



Medicare: A Primer
Alliance for Health Reform
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ED HOWARD: Welcome to this program on the basics of Medicare on behalf of Senator Rockefeller and our board of directors, we're very pleased to have you here. We're very pleased to be on the House side for the first time in about five years.

So there are some logistical differences, those of you who are regulars, we appreciate you bearing with us. We were worried that the room was so long relative to its width that you wouldn't be able to see us but since the chairs are so short you can't see us anyway [Laughter], so don't worry about that. Just look at the screen and the slides will tell you everything you need to know.

We're here to talk about Medicare. Medicare is the largest solely federal health program, covers 45 million people or so and it costs this year well north of half a trillion dollars. It was enacted in 1965. I came to work on the Hill in 1970. I can't remember the last year that Congress didn't pass some legislation substantially affecting this huge and popular and expensive program that delivers health care to elderly and disabled Americans.

So there's a need for everybody in the policy process to understand how Medicare works plus, as you all know, there were some substantial changes to Medicare enacted as part of

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the Affordable Care Act and we'll hear some expert observations about those changes as well today.

Our partner and co-sponsor in this briefing is the Kaiser Family Foundation. You'll hear from Tricia Neuman in just a moment. In fact, why don't we do that right now. Tricia Neuman is the Vice President of Kaiser Family Foundation and Director of its Medicare Policy Project. Tricia?

TRICIA NEUMAN: Thank you Ed and thank you everybody for coming today to do Medicare 101 boot camp as we call it, but we hope it won't be as painful as boot camp. We're having this program because Medicare is never far from national policy discussions.

So it's an issue that you and your bosses can never get too far from. It's true because Medicare's now 15-percent of the federal budget but it's also true because it's an important source of coverage for our parents, our grandparents, and hopefully one day for us. So we think a lot about Medicare and health care providers think a lot about Medicare and plans think a lot about Medicare.

In some ways, we take Medicare for granted but as Ed said, Medicare was enacted in 1965 before I was working on the Hill too but at the time, half of all seniors lacked health insurance coverage. I think in this day and age, we take for granted how easy it is for older people to get health insurance

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coverage. That's such an important function of the Medicare program.

So as we all know Medicare ended up playing a fairly important role in the health reform law. It was a major part of discussions particularly toward the end. As we'll soon hear, Medicare could pop back on the front burner of discussions if and when Congress gets down to work for real on the federal budget deficit. So that's all the more reason, we think, to step back and to sort of regroup and learn more about the ABCs and Ds of Medicare which is exactly what we're going to do today.

We have a really great session for you. We're going to focus on who's covered by Medicare, how does Medicare pay plans and providers, what are some of the great issues of the day that the Centers for Medicare and Medicaid serves as we're dealing with, with respect to Medicare. Then we're going to turn to the future challenges facing the program.

So without further adieu, we'll turn it back to Ed. I will say this is your chance to get the basics. Feel free to ask basic questions. If you don't want to stand up at the mics, send them in on paper. This is your time and we have great experts for you right up here on the panel.

ED HOWARD: Great. Thank you Tricia. You also have some good information about Medicare in your packets. There's

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also a set of biographical sketches that'll provide a lot of information about our panels beyond what I'll have the opportunity to say.

Some of you may be watching the web cast this. We had a particular to make it available to state and district offices of members of Congress and those of you who are doing that, you can find all of these materials including the biographical sketches and the slide presentations of those who have them at the Alliance website, which is allhealth.org. I guess by Monday, you can watch this web cast, those of you in the room, and download a pod-cast if you have nothing else to do on your ride in in the morning.

As Tricia noted, there are green question cards in your packets. You can use them at the appropriate time and microphones to which you can repair to ask the question yourself. As the lady said, without further adieu, we do have a terrific panel. Let's let them talk. The first one of those terrific people is Juliette Cubanski.

She's the Associate Director of the Medicare Policy Project for the Foundation and an expert on Medicare financing issues and an expert on the Part D prescription drug benefit. She holds a doctorate in health policy from Harvard. Her task today is to give us the broad overview of this important program. It's great to have you set the stage for us Juliette.

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JULIETTE CUBANSKI: Thank you Ed and Tricia. Good afternoon everyone. As Ed said, I'm Juliette Cubanski, Associate Director of Medicare Policy at the Kaiser Family Foundation. First I'd like to acknowledge my colleagues at Kaiser who work on Medicare policy along with myself and Tricia, are Gretchen Jacobson, Jennifer Wong, and Lindsay Dawson. So my role here is to provide you with some essential facts about Medicare, who the program serves, what the benefits are covered, and the current profile of Medicare spending and financing.

As Tricia said, Medicare was established in 1965 to provide health insurance coverage to people aged 65 and older and was expanded in 1972 to cover younger people with permanent disabilities. Today Medicare covers 48 million people, 40 million under aged 65, and 8 million people with disabilities. Medicare covers people without regard to their income or their medical history and provides the same defined benefits to everyone entitled to Medicare coverage.

This is an important feature of Medicare that distinguishes it from Medicaid and private health insurance. Medicare provides access to services critical to the health of the elderly and people with disabilities including the hospital and physician visits and a prescription drug benefit delivered

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through private plans, which have been playing an increasingly larger role in delivering Medicare benefits in recent years.

Medicare covers a population with diverse needs and circumstances, one which on the whole tends to be sicker and have greater health needs than others. Close to half have three or more chronic conditions and three in 10 have a cognitive or mental impairment. The oldest beneficiaries, those aged 85 and older are about 12-percent of all people on Medicare but as the U.S. population ages, they will be representing a larger share of the Medicare population in the future.

Many beneficiaries live on modest incomes primarily derived from social security with almost half having annual income less than 200-percent of the federal poverty level, which is around \$22,000 for a single person in 2011. A small share of beneficiaries live not in their homes or their community settings but in long-term care facilities where they use services at a higher rate than other people on Medicare reflecting their more fragile health status.

For the majority of beneficiaries, Medicare benefits are provided on a fee-for-service basis referred to as original or traditional Medicare. Benefits for hospital and physician services are divided into two parts, Part A and Part B. Part A is the hospital insurance program, which helps pay for hospital

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visits and skilled nursing stays, post-acute home health care and hospice care.

Medicare charges a deductible before it begins paying for a hospital stay, which is just over \$1,100 this year and also charges for each day of an extended stay in a hospital or a skilled nursing facility but there's no cost to beneficiaries for home health care.

Part B is the supplementary medical insurance program, which covers physician visits, outpatient hospital services, and preventive services such as mammograms and flu shots. Most beneficiaries enrolled in Part B pay a lengthy premium, which is \$115 in 2011 but this premium is income-related meaning that higher income people pay a higher monthly Part B premium. Part B services are subject to deductible and may also be subject to co-insurance of 20-percent.

Typically people gain entitlement to Medicare Part A after paying payroll taxes for at least 10 years and enroll when they turn 65. Enrollment in Part B is voluntary but the majority of people who are entitled to Part A also enroll in Part B. There is a penalty for delayed enrollment in Part B however unless a person has another source of coverage.

Part C and Part D, which I'll talk about next are different from original fee-for-service Medicare because they involve the delivery of benefits through private plans. Part

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C, known as Medicare Advantage, offers an alternative to fee-for-service Medicare where beneficiaries can enroll in a private plan such as an HMO or a preferred provider organization.

These plans contract with Medicare and receive payments from the government to provide enrollees with all of their Medicare benefits and often extra benefits that Medicare does not cover such as vision and dental services.

According to the Medicare Payment Advisory Commission, Medicare pays more for people enrolled in Medicare Advantage plans, about nine-percent more on average than if those same individuals were covered under original Medicare. This payment system has received a great deal of attention in recent years.

As a result of the health reform law, there are changes ahead as to how plans will be paid, which I believe Jon will be talking more about but suffice it for me to say that in recent years, this payment system has driven a dramatic expansion of Medicare enrollment and Medicare plan availability since 2005. As of February 2011, nearly 12 million people, a quarter of all of those on Medicare are enrolled in Medicare Advantage plans.

The Part D benefit that started in 2006 represented another large expansion of private plans in Medicare. Part D is a voluntary outpatient prescription drug benefit delivered through private plans, either standalone drug plans or Medicare

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Advantage plans that offer drug coverage. Beneficiaries in each state have the option to enroll in more than dozens of standalone Part D plans and Medicare Advantage drug plans.

Plans are required to offer a standard benefit, which is depicted on this slide with a deductible of 25-percent co-insurance for prescriptions followed by a gap in coverage, followed by catastrophic protection for high drug costs. Plans can vary the design of the standard benefit. In fact, most plans offer an alternative design that is actuarially equivalent.

This gap in coverage is commonly referred to as the donut hole. This is where, until this year, beneficiaries were responsible for paying 100-percent of the cost of their drugs until their spending reaches catastrophic levels. As a result of the health reform law, this gap is gradually closing between now and 2020.

This year, beneficiaries are responsible for paying 50-percent of the cost of their brand drugs and 93-percent of the cost of generics in the gap. Those with modest income and assets are eligible for additional assistance with Part D premiums and nearly 10 million people are currently receiving this extra help. In total, nearly 90-percent of beneficiaries now have drug coverage with a majority having coverage through a Part D plan.

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The cost of providing all of these benefits have risen along with rising health care costs and in 2010, Medicare benefit payments totaled \$509 billion. Presently in-patient hospital services comprise the largest share of payments at 27-percent followed by payments to Medicare Advantage plans and Part B benefits and then spending on the Part D drug benefit. Revenues to pay for these benefits come from several different sources.

Part A is funded primarily through payroll taxes. These revenues from which the Part A trust fund drive 85-percent of its revenue in 2010, are dedicated tax paid both by employers and employees. Part B and Part D are financed primarily through a combination of general revenues and premiums paid by beneficiaries. Part C Medicare Advantage is not shown here because its benefits are not financed separately.

Despite the important benefits that Medicare covers, there are gaps in the Medicare benefit package. Medicare does not cover vision or dental services nor does it pay for most long-term care services for those beneficiaries with extended care needs in a nursing home. Medicare also has premiums and cost sharing requirements that could prove burdensome for beneficiaries on limited incomes and has deductibles for Part

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A, Part B, and Part D, which added together make Medicare look something like a high deductible insurance plan.

Unlike typical large employer plans, Medicare does not have a stop-loss benefit that limits how much beneficiaries have to spend out-of-pocket in any one year, which is a concern because our research shows that health spending by people on Medicare as a share of their incomes has been rising in recent years from 11.9-percent in '97 to 16.2-percent in 2006. Average spending on premiums and cost sharing for Part B and Part D together consume more than 25-percent of the average social security benefit, which is about \$1,100 per month.

So with Medicare paying less than half of beneficiaries' total health and long-term care spending, many beneficiaries have some form of additional insurance coverage to help with their out-of-pocket expenses and provide additional benefits.

The primary source of supplemental coverage for one in three beneficiaries comes from employer-sponsored, retiree health benefits but it's of some concern that employer-sponsored retiree coverage has been eroding in recent years along with the rising cost of offering retiree coverage.

Medicare Advantage is another main source of supplemental coverage, supplemental in the sense that these

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plans often cover benefits that original Medicare does not cover.

Finally, private insurance policies known as MediGap primarily help cover Medicare cost sharing for deductibles and co-insurance but premiums for these policies are often quite expensive.

Last but by no means least, Medicaid provides a vital source of support for more than 8 million Medicare beneficiaries with low incomes who are known as dual eligibles. Most of these receive full coverage for the Medicaid benefits including long-term care as well as substantial assistance paying for their Medicare cost-sharing premiums but I should also note that not all low-income people are covered by Medicaid.

This leaves roughly one in 10 beneficiaries with original Medicare and no other source of supplemental insurance, which could focus attention in the coming years on the adequacy of the Medicare program, the benefits it offers, and the ways to bolster and approve those benefits but what I think most of us will probably be focusing on in the immediate future are the changes brought about in Medicare as a result of the Affordable Care Act.

I know you'll be hearing more about these changes from some of the other speakers but let me just give you a brief

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overview. The law includes several benefit improvements including, as I mentioned, phasing out the coverage gap and eliminating cost sharing for prevention services. The law also includes reforms designed to help improve the quality of care for people on Medicare and the efficiency of the delivery system.

The law includes provisions estimated to bring about major savings to Medicare including lower payments to Medicare Advantage plans, hospitals, and other types of providers as well as bringing in new revenues. The net effect of all of these provisions is lower Medicare spending over the next decade and 12 additional years of solvency of the Part A trust fund.

So while you may be hearing that Medicare faces serious long-term financial challenges, it's also important to understand that the health reform law took some important steps to improve Medicare's financial outlook as well as the coverage that 48 million people on Medicare receive. So on that note, I'll turn it back to you Ed.

ED HOWARD: Great, thanks very much Juliette, excellent start to this discussion. Next we welcome back to these briefings Dr. Bill Scanlon. Bill's a consultant to the National Health Policy Forum. He's a former member of the

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Medicare Payment Advisory Commission and he spent more than a decade as a senior health care official at GAO.

I don't want to say what GAO stands for because it's different than now. He's an economist and he's here to tell us how Medicare pays for that half a trillion dollars worth of services it buys each year. Bill thanks for being with us.

WILLIAM SCANLON: Thank you very much Ed. It's a pleasure to be here. I think this is going to be a bit like a reduced Shakespeare company's version of Medicare payment policy [Laughter] though there's probably two differences, one, I'm not going to cover every play. I can't get every payment system within the 10 minutes and secondly, there will be no humor [Laughter].

I wanted to start by just acknowledging something I'm sure you all know, which the objectives of the Medicare payment policy. One, to assure access for beneficiaries that can lead to encouraged efficiency, and third, to accommodate and now think about promoting quality. I raise these because these were very much in mind in terms of the design of policies and they're very much in the minds of MedPac every year, when it makes recommendations to the Congress about what should happen in terms of the changes in policy.

The first two have been traditionally part of the program and part of the thinking about in terms of payment

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policy with respect to the program. The third, we're in an evolutionary stage. We've gone from being concerned about whether there was enough money being paid to providers to assure that they could provide quality care to a system where we're thinking about how we can actually encourage them to provide higher quality care. This is very much a work in progress. I'm not going to touch on it more, maybe Jon or Mark will and we can talk about that sort of in the question and answer period.

The context for Medicare payment policy goes back to 1965 where the law says Medicare shall not interfere with the practice of medicine. Two of those sort of consequences of that are that Medicaid is essentially any willing, able provider program so that you'd need to deal with sort of almost all of the providers that want to participate in the program.

Secondly there's been a tradition of maintaining beneficiary freedom of choice. These are both issues in terms of how you set payment rates. A third factor to think about is the size of the program, sort of as you've heard; this is a very large program, which has both pluses and minuses.

On the plus side is it has the leverage to say here are prices, are you interested in participation and you're going to get sort of good participation. On the negative side, it is how you set those prices, it's very difficult to look at

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markets and to get sort of information from providers in order to be able to set the price because Medicare distorts the market. There's no sort of question about that.

As a result of this context and some of the dilemmas with it, we've ended up with sort of payment policies that you could put into two categories. The first category being the traditional programs' administrative prices, prices that the Medicare program sets and publishes and then says if you want to participate in the program, here's the price that we're going to pay.

Of more recent vintage is an attempt to use competition to set prices and this goes back on a wide scale to 2003 with the Medicare Modernization Act where we introduced competitive processes within Medicare for both Medicare Advantage and the Part D drug benefit. Again sort of given the size of the program, how you capture the benefits of competition becomes challenging. I'll talk about that a bit later.

With respect to administered prices, I want to start with the physician fees because they actually are going to be probably very prominent in your lives over the course of the next year. Ed mentioned earlier that virtually every year there's Medicare legislation.

It's the physician fees that are probably driving the need for Medicare legislation because of the sustainable growth

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rate, the pending reduction in fees due to the sustainable growth rate, and your need to make sure that that doesn't happen.

We started back in 1965 with respect to physicians paying reasonable charges. We turned out it wasn't reasonable at all, that what ended up being a very inflationary system with a lot of variation. It was not rationally related to quality of care, appropriateness of care at all. So we tried to move to a system that pays more rationally.

That system is the Medicare physician fee schedule or the relative value-based fee schedule. The fees are based upon relative values that were derived first from a Harvard study of the differences in the resources that it takes to provide an individual service and since then that Harvard study in the 80s have been updated by an American Medical Association committee called the Resource Utilization Review Committee.

What these values do is they measure the relative differences between two different services in the amount of physician time that's involved in delivery of that service as well as the intensity of that physician's involvement. Secondly the practice expenses involved with the service, which includes other staff in a physician's office, supplies, equipment, and rent and finally, the cost of malpractice insurance.

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To give you an example, an office visit, they'll have a relative, an intermediate office visit will have a relative value of two and some arthroscopic surgery on a knee will have a relative value of about 18.

There's 7,000 different relative values, 7,000+ different relative values reflecting the 7,000 just different procedures. To get to the fee that Medicare pays, you take the relative value of first service, multiply it by a conversion factor, and adjust it for the geographic area that a service is being performed in to reflect differences in the cost of living across areas.

The conversion factor was originally done in a budget neutral way in 1989 when we started the fee schedule and then it has been updated through a process either, first of all, related to something similar to the sustainable growth rate and since the sustainable growth rate was enacted in 1997, the sustainable growth rate or the Congressional override of the sustainable growth rate. The conversion factor today is \$34 roughly and then as I said, there's a geographic adjustment, which there are 89 areas for geographic adjustment that determine the actual fee being paid.

Why do we have a sustainable growth rate? We have a sustainable growth rate because there's a big issue in terms of Medicare costs with respect to the volume and intensity of

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services that we wanted to create an incentive to try and encourage physicians to be efficient in terms of the services that they provide. To give you an example of how we have not succeeded there, over the last 10 years, Medicare fees have increased 12-percent over a 10-year period. Medicare spending per beneficiary has increased 77-percent over that same period of time. We have a very significant volume and intensity problem.

The sustainable growth rate appeared to be working until about 2002 when there was a need to reduce fees by about five-percent, which was due to the fact that services were growing faster and we had some data errors that we were correcting. The problem is that that five-percent then triggered a series of projected changes in the physician fees that were all negative and which every year the Congress has overridden. The cumulative effect is we're now, as you know probably well, facing a -25-percent change in physician fees unless there is Congressional action.

Let me go on now to the Part A services, which are very often paid under what I'll call the prospective payment model. It's the same kind of payment model for hospitals, skilled nursing facilities, home health, as well as some other services.

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What happens is that the payments are determined by looking at data that are available to Medicare and calculating the cost per unit of payment adjusting that for differences in the types of patients that are receiving a particular service and then applying a geographic adjustor.

One of the key things here is that these payments are then updated every year based upon either what's in the statute, which often says we're going to update these payments with inflation or modified in other ways. Every year, MedPac gives you a set of recommendations about what those other modifications might entail.

This chart, which you can look at later, gives you a sense of how for individual services, this model for prospective payment is applied. There's two things I would note about this as we move forward when we're thinking about the Affordable Care Act. One of the concepts in the Affordable Care Act is the notion that we can improve efficiency through bundling.

The prospective payment systems, in some ways, have already taken us down the road towards bundling. Hospitals who went from itemizing every service to paying for a total stay, the same thing with respect to home health. With a skilled nursing facility, we don't itemize every item anymore but we do still pay on a daily basis but that's still somewhat more of a

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bundle than we paid for in the past. In the hospital case, I think we feel like we have been successful for the most part that the bundling work.

In home health, I would say that it'd be hard to find people that would say this bundling works because we realize that we've created a bundle where we don't have a concept of what belongs in it. We don't have a concept of whether we got what we're supposed to be paying for, and as a result, we've been watching about 500 new agencies form every year to take advantage of the home health payment system.

Let me now turn to competitive determined payments and as I said, it's for Medicare Advantage and Part D plans. Then we'll talk a little bit later about durable medical equipment, which we're starting right now. In competitively determined payments, the plans themselves are determining how much is being paid but in using competition, you have to give somebody an incentive to compete.

You have to tell them here's what it takes to be a winner. They have to be motivated to do that. The way we've chosen to motivate them in these two instances to say we're going to have benchmarks. You're going to bid against this benchmark and the lower you bid relative to that benchmark, the larger the market share you're likely to get.

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In the case of Medicare Advantage Plans, the benchmark has been set by the program using information from the experience with fee-for-service or traditional Medicare program or using floors that the Congress has established. The floors have created a situation that Juliette referred to in terms of how much Medicare Advantage payments may exceed the traditional cost of traditional Medicare.

The floors, in some counties, can be as high as 130 to 150-percent of fee-for-service. So a plan in those counties, is bidding against a benchmark that is much higher than fee-for-service and even though they bid lower than the benchmark, they still cost more than the traditional program and they're still able, because there's a requirement that when you bid lower, you're going to get a share of that money between the benchmark and your bid that the Medicare program is going to pay you and you're going to have to give that to beneficiaries in the form of extra benefits.

As Juliette has indicated there's significant changes to the Medicare Advantage payment system pending in future years due to the Affordable Care Act. I'm going to let Jon talk maybe more about those but I do have a slide that you can look at in your package to understand or look at some of the details of those changes.

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Let me now turn to the latest change, significant change, in Medicare payment, which is durable medical equipment. For years, we've known that durable medical equipment was being overpaid by significant amounts and it's not hard to understand in part. We were basing most of our fees on 1986 charges trended forward for inflation. With all technologies, as we all know when we buy it, they often become cheaper over time instead of more expensive and yet we're using historical fees to pay for these.

So the Congress has instituted a competitive bidding program for durable medical equipment, which is being rolled out this year, I think, in 11 areas for a limited number of products. This is a different form of competition because this competition does involve a different incentive for bidding low and that is that you can actually lose the contract.

You may not be able to provide services to Medicare beneficiaries if you have bid too high. The way that CMS designed this though, in my view, is that they made a lot of accommodations to both preserve some freedom of choice as well as to protect small businesses.

Now I've seen, as a result and potentially because of these accommodations, two important goals, but criticism that we're both being too aggressive or not aggressive enough in terms of durable medical equipment pricing. The reality is

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we're moving away from a very bad system to something that is a significant improvement in the first round. We've seen 30-percent reductions in the fees that are going to be paid for these services.

The key to all of these payment systems is vigilance. We've discovered that at MedPac over the years that you have to be vigilant in terms of monitoring what's happening under a system, making sure that you have current data, and that you're using those current data because this process of setting fees for literally thousands and thousands of services is incredibly challenging and there's a lot of effort needed to maintain a reasonable set of prices. Thank you.

ED HOWARD: Thank you Bill. Before we go on, could you just lay out what the main things you're talking about when you refer to durable medical equipment [Laughter]?

WILLIAM SCANLON: Actually I will tell you what the items that are being competitively bid, which may be sort of as a help. It's oxygen and oxygen supplies, power-wheel chairs and scooters, diabetic supplies that come through mail order, enteral nutrition services, hospital beds, and walkers. It also includes all kinds of other supplies like catheters and canes and actually, canes are in the walker group too. So it's things like that in terms of durable medical equipment.

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ED HOWARD: Great. Okay thank you. Next we're going to hear from Jonathan Blum. He is the Deputy Administrator of the Center for Medicare and Medicaid Services and head of CMS' Center for Medicare. He's responsible for everything you like and everything you hate about the vast Medicare program. He's done a stint at OMB and he's been on the staff of the Senate Finance Committee. He was at Avaliere Health just before coming to CMS and we're very pleased, Jon, to have you on our panel.

JONATHAN BLUM: Great. Well thank you Ed and thank you Tricia and thank you. I think this is my third opportunity being at this forum during my time at CMS and just to let folks know where I sit within the organization, so I sit over the Center for Medicare, which oversees the payment systems, which sets benefits, sets payment levels to all the fee-for-service providers, that Bill and Juliette discussed and also our payment rules and regulations for our private plans, the Medicare Advantage and Part D plans that participate within Medicare.

I think it's important to note that the work at CMS that ties to the Medicare program spans beyond the Center I oversee. There are separate centers for program integrity, separate centers for financial management, survey and cert quality oversight, the new Center for Innovation that was

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created with the Affordable Care Act. When we talk about Medicare and CMS, there's lots of organizations that touched the program but the world where I'd come from at CMS, it was about the benefits that are paid for and the payment systems that they're used to pay providers and to pay plans.

I wanted to kind of offer a few remarks and then happy to answer questions during the Q&A session but really wanted to talk about some of the work that we've done in the last year and are doing this year to implement new payment systems and also to implement many of the provisions that are in the Affordable Care Act. I think the first thing is just to point out that starting this year, January 1, 2011 this year, there are better benefits to our minds for Medicare beneficiaries.

The Affordable Care act, to us, changed the program in two important ways. One is to really shift the nature of the program more towards prevention and wellness starting this year, beneficiaries now has free cost sharing. They're in the traditional fee-for-service program for those preventive benefits that are recommended and also there's a brand new wellness visit that beneficiaries have the right to receive each year.

While it sounds obvious for folks who are in the kinds of health plans we're all in for the Medicare program, this is a tremendous change and hopefully a strong change for the

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better for our beneficiaries. I think what the Congress really intended is that the Medicare program become a benefit for wellness not just a benefit for sickness and we have data already to show that many beneficiaries are taking advantage of these new benefits.

The second new improvement that we have implemented starting this year is to close the Part D donut hole that Juliette talked about. The Affordable Care Act, over the next 10 years, phases down the donut hole in two important ways.

First is starting this year that we have created and are now operating the drug discount program, which requires brand name manufacturers, has a condition of being a Part D-covered drug to offer a 50-percent discount point of sale for those beneficiaries that don't qualify for extra help to receive discounts when they're paying for brand name drugs out-of-pocket.

The second change that the Affordable Care Act provides to Part D benefit is to phase down the donut hole both for generic drugs and brand name drugs over a 10-year period. So by 2020, the Part D donut hole will combine with the two programs is completely phased down.

Already, beneficiaries are benefiting from the changes and so out-of-pocket costs are down for many beneficiaries. That program is operational. We have secured all necessary

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brand name manufacturers as part of the discount program but beyond the Affordable Care Act, a lot of the work that we have done over the past couple years and are still working hard to implement is that we have stood up to new payment systems to our fee-for-service program.

Congress, back in 2008, authorized CMS to create a new bundled payment system for dialysis services, to combine both the dialysis fee but also the related drug and lab costs to a single bundled payment. That change has started, January 1, 2011. We have combined that payment system in Congress quite wisely when authorizing the program, combined the payment change also with a quality incentive program.

So we are also standing up one of the largest pay-for-performance systems to combine with that new bundled payment system, really to address both the incentives that Bill talked about, create more efficient payment but also to improve quality.

So I think this is a really great model for how we think about payment changes going forward, so really always think about the payment change combined with the quality incentive. To ensure that we give stronger incentives for providers to be more efficient, we also think about the quality mechanism at the same time.

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The second payment system that Bill talked about is the new DME competitive bid system for nine parts of the country. We have spent the last two years working very hard to solicit bids, to review bids, to approve bids, and starting January 1st of this year for those noncompetitive bid areas, we are paying much lower prices for certain durable medical items.

The average costs are 32-percent lower on average. That varies by region. That varies by product but we are extremely pleased by the results so far. We know the program is controversial. We have made compromises to always balance attention between best price and access but so far, the data that we have seen gives us great confidence that the program is working.

I think for this year, the things that CMS will be really focused on that I'm happy again to take questions on is really going to the Affordable Care Act's notion that we need to build payment systems, payment models that promotes greater accountability, greater quality, pay-for-performance, which I think is some of the most exciting work the agency now is doing.

The first wave of that work is thinking about the Medicare Advantage program and what's tremendously exciting to me is that for the first time starting in 2012, we're going to be changing the payment system to give stronger rewards, higher

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payments to those plans that have a higher quality rating and that's going to change the dynamic to how plans operate and compete within the Medicare program that I think today, the case is that plans compete based upon low premiums and extra supplemental benefits but we're already seeing plans change their business models to focus on quality, to focus on outcomes, to focus on prevention.

We have a five-star system that focuses both on process measures, outcomes measures, and patient satisfaction measures. Once you turn that into payment, that captures the attention of plans' CEOs, their boards, and what's really gratifying to us is in our work with plans to hear back, they're changing their business models. They're changing how they market themselves to focus much more on quality, much more on outcomes, and to us that tells us the payment incentives truly matter.

We are also transforming our hospital payment system. Right now, we pay hospitals a higher market basket update for reporting certain process measures and we have, as you proposed, rules to transform that, to reward hospitals that have the highest quality, and to create incentives and higher payments for those hospitals that both achieve high quality but also that improve.

We're in the comment period to those proposed rules but by 2014, we will be transforming the hospital payment system

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that Bill talks about, to be much more focused on pushing hospitals to improve their overall quality and to reward both improvement and attainment of quality.

Over the next several years, we'll be kind of building upon that framework to propose and to add measures to, we have measures but to turn into payment hospital measures for preventable readmissions, hospital-acquired conditions, really pushing towards the notion that when a beneficiary goes to the hospital that the Medicare program should reward both the most efficient care but also the highest quality care.

The last thing that we are working on and hope to have proposed rules very soon out for comment is the accountable care organization program. The Affordable Care Act created what's called the Medicare Shared Savings Program, which creates stronger incentives for physicians and hospitals working with physicians to come into the traditional fee-for-service program and come in and offer to be accountable for the entire fee-for-service benefit that's provided to Medicare beneficiaries.

Those organizations that achieve higher quality according to CMS measurement but also reduce the overall cost according to CMS measurement will have the opportunity to share in those savings. We are tremendously excited about this program.

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The law requires us to have it operational by 2012. So our goal is to create a program that will encourage lots of different kinds of organizations to come into the program, to be an ACO but really to change again that dynamic where providers, physicians, hospitals, aren't seeing the Medicare program simply as the bill payer but they're seeing it as a program that is trying to reward better care coordination, better value, more efficiency, higher quality.

So the ACO program will be one overall component to the overall strategy. So over the next year, two years and beyond, the work of the Center for Medicare really will be building the payment systems and the infrastructure both to transform the MA program but also the traditional fee-for-service program to really be that notion that we want to see about more efficient, more accountable, higher performing health care delivery system. That's the work that we're really excited about working on over the next several months. So I'll stop and turn to Mark.

ED HOWARD: Terrific. Thank you. Thank you very much Jon. Finally we hear from Mark Hayes who's now a shareholder in the health and FDA business practice group at Greenberg Traurig, which is a D.C.-based policy and lobbying firm. Most of you probably know Mark from his former incarnation as the Chief Health Counsel for Senator Grassley in the Finance

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Committee Republicans during the debate over health reform and well before that. You may not know that he is both a lawyer and a pharmacist.

So I guess he can make sure you get what you need in the way of medications and then if anything goes wrong sue the manufacturer, how's that [Laughter]? Mark, thank you very much and I know it was not easy to clear this in a variety of ways and we're very pleased to have you with us today.

MARK HAYES: Thank you. Well first off, I just thank you for the opportunity to be here. I'm just speaking for myself today. I'm not here to represent anybody else but myself and just to speak as a former Hill staffer who has worked on these issues for a long time and I got the job now of pointing out all the issues and challenges that the program faces and they are many. So I get the really unfun job now to deliver all the sort of scary things that are happening.

First to start off, everybody knows this but the program long-term is unsustainable. The part A trust fund will run out of money somewhere in the window between where those two lines hit the ground and let me tell you where this data comes from. This is from the CMS Office of the Actuary.

You can find this report on their website but there are two alternative scenarios here. The line that goes down earlier is from prior to the enactment of health care reform.

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The two lines going further out are showing a comparison of what would happen post-health care reform. So there's just a big difference that health care reform has on the solvency of the program but I'm going to go underneath that just a little bit to explain what that means.

ED HOWARD: Mark, the difference between the dotted line and the solid line on the right is the trustees report from 2010 and the one from 20-

MARK HAYES: And an alternative scenario, which yes I'm going to explain that.

ED HOWARD: I'm sorry.

MARK HAYES: That's okay. The health care reform makes a number of changes in payment systems and many of them are permanent changes in the payment systems. One of the issues that has come up is whether long-term those payment changes are sustainable. So this chart shows, long-term through 2080, what Medicare payment rates will be relative to private payments in commercial plans and under the Medicaid program.

As you can see, Medicare payments relative to those other two payment systems decrease dramatically over time such that Medicare will be paying almost, you can tell, almost half of the amount that Medicaid pays today to providers. This is primarily driven by the productivity adjustments to payment rates that are made out of health care reform.

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What the Office of the Actuary did is looked at this and said well this is probably not how this will play out. Congress will intervene in this at some point. So they developed an alternative scenario. That's what the two lines are on the first page is if you compare those, the dotted line is the alternative scenario and the solid line is their 2010 projection, the official Office of the Actuary projection.

Their projection is based on what's in current law, just the same way that the Congressional Budget Office's baseline is completely driven by what's in current law even if current law, no matter what it says. So some of the things that are in current law in Medicare don't make any sense like what's happening with the physician payment system. So if you assume that those things are going to get addressed at some point in order to keep the program going then you end up with this alternative scenario.

So then if you look at projected spending and you compare what projected spending was prior to health care reform is the very top line and you see it going up steeply, the current baseline survey of what payment rates are under current law is the dramatically lower solid line that shows spending leveling out over time.

The alternative scenario, however, if you assume that because those payment rates under current law are going down so

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dramatically compared to private insurance and Medicaid that those get adjusted back up to something that's more aligned with what the trend would be today then you end up with a projection for spending that's the dotted line and that's pretty much very close to what it was prior to health care reform.

Now I just point that out just to sensitize you to this issue and everybody has to come to their own conclusion about what you think about whether those payment systems should continue at those rates, whether that's policy. Those are your decisions that you all have to make but you need to be aware of the changes, the effect those changes have going forward to spending under the program and the solvency of the Part A trust fund.

Now switching to a different aspect here, talking about benefit design, this was already mentioned earlier that really the benefit design of Medicare is still pretty much what was written in 1965 even though benefit design everywhere else has evolved over time, private coverage has changed, employer-sponsored coverage has changed.

And a lot of that is reflected in the Medicare Advantage program but in the traditional fee-for-service program, you still see benefits that have a lot of gaps in

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coverage. As a result, that means that a lot of folks, also as mentioned earlier, have to purchase supplemental coverage.

Now here's the issue about supplemental coverage that MedPac is looking at very closely today. I think you'll find it in the budget options book that CBO just came out with that when supplemental policies erase all of the cost sharing like a typical MediGap policy would do, it drives up per capita spending substantially. You'll be hearing more about that from MedPac and there were some discussion about this during health care reform. This is a big driver of increased spending and because almost everyone has some form of supplemental coverage, it drives program costs considerably.

Another issue, SGR, already mentioned as well but I want to emphasize it here. This is another piece to the program in terms of issues and challenges. You're probably already aware of it. If you haven't already had a number of constituent visits and mail and phone calls about this, you will.

The program has, over time, what you have here is the bottom line is what the payment rate should be under current law. The top line is how the payment rates have been increased by Congress in temporary fixes. What happened along the way in about 2006 is the methodology for how these one-year fixes were done was changed.

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So it's made this cliff a really big problem and for 2012, it's really going to be about a -30-percent that is if Congress doesn't intervene again that payment rates under current law will go down. That's also something to keep in mind when you look at CBO baselines and the Office of the Actuary baselines and when you're thinking about current law, it's going to include that 30-percent cut.

You also have something from health care reform, the independent payment advisory board. This is something that gets a lot of discussion today. It really is a very unique creation for the program. It creates a new board with 15 full-time members who are appointed by the President, confirmed by the Senate.

It requires the board to recommend Medicare savings proposals if Medicare spending exceeds certain targets. What's unique about it really is that these 15 individuals make these recommendations and the HHS Secretary is required to implement the board's proposals unless Congress enacts alternative proposals with equivalent savings.

So that board will be able to rewrite things that Congress has enacted. So statutory requirements, payment systems, things that Congress has passed can be changed by the independent payment advisory board. Those things go into effect if Congress doesn't act. There are certain prohibitions

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that are temporary before 2018 that are off limits for the IPAB but those are only temporary and it's a permanent body.

The next really big category of things I want to point out is how these delivery systems, the payment systems drive utilization. This is a big issue. The payment systems in Medicare today are, in many ways, based on historical spending even though the payment systems have been updated and they drive huge variations in spending at different parts of the United States.

If you haven't gone and looked at the Dartmouth atlas and you have a few hours and you love getting in the middle of data, go Google Dartmouth atlas and look through all of this because it's really important to know about. What's fascinating is that is in the areas where spending is higher, it turns out that mortality is higher and quality is not as good. You think if all that spending was happening, you'd have better quality but that's not the case.

So that means we've got to look at these delivery systems, these payment systems and figure out why is this happening. So this is a quick and dirty overview of how payment systems drive incentives just to give you a little intro into the thinking behind this.

You have fee-for-service systems, which basically say do as much as possible for as many patients as possible.

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You've got bundled payment systems, which say basically do as little as possible in as many different settings as possible. So you see patients getting moved from setting to setting because it restarts another bundled payment system.

Then you have fully capitated systems, which say do as little as possible for as many patients as possible. So you've got all these different payment systems, they drive different incentives in the program. That is why when you look at these delivery system and payment reforms that are included in health care reform and others that are under discussion why they're so important because these payment systems all drive utilization and spending in many ways.

I'm obviously not going to go through all these but you need to be aware that they are out there. They're just starting out now. Jon has referenced some of them and we won't know how well they're going to work until years from now because they were going to change these incentives and evolve over time but they are important changes.

The last thing I want to mention here then is that all of these Medicare policies and how they drive spending spill over into the whole rest of the health care system as well. So you've got, for example, you've got employers covering 170 million people in the same markets with Medicare.

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Those Medicare payment systems drive cost shifting to employer plans. The inefficient payment models or these payment distortions drive up costs and where there aren't sufficient incentives for quality and efficiency improvements, that affects the entire system. So those are things to keep in mind in terms of not only some categories of problems that face Medicare generally but also the implications that it really has for the delivery system as a whole. Thank you.

ED HOWARD: Great. Thanks very much Mark. Now you get a chance to ask questions. As Tricia said, you should not be afraid to ask the simplest questions because this is a primer and you shouldn't shy away from more sophisticated questions because you've got a panel who can handle anything. The green cards are in your kits. You could hold them up and as a couple of folks are already demonstrating, there are microphones that you can use to ask your question verbally. We'd ask you to keep the question as brief as you can and to identify yourself. Here we go.

STEVEN SPITZ: Hi, my name is Steven Spitz and I'm going to revisit a question I asked Jonathan Blum last year and that is what would prevent the drug companies from raising their prices so when they had or they're supposed to reduce it by 50-percent. The baseline is already increased and I'm wondering what, if any, information you have in terms of what

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the name brand drugs' prices have been since in the approximate year since the Affordable Care Act has been enacted. In other words, have the prices increased substantially and then 50-percent off of the increased price or have they been relatively level? Have you studied that at all?

JONATHAN BLUM: Well here's what we can say to your answer. I remember your question from last year so thank you for [Laughter] asking it again.

ED HOWARD: Then it was theoretical.

JONATHAN BLUM: CMS' relationship with the Part D program is with plans. We don't pay manufacturers. We pay Part D plans who in turn negotiate with manufacturers for drug formulary placement and the ultimate cost to beneficiaries. When plans submitted their bids to CMS for 2011, which takes them to account, they had all the information with the new drug discount program.

The average Part D bid was lower than what CMS had previously projected. So the overall costs to the Part D program are lower than we had thought this time last year. So we are still seeing a very competitive marketplace. Beneficiaries continue to have choices and to find Part D plans that provide good value.

So while CMS' relationship in the Part D plans, our indication is that costs are, the program continues to manage

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costs, continues to put downward pressure. The Part D premium is a function of utilization times price. So from that perspective, we are very pleased.

I think it's also important to keep in mind is that the discount program offers a 50-percent discount. So beneficiaries are still paying out-of-pocket. So that creates incentives for manufacturers to think carefully about their pricing decisions but the end of the day, our relationships with the Part D plan and the actual data and the actual payments we are making to plans for 2011 is lower than we had thought, which is a good indicator to address your concern.

ED HOWARD: Very good. Before we go on to the next question, let me just say that some of the folks in the state and district Congressional offices who are watching the web cast, if you have questions, you obviously can't get them answered in real time but if you send us an email, we'll try to impose on our speakers to answer the questions if we can't do it ourselves. You can send that email to info@allhealth.org. Okay, yes Eric?

ERIC: Thanks Ed. First of all, thanks to the Alliance for those of us who've been working in health policy for several years. It's always great to get a primer especially from such an expert group of panelists. I have a question about competitive bidding, the issue that always seems to keep

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on giving. It's only been about 10 weeks out since the new rates have been put in effect but has CMS heard anything from beneficiaries regarding access issues or disruption in services?

JONATHAN BLUM: That's a great question. One of the things that we did for both our new ESRD payment system but also our DME competitive system, I think for the first time, we put in place a tremendous monitoring, claims monitoring program. It sounds obvious that a payer should be able to do this real time but CMS really didn't have the capability in the past to do this.

So I see on a week by week basis for our noncompetitive bid areas the change in claims real time. I mean we're only in about our 12th week or so of the program, so I'm not here to say we don't have more monitoring to do, but the data that I've seen on the claims basis gives me great confidence that beneficiary access has not been interrupted. We're also watching comorbidities. We're watching changes in hospital use, SNF use, every concern that came to us over the last several years, this could happen, chances are we are monitoring it.

We are starting control groups for all of our nine competitive bid areas not just for that city but a control for the next largest metropolitan area so we can compare and

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contrast use and based upon that data it gives me great confidence.

We also review and have a process in place for beneficiary complaints going into our toll-free number. We have an algorithm that says for every beneficiary that comes in with a question, for those that are about access, they get kicked to a case manager right away. They get kicked to a person in our region right away.

We have a system to ensure that beneficiary access is first and foremost. That data gives me again complaint volume and is incredibly low compared to what I thought it might be. We understand there are concerns out there about other complaints. If that's true, get them to us so I can one, see the data and two that we can respond but the data we have regarding beneficiary access issues gives me great confidence the program so far is going smoothly.

ERIC: Well that's good to hear and I'm glad you're monitoring that closely. Just as a follow-up, round two are you anticipating any delays or changes as a result of what we've seen so far in round one?

JONATHAN BLUM: Well I think we are still going through the process to assess round one. We have an obligation under statute to expand competitive bidding to 91 new parts of the country for round two. So we're still going through the

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analysis and the assessment but based upon what we've seen so far, we're confident in our program.

ERIC: Well thank you very much.

JONATHAN BLUM: Thank you.

ED HOWARD: Before we go to the folks at the microphones, so many of you have sent forward cards, we thought we'd try to get a couple of them answered and then go on. Tricia?

TRICIA NEUMAN: Yes. Here's a nice, good question for a 101. How is Medicaid different from Medicare for people with disabilities? I think for that, Juliette do you want to handle that?

JULIETTE CUBANSKI: Sure. Well I think one of the most important things to know about Medicaid versus Medicare is that Medicaid covers a few benefits that Medicare does not. I think perhaps most importantly and especially perhaps for the disabled population, Medicaid covers long-term care, which is important in keeping people with disabilities in terms of their health status stable and getting them help in terms of long-term supports and services.

People on Medicare who, people who are disabled have to get certification from social security that they have a permanent disability that they can no longer work. Once they qualify for disability insurance, they have to wait 24 months

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before they qualify for Medicare coverage. So there's quite a gap in terms of people's ability to access health coverage if they have a permanent disability.

So Medicaid can fill in the gap in that period of time. Once people qualify for Medicare and Medicaid then importantly Medicaid will help pay for their Medicare premiums and cost sharing, the deductibles, and the co-insurance that really eliminates a lot of the cost-sharing burden that other people on Medicare might face.

ED HOWARD: Yes go ahead.

MARK CANDOR: Hi, my name is Mark Candor with the American Speech, Language, Hearing Association. I think this probably is directed to Jonathan, question about DME allowable charges. We have recently found that, as an example, the allowable charge for a voice prosthetic is about one-half the price of what the invoice manufacturer charge is.

I'm just wondering what kind of mechanism Medicare have to increase these charges. Apparently for this device, it's been 10 years before there was any increase in that amount. Does some outside force have to initiate data to show that the increase is needed?

JONATHAN BLUM: Not sure about the device but happy to follow up with you separately. Basically with durable medical equipment, prior to competitive bidding that the payments that

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Medicare makes stems back from historical charges trending forward.

So we have, to Bill's point earlier, in many cases not saying about this product but just in general about DME, we have a distorted pricing system because by statute, we have to use either charge history trended forward, so paying way higher than we should for some, possibly could be paying lower than others but a lot of it has to do with the statute but let's follow up separately so I can understand more about the product that you're describing.

MARK CANDOR: Thanks.

TRICIA NEUMAN: Okay. We have a few questions in about the independent payment advisory board. One person says the independent payment advisory board cannot recommend proposals to ration care, reduce benefits, increase cost sharing, modify benefits, raise taxes, etc. and there's some providers that are exempt. That sounds like everything. So what is it expected [Laughter] to do. I'm thinking maybe Bill and Mark might want to comment on that.

WILLIAM SCANLON: There's no question I think in addition to the issues that Mark raised about the board in terms of changing something that the Congress has already enacted. The Congress also put a lot of restrictions on the

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board and gave us some targets in terms of their cost reductions that it should accomplish.

Having said that, I mean I think there are issues about how one can change the structure of Medicare payments vis-à-vis different providers and vis-à-vis different services to try and promote more efficiency. One of the things that Mark noted was the work of the Dartmouth atlas and the fact that we have these very, very different patterns of care as we move across areas of the country.

Even within single markets, we know that there's very, very big differences in terms of the patterns of care depending upon which providers that you're using. So there's a question, as we move forward in terms of the effort to monitor and measure quality, can we identify how can we achieve the same levels of quality through fewer services and can we then create payment incentives for both providers and beneficiaries to try and use more efficient patterns of care. So that's one mechanism that we can think about. How far this takes us, that has to be determined.

MARK HAYES: Another thing that the IPAB can do is change subsidy amounts. So the Part D subsidy for example, is not taken off the table by the IPAB. So even though that would happen an indirect effect to increased cost sharing on beneficiaries or increased premiums, while premiums are

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excluded, its Part B premiums. So if you look at the statute, Part D subsidies are not taken off the table. So that was something that was raised during the Senate debate. So there are plenty of other areas in which the IPAB will have authority to make recommendations.

TRICIA NEUMAN: Just as a follow-up, somebody's asking could the IPAB make recommendations with respect to physician payments and how about making some changes to the SGR, why hasn't that happened other than timing because of course the IPAB doesn't exist yet but is there anything to stop the IPAB from dealing with physician payments?

MARK HAYES: Well there's not, but the problem for the IPAB is they can only really recommend things that reduce spending and that's their purpose [Laughter] and really the problem with the SGR is that physician payments are really in the tank.

Now if Congress were to step in and fix that then that could place physician payments potentially on the table for the IPAB at some point in the future but for right now, recommendations to further reduce spending from current law on physician payments probably wouldn't work.

ED HOWARD: Unless they wanted to go from 30 to 35-percent cuts.

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MARK HAYES: Yes, that's true. They could theoretically do that. I guess there'd be nothing stopping them.

ED HOWARD: Yes go ahead.

KAREN ZIG: Hi, my name is Karen Zig. I'm with the Men's Health Network. I was just wondering what is being done to make people aware of the welcome to Medicare physical and why not just set an appointment for when a person has their first visit with a health care professional?

JONATHAN BLUM: I think it's a good recommendation. I think we can certainly always do more to make beneficiaries aware of benefits. We, at CMS, have a wonderful staff that focuses on beneficiary communications. We use the annual handbook. We use social media to ensure beneficiaries are aware of new benefits.

Prior to the new wellness benefit coming online, we had the one-time physical that not too many Medicare beneficiaries took advantage of but if we can use, not sure we have the authority to tell a beneficiary to go to their doctor but we can certainly use every kind of communication tool that we have to encourage those kinds of results.

MARK HAYES: I'll give you a specific example. I've got two parents who I manage all of their, I don't know how many people are in this situation yet but at some point, you

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may be where you're helping your parents or an elder sibling through health care challenges in their life.

So one of the things I do is manage all my parents' health benefits and pick their Part D plan and pay all their bills but I found that Medicare sends notices to my parents to remind them if they haven't seen a claim for certain preventive benefits as well just as reminders.

ED HOWARD: I was just thinking, as a Medicare beneficiary, I have not seen that yet [Laughter].

MARK HAYES: Well maybe you're up to date on all your—

ED HOWARD: Maybe so. That's true. My wife is probably keeping me up to date [Laughter]. The question for, at least initially for Bill, you mentioned in one of your slides the Relative Value Scale Update Committee and attributed it to the American Medical Association. I wonder if you could explain how that fits into the official price setting mechanism of HHS and Medicare.

WILLIAM SCANLON: Yes. I mean it's not that the Relative Value Update Committee gets to set the Medicare prices but what CMS has done over the years is relied very heavily on advice coming from the Relative Value Update Committee. It's a group of about 28 physicians.

They review different procedures several times a year in terms of whether or not there needs to be a change in the

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relative values and makes a series of recommendations to CMS. Then it's up to CMS to actually decide whether or not they're going to be incorporated into the Medicare fee schedule. For, I would say probably and this is maybe where Jon will correct me, more than 90-percent of the time, the answer is they do end up being incorporated into the fee schedule.

JONATHAN BLUM: That's the old statistic. I think there's some newer statistics where we are taking a lower rate. I think the way that CMS currently views the RVUC as an advisory body to CMS. I think probably historically there was a case or a relationship where CMS was much more passive. We took recommendations, we accepted them, and really was the RVUC that drove the agenda for which codes to review.

We've flipped that around and we have become much more direct that relationship to drive an agenda to the RVUC to identify codes that we're concerned about, to identify priorities that we're concerned about, misaligned codes, codes that have different sites of services with different payment rates. That's how we see the relationship going forward.

This year, we accepted a lower percentage of the recommendations, but we have staff that has very active hands with the RVUC. They participate in meetings. They ask questions. So we see the RVUC as helpful to our work but we

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see it as a relationship that CMS drives the agenda and that we are telling the RVUC what our priorities are.

ED HOWARD: Jon, would you say that the result of that more active stance is a shift more toward primary care and away from specialties who are in the other direction?

JONATHAN BLUM: I mean I think we have an interest to drive down or, the wrong term, but to correct misaligned codes. We are mindful and I know the RVUC is also mindful that primary care services tend to be undervalued and that is a huge concern to us. So that is part of our agenda but our goal is to make sure that we have the best possible payment system and that's how we're driving our agenda.

TRICIA NEUMAN: Do you want to go?

VINCE LANGMAN: Sure. Sure. My name's Vince Langman. I'm a nurse from, intensive care nurse from Portland, Oregon and your points, Mr. Hayes, about the fee structure, incentivizing procedures and what we do in health care, there's a lot of, as we move forward and look at what would be some other indicators of health rather than just procedures and delivery but other indicators.

I can think of body mass index or other comorbidities or there's a quality of life adjusted year scale that measures if we do dialysis or an aortic valve replacement even on someone who's in their 90s can really improve their quality of

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life but working in a surgical ICU, I see a lot of heroics done and I'm not sure how much it adds to a person's quality of life. So if you could comment on any other, what other health measures that we could use rather than just doing more.

MARK HAYES: Sure, absolutely. Thank you for the question. It's a good question because that slide really does leave you hanging about okay so what do we do? The accountable care organizations, the shared savings program that Jon mentioned is coming up and running, you may want to speak to this more as well, it's really intended to, I'm pointing to the slide that's no longer here, but it's intended to [Laughter] fill the gap in between those different payment systems and create a way in which payment systems align incentives on costs and quality, which these systems, by themselves, don't do today because they're all in silos.

So what accountable care organizations are intended to do is really be a multidisciplinary, multipayment setting approach to coordination of care and that those incentives for improving quality are built into the program.

So the way that ACOs will work is that if you both reduce spending below what was projected and you maintain or improve quality then you're going to get to share in those savings. By doing so, it's intended to get all the cross-section of providers really around the table together and

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figure out how to deliver care more efficiently and improve quality from that whole continuum of care perspective and figure out how to connect the dots better and look at those very kinds of questions that you are raising.

JONATHAN BLUM: I don't consider myself a quality expert by any means but what I think are concerns that we have with our current quality measures that we use at CMS is that we don't incorporate sufficiently the patient experience. So where we're trying to go with CMS over the long-term is to incorporate much more direct patient experience measures. What do patients care about when they are going to dialysis facilities?

That's an area that I think all of us need to challenge ourselves to develop because where CMS wants to go over time is to have our measures be about process but also be about outcomes but also about patient experience. That's work that we're trying to push hard on, so are the quality consensus organizations but that's areas where I think we all can do more.

TRICIA NEUMAN: So speaking of quality, we actually have a lot of quality questions but this one is about quality and Medicare Advantage plans. CMS has changed the payment regulation for quality ratings in MA plans and instead of paying plans only the highest quality plans, CMS plans to pay

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all plans with three or more stars, which represents the vast majority of plans and including those with average ratings.

Jon can you explain the rationale behind that?

JONATHAN BLUM: Sure. The Affordable Care Act created a payment mechanism where four and five-star plans received bonus payments that are phased in over a five-year period. We took a look at the legislation, we felt that it doesn't make sense for four-star, five-star plans to be paid the same amount. Really what you're trying to do is to kind of make it meaningful for plans to improve. You're paying the same four-star plan the same bonus as five-star plan, what's the incentive to get from four to five? That's also true when you think about how the star system works.

Our goal is to create a much stronger incentive for two-star plans to get to three, three to get to three-and-a-half, four to get to four-and-a-half, four-and-a-half to get to five. So that was a concern to us of how we think about the incentive structure within the Affordable Care Act that Congress enacted.

We have proposed a demonstration, still out for comment, but we have proposed a demonstration to modify that structure over three years to create a much more gradual payment, three, three-and-a-half, four to five to create a much stronger financial incentive to improve.

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When we talked to our actuaries, how they think about this program, it really changes the incentive structure for a plan to focus on how they invest in quality improvement rather than just kind of provide that extra marginal, supplementary benefit to a beneficiary. So we are testing the notion that when you change the payment system, you create stronger incentives to improve and that's first and foremost our policy goal.

TRICIA NEUMAN: You've been very patient. Do you want to go next?

MARYBETH BUKHOLST: My name is MaryBeth Bukholst. I'm here on behalf of the Map Rx Coalition. My question is for Mr. Blum and it was about—

ED HOWARD: I have a question for you. What is the Map Rx Coalition?

MARYBETH BUKHOLST: It is a coalition of patient advocacy organizations that have come together to continue to be a watchdog group around Part D. My question goes back to CMS' use or the ability of plans to use specialty tiers in their formularies.

The draft call letter that just came out showed that once again for what will now be the fifth year in a row that the threshold for drug costs on a monthly basis for those that are able to be put on the specialty tier will be \$600.

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That's five years in a row that that number has been unchanged and as a result, of course, that means any beneficiary cannot appeal for a lower level of cost sharing and of course is subject to very high co-insurance. My question is first of all, how is it that five years we have maintained that same level and second, what is the methodology that CMS actually uses to determine what that threshold should be?

JONATHAN BLUM: Sure. Well I think—

ED HOWARD: Jon, could you just explain somebody what the specialty tier really is?

JONATHAN BLUM: Sure. We allow Part D plans to offer tier cost sharing. There's a statutory benefit that has a percentage threshold for cost sharing but the statute permits plans to offer tiered cost sharing that are actuarial equivalent to that standard benefit that's set by law. Most plans have different tiers to their cost sharing.

They'll have one cost sharing tier for preferred generics, one cost sharing tier for preferred brand drugs, and another cost sharing tier for nonpreferred brand name drugs really to drive use towards lower cost sharing drugs.

CMS, when it created the regulations for the Part D benefit, also permits the plans to offer what's called a specialty tier. That's a tier for very high cost drugs defined through guidance as \$600 or more and that those drugs, CMS does

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not permit beneficiaries to appeal to lower cost sharing tiers. When I got to CMS in 2009, I had the same question that you did. What is a specialty tier and is this good for beneficiaries and is this a good deal for our beneficiaries?

I'm convinced that a specialty tier's not a prohibition to these drugs but encourages access. If CMS did not create the specialty tier, the concern would be that plans would not cover these high cost drugs. So on an actuarial basis, it comes out ahead for beneficiaries because they get into the catastrophic benefit. I don't think that I'm convincing you but [Laughter], can see it on your expression.

By the same time, we are convinced that by permitting plans to offer specialty tiers, we actually encourage plans to cover these high cost drugs and if we didn't then I'm convinced Part D plans would not offer coverage for these drugs. So there's a tradeoff. So I think that folks that are encouraging us to not have specialty tiers should think about what the consequences would be on Part D plans' decisions to cover these drugs.

MARYBETH BUKHOLST: I understand your rationale up to a point but for a lot of patient populations that really does not have alternatives that are in the generic form or even in a lower tier, I mean isn't there really sort of a discriminatory nature here of where can they go? They have nothing to appeal.

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I mean even at this point, even off label drugs, they still probably have to cover those through their own means. So what is the alternative for someone who may have multiple sclerosis or rheumatoid arthritis?

JONATHAN BLUM: Well I think the tradeoffs aren't necessarily the tier but the coverage yes or no and also the new discount program for specialty tiered drugs should reduce the out-of-pocket cost sharing dramatically for beneficiaries who are on such high cost drugs.

ED HOWARD: We're not at the end of the time but we are close enough to I that I would ask you as we go through these last few questions that out pull out that blue evaluation form and fill it out so that we can improve these sessions and get you back in here. So with that, go ahead, a quick second question from Mark.

MARK CANDOR: Mark Candor, I'm speaking for myself regarding an issue, which I thought would be good to bring up here, relates to the fact that I don't know the exact statistic but a huge percentage of Medicare payments are made to work on a patient during the last year of their life and I'm just wondering what kind of discussion has been going on to try to change that.

I know that Congress would never include the issue in legislation. This is a very sensitive issue but we have such

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access to technical assistance to do for the patient and in fact, a great cost, what's going to happen in the future?

ED HOWARD: I beg to differ. Congress did act on this. They put death panels into [Laughter] the ACA.

MARK CANDOR: Right, that's the first thing that came to mind and the reaction we got from the public in an instant, can't do that.

TRICIA NEUMAN: This is obviously a really fraught issue and I'll dive in unless anybody else, nobody else seems to want to [Laughter]. When I got my degree at Hopkins, the President of the hospital at the time said how do I know when somebody's in their last year of life when someone comes to the hospital door?

So I think what you see in the health reform law is a significant attempt to deal with high need, high cost patients, some of whom may be in the last year of life but who knows who's actually in their last year of life but there are a number of little seeds that have been planted, the goal for which is to try to do a better job reducing unnecessary hospital readmissions, for example, for that population.

We're thinking more sensibly about managing the post-acute process. Again it's not framed around somebody out there who says you're going to die in the next year but the idea is it's trying to target efforts to the very small share of the

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Medicare population that account for a large share of spending and do so in a way that's designed to eliminate services that aren't needed and to improve the management of care for people who are really high need, high cost.

ED HOWARD: I think these folks know a whole lot more about this than I do but in my old days at the House Aging Committee, it's my understanding that the percentage of Medicare spending in the last six months of life is substantial, 25 or 30-percent but it's been unchanged for about 30 years. So it isn't as if we are now hemorrhaging in the program because of these new pieces of technology. Jon, am I anywhere close to being right?

JONATHAN BLUM: Sure, yes [Laughter].

ED HOWARD: I'll take that. I'll take that. Harvey?

HARVEY: Great panel. Let me ask a macro question. We're up, I guess about 17-percent of GNP, all of you are probably going to be asked to go to Congress to talk about debt and deficit looking at 20 to 30 years is medical costs that overshadow everything including social security. What are you going to talk to them about, how to reduce medical costs and I'm talking about not this next year or even with the implementation of this act. In the next 20 years, what are we going to tell them?

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ED HOWARD: I might add to that question, what are you going to tell them about Medicare versus other health care spending?

MARK HAYES: I think you have a more robust discussion going on right now about these issues than has been taking place for probably 20 years or longer. What is good about that is that because everybody is focused on these very problems and really the implications they have not just for the federal budget but for the country that you have so many proposals that have come out.

You've got the President's Fiscal Commission. You've got the Bipartisan Policy Center. You have the Chairman Ryan's Proposal on his own, his proposal with Alice Grivlin. You've got the CBO options book that just came out. So probably more than in any other time that I can think of, there are more ideas and suggestions and proposals for how to tackle these problems than I think I've ever seen.

WILLIAM SCANLON: I think if you're going to go to the Congress and talk about this, you're going to ask them how many days do they have to talk about because if there's so many dimensions of this that have to be addressed and it may start with Medicare and other public programs but it also has to include the private sector.

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One of the things that we are starting to become aware of is how much divergence there is across different markets on the private sector side and the fact that in some markets, Medicare is a good payer paying even more than some private insurers and other markets, some providers are getting 400-percent of Medicare. This is all a function of markets that are really not working from a competitive perspective. So that's one aspect.

We can't ignore the role of beneficiaries and patients that they need to have more information, more sense of responsibility, in some instances, to make sure that they're doing what they can. There's a whole range of reasons why we are the highest spending country in the world and turning that around is both essential but what an unbelievably complicated task.

MALE SPEAKER: And unfortunately a country that has a very high infant mortality, 15 other countries ahead of us and longevity certainly not as good as many other countries. So we have got this incredible spending, which is just going to go up as more people live longer, more chronic disease, more drugs, more treatment, and everybody's saying we've got to get down. Seventeen-percent is just unreasonable in terms of the amount that you're going to take out of this economy. So it's a big, big problem.

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ED HOWARD: We've got a question from a physician in the audience who wants to know given the prospective cuts that loom and keep getting pushed off and given the fact that the average physician graduates with debt of \$100,000 and a quarter with at least \$200,000 worth of debt, how do you balance compensation being forced downward at the same time that costs are going up if only to pay off the debt [Laughter]?

TRICIA NEUMAN: Would you rather talk about death panels?

WILLIAM SCANLON: No. One there's a premise in that question that Congress is not going to act. That is one factor to take into account. At the same time, I think we need to note that physicians remain the highest paid occupation in the country, that applications to medical school are still more than ample, and that the reality is that when you compare physician debt to debt for other occupations, the physicians are the ones that have the highest ratio to income to their debt of any of the other occupations.

So I think that we need to think about how we address this on two fronts. One would be very nice to not have the SGR cuts looming over us on an ongoing basis, I mean both for your lives here in the Congress as well as for physicians.

At the same time, we have to be looking at medical education and ask ourselves is this debt all justified or can

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we make medical education more efficient. Can we think about changing the content within undergraduate medical education or medical school?

Can we change residency programs so that they become more efficient? These things, I mean it's again the answer to most about the dilemmas that we face is there're multiple fronts that one needs to start to think about pursuing.

ED HOWARD: Are there not debt repayment provisions within the ACA that are intended, at least, to move us toward greater primary care physician training? Tricia, are we good time or maybe one more question?

TRICIA NEUMAN: One more question. So this one is near and dear to the heart of the Kaiser Family Foundation, because it has to do with dual eligibles. I think, Ed, we are going to do another session on dual eligibles. There's a question that, of course, goes to Jon, which is what is the new federal coordinated health care office for duals doing but before we get to that, I'm going to turn to Juliette to say who these duals are? Who are dual eligibles? How many are there? Why do we care about dual eligibles?

JULIETTE CUBANSKI: Well it's a good question because it's an important population covered by Medicare. The duals are about 20-percent of Medicare beneficiaries. There are

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roughly 8 million dual eligible people as they qualify for Medicaid because they have low incomes.

So the majority have incomes less than 100-percent of poverty, which is about \$10,000 for an individual. By virtue of their health status, they are spending more than your average Medicare beneficiary. They have a higher rate of chronic conditions. They have a higher rate of mental and cognitive impairments. So this population is generally far more fragile and vulnerable than the nondual eligible on Medicare.

JONATHAN BLUM: So the Affordable Care Act created or directed CMS to create a new office within to bring a team of folks in to help identify barriers to the better coverage, to work with the Innovation Center, to develop novel programs, to better integrate and coordinate care for the dual eligible population.

There's a long history of two separate programs, Medicare and Medicaid providing two levels of service without talking to each other very well, without good integration. We have a wonderful director, Melanie Bella, who is leading a team of about 15 or 20 folks or so but really their charge is to help bridge and help identify opportunities for Medicare and Medicaid to work better, to serve the population.

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This is a huge cost driver both for Medicaid programs but also for the Medicare program, just a huge issue of just very vulnerable populations falling through the cracks. We're looking at all different kinds of models be it through plans, through better state integration, Medicare integration, provider integration.

They've also solicited proposals that we're currently reviewing for states to bring us ideas for ways to better integrate and care for the dual eligibles. So it's a really exciting agenda at CMS and I defer to Melanie on the specifics but she has brought new energy to CMS and to the groups to better integrate care.

ED HOWARD: Terrific. Well we have come to the end of our time. Thank you for sticking with it. Thanks to our friends at the Kaiser Family Foundation for their multiple contributions to this program. Let me remind you as you scoot out to carry the blue evaluation form completed with you and ask you before you do that, I guess you don't have as many hands as you need to do it all, to join me in thanking our panel for a really elucidating session [Applause].

[END RECORDING]

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