how fast do you do it.

So academic medical centers, the ones that I know

of got into this long ago, and, yes, maybe the clinics were primarily on campus, primarily for teaching, and had a high percentage of either uninsured or Medicaid, and you could say this is a way to prop them up. Whatever it was, it has existed in a reasonable fashion and is not where the big growth in this is occurring.

But I do look at -- there's many millions of dollars for some institutions, so I do look at -- I look at one of our own clinics in a Hispanic neighborhood. It has a pilot medical home and has electronic medical records. We're working on diabetes in particular. And it has a fair amount of Medicaid. And so I try to look at the outlet for Medicaid patients, which is, you know, when they're all supposed to be covered here in a few days and I say, how many places are there that are willing to kind of do this, and there aren't many. And if you look at some of the newly employed that are sitting out there in their community, they are not taking Medicaid now. So it's more of the system impact that I'm worried about, because I think not all academic medical centers by a long shot, but I know of one, for example, that already is quietly kind of weaning themselves of the commitment to Medicaid, and so this is

where a lot of that care goes on and it's -- again, we're looking out after Medicare, not Medicaid, but just that unintended consequence, I'm not sure.

I can support the principle. I don't know about the execution, though. I can't just say, okay, next year, let's just flip the switch. Whether we have a moratorium, which is one way to go which would be one way maybe to address this, or some transition, I don't have the exact answer, but I think this is a bigger impact on some organizations and some communities than maybe some think.

DR. BAICKER: It seems pretty clear that, in general, the big picture principle of paying the same thing for the same service delivered to the same patient makes a lot of sense, and what we're struggling with is how are we defining the same patient and how are we defining the same service. And factors like a clinic being open 24 hours a day is in some ways a different service on the margin, but that is bound to be small relative to a 400 percent difference in the price, that around the margin, the features of the setting may, in fact, make us think about the service slightly differently.

And then the other piece of that is getting the

patient adjustment right, that clearly we want patients treated in appropriate settings so different patients may be appropriately served in different places, and that's about getting the risk adjustment right and about getting the patient characteristics that should affect the service entering, where as those that shouldn't not, and that, to me, then makes a lot of sense to start with E&M because it seems less susceptible to subtle differences in patient characteristics.

Now, then getting that price right, okay, so there should be one price for one uniform good that's hard to describe, defined to one uniform patient that's hard to pick out, what that price should be. It then gets to Mike's point of if you dial it too high, you get too much of that service, and if you dial it too low, you get too little of that service, and that's something we struggle with more broadly. But then layering in that price differential seems to make all of those problems worse. So it doesn't solve the problem of what's the right price for us, but with those two component sticks, then it seems like we've gone a long way there. At least you've reduced the problem to something we can get our hands around a little better.

MR. ARMSTRONG: I just very briefly and simply would say I believe I support the policy option as you've talked about it. I think it's really pretty straightforward. We're paying -- you know, I see this as a commercial payer, too. I'm paying 200, 300 percent of what I used to, same service, same setting, different structure, and so I think it's kind of straightforward. Frankly, I think it's conservative, and to the degree we could start this Monday morning, I would.

MR. HACKBARTH: Okay. Thank you. I think this was a very good discussion and appreciate all of the insight and thank you guys for the good work on this.

So our last session for this meeting is a discussion of a mandated report on Medicare coverage of and payment for infusion services.

DR. SOKOLOVSKY: Good morning. This morning we want to continue our discussion of the Congressionally requested study on home infusion. I won't dwell on this, but I wanted to briefly remind you of the issues that Congress has asked us to examine for this report.

Today we're going to be focusing on the third and fourth bullets there, looking at payment methodologies and

issues surrounding abuse of a home infusion benefit. We want to tell you about the results from our interviews with plans and providers on how home infusion is provided and paid for in the private market and under Medicare.

Interviewees described factors that make home infusion appropriate or inappropriate for particular products and particular patients, how plans manage and pay for home infusion, and the decisions that confront the Medicare beneficiary if infusion therapy is required post-hospital discharge. Finally, we'll describe the next steps we plan for this analysis and look for input from you about other steps to take.

First I'd like to begin answering the questions that you posed in September. Bob, you asked about whether providing home infusion affects Home Health payments. And the answer is that yes, it can. Providing home infusion benefits increases your points, which can bump you into a higher case-mix. However, I do want to emphasize that only a small percentage of Home Health episodes involve infusion.

We'll be responding to some of your other questions during the course of this presentation. A Medicare beneficiary needing infusion therapy can get it in

a number of different settings, including hospital outpatient, physician offices, ambulatory infusion suites, and skilled nursing facilities and the home.

Medicare coverage for home infusion, as we discussed in September, is limited and spread across different payment silos. Recall that coverage for infusion drugs is split between Part B and Part D. If the drug is covered under Part B, the DME benefit, generally payments will include the cost of equipment and supplies.

And also, by special statutory provision, Part B covers intravenous immune globulin, IVIG, in the home, but only for beneficiaries with primary immune deficiency. Part D covers drugs not covered by Part B if the drugs are on the plan's formulary and they meet any prior authorization requirements that the plan may have.

Nursing visits are covered under the Home Health benefit if the patient is homebound. Some supplies will also be covered under that benefit.

In September, we provided data on payments for home infusion for Medicare beneficiaries. In order to find out how private payers and Medicare Advantage plans are covering, managing, and paying for home infusion, we

contracted with NORC to conduct interviews with health plans, home infusion providers, and hospital discharge planners.

Staff have also conducted interviews with physicians, home health agencies, beneficiary advocates, CMS, and the VA, as well as other stakeholders, and these interviews are ongoing. We cannot independently validate the accuracy or generalizability of the information they provided, but our findings are generally consistent with the previous GAO report on home infusion and, in the case of Medicare beneficiaries, the data that we previously analyzed.

As you asked in September, Ron, we have included a discussion of the GAO report in our mailing materials. In the next few slides, I'll try to take you through how the decision is made that home infusion is appropriate for a patient and how the resulting care is managed.

It's important to note that there's a whole lot of variation. However, the most common scenario begins in the hospital. The decision to provide home infusion begins with a conversation between the physician and a hospital discharge planner. In the case of antibiotics, which are

the most commonly prescribed product, the patient may be suffering from an orthopedic, joint infection, bone infection, or some other post-operative infection.

If oral medications won't work, the physician will probably give orders for infusion therapy in the hospital. Then the physician works with the patient and the discharge planner to determine the most appropriate site of care following discharge. Both physicians and health plans generally said that home was the optimum setting, but a number of factors determine if home infusion is appropriate.

First are the clinical factors. A physician must consider the risk profile of the drug, for example, are there likely dangerous side effects, how stable is the drug, does the patient need more than one different kind of drug each day. And then he has to consider, along with the discharge planner, the specific patient.

Since the goal of home infusion is usually to have patients or care givers learn to self-administer the medications, and there are some exceptions to this, they look at whether the patient or care giver is both able and willing to self-administer.

And then they look at other factors like does the

home have reliable refrigeration, electricity, water supply. Does the patient have a history of IV drug abuse? Is there reliable transportation to get to the hospital if there are adverse effects? And does the patient have multiple co-morbidities and be too medically complex for this home infusion to happen in the home? Yeah.

Next, the discharge planner looks at insurance coverage. Private payers tend to have broader coverage of home infusion than fee-for-service Medicare, but coverage varies by drug. Does the plan think that this drug is safe and cost-effective for home use? And will the plan approve nursing visits? All play into whether home infusion will be prescribed.

In the private sector, before home infusion begins, plans must approve coverage. And all plans we spoke to use prior authorization, although not for all drugs. Plans ask the physician to provide the diagnosis, the prescribed drug, the dosage, and the expected duration of therapy. The plan will have to determine whether the drug is on its formulary.

In the case of Medicare Advantage plans and stand-alone Medicare drug plans, they may also have to determine

whether the drug is covered by Part B or Part D. And if D, whether the beneficiary is in the coverage gap.

In answer to your question, Herb, we looked at this B/D overlap issue briefly, and, in fact, although everybody told us that the prior authorization process was generally pretty smooth and took less than a day, the B/D overlap issue did create an administrative burden and could slow down the process.

Home infusion providers said that the coverage gap could also be a problem for Medicare beneficiaries. Some plans limit prior authorization to expensive drugs, and they may require, in the case of antibiotics, a consultation with an infectious disease specialist.

All plans also do retrospective reviews of home infusion with the number and intensity varying basically -- if they're very intense on prior authorization, there's less post-review. But when they do it, they look for outliers like an excessive length of therapy or an excessive number of nursing visits.

For example, one physician told us that IV antibiotic therapy lasts longer than eight weeks, it should raise a red flag. Some integrated plans take primary

responsibility for coordinating care and they may have their own infusion providers and nurses.

The interviewees we spoke to from health plans each said that abuse of home infusion benefits was no more prevalent than abuse of other services. They believe that their utilization management activities help deter and prevent abuse. However, some interviewees questioned how these activities would be accomplished under a fee-for-service system.

The kind of problems that they did mention included double billing for a drug under both the pharmacy and the medical benefit. Our claims analysis also found some questionable claims that could bear further scrutiny. For example, we found more beneficiaries receiving Part B home infusion pumps than beneficiaries receiving Part B home infusion drugs.

[Laughter].

DR. SOKOLOVSKY: Once a physician has determined that infusion is indicated, care coordination requires continued interaction among multiple individuals, mostly nurses and organizations. If the physician that orders home infusion remains in charge of the patient's care following

discharge, the home infusion provider and home health agency will communicate directly with the physician's office.

In some cases, the patient will come to the office once a week for a nurse to do blood work, change dressings, and check the catheter. If another physician takes over the patient's care, we were told that there were sometimes gaps in coordination.

Hospital discharge planners have primary responsibility for care coordination while the patient is in the hospital. They check to see if the plan has a preferred home infusion provider or home health agency, and then they make a referral.

And finally, one of their most important jobs, they make sure that the patient is not discharged until both the needed drug and a visiting nurse can be assured to be at the patient's house before the next drug administration is needed. But after discharge, they have no further role.

The home infusion provider gets insurer authorization for the needed medications. The check health plan coverage. And this may include working with the physician to change the drug regimen to a drug on the plan's formulary or to get an exception. They prepare and deliver

the drug to a patient.

If they don't have their own nurses, they make a referral to a home health agency for a visiting nurse. And they told us that they share responsibility for educating the patient on how to administer the drug and how to detect dangerous side effects.

Nurses from home health agencies, when required, educate the patient, draw blood for lab work, monitor and clean lines and catheters, and check for any medication errors. They also communicate any concerns to the physician.

Now Kim will discuss how plans pay for home infusion.

MS. NEUMAN: We asked health plans and home infusion providers how commercial insurers and Medicare managed plans typically pay for home infusion. While there is some variation, the most common methodology is a three-component payment structure.

Under this approach, there would be one payment for the drug, there would be a second payment, which is a per diem fee typically, to cover supplies, equipment, pharmacy services like compounding, and other non-nursing

services like care coordination. We heard varied reports about the typical plan payment for the per diem. For example, for antibiotics, interviewees cited typical per diems ranging from $75 to $150 per day.

DR. SOKOLOVSKY: We must have lost the connection. I think you should go on.

MS. NEUMAN: Okay, the slides. Okay. So as I was saying, for antibiotics, interviewees cited a typical per diem ranging from $75 to $150 per day. It's important to note that some of the things covered by the per diem, for example, pharmacy services, are currently covered by Medicare Part D through the drug payments.

The third component is nursing. If nurse visits are needed, many plans make a separate payment for each visit. Karen, in September, expressed interest in bundled payment approaches. While much less common, we have heard that some plans pay in broader bundles, but maintain a per diem structure.

So, for example, some plans include nursing in the per diem for supplies. We also heard instances of certain drugs being bundled in the per diem for supplies. However, none of these bundles are for episodes. They're per diem

bundles.

We also spoke with a few plans that used a capitated approach, paying a per member per month payment to a home infusion provider or a medical group to cover all infusion services their members might need.

Mary, you asked in September for more information on the beneficiary's experience accessing home infusion. As we've discussed, Medicare covers some or all components of home infusion depending on the circumstances, and our analysis in September showed that many Medicare beneficiaries, more than 100,000 in 2009, received home infusion drugs covered by Medicare.

From the interviews, we heard that dual eligibles, beneficiaries with employer-sponsored supplemental insurance that covers home infusion, and beneficiaries in some Medicare Advantage plans have the easiest access to home infusion services. For other beneficiaries, we heard a really mixed picture and it's difficult to generalize.

Overall, we heard that out-of-pocket costs for home infusion influenced site of care for some beneficiaries. But interviewees gave varied accounts of the type and amount of out-of-pocket costs and the extent to

which they lead beneficiaries to seek care in alternate sites.

For example, some interviewees said the cost of the per diem supply fees left most Medicare fee-for-service patients without other coverage to seek care in alternate settings; while a few other interviewees said that the per diem did not typically influence site of care because some providers would offer a reduced rate, a payment plan, or charity care.

Some discharge planners mentioned the Part D coverage gap as being a significant issue affecting access to home infusion, while others told us the coverage gap was not much of a factor. We heard less about out-of-pocket costs for nursing being an issue. Discharge planners said that most beneficiaries who receive IV antibiotics meet the homebound criteria and can receive Medicare home health. That may be less the case for other drugs.

In terms of where patients receive care, if the financial costs of home infusion were prohibited, we again heard a mix, with some interviewees saying all or most such patients went to SNFs, others saying most went to outpatient clinics, and still others saying it was a mix between those

two settings.

So this brings us to next steps. We have two remaining issues to examine that were part of the study request from Congress, and we'll address those in March. First, we'll do an assessment of sources of data on the cost of home infusion that might be available to construct a payment system.

Second, we'll do an assessment of the cost implications for Medicare of providing infusions in the home versus alternative settings. This will be based on information from the interviews, a literature review, and we'll also do our own analysis where we'll develop illustrative scenarios of situations where home infusion may generate net savings or additional costs for Medicare.

We'll also pursue any additional issues based on your deliberations. And as far as your discussion today, to the extent that in your work you've dealt with issues related to home infusion, we think we would benefit from hearing that perspective to help inform the research.

So with that, we conclude our presentation and look forward to any questions and your discussion.

MR. HACKBARTH: Okay, thank you, Joan and Kim.

Scott, I think you're up, Round 1 clarifying questions. Cori.

MS. UCCELLO: Do we know if home infusion is used more frequently in MA plans versus fee-for-service?

MS. NEUMAN: So we looked at that with the Part D data that we have, and the one caveat is that this would not reflect any Medicare Advantage plans that provide drugs bundled together with the services under Part C as a supplemental benefit. So taking those MA plans out, what we saw actually was a higher use of home infusion drugs among Part D enrollees and PDPs on the fee-for-service side than we found in Medicare Advantage.

The driver of that is low-income subsidy enrollees. We see higher use of home infusion drugs among LIS enrollees in PDPs than LIS enrollees in MA-PDs. We don't see a difference between PDPs and MA-PDs for the non-LIS.

DR. CHERNEW: I have a question. The tone that I got was that the idea was that home infusion would be efficient because it could keep people out of other settings. And my question is, in some settings like inpatient, if you shorted the inpatient stay, that savings

wouldn't be captured unless the DRG rate was adjusted one way. In other words, it wouldn't be captured by the system.

But others like if you shortened a nursing home stay, because the bundling is per diem or something like that, you would save?

MS. NEUMAN: That's correct. It really depends on how the payments are structured in the hospital versus the skilled nursing facility, and as you said, Medicare pays a DRG for the hospital, and that's different from what a lot of other private payers do. They often pay a per diem.

So they could get potentially more savings on the hospital side than Medicare might. But as some point out, you see lots of doctors when you're in the hospital, so there could be some savings on the hospital side from reduced doctor visits, possibly. That would obviously be offset by how much it costs to do this in the home.

So it gets complicated and we're hoping to be able to draw this out for you more in March and come up with some scenarios, because clearly, things depend on what kind of setting you're shifting them from.

DR. CHERNEW: Right. And so, my second sort of related question is, and you said some of this in your

comment about the pumps and the drugs. I didn't get a very good sense of how much potential for over-use you think there is in home infusion. If you think that it's something where no one is getting home infusion when they shouldn't or whether it's something that if you just encouraged it a lot, there are going to be people using it when they really shouldn't be getting any treatment.

DR. SOKOLOVSKY: I don't think we can answer that yet. I think we're a little -- I mean, some of the points are what we're seeing in the claims, the idea that there wouldn't be the same kind of management in MA. One of the drugs that can be covered by home infusion is pain medication. That might be an area that you would really be concerned about. But I don't think we really have an answer yet. We're hoping to dig into it more.

MR. KUHN: I have two real quick. One is, given the conversation we just had on the prior subject matter of a site neutral payment system on the ambulatory side, how much is there a variation in terms of payments for infusion, whether it's in the home or in the outpatient department, physician office, or whatever the case may be? Do we also have variations across different settings here as well?

MS. NEUMAN: So that is something we're planning to break out for you in March where we can show how much it costs to do drug administration in the hospital versus the physician's office, and then you'd have to think about what Medicare might be doing in the home. And so, we don't have that for you now, but we do intend to have that for you in March.

MR. KUHN: Okay, thank you. And the second question is, we talked about the different kinds of drugs that are part of home infusion, and I think I've read recently, and maybe you can tell me or some of the clinicians around the table, are we starting to see oncology, chemotherapy drugs starting to be used in home infusion? Is that being migrated to the home yet or is that starting to occur? Do we know?

DR. SOKOLOVSKY: We heard from some providers that they were doing chemotherapy in the home. I would say that it was still a very small minority in the interviews that we did.

DR. HALL: Well, you know, a lot of infusion is -- almost all infusion is done on an ambulatory basis now. But a lot of it's done at centers, particularly biologics and I

think there are a lot of reasons for that in terms of handling of a product, and there are some facility fees that go along with that. I haven't seen a huge infusion of infusion therapy in the home.

MR. KUHN: Okay, thanks.

DR. NAYLOR: So I don't want to misread, but just based on what -- thank you for all the efforts to update us on different components, especially on that kind of the beneficiaries' experience with this, and I know that that is a limited database around this.

But is the work suggesting so far, not just with the kind of silo payment, but also with the way services are delivered, at least the potential of a capitated approach? You say that a few places are beginning to use this.

I'm wondering if just even doing a little bit more digging with whomever is using that approach to see if some of the challenges that are being uncovered and reported in your interview data may or may not be mitigated by having a more comprehensive approach to addressing the service needs of this population.

MS. NEUMAN: We can look more at that. My sense is that it's a minority that are doing a capitated approach

and it tends to be an integrated kind of system, health plan together doing it. So it's not the norm, but we can get more details on the folks that are trying to do it.

DR. NAYLOR: And will you by -- you mentioned some network of a couple hundred home infusion agencies that are providing or generating quality data. Do you know if we'll have any of those data before the March report?

DR. SOKOLOVSKY: I don't know. Some of those providers that we spoke to who are involved in this network have spoken to us about getting data to us, but I don't know how quickly or how soon that can be done.

DR. NAYLOR: All right, thank you.

MR. GEORGE MILLER: Yes. On Slide 8, you said that the plans said the abuse of home infusion benefits are no more prevalent than other services, and I'll focus in on home care. We thought there may have been just a little bit of abuse there. So are we talking about the same magnitude of home services or just in general we don't think there's -- I'm just trying to get a picture of where we think that potentially could be. Or do you know?

DR. SOKOLOVSKY: They said in general --

MR. GEORGE MILLER: In general, okay.

DR. SOKOLOVSKY: -- that they didn't see that as being an issue for them.

MR. GEORGE MILLER: Yeah. I didn't know if this was more ripe for that type of abuse than other services. The second question I have is just, do you have demographic information on what the characteristics demographically of a patient that has home infusion looks like? Or can you get that from the data? Can you pull the demographic characteristics?

MS. NEUMAN: You mean from the Medicare claims --

MR. GEORGE MILLER: Yes.

MS. NEUMAN: -- that we've paid for home infusion drugs?

MR. GEORGE MILLER: Yes.

MS. NEUMAN: Yeah, we have. We have looked at that. I think we had a little bit more detail on that in September.

MR. GEORGE MILLER: I don't remember.

MS. NEUMAN: And my -- the one difference, it was either with B or D -- I can go and dig it out -- there was one category where there were differences across racial and ethnic groups. Let me just go look. And then there was

also higher use among beneficiaries with ESRD used home infusion drugs, both B and D, more commonly.

Older beneficiaries, I believe for Part D, were more likely to use them. And then as I said, I think racial and ethnic minorities, there was a difference on the D side.

MR. HACKBARTH: Can I follow up on George's first question? The way I interpreted that first bullet is that this is in the context of private plans that pay for home infusion. The context might be different there depending on the type of plan. There may be a payment structure or oversight mechanisms that would not necessarily exist in fee-for-service Medicare to limit potential abuse.

DR. SOKOLOVSKY: And we did have several interviewees who pointed that out.

MR. HACKBARTH: Yeah, yeah. Okay. Bruce. Bill. Karen.

DR. BORMAN: I just wanted to touch on the more pumps than drugs, which certainly seems so counter-intuitive to being reality, and my only question would be, do we have a sense whether that potentially could be a combination of fluids, hydration, and drugs? Because there are some drugs that are not compatible with various things and you might,

in fact, need a separate infusion to follow on that drug, or in terms of hydrating in anticipation of that drug, but you couldn't mix it with the drugs.

So I suspect that most of these times it is a good marker for something's funny, but that there could be some clinical circumstances where potentially that more pumps than drugs maybe could make sense. So I just throw that out as just being a little bit -- you know, we just need to be sensitive to the clinical context when we pick markers.

MS. NEUMAN: And we're sort of following up on this point and looking at it a little bit more. It's actually more beneficiaries getting pumps than getting drugs. So the more product possibility wouldn't be driving this result.

DR. BORMAN: Would just an electrolyte or fluid solution be considered a drug?

MS. NEUMAN: We'll be capturing --

DR. BORMAN: I guess would be my question. Would you capture it? That would be the only --

MS. NEUMAN: Yeah, we'll check.

MR. HACKBARTH: Round 2, Scott.

MR. ARMSTRONG: Just briefly, I would say I'm

impressed with the analysis. I think the direction that you're going in makes terrific sense. It's very consistent with many of the other policy directions that we've been heading in. In my own experience in a care delivery system that is really expanding the use of home infusion and other home services, for our payment policy to reinforce that, I think, is the right direction.

DR. BERENSON: I just want to say that I agree -- I'd better not talk -- you're approaching this very systematically, you're going in the right direction. I just wanted to be on record as saying I think this is going exactly right.

DR. HALL: In the course of your analysis, you know, I think the 90 percent/10 percent rule will probably prevail, that 90 percent of the services are bunched in 10 percent of the patients. I'm not sure that's going to be true for Medicare, but it would be well worthwhile looking at that.

DR. CASTELLANOS: Kim, you asked if we express any personal experience that you have. Obviously with urinary tract infections, this is a big field for us. Quite honestly, we don't do it. We do it as a referral to an ID

doctor. I know that's more expensive for the system, but it's so complex, there's no uniformity, and if I stress anything that you can do, is really try to get a uniform policy and try to make it a lot simpler.

Herb, you asked about oncologists. Yes, they do it. I think ID doctors are the main ones. Rheumatologists are doing it now and GI doctors are doing it.

George, you talked about abuse. A big thing in Florida is home infusion, outpatient infusion fraud. That's a big, big topic, but I think that's been dealt with separately, I'm pretty sure. You mentioned that, too, Mike, I think.

But if I could suggest anything, it's just make it a lot of simpler, more uniform, and make it something that I don't have to refer to somebody because it's so complex. I'm sorry to say this. I don't have a lot of time and it costs me more time and energy to do it.

The other concern I have is that -- and it really isn't a concern -- it's the SGR issue with Part B drugs. As you remember, that Part B drugs were a big issue in SGR, was taken out. We want to make sure if we keep them in Part B, that they're taken out of the SGR, that is. Thank you.

MR. GRADISON: Just to say thank you for helping to make a more orderly -- I mean, have such an orderly analysis of really such a complex subject. I'm can only think of one with so many moving parts.

DR. BORMAN: Just a couple of questions and thoughts. I do have some experience with a fair number of patients. I'm getting mostly antibiotics, but occasionally some other drugs.

And my first question is a little more to Glenn and Mark. Do you sense we have boundaries on where we can go in this report in terms of if we said in the end this is crazy and there should be a clearer, simple uniform way that has to cut across all this business of this one is B and this one is D? Is that within our purview to recommend? Is that sort of out of scope in this particular report?

MR. HACKBARTH: Go ahead.

DR. MARK MILLER: Of course, we would never say anything that's crazy. I think there is -- I think as usual, we could take a fairly wide latitude here. I think in part the way I think we're approaching this is they structured some questions for us and we're trying to fit in behind those questions.

I think there's this general thought, and some of this came up here, Oh, if you just do this, it's more efficient and it saves money. I think what this report is going to show is that that question is highly dependent on not just the payment system changes or what payment system is coming into and going out of, but the drug in question and that type of thing.

And so, at least so far -- and this is still a ways off so I hadn't thought of a really hard deadline or a real hard finished product for us -- is we could go to here is the response to the mandate, this is the information you asked for, here's where it seems to work, where it doesn't seem to work, where you might have an advantage and you might not, and be done there.

I don't think there's anything that restricts us from going further from that, but I think we have to minimally do that.

DR. BORMAN: Okay. Then just briefly, do you have a sense why we have this mismatch? Is there some piece of history here that we're missing that causes us to regard this as very difficult to deal with? Is there some underlying rationale that we're all missing that's explained

by knowing the history of how this came together, or is it truly just different things happened at different times and nobody was pulling it all together, do you think?

DR. SOKOLOVSKY: Yes.

[Laughter].

DR. BORMAN: I was trying to find a polite way of saying it. Then in terms of the point that Mike Chernew brought up, I think, about how you would determine what the DRG piece of this is that might unfairly remain if you encourage all this home infusion.

I think it's going to be hugely problematic to figure out unless you went for maybe the most common reasons to do this, the most common diagnoses, and say that this is so much of the business that this is most likely to be the impact. Because I think it's going to be all in the length of stay primarily, that if you put a week out of the length of stay, there's going to be a pretty big incremental value on the hospital side, maybe a bit less so on some of the drugs and some of those kinds of things.

But it's going to be in that length of stay. That's going to be really tough, I think, to tease out and I don't think we could begin to address that question.

MR. HACKBARTH: And I agree with that, Karen. Mike's analytic point, conceptual point is exactly right.

DR. BORMAN: Right.

MR. HACKBARTH: I don't think it leads to a policy of trying to figure out the precise amount by which to reduce the hospital inpatient rates to offset this. Instead, I think what we would do is what we always do, look at the overall relationship between what we pay hospitals for inpatient services and what the costs are that they incur in the aggregate and try to keep those numbers in balance.

But we wouldn't want to adjust rates to offset somehow this transition to another setting.

DR. BORMAN: Right. And then my last two things, I would absolutely support what Bill Hall said in terms of, I think the real mover and shaker in this general topic is doing this infusions in HOPDs or other infusion centers and much less so in this -- maybe in the home infusion market now.

I think home infusion has helped us think about it, but then has led to doing so much of this in a more center because of the relatively higher side effect profile

and complexity of handling the drugs in administration that needed to be done in a center rather than in the home. So I think that really, at the end of the day, it might be this is a smaller piece of the question about infusion therapy.

And then from a personal standpoint, the other group that I would say, and it seems counter-intuitive, that at least in some hospital systems or care systems that has pretty good access to home infusion are the under-funded, and that's because there isn't all this complexity of going around and figuring it out.

It's pretty clean for a given system, that they're going to get this patient who's under-funded out of the hospital days earlier with X savings and they can easily afford to put that into the home infusion piece.

So in addition to sort of the MA and some of those people you had there, there's kind of a counter-intuitive piece where the under-funded, in fact, benefit, and it tells you it's a back-handed comment on the system we have for Medicare, I think.

MR. HACKBARTH: Yeah, yeah. So let me pick up with that. This interests me because I think it's an example of a broader set of policy issues, that things

migrate from inpatient settings to outpatient settings or even the home as technology changes, as clinical practice changes.

And part of that migration is where you move into settings where there's less institutional control, less formal oversight, and if you combine that with some subjectivity in whether the service is needed, you have the potential for misuse, overpayment, and the like.

In a system like Scott's, this isn't much of an issue because they are organized in a way to provide ongoing clinical oversight and they have financial responsibility for the whole thing. And so, their decisions are presumably guided by all of the right factors.

But in a disaggregated care delivery system paid for on a fee-for-service basis, you don't have everything lined up. And, you know, as long as stay in fee-for-service and as long as technology and clinical practice continues to change, I think we can be sure that the general direction is going to be down this path towards more things moving out of tight institutional settings into looser settings.

It's a problem we're going to face repeatedly. That doesn't mean I have a solution to it, but this is an

example of a much bigger phenomenon.

Okay, thank you, Joan and Kim, for your careful work on this.

We'll now have our public comment period. Please begin by identifying yourself and your organization, and let me do my usual statements about your best opportunities to provide input to our work are actually not through this comment period, but rather by engaging in conversation with our staff, and also using our Web site where you can file comments as well.

When the red light comes back on, that signifies the end of your time. Thank you. Go ahead.

MS. CARLSON: Hi. I'm Eileen Carlson from the American Nurse's Association. I'll just be really brief. I'm also a registered nurse. On the home infusions, this may be totally off base, but one of the possibilities is that insulin pumps may have been counted, which obviously insulin is not counted as an IV med. So that's one thing to look at.

I just want to say that I'm really glad to see you all looking at the costs and possibilities for paying for home infusions, and I'd like to see some attention drawn,

and perhaps this is really the fundamental reason this is being looked at, at the -- it's the quality issues involved. I guess I shouldn't say quality, but health care associated infections. That's really one of the major reasons for going to home care and having infusions at home.

Don't quote me specifically, but I think there's recent data showing that three out of ten patients in a hospital have some kind of error or suffer some kind of condition. So obviously, when you go in the home setting, as long as it's a good environment, that can be a good thing in and of itself, and maybe saving costs that you wouldn't ordinarily look at, at home. So I just want to emphasize the need to do that.

And then with respect to ambulatory care, once again we're really glad to see you all looking at this, and I just wanted to mention that -- and I'm really glad to see that you pointed out that staff nurse costs would be possibly a part of the payments made to hospitals in outpatient departments.

And one of the things that ANA has been looking at is, as you're probably well-aware, staff nursing costs are usually part of the room and board and are not identified

separately. We have a health care economist and we've been looking at trying to pull those out and identify them, and I think if that was done, that might be very helpful to you all.

So if there's anything we can do in that respect, there's a dataset called Nursing Intensity Weights that was used in New York State for Medicaid, and one of the purposes was to ensure adequate staffing per patient. And that's been developed pretty in-depth. So that's one dataset that might be helpful. Thank you.

MR. PLUMMER: Good morning. It is my understanding that the MedPAC is providing information to the super committee that is studying the reduction of health care costs to reduce the deficit in the United States. And I'm a hospital CEO. I'm a CEO of a 25-bed hospital, critical access hospital, and I have some information that I believe the MedPAC should look at when they make considerations and provide information to this committee so that accurate information is being provided to the committee, and that we need to look at all aspects of health care and all aspects of critical access hospitals in the United States.

And critical access hospitals were designated by Federal legislation and that designation was given to the rural community in which these hospitals are located. When these hospitals or when these communities decided they could no longer support their local hospitals and turned them over to systems or larger hospitals for operation, I believe that they should have gave up their critical access status at that time, or not maybe gave it up, but in the regulation, they should have -- it should have been taken away from them.

Information that we have discovered through research and development shows that systems that take over critical access hospitals have what they call home office expense that they are reimbursed on that brings and drives the costs of that critical access hospital up and puts that money back into the coffers of the system that now owns that hospital.

That money is not spent in that rural community in which that hospital is located, but is spent maybe in the bigger city or the metropolitan area where the system is located. And I believe there's a lot of savings out there and I think that MedPAC should look into this and provide

that information to this committee.

We've provided it to many members of the committee, but we think you need to do some research and look into that if you would. I am from Pennsylvania. My name is Carey Plummer. I'm the CEO, President and CEO of the hospital in Jersey Shore, Pennsylvania. Who could I give this to? Thank you.

MR. HACKBARTH: Okay, thank you very much. We are adjourned.

[Whereupon, at 11:08 a.m., the meeting was adjourned.]