

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 2, 2010
10:13 a.m.

COMMISSIONERS PRESENT:

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

AGENDA	PAGE
Assessing Payment Adequacy: hospital inpatient and outpatient services - Jeff Stensland, Craig Lisk, Julian Pettengill	6
Public Comment	100
Assessing payment adequacy: physician and ambulatory surgical center services - Cristina Boccuti, Kevin Hayes, Ariel Winter, Dan Zabinski	106
Assessing payment adequacy: outpatient dialysis services - Nancy Ray	189
Assessing payment adequacy: hospice - Kim Neuman	244
Assessing payment adequacy: skilled nursing facility services - Carol Carter	289
Public comment	319

1 P R O C E E D I N G S [10:13 a.m.]

2 MR. HACKBARTH: Okay. It's time for us to start.

3 DR. STENSLAND: All right. Good morning. This
4 session will address --

5 MR. HACKBARTH: He is raring to go.

6 DR. STENSLAND: Out of the gates.

7 MR. HACKBARTH: False start. Before you start,
8 Jeff, I just wanted to make a couple comments about the
9 context of what we're going to be doing the next couple days
10 for the benefit of the audience here.

11 This is our first set of update recommendations
12 since the passage of PPACA, and I thought it might be
13 helpful for the audience to just put this in that context.
14 Of course, PPACA had specific provisions related to updates
15 for the various provider groups in the Medicare program,
16 including making long-term, 10-year changes in the budgetary
17 baseline for those provider groups.

18 What MedPAC does is different. Our charge under
19 the statute that created MedPAC is to provide Congress not
20 with a long-term set of update recommendations but year-by-
21 year recommendations on what's an appropriate update
22 consistent with the efficient delivery of services for the

1 provider group in question, whether it be hospitals or home
2 health agencies or skilled nursing facilities. So our
3 charge is to make a recommendation at this cycle for fiscal
4 year 2012.

5 Today the Commission will hear draft
6 recommendations that I have prepared. They're my proposals,
7 not the staff's, and there has been some confusion about
8 that in years past. So these are my proposals. The
9 Commissioners will discuss those draft recommendations today
10 with final votes to come in January.

11 Our specific task here is to make recommendations
12 to the Congress for updates. Often in the past we have
13 coupled an update recommendation with a recommendation for
14 changing the payment system to redistribute the dollars. An
15 example of that would be in recent years we have made
16 recommendations for a physician update, but then coupled
17 that with a recommendation for a bonus for primary care
18 physicians. So we may do that as well in this year's
19 report.

20 But even with those recommendations for
21 redistribution of the dollars, sometimes it is frustrating
22 for the Commissioners to work within the framework of this

1 siloed payment system when many of the important issues in
2 improving health care delivery, both its efficiency and its
3 effectiveness, require work across the silos, collaboration
4 among physicians and hospitals and post-acute providers for
5 a second.

6 The way that MedPAC tries to support better
7 coordination and integration of care by different provider
8 types is not through the update process but through our
9 recommendations for payment reform, of which we have made
10 many, some of which were included in PPACA.

11 This meeting and tomorrow's meeting and our
12 meeting in January are not principally focused on payment
13 reform. These meetings are focused on the update. But that
14 is in no way to suggest that payment reform is not an
15 important goal of this Commission or goal for the Medicare
16 program. Payment reform is essential in the future. It's
17 just not the principal focus of our work this month and next
18 month.

19 The recommendations that we present today will be
20 in a slightly different format than in previous years.
21 Actually, this is a change that has been happening over the
22 course of the past three or four or five years. There was a

1 point where many of our recommendations were cast as market
2 basket minus productivity or market basket, and we used the
3 market basket, the input price increase as the reference
4 point. In recent years, we've applied that framework less
5 and less frequently. We have had more and more exceptions
6 to the point where I think last year there were only two
7 update recommendations that were in that format of market
8 basket minus productivity.

9 Given that the exceptions have now basically eaten
10 the rule, I am recommending that this year we just do away
11 with that format altogether and that for each of the sectors
12 we recommend a specific number, 1 percent or 2 percent,
13 whatever it might be for the particular group, and not cast
14 it in terms of the market basket.

15 Did I hit all of the major things?

16 So that is the context. We have wall-to-wall
17 update discussions this month. Now, Jeff, go for it.

18 DR. STENSLAND: All right. Our first update
19 discussion will evaluate the adequacy of Medicare payments
20 to hospitals and will set the stage for your deliberations
21 on update recommendations for both inpatient and outpatient
22 payment rates.

1 We will discuss the indicators of payment adequacy
2 and how changes in documentation and coding have increased
3 hospital payments. We will then present the Chairman's
4 draft recommendation on updating Medicare payment rates for
5 2012.

6 There is a lot to cover, so we are going to go
7 fairly quickly. A lot of the detail is in your mailing
8 materials.

9 We evaluate the adequacy of hospital payments as a
10 whole, meaning we examine whether the amount of money in the
11 system [including both inpatient and outpatient payments] is
12 sufficient. In 2008, Medicare spend roughly \$148 billion on
13 traditional inpatient and outpatient fee-for-service
14 payments. This represents a 6-percent increase in spending
15 per beneficiary from 2008. The 6-percent growth rate is
16 higher than in recent years and reflects a combination of
17 documentation and coding improvements on the inpatient side
18 and rapid growth in volumes and case-mix on the outpatient
19 side.

20 Each year the Commission deliberates and makes
21 judgments as to the adequacy of hospital payments. Today
22 you will discuss whether fiscal year 2011 payments are

1 adequate taking into consideration the indicators of payment
2 adequacy that you see on this slide. This same set of
3 indicators is used for all the sectors we will talk about
4 today and tomorrow.

5 In addition, the statute authorizing MedPAC
6 requires that MedPAC consider the costs of efficient
7 providers when making update recommendations.

8 Last month Zach discussed how capacity was
9 increasing in the hospital sector and how access to capital
10 has recovered since 2008. We see strong volume growth in
11 outpatient services and a slight decline in inpatient
12 volume. Following the freezing of the capital markets in
13 the fall of 2008, we have seen a steady improvement in
14 conditions and a decline in interest rates over the past two
15 years.

16 Turning to quality of care, all the quality of
17 care indicators are either improving or stable. We see
18 improvements in hospital and 30-day mortality for the
19 conditions we monitor including AMI, congestive heart
20 failure, stroke, hip fracture, and pneumonia. And this is
21 all good news for patients. There has also been some
22 improvement in patient satisfaction measures.

1 However, two indicators have remained stagnant.
2 Readmission rates have not improved, and patient safety
3 measures have not made statistically significant
4 improvements. In the past, the Commission recommended
5 financial incentives to spur improvements in the readmission
6 rates, and CMS will start readmission penalties in 2013.
7 With respect to patient safety, a report by the office of
8 the inspector general and recent academic literature
9 suggests there is still a need to improve patient safety at
10 many hospitals.

11 So overall there is a bit of a mixed picture with
12 respect to quality. But stepping back to think about the
13 big picture of the challenge of sustainability in the
14 program and maintaining quality metrics, one positive
15 finding from 2009 was that we were able to have much slower
16 cost growth in the hospital sector while all the quality
17 metrics either improved or remained stable.

18 Now Craig will talk a little bit about how costs
19 were constrained and what happened to payments.

20 MR. LISK: Good morning. I am now going to talk
21 about payments and cost growth and margins. 2009 was a
22 different year as the pattern we typically have seen between

1 payment and cost growth changed. Let me start with
2 payments. Medicare inpatient payments per case rose by 5.3
3 percent per discharge in 2009. Payments increased due to
4 two factors. One was an update in payment rates of roughly
5 2.5 percent after netting out the 0.9 percent adjustment
6 made for documentation and coding improvement, or DCI. In
7 addition, the reported case-mix grew by 2.6 percent, the
8 result of documentation and coding improvements hospitals
9 made during the second year of implementation of MS DRGs.
10 This was the highest increase in case-mix in 20 years.
11 Payments per case rose faster for rural hospitals than urban
12 hospitals, in large part due to sole community hospitals
13 being able to reset their base year hospital-specific rates
14 to a more recent year starting in 2009.

15 Moving to costs we see a different picture.
16 Growth in costs per discharge fell to 3 percent in 2009, the
17 lowest level since fiscal year 2000. The lower cost growth
18 is likely the result of several factors. One is the economy
19 and the recession, as hospitals needed to adapt to an
20 increase in the uninsured and a decline in total inpatient
21 discharges. Hospitals also needed to recover from their
22 historically poor financial performance in 2008 when

1 aggregate total margins dropped to their lowest level in
2 decades. Underlying input price inflation for hospitals was
3 also lower in 2009.

4 So what does this all mean for margins? A margin
5 is calculated as payments minus costs divided by payments
6 and is based on Medicare allowable costs. The overall
7 Medicare margin covers acute inpatient, outpatient,
8 hospital-based home health and skilled nursing facility, and
9 inpatient psychiatric and rehabilitation services in
10 hospitals covered by the inpatient prospective payment
11 system.

12 Because payments grew faster than costs, we
13 actually see an increase in the overall Medicare margin from
14 2008 to 2009, where it averaged -5.2 percent, up from -7.1
15 percent in 2008. The increase was driven by increases in
16 both the inpatient and outpatient Medicare margins which
17 comprise the bulk of the services included in the overall
18 Medicare margin. This is the first increase in the Medicare
19 inpatient margin we have observed since 1996.

20 Our next slide shows how the overall Medicare
21 margins differ across hospital groups in 2009.

22 Rural hospital margins were -4.9 percent in 2009,

1 which is slightly better than the urban hospital margins.
2 The aggregate urban hospital margin was -5.2 percent. If we
3 also consider the 1,300 critical access hospitals in the mix
4 here, the rural hospital margin would be -3.3 percent if
5 they were included. Critical access hospitals receive
6 payments of their costs plus a 1-percent profit, plus 1
7 percent.

8 Jeff will now discuss our margin projections.

9 DR. STENSLAND: We estimate that the overall
10 Medicare margin will fall from -5.2 percent in 2009 to -7
11 percent in 2011, and the drop is primarily due to a
12 reduction in inpatient payment rates that occurred in fiscal
13 year 2011. In 2011, the 2.35-percent update was more than
14 offset by a 2.9-percent reduction in inpatient payment rates
15 that was required by law to recover past overpayments
16 stemming from documentation and coding improvements. The
17 general idea is that margins improved in 2009 due to the
18 coding improvements, and then margins will fall back in 2011
19 when CMS reduces payments to recapture past overpayments due
20 to coding.

21 The second significant change in 2011 involves
22 Medicare payments to hospitals that adopt meaningful

1 electronic medical records. While we expect these payments
2 to be substantial, we also expect the IT payments will be
3 partially offset the additional health IT costs that
4 hospitals will face in 2010 and 2011 as they bring new
5 health IT systems online or modify their existing systems to
6 meet the meaningful use standards.

7 Given the HIT expenditures and the price trends
8 that we -- or the cost trends we see for hospitals so far in
9 2010, we expect cost growth to exceed the 2011 market
10 basket, resulting in a decline in margins from 2009 to 2011.

11 Now, Craig just talked about a natural experiment.
12 That is, in 2009 we were able to see what happened to
13 hospitals' costs when an external financial shock caused
14 them to be under financial pressure. What we saw was a drop
15 in cost growth.

16 In addition to looking at cost growth over time,
17 we also conducted a study across hospitals to see if
18 individual hospitals under the highest financial pressure
19 had lower costs than hospitals that have more financial
20 resources.

21 As you can see from the second row of this table,
22 we found that hospitals under pressure kept their costs down

1 to 92 percent of the national median. As we can see in the
2 third row of the table, the lower costs contributed to
3 higher Medicare margins of 4.7 percent at the median for the
4 high-pressure hospitals. The details on how we measure
5 pressure are in your mailing materials.

6 Now, a key question after looking at these
7 findings regarding financial pressure is whether there is a
8 set of hospitals that can perform well on the cost metrics
9 and still perform well on quality metrics.

10 And so that brings us to talking about efficiency.
11 For the audience, I want to be clear that when say
12 efficiency, we mean producing good outcomes at a relatively
13 low cost. Efficiency is about more than just costs.

14 To determine who is efficient, we used the same
15 criteria as last year. I will not go into the detail here,
16 but in general, hospitals are categorized as being
17 relatively efficient if they perform well on mortality,
18 readmissions, and inpatient costs in 2007 and 2008, as well
19 as 2006.

20 We then, after determining who is relatively
21 efficient historically, ask how well they did in 2009, if
22 they were able to maintain that good performance level.

1 We ended up with 219 hospitals that appear to be
2 relatively efficient providers looking at their performance
3 over 2006 to 2008. This represents about 10 percent of the
4 PPS hospitals in our sample.

5 In general, we find that these top performers were
6 able to outperform the comparison group on the mortality
7 measures in 2009. For example, the median top performers
8 had a 30-day mortality rate was 3 to 7 percent below the
9 national median on all three CMS mortality measures: AMI,
10 heart failure, and pneumonia. We also found readmission
11 rates were roughly 4 percent better than the national median
12 when using the methodology.

13 We also see that this set of relatively efficient
14 providers is able to achieve better quality metrics on
15 average while keeping median standardized costs 10 percent
16 below the national median. Lower costs allow these
17 hospitals to generate a slightly positive Medicare margin in
18 2009. As you see, the median margin was 2.7 percent for
19 that group of 219 relatively efficient hospitals.

20 We also examined how the hospitals in the
21 relatively efficient group were evaluated by their patients,
22 and we found that 66 percent of patients rated the

1 relatively efficient hospitals either a 9 or a 10 on a 10-
2 point scale. This is similar to the comparison group which
3 received a top rating from 64 percent of their patients on
4 average.

5 Last year you also asked for some more information
6 on who was in the efficient group of hospitals. So this
7 year we examined whether there are certain structural
8 characteristics such as size, service offerings, physician
9 integration, ownership, and rural location that are
10 associated with being more or less likely to being in the
11 efficient group. We did not try to compare the quality of
12 management or the culture of the hospitals. We are not
13 saying these are not important, only that they are not
14 quantifiable with currently available data.

15 Now, while there is no single structural
16 characteristic that guarantees good performance, there are
17 some that are associated with stronger performance. Our
18 multivariate regression work suggests that larger hospitals
19 that are under some financial pressure to constrain their
20 costs and those that are integrated with their physicians
21 are more likely to be in our efficient group.

22 Julian will now take us through some of the

1 documentation and coding issues that Craig touched on
2 earlier.

3 MR. PETTENGILL: To begin, I want to remind you
4 and the audience of the background on the documentation and
5 coding issue. Following MedPAC's recommendations, CMS began
6 a transition to cost-based weights in 2007 and to Medicare
7 severity DRGs in 2008. Both of these policies were fully
8 implemented in 2009.

9 The policy goal was to improve payment accuracy
10 and reduce the gains that hospitals could make by engaging
11 in patient selection. These case-mix refinements were
12 expected to redistribute payments among hospitals because
13 they would better capture differences in expected cost among
14 patients and in case-mix across hospitals. The effect on
15 overall spending, however, was intended to be budget
16 neutral, as required by law.

17 As expected, adoption of MS DRGs gave hospitals
18 incentives to improve diagnosis documentation and coding,
19 and those improvements raised measured case-mix and payments
20 in the inpatient payment system. We expect and encourage
21 hospitals to improve documentation and coding; however,
22 Medicare's total payments should not increase because the

1 change in case-mix measurement did not alter the real
2 underlying complexity of patients or the treatment costs for
3 patients admitted for inpatient care.

4 To counterbalance any changes in total payments
5 resulting from documentation and coding improvements, or
6 DCI, current law requires budget neutrality adjustments,
7 which are described in the next slide.

8 To offset the increase in payments projected by
9 its actuaries and preserve budget neutrality, CMS said that
10 it would reduce the inpatient base payment rates by 4.8
11 percent over three years.

12 The hospital industry argued that this estimate
13 was too high, and Congress responded and current law now
14 reflects the following agreement: CMS would prospectively
15 lower the base payment rates by 1.5 percent over two years,
16 0.6 percent in 2008, and an additional 0.9 percent in 2009.
17 However, if the 1.5 percent turned out to be too little
18 based on actual data, CMS is required to do two things:

19 First, CMS must change the base rates for 2010,
20 2011, and/or 2012 to recover the 2008 and 2009 overpayments,
21 with interest. The details are in the chapter, but the key
22 number is that overpayments in 2008 and 2009 amounted to 5.8

1 percent of inpatient payments. Because CMS did not make any
2 adjustment for 2010, the whole 5.8 percent must be recovered
3 in 2011 and 2012.

4 The second thing CMS has to do is they must adjust
5 the base payment rates to prevent further overpayments going
6 forward. The key number here is that overpayments were 3.9
7 percent in 2009, and comparable overpayments will continue
8 each year until CMS makes the required offsetting
9 adjustment.

10 To summarize, CMS must temporarily reduce the
11 payment rates in 2010 and 2012 to recover the 5.8 percent in
12 overpayments. And then, in addition, at some point CMS must
13 also reduce the payment rates by 3.9 percent to prevent
14 further overpayments from occurring.

15 The next slide shows where we are right now in
16 2011.

17 As Craig mentioned earlier, the forecast increase
18 in the market basket index for 2011 is 2.6 percent. CMS
19 adopted a temporary reduction in the payment rates of -2.9
20 percent to recover overpayments that occurred in 2008 and
21 2009. This adjustment will recover just about half of the
22 5.8 percent overpayments that occurred.

1 CMS decided not to adopt an additional adjustment
2 in the rates to prevent further overpayments. Their
3 rationale for this decision was that the total adjustment of
4 6.8 percent that would be needed to accomplish both recovery
5 and prevention of further overpayments would have been
6 financially disruptive for many hospitals. So the
7 adjustment of -3.9 percent remains to be done. Meanwhile,
8 further overpayments have occurred in 2010 and are occurring
9 in 2011, and these overpayments cannot be recovered under
10 current law.

11 The other major factor affecting the payment rates
12 in 2011, as you can see in the slide, is the budget
13 adjustment of -0.25 percent that was included in PPACA.
14 Taken together, the net change in payment rates is -0.55
15 percent.

16 Now Jeff will present the Chairman's draft
17 recommendation on updates.

18 DR. STENSLAND: Before we present the Chairman's
19 recommendation, I want to remind you of the principles
20 behind last year's recommendation on DCI that are in the
21 2010 MedPAC March chapter.

22 The first principle is that the transition to MS

1 DRGs should be budget neutral, and to make it budget
2 neutral, we need the two types of adjustments that Julian
3 just mentioned. The first is we need the 3.9 percent
4 adjustment to prevent future overpayments; and, second, we
5 also need an additional adjustment to recover all past
6 overpayments, not just those in 2008 and 2009.

7 The second principle we talked about last year was
8 that these adjustments should occur gradually to prevent a
9 large financial shock to hospitals.

10 So consistent with those principles and given the
11 payment adequacy indicators we just discussed, we now have
12 the Chairman's draft recommendation.

13 The recommendation reads: "That Congress should
14 increase payment rates for the acute inpatient and
15 outpatient hospital prospective payment systems in 2012 by 1
16 percent." The idea being that we need to make an adjustment
17 to reduce the overpayments being made to DCI, but this
18 should be done gradually. Therefore, hospitals should still
19 get a 1-percent inpatient update.

20 The recommended update for outpatient services is
21 also 1 percent, and this is appropriate for two reasons.
22 First, we see substantial increases in outpatient volume in

1 recent years with outpatient payments rising by 11 percent
2 in 2009. And, second, a 1-percent update is consistent with
3 the Chairman's draft update recommendations that you will
4 hear later today for ambulatory service providers that
5 compete with hospital outpatient departments for the same
6 types of services. The recommendation would result in an
7 increase in spending over current law, as I will now
8 explain.

9 In this slide we compare current law to what would
10 happen under the Chairman's draft recommendation, so let's
11 walk through this line by line.

12 The first line is the market basket forecast of
13 2.6 percent.

14 Now we turn to the second row. We see the DCI
15 adjustment which would be used to reduce the level of
16 overpayments occurring to hospitals due to documentation and
17 coding. CMS has stated that it needs to eventually reduce
18 payments by 3.9 percent to correct for DCI. We concur. The
19 question is only how rapidly should this will be done. CMS
20 has not stated if it will do any of the adjustment in 2012.
21 Hence, it could have an adjustment anywhere from 0 percent
22 to 3.9 percent in this second row under the CMS "current

1 law" column.

2 In contrast, the Chairman's recommendation of a 1-
3 percent update implies that the implicit documentation and
4 coding adjustment will be 1.6 percent. This means that
5 roughly 1.6 percent of the needed 3.9 percent in prospective
6 reductions would take place in 2012. This means that
7 overpayments will be continuing even given our
8 recommendation and that further adjustments in the future
9 will be needed to bring us back to the principle of budget
10 neutrality we just talked about in the prior slide.

11 Now, moving to the third line, current law
12 requires a productivity adjustment based on the forecast for
13 the 10-year multifactor productivity. The forecast now
14 stand at 1.3 percent. There is an additional 0.1-percent
15 offset in current law which would result in a total 1.4-
16 percent reduction in payments due to the productivity
17 adjustment and that budgetary offset.

18 Now, turning to the Chairman's recommendation,
19 just as in the past, the Commission will evaluate whether a
20 productivity adjustment is appropriate for a given sector in
21 a particular year. This year, given the need for the
22 documentation and coding adjustment and the payment adequacy

1 indicators we have just talked about, an additional
2 adjustment for productivity may not be warranted. Now, this
3 does not mean that it will not be warranted in the future;
4 it just means it does not appear appropriate for 2012 if the
5 documentation and coding adjustment occurs.

6 So what is the bottom line? Under the current
7 law, the projected update at most 1.2 percent. It could be
8 less if CMS chooses to start taking prospective DCI
9 adjustments in 2012.

10 Under the Chairman's recommendation there is no
11 uncertainty. The update would be a firm 1 percent. And any
12 difference between that and the full market basket would be
13 seen as an adjustment for DCI.

14 We noted on the previous slide that the Chairman's
15 recommendation will increase spending. That is because it
16 would remove the productivity adjustment in 2012. Now, it
17 would also put in a firm implicit adjustment for DCI, but
18 that is something that is already required in law to take
19 place over time. So what we are doing is removing the
20 productivity adjustment and shifting the timing of the DCI
21 adjustment, and on net, that results in an extra cost.

22 So now let's just to recap the recommendation

1 rationale. First, a DCI adjustment is needed, but it should
2 not cause a financial shock to the hospitals. Given the
3 need for an adjustment and the payment adequacy indicators,
4 a 1-percent update is appropriate for inpatient payments.
5 The difference between the full market basket and the 1-
6 percent update should be seen as an adjustment to prevent
7 further overpayments due to DCI. Given the current payment
8 adequacy indicators and the required DCI adjustment, no
9 additional adjustment for productivity would be warranted
10 for 2012.

11 Now, the 1-percent increase on the outpatient side
12 is appropriate for two reasons. First, we see outpatient
13 volume growth by 4 percent. Second a 1-percent update would
14 be consistent with the magnitude of the chairman's draft
15 recommendations you'll hear later, the ambulatory care
16 sectors, including physicians' offices and ASCs. And I want
17 to say that the relative prices between outpatient
18 facilities and free-standing physician offices is irrelevant
19 here. That's because the two sites of care are substitutes,
20 and we're starting to see a shift in the site of services
21 from the free-standing physician clinics to hospital-owned
22 clinics that are partially paid under the outpatient fee

1 schedule, which is a higher payment schedule than the
2 physician offices.

3 The volume of office visits at free-standing
4 clinics grew by less than 1 percent from 2008 to 2009. And
5 in contrast, the volume of physician office visits at
6 outpatient practices owned by the hospital grew by 11
7 percent in this same year, and this suggests that
8 acquisition of physician practices by hospitals are taking
9 place, and the hospitals are then converting the physician
10 clinics into part of their outpatient department.

11 So we're balancing several factors here. On the
12 one hand, outpatient margins are negative. But, on the
13 other hand, the volume of outpatient services, particularly
14 those that they compete with physician offices for, are
15 growing relatively rapidly, much more rapidly than the
16 physician fee schedule. So, on balance, we have a draft
17 recommendation of 1 percent which results in a positive
18 update, but not an update that's larger than the update
19 recommended for physician services who compete with the
20 hospital outpatient departments.

21 Now I'll open it up for questions.

22 MR. HACKBARTH: Let me just make a comment on that

1 last point. So trying to synchronize, if you will, the
2 update for hospital outpatient departments with ASCs and
3 some of the other substitutes obviously does not solve the
4 problem of different payment rates for the same service in
5 different locations. I think that is an important
6 developing problem in the Medicare program that we'll have
7 to address at a later point. But by synchronizing the
8 updates, as Jeff described, I think we're picking up on
9 advice that Mike gave, let's not at least make it worse,
10 this dissimilarity in the rates, while we wait for a better
11 fix. So I just don't want to aggravate the problem further,
12 and that's why I thought synchronizing the updates made
13 sense.

14 So let's begin with our round one clarifying
15 questions.

16 DR. DEAN: Just on the first page, the actual
17 total spending of Medicare on hospital services, assuming
18 that these numbers do not include critical access spending -
19 - and what about Medicare Advantage, is that in there?

20 DR. STENSLAND: It does not include Medicare [off
21 microphone].

22 DR. DEAN: So do we know total spending is for

1 hospitals?

2 DR. STENSLAND: We wouldn't know exactly what the
3 Medicare Advantage people are paying their hospitals.

4 DR. DEAN: That's what I figured.

5 DR. STENSLAND: So we don't have that. Critical
6 access hospitals is about another \$8 billion.

7 DR. DEAN: \$8 billion, okay.

8 DR. STENSLAND: So they are, you know, maybe 10
9 percent of the outpatient but a smaller share of the
10 inpatient. They're restricted on the inpatient side, as you
11 know, beds.

12 DR. DEAN: Is there any way to estimate what
13 proportion of the spending is Medicare Advantage?

14 DR. STENSLAND: We could, but we probably could do
15 a better estimate maybe in the future once we start getting
16 encounter data that I think we'll be getting this year, so
17 we could at least see what the admissions are on the
18 Medicare Advantage.

19 DR. DEAN: Do you think it's roughly equivalent to
20 the enrollment? That's 22 percent or something like that?

21 DR. STENSLAND: I wouldn't speculate.

22 DR. DEAN: You just don't know.

1 DR. STENSLAND: In the ballpark, but I wouldn't
2 speculate.

3 DR. DEAN: Okay.

4 DR. BERENSON: I believe the actuary actually does
5 an allocation of the Medicare Advantage spending to the
6 various trust funds, and so they have a basis. I don't know
7 what it's based on, but there's at least a number that you
8 could use to give a ballpark for how much we're totally
9 spending.

10 DR. NAYLOR: So the collection of reports are
11 really outstanding, and being able to look at assessment of
12 payment adequacy across sites and providers, using the same
13 criteria, was just terrific.

14 Two questions. On the quality measures -- and you
15 in the report obviously highlighted some of the newer data
16 in terms of quality challenges -- you also talk about the
17 fact that one of the pay-for-performance
18 opportunities/disincentives will go into effect in 2013.
19 Has this payment consideration taken into -- you know, did
20 you review other very short term opportunities to get at
21 some of the issues where we're not seeing changes in
22 readmission, we're seeing challenges around patient safety

1 and so on? So beyond that which is already going to go into
2 effect through the Affordable Care Act, any other short-term
3 opportunities for P4P explored?

4 DR. STENSLAND: We don't have anything other than,
5 you know, what's on the books in terms of the value-based
6 purchasing that will be coming into effect in 2013, at the
7 same time the readmission penalties come in in 2013.

8 DR. NAYLOR: My second question: I wasn't able to
9 do this. Are you able to link -- even though this probably
10 is beyond the scope, but are you able to link what you're
11 seeing in terms of changes in inpatient and 30-day mortality
12 rates to use of post-acute services?

13 DR. STENSLAND: I have not done that analysis to
14 see if -- I haven't done that.

15 MR. BUTLER: So I have some questions on coding,
16 and comments, but they kind of relate to the recommendations
17 so I'll save them until round two unless you want me to put
18 them in now.

19 My only comment on this is page 9, I think where
20 you say HIT payments will be partially offset by increased
21 costs. Just to clarify, for those of us in both the
22 implementing physician and hospital systems, you know, our

1 honest assessment of this is that the physician payments may
2 cover the full costs if done right. The hospital payments
3 don't come close -- I mean, it's a fraction, the payments
4 are a fraction of the cost of putting in the system. So
5 it's kind of -- you've kind of got it backwards. Unless you
6 have data that I don't have, the cost of implementing far
7 exceeds the stimulus payments that we'll be receiving.

8 MR. HACKBARTH: In some cases, hospitals have
9 already implemented the system, and so there's no
10 incremental cost in putting --

11 MR. BUTLER: That's an exception, so if there are
12 already meaningful users, there's some incremental costs in
13 reporting and so forth. In those cases, you're right, the
14 payments would exceed costs. But if you were just in the
15 process, as many or more often is the case, these don't
16 cover the -- that's a clarification.

17 DR. CHERNEW: I just want to be crystal clear that
18 I understand what's going on in this. What's happening is
19 this 3.9 percent is this -- eventually it would have to be
20 reduced by that much. We are essentially -- in the "current
21 law" column, CMS could do something, and we don't know what
22 that's going to be. And in the recommendation that we have,

1 we've said 1.6. So to make the two columns comparable, it's
2 like we're imposing the one -- because what's going to
3 happen is if we do our recommendation, next year when this
4 comes up, instead of saying 3.9 there, it's going to say
5 2.3, right, under the --

6 DR. STENSLAND: Right.

7 DR. CHERNEW: Under the recommendation, going
8 forward, that would say 2.3 in year 2013. And if you had
9 the current law recommendation the way you've done the
10 match, since you couldn't actually add in the CMS discretion
11 because it's a string not a number, you assumed it was zero
12 for the math. So if you did the current law going forward,
13 when we get 2013 that would stay at 3.9 or have to go in as
14 a bigger number. I don't know. That may not have --

15 DR. STENSLAND: Right, that's --

16 DR. CHERNEW: You may need a clarification on my
17 clarification.

18 DR. STENSLAND: That's correct.

19 DR. CHERNEW: Okay. I understand. So it's
20 actually -- we're basically higher -- our recommendation
21 should be thought of as higher than current law in some
22 sense because we're taking 1.6 of the 3.9 and putting it in

1 now, and you haven't put any of that in this.

2 DR. STENSLAND: Right. It would result in higher
3 Medicare spending than current law.

4 MR. HACKBARTH: And so my proposal is that we say
5 we want a modest update, the 1 percent, and work back from
6 there, and that implies we're taking a certain amount of DCI
7 now, but it also means that we've got to take out into the
8 future --

9 DR. CHERNEW: Less.

10 MR. HACKBARTH: Well, by virtue of the fact that
11 we're taking out some now --

12 DR. CHERNEW: Right.

13 MR. HACKBARTH: We're ahead of CMS, who has not
14 taken out any.

15 DR. CHERNEW: Right.

16 MR. HACKBARTH: But because we're not taking it
17 all now, that means we've got to stretch out into the future
18 the recoveries.

19 DR. CHERNEW: Right, exactly. But the right way
20 one could think of current law, just to make these columns
21 comparable, would be to say that the CMS is -1.4 and we're a
22 +1, because what we're basically doing is taking out the --

1 we're basically getting rid of the productivity and budget
2 adjustment part.

3 MR. HACKBARTH: Right [off microphone].

4 DR. CHERNEW: And that's my understanding of --

5 MR. KUHN: And on that chart, I wanted to come
6 back and ask a question about that chart. So basically the
7 productivity adjustment of the 1.4 is the PPACA provision
8 that's in there, so we're basically saying let's back away
9 from -- or asking Congress to repeal that provision of the
10 reform law? Is that what we're saying in this
11 recommendation?

12 MS. UCCELLO: Is this in a sense more that -- I
13 mean, this 1.6 is a residual from backing out this 2.6
14 versus 1.

15 MR. HACKBARTH: Yes [off microphone].

16 MS. UCCELLO: And that you have chosen to allocate
17 that residual to part of that 3.9.

18 MR. HACKBARTH: Right.

19 DR. MARK MILLER: That's right.

20 MS. UCCELLO: And how explicit, I guess, is that
21 in the recommendation?

22 DR. MARK MILLER: In the words --

1 MS. UCCELLO: And it's not.

2 DR. MARK MILLER: In the words of the
3 recommendation, you're correct. I mean, the way to think
4 about the recommendation -- and I'm looking at you guys to
5 make sure this is correct. The way to think about the
6 recommendation is the stated principle and what it's
7 supposed to be devoted to is all expressed on the slide
8 before in the sense where we're saying this is what we're up
9 to, and then you come to the recommendation, and this is the
10 de facto update. It's a real important point, though, just
11 conceptually because what we're -- we're doing a few things
12 here. We're saying legislatively you need to be recovering
13 all of this over time, and we're also expressing a statement
14 about which gets recovered first, because there were very
15 strong statements last year where people were saying stop
16 the prospective overspending, then engage -- you were very
17 pointed on this, George -- then engage in the recovery
18 process.

19 So what we're trying to say to the Hill is this is
20 an important priority, change the underlying law, get it
21 all, and start taking it in this order.

22 Any damage by that statement?

1 DR. STENSLAND: I think just to re-emphasize what
2 you said, how the 1.6 is the residual, the firm number is
3 the 1, and that top market basket forecast, that will be
4 updated two more times again before payments actually come
5 into play. So that number could in the end be 2.1. It
6 could be 3. And as that top number changes, the adjustment
7 allocated to DCI will change, but the 1-percent change in
8 the update -- the 1-percent update wouldn't change.

9 MS. UCCELLO: Okay. Thank you for that.

10 One more question. I just want to confirm that
11 what you said when you were talking on Slide 16 was that any
12 future overpayments would not be recovered by law.

13 MR. PETTENGILL: Current law does not grant CMS
14 the authority to recover those payments, those overpayments
15 that occur in 2010, 2011, 2012, whatever. They only have
16 the authority to recover overpayments that were made in 2008
17 and 2009.

18 MS. UCCELLO: Okay.

19 MR. HACKBARTH: Do they have the authority to
20 prospectively reduce the rates to prevent future
21 overpayments?

22 MR. PETTENGILL: Yes.

1 MR. HACKBARTH: So what has happened is by not
2 acting to prevent future overpayments, they're creating this
3 window where overpayments that happen in 2010, 2011, they
4 can't retrospectively go back and get those. They can only
5 retrospectively go back and get 2008 and 2009 overpayments.
6 But they could act tomorrow to prevent future overpayments,
7 correct?

8 MR. PETTENGILL: Presumably in the next rule for
9 2012.

10 MR. HACKBARTH: In the next rule, right.

11 I want to go back to Herb's question about does
12 this imply -- is this a recommendation to change the current
13 law in PPACA, and the answer to that is yes, for 2012.

14 MR. KUHN: [off microphone] For 2012 only.

15 MR. HACKBARTH: Right. Clarifying questions?

16 MR. GEORGE MILLER: Like Peter, I have one about
17 the outpatient payments, but I think I'll deal with that in
18 round two based on the recommendation.

19 My question is on Slide 12, please, and it deals
20 with the Medicare margins for the efficient providers.
21 You've given the median, that 2.7. Can you give me the
22 range of how many of the 219 hospitals would have negative

1 margins still? Do you have that information?

2 DR. STENSLAND: I don't have it in front of me.
3 There's going to be a substantial number that still have
4 negative margins in the efficient group.

5 MR. GEORGE MILLER: Okay.

6 DR. STENSLAND: You know, 80, 90.

7 MR. GEORGE MILLER: 80, 90, okay. So even at an
8 efficient hospital they have negative margins by your
9 definition, which would mean that all the other criteria
10 going forward, quality measures, low-cost providers, they
11 still don't have a positive margin for taking care of
12 Medicare patients, and as a result, how do they buy the HIT
13 just purely if Medicare was the only payer and that was
14 their only patient? So is this a good indicator of the
15 negative margins, that number?

16 MR. HACKBARTH: This is how I came to the
17 recommendation, that we ought to provide for the 1-percent
18 update.

19 MR. GEORGE MILLER: Right.

20 MR. HACKBARTH: So I look at the efficient
21 provider group, as is our statutory charge, and I say, well,
22 first of all, it's about 10 percent of the total number of

1 hospitals.

2 MR. GEORGE MILLER: Right.

3 MR. HACKBARTH: And for that group the average is
4 2.7 and there's a range, a distribution around that average.

5 MR. GEORGE MILLER: Right, right.

6 MR. HACKBARTH: I knew some of them were negative.

7 MR. GEORGE MILLER: Right.

8 MR. HACKBARTH: So given that, I thought at least
9 a modest update was appropriate, even though that requires
10 that we recommend that for 2012 the current law be changed
11 and we incur a higher cost than is in the current law
12 baseline. So that was my logical process. Obviously,
13 there's never magic about any one number, 1 percent or, you
14 know, any other, but that's how I came to that
15 recommendation.

16 MR. GEORGE MILLER: But as we talked earlier,
17 thinking about silos and silos only, I guess I have a little
18 bit of a struggle with that when we have other sectors,
19 other silos that have huge Medicare margins. And so, you
20 know --

21 MR. HACKBARTH: [off microphone] They'll have
22 their turn.

1 [Laughter.]

2 MR. GEORGE MILLER: Yeah, all right. I'll address
3 it in round two.

4 DR. BERENSON: I just want to understand even a
5 little more the 3.9 percent. Is it right that the
6 adjustment -- the more adjustment we make early, the less
7 amount of subsequent overpayment which can't be collected
8 will occur? In other words, it argues for trying to do as
9 much as you can early on consistent with other
10 considerations. Is that basically correct?

11 MR. PETTENGILL: That's exactly right.

12 DR. BERENSON: Okay.

13 MR. KUHN: Two quick questions. One, when you
14 were talking about the migration of patients to hospital
15 outpatient departments, out of physician offices, elsewhere,
16 did we look at the data in any way to look at the acuity of
17 those patients? Because there is this general notion that
18 some of the tougher cases, the higher acuity cases are
19 treated in the hospital outpatient department versus ASCs or
20 physician office. Is there data that backs that up? Have
21 we looked at that part of the migration of those patients?

22 DR. STENSLAND: Historically, we did look at ASCs

1 versus hospitals and found the hospitals have the more
2 difficult cases than the ASCs, and there is a significant
3 difference already in the payment rates between the two. I
4 think also in our specialty hospital study, we went around
5 and talked to folks that ran ASCs and ran specialty
6 hospitals, and the surgeons themselves or often the
7 anesthesiologists would say, "Yes, if it's a difficult case,
8 if there's a high anesthesia risk, I'll take them to the
9 hospital rather than the ASC or the smaller specialty
10 hospital." So there is that severity difference there, at
11 least on the ASCs.

12 I don't think we've done that on the physician
13 office visits, and that 11-percent growth versus 1-percent
14 growth that I talked about, that is specifically for clinic
15 visits, either in a hospital-owned outpatient department or
16 a physician's office, and we haven't, you know, determined
17 whether there's something different about the level three
18 office visits and the severity of the people going from one
19 to the other.

20 MR. KUHN: Okay. Thanks, Jeff. And can I go to
21 Slide 5 real quick -- or, I am sorry, Slide 6. And I was
22 just curious on that top bullet, payments rose 5.3 percent

1 per discharge, and then you have the cost growth of 3
2 percent. The cost growth you indicate is the highest since
3 -- or the lowest since 2000. What was the 2008 or 2009
4 numbers in terms of the rise in payments? I'm just looking
5 for some trend that might be going on there, what that might
6 look like.

7 MR. LISK: Let me see if I can get back to you.

8 MR. KUHN: Okay.

9 DR. KANE: I'm still trying to understand the
10 coding piece. Slide 16, is this 2011 column what actually
11 happened?

12 MR. PETTENGILL: Yes.

13 DR. KANE: So does that mean there remains 2.9
14 percent from prior that needs to be recovered plus another
15 3.9 for current and future or for just 2011 or for 2011 and
16 2012? What does the 3.9 percent relate to?

17 MR. PETTENGILL: The 2.9 percent is recovering
18 overpayments that occurred in 2008 and 2009, and the total
19 overpayment in those two years was 5.8 percent, so you're
20 getting half of it in 2011.

21 DR. KANE: Yeah.

22 MR. PETTENGILL: And if CMS leaves the -2.9

1 percent in the rates in 2012, you'll get the other half of
2 it. But that will not affect the rates because it's a
3 temporary adjustment. CMS put it in in 2011, and in 2012,
4 they will withdraw it and put it back in again. So it's a
5 net wash for the payment rates.

6 DR. KANE: I'm still not -- I'm sorry. It would
7 have helped to have had this a little more beforehand when I
8 could really understand it. So the 3.9 percent is not
9 related to the prior years. It's the current overpayments
10 for 2010 and 2011?

11 DR. STENSLAND: Yes, I would think of it as, you
12 know, payments were here, they should have been here, and
13 this was happening in 2008 and 2009, and it continues to
14 happen.

15 DR. KANE: Yes.

16 DR. STENSLAND: So to close the gap, we have to
17 take this 3.9-percent adjustment and bring it down to where
18 it's supposed to be. But bringing it down to where it's
19 supposed to be going forward means we still overpaid back in
20 2008 and 2009 when there was this gap. So this 5.8 percent
21 is trying to fill in that historical gap of 2008 and 2009,
22 and the 3.9 percent is trying to move rates from where they

1 are to down to where they should be going forward.

2 MR. PETTENGILL: Right.

3 DR. KANE: So the total amount that you'd want to
4 lower rates at some point, if you could do it by 2012, is
5 around 6.8 percent? Is that right? Or it will get worse if
6 you don't do it all in 2012 because you'll be overpaying in
7 2012, 2013, 2014?

8 DR. BAICKER: You don't have to recover [off
9 microphone].

10 DR. KANE: Yeah, you don't have to recover those.

11 DR. MARK MILLER: Also, just --

12 DR. BAICKER: [off microphone].

13 DR. KANE: I'm sorry. I'm trying to figure out
14 which years belong to which, and so you don't have to
15 recover the 3.9 but you do have to recover the 5.8?

16 MR. HACKBARTH: The current law requires that CMS
17 recover the 5.8. They've recovered 2.9. The other 2.9
18 would be published in the proposed rule for 2012, which will
19 come out -- in the spring?

20 DR. STENSLAND: Right.

21 MR. HACKBARTH: But that's required by the law as
22 written today, so we've sort of assumed that's going to

1 happen at that point. Correct?

2 DR. STENSLAND: Right.

3 MR. PETTENGILL: The current law specified that
4 CMS would have to recover overpayments that occurred in 2008
5 and 2009. It also said that CMS would have to lower the
6 rates to prevent further overpayments from occurring, but it
7 didn't set a date by when CMS would have to do that.

8 DR. KANE: Okay. But then if they -- I see, but
9 they don't have to recover if they don't do it.

10 MR. PETTENGILL: Mm-hmm.

11 DR. KANE: So then we have a little thing here
12 that says that the actual update in 2011 was 1.2 percent,
13 but this says it was -55 percent. How do we relate that -55
14 -- minus half a percentage to the update of 1.2 percent for
15 2011 that was the actual update from our little cheat sheet?

16 MR. HACKBARTH: [off microphone].

17 DR. MARK MILLER: The distinction there, we tried
18 to make this point. The reason that that sheet is hard to
19 put together is there's action the Congress takes and
20 there's action the Secretary takes, and we were trying to
21 point out that that sheet tends to report what the Congress
22 has done.

1 DR. KANE: What Congress -- and this is reflecting
2 what the Secretary --

3 DR. MARK MILLER: This is the Secretary sort of
4 being directed by law to dig out things out of the payment
5 rate.

6 DR. KANE: So the actual update in 2011 was minus
7 half a percent?

8 DR. MARK MILLER: Well, I'd defer to these guys on
9 that.

10 DR. KANE: These are little numbers, but there are
11 big ranges on -- you know, a small and a large number.

12 DR. STENSLAND: The increase in payments was a
13 -0.55 percent, and that was because of that big 2.9 percent
14 reduction.

15 DR. KANE: Yeah.

16 DR. STENSLAND: But that 2.9-percent reduction is
17 temporary, so kind of think of it this way: You owe me some
18 money. You're going to make a payment to me in 2011.
19 You'll make another payment to me in 2012. Okay. You don't
20 owe me any money anymore, so now your rates would bounce
21 back up in 2013 unless there was another action to recover--

22 DR. KANE: So in a way, it would be helpful to

1 have the whole coding piece not be a discussion about the
2 update, which is actually a separate issue, and then there's
3 repayment, even though the net impact is that, not one-point
4 -- I don't know, I guess I'm getting confused where we throw
5 this into our conversation.

6 MR. HACKBARTH: The reason for linking the two,
7 again, is that, you know, at the end of the day, what
8 matters to the financial performance of hospitals is the net
9 change in their payments. We get to them through different
10 logical streams, and, you know, my judgment -- and it's open
11 for your discussion -- was that what we ought to do is
12 assure the 1 percent -- get the 1 percent and then work the
13 DCI numbers back from there and say that we want to assure
14 they get 1 percent, then the DCI number is going to float,
15 and as Jeff said, the other floating number here is the
16 actual market basket, which won't be nailed down until
17 later. But I'm trying to focus on the amount that they're
18 going to get paid.

19 DR. KANE: Well, again, somebody's going to do
20 something to that amount, too, so you don't really know what
21 the amount is they're going to get paid, because we made a
22 recommendation for 2.5 plus pay for -- so we're adding in a

1 whole new set of considerations that we historically don't
2 consider in our updates. And I think -- but we are having
3 it affect our update discussion by saying let's take out the
4 productivity piece. I'm just wondering if -- it's harder,
5 it's just harder to understand exactly what the -- how your
6 logic went, I guess. I understand you want to end up with a
7 1-percent increase, but it's a little hard to make sense of
8 it for me. I'll keep thinking about it.

9 DR. STUART: Actually, one way to get over this
10 would be to put the implications for 2013, because what that
11 would do is then that would, I think, answer the question
12 about the 2009 -- about the recovery of 2.9 percent that has
13 to be taken out in 2012, but it's going to be gone in 2013.
14 So at least showing those three years, 2011, 2012, 2012, I
15 think might help.

16 My question follows up on Herb's. If you could go
17 back to Slide 2, please. I'm trying to understand the
18 source of the increase in spending, and I recognize this is
19 spending, not rates, because if we're talking about change
20 in acuity, that would be adjusted presumably through the DRG
21 system. But 11.7 percent still seems really high, and I'm
22 wondering whether there is any evidence that the increasing

1 rates of MA participation -- I'm not sure what they were
2 between 2008 and 2009, but the extent to which there has
3 been a change in the average acuity of fee-for-service
4 recipients as opposed to MA recipients, and it gets back, I
5 think, a little bit to what Tom said as well.

6 Has there been any analysis of whether increasing
7 MA enrollments has affected the residual fee-for-service
8 spending?

9 DR. STENSLAND: There hasn't, and maybe I could
10 explain that 11.7 percent briefly. There was an update of,
11 what, 3.9? Something on that order for outpatient payments.
12 So there's a big update -- 3.6 -- that occurred in 2009. So
13 that's part of it. About a third of the growth in volume on
14 outpatient was simply due to more physician office clinic
15 visits, and this could be associated with the hospitals
16 buying physician practices and then they have this greater
17 number of physician visits. So this is more like a shift
18 from the physician fee schedule to the hospital outpatient.
19 That explains a good chunk of it.

20 Then there was also some shift that we talked
21 about before on there's a few more observation days now and
22 a little less one-day stays. That shifts things from

1 inpatient to outpatient. All those things are all kind of
2 pieces in the pie that if you take the 11 and subtract all
3 those, you don't have that big of a number left. And case-
4 mix growth, too.

5 DR. STUART: But am I correct in saying you
6 haven't explicitly looked at changes in the fee-for-service
7 population as a result of increased MA enrollments?

8 DR. STENSLAND: Correct.

9 DR. BAICKER: I'm trying to make sure that I
10 understand the juxtaposition of Slides 16 and 19. So
11 looking at Slide 19 again, which we all seem to love, that 1
12 percent, this is relative to current law, so it doesn't take
13 into account the 2.9 percent decrease that's already baked
14 into current law, so they would not actually get a update of
15 1 percent, they would get an update of -1.9 percent?

16 DR. STENSLAND: No, because you can think of it as
17 -- the 2.9 percent dropped payments down in 2011, and that's
18 not going to change at all. It's kind of like having \$100
19 taken out of your paycheck -

20 DR. BAICKER: Okay, so that's already in there.

21 DR. STENSLAND: Yeah.

22 DR. BAICKER: Got it. So then the level is down,

1 and you're looking at the new trajectory. And then I want
2 to be sure I understand the rationale for keeping the
3 productivity and budget adjustment at zero. Getting in that
4 DCI adjustment early, otherwise you are overpaying in
5 perpetuity, makes a lot of sense to me. But then what is
6 the implication in saying because of that we're not
7 adjusting -- and maybe we're not saying because of that.
8 But it seems like we're saying because of that we're not
9 taking into account productivity increases that otherwise
10 would have been taken into account. Is that the right
11 message to send about how this budget neutrality of DCI is
12 really working? And is it just that we're very nervous
13 about having anything less than 1-percent increase? And
14 then does that imply that this is the right allocation
15 between those two streams of it setting that precedent about
16 productivity adjustments?

17 MR. HACKBARTH: I am suggesting, proposing, that
18 we focus on the 1 percent, the net increase in rates and set
19 aside the productivity adjustment. And the reason I'm
20 suggesting that is because I look at the margin information
21 specific to the efficient provider group, and the average is
22 2.7, as Jeff indicated. Even some of that 10 percent of the

1 hospital pool is negative, and I think a small update is
2 appropriate given that picture. And, you know, there's no
3 magic in one versus any other number, but that's what I'm
4 proposing. But it does imply, if you will, that we're
5 saying, oh, no productivity improvement is required, we're
6 doing this DCI adjustment instead. So I'm working back from
7 the 1 percent, which I think is a reasonable thing to do.

8 Ron?

9 DR. CASTELLANOS: Let's get off that subject for a
10 second. Slide 12, please. Just a simple question. You had
11 a small sample size of only about 2,100. Is there a reason
12 for that?

13 DR. STENSLAND: Yes. So we start with all the
14 hospitals and then we take out the critical access
15 hospitals, which are 1,300-and-something. They have
16 different cost accounting rules.

17 DR. CASTELLANOS: Right.

18 DR. STENSLAND: Then we take out Maryland, which
19 is in their own rate-setting system.

20 Then there was also a concern that people had
21 brought up in the past of, well, are these efficient guys
22 just treating the easy cases? Are they not taking the poor

1 patients? So we took out the ten percent of hospitals that
2 had the lowest Medicaid shares, and those are out of there.

3 Then there is also a concern that some people
4 raised that, well, maybe they have a low unit cost just
5 because they are running a lot of people through the
6 hospital. They are putting people in the hospital that
7 don't really need to be there. So then we took out
8 hospitals that were in counties that were of the -- that had
9 the highest service use per capita, and that brought us all
10 down to about 2,400 or something.

11 And then there are a couple hundred more that drop
12 out if you don't have decent cost report data all the way
13 from 2006 to 2009. Sometimes there is an aberration in the
14 cost reports, or the cost reports conflict with the claims
15 data, and then we toss those out and it's a couple of more
16 hundred. That's a long story of how you get down to about
17 2,300.

18 DR. CASTELLANOS: My second question is, like
19 Mary, I like what you do about looking across sites and
20 providers. It's a nice, refreshing way of looking at it.
21 One of the things you mentioned was the outpatient office
22 visits and clinic visits being up 11.7 percent, I think you

1 said. I was just wondering, have you looked at utilization
2 also? I think that may be important, because if the
3 hospital is doing a better job in utilization and ordering
4 versus the physician community, maybe we can see something
5 here. And I'm not suggesting that there's a difference, but
6 I was just curious if you've looked at utilization of
7 services in this community of physicians, of hospital-based
8 or clinic-based.

9 DR. STENSLAND: You can save some of that for when
10 we talk about the physicians later on and the stuff that's
11 in the Physician Fee Schedule. That might give you a better
12 feel for that.

13 In terms of the one specific thing we looked at
14 for this meeting was these clinic visits, and you have
15 overall growth in clinic visits of only about 2.7 percent,
16 something on that range, all right. And then you had the
17 spread of something like less than one percent for the
18 general physician practice and 11 percent for the hospital-
19 owned, so --

20 DR. CASTELLANOS: I guess my question is, is
21 anybody looking at utilization at all?

22 DR. STENSLAND: Certainly when they talk about the

1 physician side, they'll talk about utilization, and we can
2 look at it again, too.

3 MR. ARMSTRONG: So, Glenn, I have two questions
4 and neither one has to do with the DCI adjustment. The
5 first, building on, I think, George's comment, Slide 7, I
6 look at these margins -- I actually, frankly, was a little
7 surprised to see this, and understand that part of the issue
8 -- maybe the real issue is there's just huge variation in
9 margin from hospital to hospital. So we did a series of
10 analyses to try to understand, were there patterns around
11 the variation, and it turned out one of our most productive
12 evaluations was around the efficient, the subgroup of highly
13 efficient hospitals. And then, Glenn, you commented on that
14 had some influence over your final recommendation, just as
15 you looked at that analysis, and I appreciated hearing that.

16 But I'm still left wondering about the
17 sustainability of these kind of negative margins, and so
18 then what I understand is we actually have a set of
19 criteria, adequacy criteria, and that really is the primary
20 set of criteria we use to judge whether these payments are
21 adequate over the course of time rather than the margin
22 number itself. But I just -- do we have any kind of target

1 or any sense for adequacy of margin, or is that really just
2 an independent variable, the four adequacy criteria we
3 normally use or being the primary criteria?

4 MR. HACKBARTH: Jeff, could you put up the slide
5 that has the high pressure, medium pressure, low pressure.

6 DR. STENSLAND: The margins?

7 MR. HACKBARTH: Yes.

8 DR. STENSLAND: Yes, there.

9 MR. HACKBARTH: So over a period of maybe four or
10 five years now, we have been focused on why margins might be
11 negative, and looking at time series information, cross-
12 sectional analyses to try to get a better grip on why
13 margins are negative. And one of our central conclusions is
14 that where hospitals are in terms of their margin, where
15 hospitals are in terms of their cost is a function of their
16 payment environment. This is a largely not-for-profit
17 sector and if you provide more money, most of it is going to
18 be spent in pursuit of the organization's mission. And if
19 you want to push down costs, you are going to have to apply
20 some consistent pressure on costs.

21 And so we look at this analysis, and some
22 hospitals experience more cost pressure than others and we

1 think that this is consistent with that world view. When
2 institutions face pressure, they're able to reduce their
3 cost, you know, 12 percent below the low pressure group.
4 And so what we think is that not just Medicare, but
5 preferably all payers need to apply more consistent pressure
6 if we want the efficiency to improve.

7 Now, that may entail negative margins for some
8 institutions for some period of time. If you go the other
9 path to say, oh, the margins are negative, we have to
10 increase the payments, then the money is going to be spent
11 and you are just going to be chasing your tail and never
12 deal with escalating costs, is the problem.

13 MR. ARMSTRONG: Okay. I realize there are two
14 different types of issue that we deal with. One is setting
15 the payment and the other are the payment reform topics, and
16 we are not talking about those and so I see how this could
17 easily get into that kind of a conversation, but thank you.
18 That answers my question.

19 The second question I had was related to the huge
20 swing from inpatient to outpatient volumes. I should
21 understand this better, but we adjust for severity on the
22 inpatient side but not on the outpatient side, is that

1 correct?

2 DR. STENSLAND: When we talk about the volume
3 numbers, the four percent versus the negative-one percent?

4 MR. ARMSTRONG: Actually, I'm talking just about
5 the --

6 DR. MARK MILLER: He's just asking about the
7 payments --

8 MR. ARMSTRONG: The payment itself.

9 DR. STENSLAND: There is severity -- there's the
10 APCs on the outpatient side --

11 MR. ARMSTRONG: There is.

12 DR. STENSLAND: -- so they're adjusted for the
13 type of thing you're doing, and it's more like a piecemeal
14 kind of thing. And then on the inpatient side, it's the
15 bundle which is adjusted for that severity.

16 MR. ARMSTRONG: Okay, great. Thank you.

17 MR. HACKBARTH: Just one other. Scott, on your
18 first question. So this is the cross-sectional analysis.
19 The time series look at Medicare margins is also
20 interesting, and that was in the written materials. Jeff
21 didn't represent it here. But basically, it shows there is
22 this relationship between Medicare margins and how much

1 hospitals are being paid by private insurers. And
2 basically, since the managed care backlash, payments from
3 private insurers have become more generous. They have fewer
4 tools to negotiate with. There has also been some
5 consolidation on the hospital side, and so private payments
6 in many markets have been pretty generous for the last ten
7 years or so.

8 Again, these are largely not-for-profit
9 institutions that get that added revenue. What do they do?
10 They invest it in their mission. Well, that increases their
11 cost structure for Medicare, as well, and it tends to drive
12 the Medicare margins negative. So do you see the dynamics
13 there?

14 MR. ARMSTRONG: I do. I have never seen the data
15 presented this way and it highlights for me the interplay
16 between those different variables. But I realize for us
17 today, that is in the back of our mind but not really that
18 relevant directly to the rate decisions that we will be
19 making.

20 MR. HACKBARTH: Well, it's relevant to the extent
21 that it helps us figure out what's an appropriate number for
22 an efficient provider and how many efficient providers there

1 are.

2 MR. ARMSTRONG: Right, and that will maintain a
3 stable, adequate system into the future.

4 MR. HACKBARTH: Yes.

5 DR. BORMAN: I guess just a couple of maybe
6 clarifying for me comments, to think aloud. First off, I
7 have to say that I find the concept of setting the
8 productivity piece aside a helpful piece because I certainly
9 had concerns about what we really represented in that and
10 the consistency with which that got represented and how we -
11 - so I would support, as I think I understand you having
12 explained it, setting that piece aside.

13 For me, quality -- because I need to think about
14 this a little more qualitatively, not having my economist
15 colleagues' ability to drill into this a bit -- I remain a
16 little puzzled about how an entity that has consistent
17 negative spending other than the Federal Government, which
18 can print money, can continue to balance its checkbook at
19 the end of the month or the year or whatever. But I
20 understand there's lots of things in the background, other
21 sources of income, whatever it may be, that enable these
22 entities to continue to exist and I am not going to become

1 expert in those things.

2 I do think for me, and it would help me if you
3 would say that this fits into a lexicon of thinking about
4 this, you have proposed a firm one percent update. A way to
5 think about it is how it interacts with the DCI. But, in
6 fact, they are really two separate pieces that, albeit at
7 the end of the day for the hospital add up to that number,
8 but, in fact, you're not proposing -- you are proposing this
9 primarily based on these and the efficient provider data as
10 opposed to what it particularly represents about the DCI.
11 It is kind of a side benefit, perhaps, that it addresses the
12 DCI based on the prior discussions we have had about the DCI
13 and the need to do something with that, but that one can
14 think of it as, okay, there is this firm one percent, and in
15 the background, it could be attributed in a variety of ways
16 in the hospital cost calculation environment. This is one
17 way of thinking about it and showing that it does make a
18 downpayment, if you will, on that problem as opposed to
19 getting a recurring whole of money. Is that a fair way to
20 conceptualize, or did I miss something?

21 MR. HACKBARTH: Yes. I want to just emphasize one
22 thing. I do think that we need to make an update

1 recommendation that reflects our best judgment about
2 requirements of efficient providers, and my number there is
3 one.

4 I wouldn't want anybody to draw the inference
5 that, oh, I don't think recovering DCI is important, because
6 in this framework, it's sort of a residual number. I think
7 that is a really, really important principle, that when we
8 change coding systems, it does not result in an increase in
9 payments. That has been a principle that we've applied not
10 just for hospitals, but all of the other provider groups.

11 If you allow a simple change in coding systems to
12 result in increased payments, basically, one of the effects
13 of that is that you've undermined the update as a tool of
14 policy. Now, the money flowing into the system is driven by
15 a change in the coding system as opposed to a policy
16 judgment about what the right expenditure should be. By
17 definition, coding changes should be budget neutral. They
18 redistribute the dollars. That is why we do them. But in
19 the aggregate, they need to be budget neutral.

20 DR. BAICKER: Can I just ask for a clarification
21 on that, because I think I'm still a little fuzzy on what
22 the subcomponents mean. My understanding is that there's

1 some obligation for CMS to make up the 3.9 percent over some
2 ill-defined period of time. So to the extent that somebody
3 calls that 1.6 a downpayment on that, that affects the
4 future requirement to recover that. My understanding from
5 what we've just said is that we're just saying the one
6 percent without any -- certainly nothing we say is really
7 binding, but no binding description of how that should be
8 allocated between those two subcomponent lines, the
9 productivity increase and the 3.9 percent we're trying to
10 recover. But we feel very differently about it insofar as
11 it affects future streams of updates that will be required
12 of CMS. So is there some way that we want to convey -- is
13 it possible to convey how we want that allocation to be, or
14 are we just saying one percent and being done?

15 MR. HACKBARTH: Let me take a crack at it. [Off
16 microphone.] -- behind to do the correction. See, I would
17 separate -- put aside the productivity thing and just not
18 focus on that and focus on two things. One is the bottom
19 line, the one percent, and then the amount that is credited
20 towards DCI recovery is going to float and it's ultimately
21 going to be determined by the difference between one percent
22 and the final market basket. And -- go ahead.

1 DR. BAICKER: It's that last statement that I
2 wasn't sure I understood. Do we feel the same way about a
3 one percent update that is called 1.6 percent towards DCI
4 and zero towards productivity as we feel about a one percent
5 update that's called one percent towards DCI and point-six
6 percent towards improved productivity? Are those the same
7 in our book or not, because we're assuming -- that last
8 statement, you see, doesn't necessarily --

9 MR. HACKBARTH: All other things being equal, I
10 would like to see more of the DCI money recovered sooner
11 rather than later, but you've got a choice to make. You can
12 say, well, I'm going to focus on DCI recovery and I'm going
13 to let the net payment to hospitals float and be the
14 residual, or you can say, I'm going to have the net payment
15 to hospitals be fixed and have the DCI float. There's not a
16 right or a wrong answer on how to do that. My judgment is
17 given the financial analysis, that the important thing is to
18 focus on the bottom line payment to hospitals and have the
19 DCI float. Different people could do it different ways.

20 DR. CHERNEW: Do we have to be explicit that the
21 DCI is floating, or -- in other words, do we have to add to
22 our recommendation, this is going to DCI as opposed to going

1 to productivity or not?

2 MR. HACKBARTH: Productivity -- forget it. The
3 residual is going to the DCI. That is my recommendation.

4 DR. CHERNEW: You need to be explicit about that.

5 MR. HACKBARTH: Yes. Yes. Okay. We've got
6 people who want to make their Round 2 comments, so let's
7 move on and then you'll have another crack. Start over
8 here, Mitra and then Tom.

9 MS. BEHROOZI: So where we just ended was what my
10 Round 2 comment was going to be, that after four-and-a-half
11 years, I finally don't have to think about what productivity
12 and the general economy, blah, blah, blah, what that means
13 when it comes to updates in silos with respect to Medicare
14 payments. Hooray. I love starting with the efficient
15 provider. I like what George brought up about the fact that
16 at a 2.7 percent average margin, clearly, there are people
17 not doing so well, even though we consider them efficient.
18 I do think we need to be explicit that the rest of whatever
19 the market basket is goes to the DCI.

20 I also think that in terms of what you've asked or
21 posited in the paper about future work on the efficient
22 provider -- you talk about maybe looking at the lowest-cost

1 providers with the highest quality outcomes, but I think
2 given that we're talking about ten percent of the group that
3 you're looking at, which is only 290 hospitals out of all
4 the hospitals in the country, getting down to a really,
5 really small number will make it too rarified kind of a
6 group and not have enough factors that are widely
7 applicable.

8 So I'd suggest that while you've given us a sort
9 of qualitative breakdown of the factors that you see at
10 least weakly, the structural factors at least weakly aligned
11 with efficiency, that maybe we could see a little more of
12 the data behind that and some of the charts that break out
13 the characteristics and what the margins are and what the
14 costs are and things like that to maybe think about where to
15 look a little bit deeper.

16 One of the interesting findings is that the high
17 financial pressure hospitals, which tend to have better
18 margins and is one of the criteria for being in the
19 efficient group, also tend to have higher readmission rates.
20 So if we only looked at the lowest-cost hospitals with the
21 best outcomes, it seems like we'd be missing an important
22 subset of hospitals with certain problems, certain issues

1 that might be more common across the board.

2 MR. HACKBARTH: Mitra, did you indicate your
3 overall feeling about the recommendation?

4 MS. BEHROOZI: Yes. I think it's absolutely the
5 right direction. I like having a number and not fooling
6 around with productivity, and I understand it. You said the
7 importance of addressing DCI and not letting that be a
8 driver of the higher payments.

9 MR. HACKBARTH: Yes. Tom?

10 DR. DEAN: I'm not sure, some of this might be
11 still Round 1, but I guess the questions that I have still
12 get to the concern, and I realize we can't really deal with
13 that given the current structure of the system, but we tend
14 to look at this as though it's a uniform group of hospitals,
15 and within this group, there is a huge diversity in terms of
16 their needs, what they're doing, a whole range of different
17 aspects.

18 And so in terms of whether this is an appropriate
19 thing, I mean, I think it's reasonable, but it's reasonable
20 for some and unreasonable for others. I'm not arguing.
21 It's probably the best we can do. But I still am just -- I
22 guess I want to get on the record I'm uncomfortable with

1 the, not the recommendations, but the overall structure.

2 But behind that, do we know in the efficient group
3 what the range of margins are or how many are positive and
4 how many are negative? Again, we're looking at an overall
5 sort of median rather than a range.

6 That, and in sort of the same vein, do we know how
7 evenly distributed the DCI overpayments are? Are they
8 evenly distributed across, or are they dependent upon the
9 particular activities that a particular institution is
10 involved in? I mean, if they do more procedures, if they
11 have more medical cases or whatever, how evenly distributed
12 are the overpayments? Or do we know that? Maybe we don't
13 even know it, and if we don't, it may be the best we can do.

14 DR. STENSLAND: The overpayments are easier
15 because -- and then you could say they're exactly evenly
16 distributed because it was supposed to be a budget neutral
17 system which was going to take money out of the system as a
18 whole, meaning that everybody got too much and now everybody
19 will take a haircut, and so there's no distribution issues.

20 DR. DEAN: But it would depend on the distribution
21 of diagnoses for each institution, wouldn't it?

22 DR. STENSLAND: There's two things going on. The

1 one thing was we're going to have greater severity
2 adjustment in our MS DRGs than we had in our DRGs. And so
3 then we're going to redistribute money, and that's the
4 intention of that, to say, oh, you take tougher cases. You
5 get more money. You don't take tough cases. You get less
6 money. So there's the redistribution.

7 Then the second question is, okay, well, how do we
8 make the whole pot of money equal? So then we've got to
9 say, is the whole pot of money bigger or smaller, and we
10 say, well, the whole pot of money is bigger, so then we've
11 got to reduce the size of the whole pot by a little bit and
12 that's the DCI adjustment.

13 DR. DEAN: [Off microphone.]

14 MR. HACKBARTH: Maybe we can try to -- just to
15 pound on the redistributive point, your initial point about
16 not all hospitals are the same, that's why we did DCI and
17 why we've done other adjustments in the past that are
18 redistributive in nature, because they're not all the same
19 and we're trying to make the system more equitable and
20 reflective of those differences.

21 DR. DEAN: [Off microphone.] Yes, I understand --

22 MR. HACKBARTH: Tom --

1 DR. DEAN: [Off microphone.]

2 DR. STENSLAND: An efficient provider -- I don't
3 have that number. We can get you that number, and it's
4 going to be a little trickier than you think, and I can
5 start maybe going through parts of the --

6 MR. HACKBARTH: [Off microphone.]

7 DR. DEAN: Yes --

8 MR. HACKBARTH: Well, in the interest of time, we
9 are way behind schedule. You can explain why it's tricky
10 when you provide the number.

11 Tom, are you prepared to say, bottom line, how you
12 feel about -- microphone.

13 DR. DEAN: Yes.

14 MR. HACKBARTH: Mary?

15 DR. NAYLOR: So I think the recommended one
16 percent increase is reasonable and would certainly like to
17 know what it's going to mean when we add all these together
18 in terms of total expenditures, but it seems reasonable,
19 given all of the data that you've made available.

20 I have -- these will reflect my limited
21 understanding, but based on this conversation, I would want
22 to make sure that the one percent survives what seem to be

1 necessary changes in the Affordable Payer Act, you know,
2 that it really does -- that we end up with one percent and
3 not something less than one percent if we're not successful,
4 and maybe I might be misinterpreting.

5 I would want to make sure, also, that if any --
6 and I don't know this, but if there is any relationship
7 between the use of post-acute services, which have grown in
8 areas, and some of the gains that we've made in quality,
9 such as reductions in 30-day mortality, that we don't make
10 adjustments that might negatively affect some of the
11 positive gains seen in some of these quality measures.

12 And I am concerned about the ongoing safety issues
13 and performance issues within the hospital that are really
14 out there, and I'm wondering -- not to make it any more
15 complex, but if there's any opportunity as the performance
16 measures become better, and there's a real push to do that,
17 that we might be a little bit nimble here. So if we have
18 one percent and we see really in the next couple of weeks or
19 months that there are better measures of quality that we
20 really want to push, that we might want to say, could that
21 one percent be distributed in some way that would recognize
22 better performance on these really core, critical safety

1 issues. Thanks.

2 MR. BUTLER: My turn. Okay. I know you don't
3 want to hear about coding more, but I have to say one thing
4 on this because we have locked into 5.8 and 3.9 and I still
5 don't believe it's that high, but I know MedPAC staff and
6 CMS have run one year's data through the two groupers that
7 support that number. I understand that. It doesn't
8 reflect, though, potentially the fact that the new coding
9 also could have had less attention to the old grouper and
10 therefore have some lower coding that had been dismantled,
11 and so it doesn't necessarily reflect accurately the
12 increase.

13 Secondly, and I know you've looked at the past ten
14 years and said there's something like a point-one increase
15 in case-mix overall, but if you look at the last six years
16 or something, it's more like point-seven average per year.

17 And finally, we've talked about and we know in our
18 own organization a huge increase in this time frame in
19 observation stays, which frankly are the lower-end case-mix.

20 So I think I'm not disagreeing that a significant
21 amount of coding adjustment needs to occur, but I wouldn't
22 be so sure that this is a precise number. It's, to me, the

1 maximum number. It's not necessarily -- okay.

2 Having said that, I like where Glenn started. I
3 don't like the one percent, but I understand the rationale
4 for it. It's predictable. It feels reasonable. If you
5 look at the entire inpatient budget with a one percent
6 decline in volume, we're basically, in effect, continuing --
7 we're basically locking in a zero increase for inpatient
8 care. If you could do that in every part of the Medicare
9 budget, you'd be pretty good because the number of
10 admissions are in balance. So my anxiety is not the one
11 percent, even though we've never demonstrated we can do it
12 for one percent. Despite that, it doesn't mean we shouldn't
13 have to do that.

14 One more on 19, if you could put it up. I'm
15 getting hung up on this DCI nevertheless. We all are. And
16 what this says to me, unfortunately, is that if we recommend
17 it this way explicitly and it says 1.6 for DCI, then we said
18 all of this coding is absolutely -- it's all due to coding,
19 and we've told CMS, in the absence of change in law, that a
20 real update is going to be 1.2 minus 1.6, that's what I
21 would take if I was CMS. I would say, thank you very much.
22 We'll take the 1.6, move it to the left column you've

1 recommended. Congress doesn't change the law. Then what we
2 really are recommending is point-four minus, and that would
3 be a path of least resistance for CMS. If nothing else
4 happens, we've given them guidance to pull 1.6 out. So it's
5 not -- I don't think the practical application would be one
6 percent. So that would be my concern, not the one percent,
7 the ultimate use of this.

8 MR. HACKBARTH: So that puts a premium on our
9 being very clear about how we arrived at the 1 percent, and
10 that it's the bottom line. You don't take the 1.6 and apply
11 it to the other column. So that's a matter of presentation.
12 We'll have to take great care in doing that.

13 Mark or you guys up front, any reaction to Peter's
14 comment on the analysis, anything that you want to take --

15 DR. MARK MILLER: Well, I don't know how much you
16 want to take time on this. There has been some e-mail
17 exchanges on that. Suffice it to say we don't agree, but I
18 don't know if we want to go through it in detail.

19 MR. HACKBARTH: Okay.

20 DR. CHERNEW: So my first point is [off
21 microphone] I am also generally fine with the 1 percent.
22 I'm very worried about us not being explicit, as Peter was

1 and other people have said, about how that's played out,
2 both because of Peter's issue, because of other
3 implications. So I think we need to think about how to be
4 more explicit than just let it be a resource. That's my
5 first point.

6 The other point more broadly is I think generally
7 looking at margins is misleading. There's all kinds of
8 accounting things. The margins are responsive to the
9 pressure that the hospitals are under. And so I think we
10 run into a trap if we interpret our task as trying to get to
11 a zero Medicare margin forevermore. And so there's many
12 indicators, of which margin is one, and I don't want to
13 dismiss it completely. But I think too often there's a
14 tendency to use margin as the main goal and view our task as
15 making margins zero. And I don't do that, and I think the
16 power of the other analysis shows you one shouldn't do that.

17 Other indicators that I think are important,
18 although not exclusively dominant, are indicators like the
19 capacity and access measures. My biggest concern -- and
20 that concern has been growing over time -- is that those
21 measures move with a lag, and the problem you have is
22 looking backwards to say capacity looks like it was good and

1 the access looked like it was good, so we're going to cut
2 you a lot, and all of a sudden you have a problem, but now
3 what? You know, you could cause real harm if you aren't
4 careful. So the closer we get to the bone -- I don't like
5 that in the health care setting, but the closer we get to
6 the bone in the payment rates, the more careful we have to
7 be with our -- is scalpel the right -- whatever instrument,
8 saw, whatever decade we're in.

9 Anyhow, I think that matters a lot, and we have to
10 think about that sort of going forward, and I can only look
11 to other experts as to how close we're getting. But that
12 matters.

13 The other challenge that I think we have -- and we
14 somehow seem to be moving across the board in this SGR kind
15 of world, which is volumes are going up so we're going to
16 keep prices down because the budget cares about spending,
17 and so if volumes are going up, in order to keep spending we
18 have to get the prices down. But they're not symmetric.
19 That generally assumes that the volume increase sort of
20 comes with no cost. But it comes with a cost. You actually
21 did stuff to do the volume. So you can't just look at
22 overall spending and assume it doesn't matter to a hospital

1 or anyone, their revenue. It matters if they get their
2 revenue in price versus if they get revenue through volume.
3 And we don't do a great job of thinking about that. And,
4 more importantly, when we see the volume going up, it makes
5 a huge difference to me if I look at that volume going up by
6 those very large numbers and think, you know, that's really
7 justified clinically, and we need to think about how to
8 maintain that increase, and we should think about having to
9 pay for that or what to do; or if I think, as is other times
10 implied, oh, they're just pumping through volume because
11 we're ratcheting down the prices, so they're keeping their
12 revenue the same, and their goal is to hit a revenue target.

13 So my view is that most facilities don't have a
14 revenue target. It's much more of an overall financial
15 health target, and so the cost part matters. Price and
16 quantity aren't symmetric. And so I guess my bottom line is
17 that leads me back where I think the 1 percent is probably
18 reasonable, all things considered. I think it's important
19 that we both be explicit about where that goes because we
20 have to think -- because what we choose, as Slide 19
21 suggests, what we choose sets not only the update for next
22 year, which I know is our focus, but it sets the current law

1 trajectory based on how much is taken out of the DCI and
2 other types of things. And I'm very worried -- we need -- I
3 guess I couldn't speak more strongly about trying to get as
4 good as possible early warning systems, not current -- we
5 have a lot of rearview mirror warning systems on access and
6 capacity. We don't have as many good future warning
7 systems. And we spent a lot of great time putting emphasis
8 on doing the efficiency stuff, which has been really
9 interesting, both substantively and also just
10 paradigmatically, helping us think about things, but also
11 future warning systems become increasingly important in the
12 system. And I don't know how we do that, but that's where I
13 think, as we move forward away from these two months, we
14 need to think.

15 MS. UCCELLO: I'll just be brief. I'm comfortable
16 with the 1 percent, and I'm persuaded that we can and should
17 explicitly say that the residual should go to the DCI. I
18 think it makes sense to make that the priority.

19 MR. GEORGE MILLER: Yes, I'm a little bit still
20 hung up on the efficient provider issue, particularly
21 because I think in this analysis we use a median number, and
22 everything else that I recall we've used an average number.

1 So can you help me understand why for efficient providers we
2 only use the median number versus the average number?

3 DR. STENSLAND: Normally in margins we use the
4 aggregate number, so we take all the costs for all the
5 hospitals and all the revenue for all the hospitals in the
6 country and say what's the margin on an aggregate basis,
7 because the question is, is there enough money in the pool
8 in aggregate?

9 MR. GEORGE MILLER: Right.

10 DR. STENSLAND: So that's our general margin
11 number.

12 Here we're trying to look at the individual kind
13 of financial health of individual hospitals, so I wasn't
14 going to take an aggregate number. I'm going to try to get
15 the median to look at kind of an individual basis, and also
16 the median allows me to take out any really oddball cases,
17 which at the fringe, you know, might be reality and at the
18 fringe it might be an error in the cost report or something
19 screwy that happened in one year.

20 MR. GEORGE MILLER: But then to Tom's point, then,
21 again, you have got efficient, by your definition, hospitals
22 that have negative margins, and from a financial standpoint,

1 I know we've talked about a lot of issues, but they can't
2 reinvest in that hospital based on those margins. They
3 won't have the cash. That means somebody's got to cross-
4 subsidize them. And I know we had part of that debate, but
5 if 10 percent of the hospitals are efficient and the
6 recommendation based on that small segment and part of that
7 small segment has a negative margin, you're saying the 1
8 percent is okay for the entire industry. Is that correct?

9 [Dr. Stensland nods.]

10 MR. GEORGE MILLER: Okay. All right. I don't
11 agree with that, but you asked so...

12 Then the number two issue then is on Slide 20, and
13 I do understand the 1 percent -- I'll contradict myself a
14 little bit -- on the inpatient side, and particularly with
15 the DCI, I understand that logic. And so the inpatient
16 hospital side should go up 1 percent. So I can support
17 that. But I'm not sure I follow the same logic for the 1
18 percent for the outpatient. We've got a shift of business
19 that is in theory more cost efficient and better suited on
20 the outpatient basis, but the recommendation is only a 1-
21 percent increase when I thought the cost overall, both
22 inpatient and outpatient, had gone up 3 percent. So what's

1 the rationale for the outpatient recommendation only being 1
2 percent? Because I was assuming that it was tied into the
3 DCI overall, and that was --

4 MR. HACKBARTH: As Jeff indicated, one important
5 consideration in that is this problem that we have -- and I
6 think a growing problem -- whereby Medicare pays different
7 rates for the same service based on where it's provided,
8 what sort of setting: physician office versus hospital
9 outpatient department versus ASC, for example. Those rates
10 are not synchronized today.

11 MR. GEORGE MILLER: Okay.

12 MR. HACKBARTH: And I think there's evidence --
13 and correct me if I'm wrong, Jeff, but there's evidence that
14 the fact that those rates are not synchronized is starting
15 to influence decisions about where things are done, and not
16 surprisingly, things aren't going to the lowest-cost, most
17 efficient setting, but people are looking for the added
18 revenue and taking things into higher-cost settings.

19 So that's a long-term problem that we're not going
20 to address through the update recommendation. My thinking
21 was, though, probably it would be good if we at least stop
22 making the problem worse. And so in thinking about the

1 appropriate update for hospital outpatient, I thought maybe
2 we ought to think about synchronizing that with what we're
3 doing for physician offices and ASCs so that we're not
4 digging the hole deeper.

5 MR. GEORGE MILLER: Yeah, but the logic --

6 MR. HACKBARTH: It's not very analytic but --

7 MR. GEORGE MILLER: I was going to say, but that
8 logic says -- and, again, my physician friends around the
9 table, I apologize, but the physician makes the
10 determination where that patient goes. And if that
11 physician has a financial interest in a setting, you get two
12 patients, one has poor history, poor problems, and high
13 risk, they'll take that patient to the hospital outpatient
14 department versus taking them to an ASC or their own office.
15 But you're saying you want to synchronize the payments.

16 MR. HACKBARTH: Let me be clear that I don't think
17 that -- I don't use "synchronized" to mean that the raw
18 payment rates need to be identical. I do believe that
19 different patients are treated in different locations. You
20 know, when I ran a physician group, I know for a fact that
21 relatively simple cases we sent to an ASC, and we did the
22 more complex patients, exact same procedure, in the

1 Brigham's hospital outpatient department. And as a result,
2 when I negotiated the contracts with the ASC and the
3 Brigham, I agreed to pay the Brigham more than I agreed to
4 pay the ASC. So I think that's a reality, and what you want
5 to do is get to a level playing field on a risk-adjusted
6 basis. Easier to say than it is to do in the real world.

7 In terms of who's making these decisions, of
8 course, one of the other big developments is that hospitals
9 are now buying up physician practices, and the physicians
10 are working for hospitals that make these decisions. And so
11 we're dealing with a changing dynamic environment, and
12 that's part of why I think addressing the disparity in rates
13 for the same service based on location is an increasingly
14 important problem for Medicare.

15 MR. GEORGE MILLER: Well, then, you know -- well,
16 I guess we could debate this another time, but, again, that
17 hospital has a different criteria to be a hospital,
18 different conditions of participation than an ASC does.

19 MR. HACKBARTH: And that's --

20 MR. GEORGE MILLER: And quality of care, infection
21 control issues --

22 MR. HACKBARTH: We're in agreement on that, and

1 that's why, you know, we recommended three or four or five
2 years ago now that we start the task of synchronizing the
3 ASC rates with the hospital outpatient department rates. We
4 didn't advocate for strict dollar neutrality. We said we
5 ought to start moving towards using the same relative
6 values, but we said because of the differences in the
7 patients, differences in regulatory requirements, we thought
8 it was appropriate for hospitals to be paid somewhat more.
9 But this issue I think is going to be increasingly a
10 problem.

11 DR. BERENSON: Yeah, I disagree, I guess, with
12 George on sort of interpreting all the data. I'm with the
13 Chairman on the importance of Slide 10, which is how
14 hospitals behave when they're under financial pressure. In
15 recent years, we've seen sort of an unfortunate natural
16 experiment with the recession that hit in the fall of 2008,
17 pressure on volumes for hospitals, change in payer mix with
18 people going uninsured or moving into Medicaid, and
19 hospitals, as I understand it, have responded by significant
20 practice expense reduction -- I mean cost reductions. And
21 it's the reason we need to be looking at quality metrics and
22 access metrics and things other than just margins. But I'm

1 persuaded that hospitals under high pressure with a 4.7-
2 percent Medicare margin can do pretty well and that we want
3 to be maintaining pressure, because I also think we should
4 try to get the 3.9 percent paid off as quickly as possible.
5 I was initially tempted to think maybe we could be even more
6 aggressive in year one, maybe going to half of the 3.9,
7 getting us to a positive but lower than 1 percent, but that
8 2.9-percent reduction that will take place, even though it's
9 not in the update, it's in the base and it is real. So I
10 come out to the 1 percent as a reasonable place to be, and
11 I'm with all of those -- Kate raised the issue, and I think
12 there's a growing consensus. We have to be very explicit
13 about the DCI, and we also -- I think Peter's point is well
14 taken. We want the bottom line to be 1, not the 1.2 minus
15 DCI. So that's where I would come out.

16 MR. KUHN: On this particular recommendation, I
17 still want to kind of sort through kind of where I am at the
18 end of the day on it. But, one, I understand your logic in
19 the 1 percent, and I think it's a reasonable proposal we've
20 put on the table, and actually I think it's quite brilliant.
21 I think you've done a nice job of putting something together
22 here.

1 My concerns are a couple, though. One is, at
2 least on the outpatient, on the 1 percent, we don't collect
3 cost data for either physician office or ASC, so it's really
4 kind of hard to do. So I understand the synching up issue,
5 but it's kind of hard to do a real comparison there without
6 the cost data. Also, the acuity issue of what goes on in
7 the outpatient department concerns me a little bit, too, so
8 I want to think about that more.

9 On the DCI issue, I have to confess that I have
10 tortured, I think, the MedPAC staff for the last two months
11 with numerous e-mails and lots of phone conversations
12 working through this, and they have been extraordinarily
13 patient and very diligent in terms of answering a number of
14 different questions. And so in that vein -- and I know time
15 is short here, but I think it would be helpful at least to
16 get on the public record from -- I know Mark just stepped
17 out, but either from Jeff or Julian or someone. You know,
18 the National Hospital Association made an interesting pivot
19 this year. Up until this year, they were saying there was
20 no improvement in terms of coding, it didn't enhance
21 hospitals. But I think this year in terms of their comment
22 letters with CMS, they said, yes, there is improvement in

1 coding in terms of driving additional revenue to hospitals.
2 It's just the order of magnitude, and they disagree with the
3 numbers that are out there, a little bit what Peter was
4 talking about.

5 And so they raised a number of different issues,
6 one issue being the fact that MedPAC and CMS look at the
7 years of 2008 and 2009; they look at a 10-year trend. They
8 look at the issue of under-coding and the fact that when you
9 fill the eight or nine slots that are out there, there are
10 certain codes that you could continue to use, but they won't
11 improve the application of the specific MS DRG, and,
12 therefore, those fall out of the denominator and that could
13 impact the numbers out there. The whole issue of migration
14 to the outpatient department could be impactful in terms of
15 case-mix and kind of what's going on out there.

16 And then, finally -- and I know we've talked about
17 this before, but there continues to be a lot of concern in
18 the hospital community about the impact of the RAC audits
19 and the fact that the RAC auditors, as a result of focusing
20 on one-day hospital stays, many hospitals have started to
21 move people to 23-hour observation care, and that, too, is
22 impacting kind of what's going on out there.

1 So, you know, if it's possible, quickly in the
2 time that we have, you know, any general observations about
3 those comments that the national hospital groups have made
4 and how that kind of syncs up or differentiates from our
5 analysis that we've done here.

6 MR. PETTENGILL: Well, the hospital associations
7 looked at the trend over time in inpatient case-mix, and
8 whatever -- the comments about the shift from inpatient to
9 outpatient, the RAC medical necessity reviews, and so forth,
10 all show up in the inpatient case-mix. They're all in
11 there. Okay? If there is any effect from any of those
12 things, it appears in the inpatient case-mix number.

13 What trend you get for inpatient case-mix depends
14 on how you do it. Which grouper and weights do you use? Do
15 you take into account the fact that when CMS calculates
16 case-mix indexes they are always recalibrated to the
17 preceding year. Do you take that into account? Which
18 hospitals do you include? And depending on how you do it,
19 you can get a steeper line or a flatter line. Their line is
20 steeper; ours is flatter.

21 But I think the main point that we would make is
22 that we are not looking at a trend in 2008 and 2009. We are

1 comparing two aggregate national case-mix indexes: one
2 based on the new grouper and weights, the other based on the
3 old grouper and weights. When the weights for the new
4 grouper were recalibrated using the then latest available
5 data, those two aggregate CMIs matched exactly.

6 Two years later, when you take the claims and run
7 them through the two groupers and compares the two CMIs,
8 they don't match. They're wide apart. What's the
9 difference? Okay. There's no trend in a single year's
10 data. The difference is that there were changes in document
11 and coding in the more recent claims that affected one
12 grouper and not the other, and that's the difference.

13 DR. MARK MILLER: When you say claims, you mean
14 the same set of claims run through the two groupers?

15 MR. PETTENGILL: Say that again?

16 DR. MARK MILLER: The same set of claims.

17 MR. PETTENGILL: The same set of claims, yes.

18 DR. KANE: So in thinking about leading indicators
19 along Mike's suggestions, there are some issues around the
20 big changes we're hoping that hospitals will undertake in
21 the next five to ten years around accountability,
22 coordination, and integration. And I guess with that in

1 mind, I'm happy with the 1 percent. I think it's, you know,
2 better than less. I think the historic data tells us, you
3 know, some hospitals have done well and a lot of them have
4 other ways to make up the difference. And so, you know, the
5 industry is still thriving in many ways. And the stuff I
6 look at, which includes some of the investment income, you
7 know, that actually yanks them around a heck of a lot more
8 than Medicare does.

9 So, you know, I guess overall I'm not worried
10 about the financial health -- I don't think the financial
11 health of hospitals hinges on this update, and so I think
12 the update is more of a signal on what kind of things we
13 like to see happening. And, you know, if code reduction is
14 one of them, that's okay.

15 I guess my only concern -- and I had a lot of
16 trouble just understanding it, but now I think I do. But I
17 don't know why I would -- I'm not sure it's a good political
18 signal to say that the productivity should be zero and just
19 overlook the law, only because people might say that's the
20 tip of the iceberg, we're never going to recover the \$500
21 billion, and this is just another example of, you know,
22 Congress saying they're going to create savings that they

1 never actually implement. And I just don't know that I want
2 to start us down that, you know, right off the bat, saying
3 let's ignore current law, given all the pressure to
4 implement this \$500 billion in cost savings at some point.
5 Right off the bat you say ignore it because we have other
6 issues. So I just don't know. I'm not a politician. I
7 just find that a little bit jarring and a little hard for me
8 to just want to go out and justify.

9 All that said, I don't think the update is really
10 the big issue, but I think the signals that we send are the
11 big issue, and I would like to have more of a discussion
12 around what should be in P4P. And I think Mary started this
13 discussion; I think George just had a little bit. To me,
14 one of the things -- I mean, certainly the quality metrics
15 we've got are fine, but I think we should start putting in
16 some P4P like the readmission rate to start to push
17 hospitals to say you should be coordinating across the
18 silos, you should be, you know, informing the patient, this
19 should be much -- and some of the ones that come to mind,
20 you know, ambulatory-sensitive conditions, should we start
21 trying to downgrade hospitals because of a high proportion
22 of ambulatory-sensitive conditions, you know, push them

1 towards trying to improve their primary system. The
2 percentage of the last end-of-life episode that's in
3 intensive care, should we start trying to signal that we
4 want to see changes in the way care is provided that has the
5 patient and the family and the decisionmaking all part of
6 the care.

7 So I think the update is really, you know, a
8 signaling device. It's not that meaningful for whether this
9 hospital industry is going to survive or not. There are so
10 many much bigger things that are happening, but what is it
11 we want to signal? And I think this goes back to something
12 I was trying to say earlier. What's the value of hospital
13 care? How do we start to just make it more explicit and
14 reward what we think is valuable and more explicit and
15 penalize what we think is not good care? And I agree with
16 Mary that the safety and the readmission rate and the
17 ambulatory-sensitive admissions and the potentially
18 inappropriate end-of-life care, I think there are some ways
19 we can start to capture that. I would much rather we put
20 that level of energy we just put into coding into the stuff
21 that I think really signals something meaningful.

22 So, you know, 1 percent is fine, but I want the

1 signals to be stronger in terms of where we think the system
2 should be going, you know, and have some more leading
3 indicators of our own to say we're going to start penalizing
4 this, we're going to start rewarding that, and we want to
5 start developing those metrics like next year. And I'm not
6 going to be here to help you with that, but I've been --
7 this is my sixth year, and I really want to get my last word
8 in on that.

9 [Laughter.]

10 MR. HACKBARTH: And it hasn't all been for naught,
11 and PPACA starts down that path. You know, it picked up on
12 recommendations that we had made about readmissions and
13 said, well, that's a variable that we really ought to be
14 focusing more on. They also have instituted or in the
15 future will be instituting adjustments for infection rates,
16 and then there's the broader pay-for-performance package
17 which, you know, will have component parts that we can help
18 them develop and use as a tool for focusing hospital efforts
19 in the future. So some of the groundwork has been laid for
20 it.

21 DR. KANE: Right, but I think we really want to
22 start thinking about how do we create messages that say

1 coordination across the silos is really important, whether
2 or not you're in an ACO, that the patient being a part of
3 the decisionmaking is really important. So if we're stuck
4 with these little silos, what can we do within them? We can
5 start rewarding things to start to improve that.

6 MR. HACKBARTH: Yeah, and of course, there is the
7 bundling pilot in PPACA as well, which is very much directed
8 at that. So some progress is hopefully on the way.

9 DR. STUART: Yeah, I agree with the overall
10 recommendation. I'm not sanguine with the math. If we
11 could go to Slide 19 again, we've seen it a lot. If you
12 look at that column under current law, the math is you start
13 with 2.6 and then you subtract and then you end up with a
14 net. But the way we come up with the math on the far right
15 column is that we start with the 2.6, we justify the -1.6
16 for DCI, and then we say, all right, well, we want to give 1
17 percent and so, therefore, the productivity and budget
18 adjustment is zero.

19 So it's not that we looked at budget and
20 productivity and said, oh, well, it's zero. It became zero
21 because we wanted to give the 1 percent. So I think it
22 might be more honest to take out the zero and just put "not

1 considered," because that's essentially what we have here.
2 And then it would get around the question of somebody that
3 looks at this slide and says, okay, well, how did you come
4 up with zero for productivity and budget adjustment? So I
5 don't disagree with the bottom line, but I think that it
6 might help us if we make it clear that we have not
7 considered that.

8 I also want to say just a quick point about P4P,
9 and I recognize what is in PPACA and how that's going to
10 affect us. But I'm also looking at what the recommendations
11 were over the last three years, and for every year since
12 1908 or 1909--

13 [Laughter.]

14 DR. STUART: I really am trying to go back here.
15 From 2009 to 2011, we made an explicit recommendation for
16 P4P, and I'm just wondering whether by not having that in
17 the recommendation this year we're signaling, well, we don't
18 think that that's an important issue. And I think it would
19 be relatively easy to come back and use language that we had
20 last year and add that to this year's recommendation.

21 MR. HACKBARTH: For sure I don't want people to
22 think that because it's not in the recommendation we don't

1 like it anymore. There are lots of things that we recommend
2 and then they happen, and we don't re-recommend them every
3 year. But what we can do is just in the text make reference
4 to some of these readmissions and pay for performance and
5 say we think these are good directions that are now in
6 current law, things that we've recommended in the past, we
7 continue to support them.

8 DR. BAICKER: I'm on board with the 1 percent, and
9 I share everybody's concern about framing the sub-components
10 carefully in a way that neither implies we're indifferent to
11 one and also signals or telegraphs what we think will happen
12 in the future with those components if what we recommended
13 now were to happen. So that framing seems important; the 1
14 percent seems fine.

15 DR. CASTELLANOS: I agree with Kate for sure, and
16 I would like you to turn that slide off. I think I've seen
17 enough of it.

18 [Laughter.]

19 DR. CASTELLANOS: Two things. One is a level one,
20 and I should -- when we looked at the four categories for
21 payment adequacy, last year there was a little bit of
22 discussion about surveying the physicians to find out how

1 they feel about what hospitals are providing, the services
2 they're providing, the quality, the beds, what they can do
3 better, et cetera. I know the American Hospital Association
4 does that, but it would be nice if -- you know, the
5 physician is really the end user in the hospital, and it
6 would be nice to get some kind of input from the physician
7 community.

8 And just to answer George's question, George, I
9 like us moving towards a synchronized system. There's no
10 question that the raw payment rates shouldn't be the same.
11 The hospital definitely, with the ASC and the outpatient
12 facilities, has a higher cost. But I think we need to start
13 moving towards synchronization.

14 MS. HANSEN: I support the recommendation based on
15 the principles and based on the emphasis that people brought
16 up, but I want to then just underscore the signals I think
17 are important. You know, I'd say let's sweat the big stuff
18 as we are concerned about the right kind of message of some
19 of the image, but the signal of quality and safety perhaps,
20 since we've done this in other recommendations and we can
21 tie it back, I think need to be elevated so that we pick up
22 on the readmission, we pick up on some of these never

1 event-type of things, and build it in so that's part of the
2 composite package.

3 MR. ARMSTRONG: I, too, support both your
4 recommendation, Glenn, but also the direction that the
5 conversation has taken us in in terms of clarity around
6 what's behind this.

7 I want to say I support this in part because the
8 analysis within the constraints of this inpatient and
9 outpatient hospital-based rate decision has been excellent
10 and I understand it. I think part of the issue that we keep
11 stumbling into is how does this fit within a slightly
12 broader context, and my hope would be that, perhaps at the
13 end of the afternoon tomorrow and in the spirit of trying to
14 put all these on to a single sheet of paper, we can just
15 make sure we have a story that makes a 1-percent
16 recommendation around hospital rates that holds together in
17 the context of all the other rate decisions that we're
18 making.

19 DR. BORMAN: I would generally support the
20 recommendation and the principles behind it. I think we are
21 grappling a bit about balancing hospital-provided services
22 as a public good, kind of like electricity or water,

1 compared to serving as an economic growth engine generally
2 for our country, and that leads us to some dichotomies
3 perhaps that will play out over time.

4 I think our focus on the efficient provider is
5 hugely important. The hospital happens to be the arena
6 where we have the best data to begin to try and define what
7 that is, and I know that staff are working to move that
8 forward in other areas to try and give a sense of parity to
9 all the silos that we currently deal with.

10 I personally have a little less angst about
11 attributing the coding piece because, as many of you or all
12 of you probably know, physician fee schedules are regularly
13 subject to behavioral offset and coding change adjustments.
14 And so this is not the first time that these kinds of things
15 have been applied in the system somewhere, and it's done on
16 a regular basis. And so I think that, again, in trying to
17 look at parity given the system that we have, choosing to
18 attribute this in this way, another reason that I like the
19 attribution is that in a very twisted way of thinking --
20 because I know they're not the same -- I think there is the
21 opportunity here if we don't do something about what is a
22 growing sinkhole, at least by Medicare's definition, of

1 overpayment, we almost create ourselves getting into an SGR-
2 like situation that becomes a sinkhole that has to be
3 filled, and we will have no way to fill it. And so I think
4 that we have to move forward on that.

5 MR. HACKBARTH: Okay. Thank you.

6 We'll now have our brief public comment.

7 We are now at 12:20. We are, as you know, from
8 looking at the schedule, way behind schedule. So if you
9 would please keep your comments brief and limit them to no
10 more than a couple minutes. When the red light comes on,
11 that signifies the time is up. And also, please begin by
12 introducing yourself and the organization that you
13 represent.

14 MS. KIM: Hi. I'm Joanna Kim. I'm with the
15 American Hospital Association.

16 Regarding the documentation and coding issue, we
17 agree that hospitals have improved their documentation and
18 coding in response to the implementation of the MS-DRGs, and
19 that a cut in addition to those that have already been made
20 in 2008 and 2009 is warranted, but we disagree with the
21 magnitude of the cut from what the CMS analysis has found.

22 CMS states in its analysis that it doesn't

1 consider real case-mix because it uses one year of claims
2 run through two groupers, and the patients those claims of
3 course have not changed. But the corollary is that the
4 claims themselves have also not changed and the coding of
5 those claims has not changed. So we don't quite understand
6 how CMS then says they're looking at coding change when
7 they're only looking at one set of claims.

8 What we actually think CMS is looking at is any
9 increase in patient severity and any increase in case-mix
10 index regardless of whether it stems from real increase in
11 patient severity or documentation and coding change.

12 We think the appropriate way to look at
13 documentation and coding change is to go back in time and
14 look at historical claims, all put under the same grouper.
15 You would then look at the trend in those claims, and any
16 change in trend in 2008 and 2009 would be considered
17 documentation and coding change.

18 We can argue over the details of that analysis and
19 whether the trend line would be steeper or flatter, but even
20 when you make changes to the analysis, some of which CMS and
21 MedPAC have suggested, the magnitude of the cut still ends
22 up being quite a bit smaller than what CMS has decided.

1 In addition, we ask the commissioners to consider
2 the fact that while we have incentives to improve
3 documentation and coding with respect to conditions that are
4 important under MS-DRGs, there are also incentives to not
5 necessarily keep coding things that are important under CMS-
6 DRGs but no longer important under MS-DRGs.

7 So when CMS has looked at the claims under the two
8 groupers, if we've stopped coding things that are only
9 important under CMS-DRGs, that number is then going to look
10 smaller as far as that case-mix index, which would
11 artificially inflate the number CMS has found using their
12 methodology. We've looked at that, and we have found that
13 the number is artificially inflated because of this so-
14 called negative documentation and coding cut, if you will.

15 So we would urge the Commission to consider that
16 every small percent in the documentation and coding cut is
17 very important. A 0.1 percent cut represents \$100 million
18 to hospitals. So it is important to get it exactly right.

19 Regarding the update recommendations, as I just
20 said, we do disagree with the magnitude of the coding cut.
21 So we do sort of disagree then with the inpatient
22 recommended update. But regarding the outpatient update,

1 the volume there has increased in response to RAC audits, in
2 response to technology advances and in response to
3 efficiency pressures. Those account for the increase in
4 volume, and we see this occurring as the inpatient volume
5 has decreased. So it is really a shift there.

6 I would also say that in order to try and create a
7 level playing field with ASCs, it's really important not to
8 necessarily recommend the same update, but to make sure the
9 providers in both settings are paid their costs. And I
10 think it's very clear that the outpatient providers aren't
11 paid their costs. I think the margin was on the magnitude
12 of greater than negative 10 percent.

13 So with that, we would urge the commissioners to
14 reconsider the recommendation for both outpatient and
15 inpatient, but especially outpatient, because we think a
16 full update recommendation there is warranted. Thank you.

17 MR. HACKBARTH: Okay, we will adjourn for lunch
18 and reconvene at -- yeah, let's shoot for 1:00.

19 [Whereupon, at 12:24 p.m., the meeting was
20 recessed, to reconvene at 1:00 p.m., this same day.]

21

22

1 Commission is different. Our responsibility to the Congress
2 under the statute that created MedPAC is to provide the
3 Congress our best advice, year by year, on the appropriate
4 update for each provider group. And further, the Congress
5 has said that they want us to base our advice on what we
6 think is an appropriate update for an efficient provider of
7 services.

8 The significance of PPACA and the changed baseline
9 is that depending on what MedPAC recommends our
10 recommendation could cost or save money relative to the new
11 baseline, but our recommendations aren't driven by the
12 baseline. The Congress is asking for our independent
13 judgment about what the appropriate update would be.

14 As always, we find updates are, in and of
15 themselves, an imperfect tool of policy and that they apply
16 across the board equally to all providers when in fact many
17 of the most important issues in Medicare policy have to do
18 with how the dollars are distributed among different types
19 of providers, both to assure fairness among providers and to
20 encourage efficient, effective care.

21 In addition, many of the most important issues
22 that we grapple with as a Commission have to do with how to

1 change Medicare's payment systems and replace them with
2 payment methods, payment reforms that create better, more
3 appropriate incentives for the effective delivery of high
4 quality care. That's a very important discussion and one
5 that occupies much of the Commission's time. However, for
6 today and tomorrow and in our January meeting, our focus is
7 on the payment systems as they exist and what the
8 appropriate updates are of those payment systems.

9 I think those are the important points I wanted to
10 make, and so with that let's turn to the subject of
11 physicians and ambulatory surgical centers. And who's
12 leading the way? Cristina?

13 MS. BOCCUTI: I'll start, yes. So in this
14 session, Kevin, Ariel and I are going to present analyses on
15 physicians, other health professionals and ambulatory
16 surgical centers.

17 So first, I'll start with a bit of background on
18 physician and other health professional services. These
19 services include office visits, surgical procedures and a
20 broad range of other diagnostic and therapeutic services.
21 Providers can furnish them in all settings, not just
22 offices.

1 In 2009, Medicare spent about \$64 billion on fee-
2 for-service physician services, accounting for 13 percent of
3 total Medicare spending. And among the 1 million
4 practitioners billing Medicare's physician fee schedule in
5 2009, roughly half were physicians. And when I say
6 "billing," I should correct that and say really registered
7 with Medicare, and roughly half of those were physicians
8 that were actually billing Medicare.

9 The other health professionals, such as nurse
10 practitioners, physical therapists and chiropractors, can
11 also bill.

12 Almost all fee-for-service Medicare beneficiaries
13 received at least one physician service in the year 2009.

14 So in our payment adequacy analysis we examined
15 several indicators, and the first is access. As you recall,
16 MedPAC sponsors a phone survey that asks about access to
17 physicians. We completed this year's survey a little more
18 than a month ago, so the date is very current data on this.

19 We surveyed both Medicare and privately insured
20 individuals, aged 50 to 64, and then for Medicare it's 65
21 and older, to assess the extent to which any access problems
22 are unique to the Medicare population. We surveyed over

1 8,000 people which included an over-sample of African
2 Americans, Hispanics and Asian Americans.

3 We also look at other national surveys, both of
4 patients and physicians. And then of course we examine
5 annual growth in the volume of services that beneficiaries
6 use. In addition to patient access, we also examined
7 quality indicators, and finally we'll discuss some indirect
8 measures of financial performance in this sector.

9 So recognizing Matlin Gilman's diligent work on
10 the access survey, I'm going to get right to it.

11 We continue to find that most Medicare
12 beneficiaries and privately insured people do not regularly
13 experience delays getting an appointment. Moreover,
14 Medicare beneficiaries are able to get timely appointments
15 more frequently than privately insured individuals.
16 Specifically, among survey respondents in seeking an
17 appointment for routine care, 75 percent of Medicare
18 beneficiaries and 72 percent of privately insured
19 individuals reported that they never experience problems.

20 As expected -- let's see. So that was 75 and 72.

21 And as expected, for illness or injury, timely
22 appointments were more frequent and more common for both

1 insurance groups. Among survey respondents seeking an
2 appointment due to illness or injury, 83 percent of Medicare
3 beneficiaries and 80 percent of privately insured
4 individuals reported that they never experience delays
5 getting an appointment.

6 We also asked respondents about their ability to
7 find new physicians when needed. Overall, Medicare
8 beneficiaries are less likely than privately insured
9 individuals to report problems finding a new physician.
10 Keep in mind that only a small number of survey respondents
11 sought a new primary care physician in the year -- only 7
12 percent in the Medicare population and the same percent,
13 that's 7, in the privately insured population. So this
14 suggests that most are satisfied with their current primary
15 care provider.

16 But among the small share that are looking for a
17 primary care physician, 79 percent of Medicare beneficiaries
18 and 69 percent of privately insured individuals said that
19 they experience no problems. This difference between the
20 groups is statistically significant.

21 Twelve percent of Medicare respondents looking for
22 a new primary care physician, however, reported a big

1 problem finding one compared with 19 percent in the
2 privately insured population. Given the low share of people
3 looking for a primary care physician, the proportion of
4 Medicare beneficiaries reporting a big problem corresponds
5 to less than 1 percent of the Medicare population, but of
6 course this problem is concerning.

7 Now to specialists, if we're looking at
8 specialists, we see that as in previous years we found that
9 access to new specialists was generally better than access
10 to primary care providers when you're looking for a new
11 physician, and 87 percent of Medicare beneficiaries seeking
12 a new specialist reported no problems compared with 82
13 percent of privately insured individuals.

14 From the over-sample of minorities in our survey,
15 we continue to see that minorities experience more access
16 problems than whites. We found that this disparity is
17 greater among privately insured individuals than we saw in
18 the Medicare population. For instance, regarding
19 appointments, minorities in both insurance categories were
20 less likely than whites to report never experiencing delays
21 scheduling routine care appointments. That is 74 percent of
22 Medicare beneficiaries -- 74 percent of Medicare minorities

1 -- and 66 percent of privately insured minorities reported
2 never having delays.

3 Regarding finding a new physician, among those
4 looking for a new specialist, 9 percent of Medicare
5 minorities and 13 percent of privately insured minorities
6 said that they encountered big problems. Differences though
7 were smaller among those seeking a new primary care
8 physician.

9 Moving on, other organizations have conducted
10 surveys asking similar questions about access to care as we
11 do in the MedPAC survey, namely CMS, the Commonwealth Fund,
12 HSC, and AARP has done them as well. But in the interest of
13 time I'm not going go through these results specifically,
14 but it's important to note that they show findings that are
15 analogous to ours, and we provide more information on these
16 surveys in the draft materials and will do so in the
17 chapter.

18 As I said, we also look at physician surveys.
19 This is opposed to the beneficiary and the patient surveys
20 that we've been talking about. And here on this slide I'm
21 just going to review the first bullet because the others
22 have been included in previous years' discussions. The

1 National Ambulatory Medical Care Survey, which is conducted
2 annually, continues to show that a large majority of
3 physicians accept some or all new Medicare patients. Note,
4 however, that the rate among primary care physicians, which
5 is 83 percent, is lower than that for specialists.

6 Looking at growth in the volume of services
7 provided, we continue to see annual increases in the volume
8 of services physicians provide per beneficiary. Across all
9 services, volume increased about 3 percent per fee-for-
10 service beneficiary in 2009. But looking cumulatively,
11 growth has been slower for E&M and major procedures, which
12 are the bottom two lines on that graph, relative to the top
13 three.

14 So moving on to our assessment of ambulatory
15 quality, John Richardson managed this work, so I want to
16 thank him. And using our claims-based set of measures, we
17 found that most of our quality indicators, that is 35 out of
18 38, improved slightly or were stable from 2007 to 2009.
19 Among the three indicators that declined, differences were
20 small but statistically significant, and we describe these
21 measures further in your draft materials and will do so
22 again in the report, but feel free to ask questions.

1 And now Kevin is going to review some indirect
2 measures of financial performance.

3 DR. HAYES: Among other indicators for this
4 sector, the Commission considers, first, the ratio of
5 Medicare's payment rates to rates for private PPOs. For
6 2009, we found that the ratio was 80 percent, no change
7 compared to 2008.

8 Another indicator is the share of allowed charges
9 that Medicare pays on assignment. "On assignment" means
10 that Medicare's fee schedule amount is accepted as payment
11 in full. In 2009, the assignment rate remained very high,
12 at 99 percent.

13 Looking forward to 2012, the year for which you
14 would make an update recommendation, CMS's preliminary
15 forecast of the Medicare Economic Index is 0.7 percent.
16 This is a forecast of changes in input prices for
17 practitioner services, adjusted for productivity growth in
18 the national economy.

19 Speaking of the MEI, we note that this sector's
20 updates have been less than changes in input prices, whether
21 those changes are measured by the MEI with or without a
22 productivity adjustment. During the 10-year period ending

1 in 2009, the updates rose at a cumulative rate of 7 percent
2 while the MEI rose 20 percent. Using the MEI without a
3 productivity adjustment, we see that input prices rose 34
4 percent.

5 And that is 34 percent, by the way, not the 24
6 percent that was in the draft chapter. I apologize for that
7 mistake.

8 Whatever the number, the problem with comparisons
9 of the MEI and the updates is that they do not consider
10 volume growth and its effect on physician or practitioner
11 revenues. Over the same 10 years, Medicare spending for
12 practitioner services per beneficiary increased by 61
13 percent. The difference between this spending growth and
14 the updates is accounted for by growth in the volume of
15 services, and it is the updates plus the volume growth that
16 bring about increases in practitioner revenues for Medicare.

17 As an addition to our work on the physician
18 update, we are looking this year at physician compensation,
19 using it as an indirect indicator of the financial status of
20 this sector. This is compensation exclusive of practice
21 expenses incurred. As you know, we have worked with the
22 Medical Group Management Association and the Urban Institute

1 for a study that considered, one, the actual compensation
2 received by physicians and, two, the compensation simulated
3 as if all services were paid under Medicare's physician fee
4 schedule. Based on data for 2007, actual compensation,
5 averaged across all specialties, was about \$273,000 per
6 year. As expected, simulated Medicare compensation for all
7 specialties was lower, about 12 percent lower, at \$240,000.

8 By specialty, we see disparities. Some are due to
9 hours worked, and I will get to that in a minute.

10 Otherwise, actual versus simulated Medicare compensation
11 varies in a way that is consistent with what we know about
12 differences between Medicare and private payer rates. But
13 the bigger disparities are not so much within the specialty
14 and whether it's actual versus simulated Medicare
15 compensation. The biggest disparities lie in how
16 specialties compare to each other, and it appears that the
17 highest compensation is going to those who furnish high-
18 volume growth services.

19 We see those disparities when we look at hourly
20 compensation -- a measure that accounts for differences
21 among specialties and hours worked per week. The specialty
22 groups with the highest hourly compensation were the

1 nonsurgical procedural specialties and, separately,
2 radiology. Nonsurgical procedural specialties had
3 compensation that averaged \$239 per hour; for radiology, the
4 average was \$244 per hour. These rates were more than
5 double the \$114 rate for primary care. Use of Medicare, of
6 simulated Medicare hourly compensation instead of actual
7 hourly compensation resulted in some narrowing of the
8 disparities between primary care physicians and specialists,
9 but it was minimal.

10 The data on physician compensation raised concerns
11 about equity and the future of the practitioner workforce.
12 First, mispricing can lead to compensation skewed in favor
13 of some practitioners at the expense of others. In
14 addition, some practitioners can generate volume more
15 readily than others. On the issue of the practitioner
16 workforce, the Commission has voiced the concern that the
17 specialty mix of new practitioners is tilted towards
18 specialists instead of primary care. Research has shown
19 that compensation is an important predictor of specialty
20 choice.

21 Cristina will now present our draft update
22 recommendation.

1 MS. BOCCUTTI: So for the Chairman's draft
2 recommendation for these fee schedule services we have up
3 there, the Congress should update payments for physician fee
4 schedule services in 2012 by 1 percent, and a bit of
5 background for this.

6 So for this year, that's 2010, the update was 0
7 percent from January to May, and then 2.2 percent from June
8 through December. For 2011, the SGR currently calls for a
9 23 percent cut. Then for 2012, the year for which we're
10 making this recommendation, the SGR calls for another 5
11 percent cut and then again in subsequent years.

12 The Commission has stated that it's not supportive
13 of these continued annual cuts, but the difficulty here is
14 of course we don't know what Congress is going to be doing
15 about the updates.

16 Anyway, given the array of factors that we
17 reviewed here in this presentation, that go into this
18 recommendation, there has been generally good access, stable
19 quality, increasing volume. In a need to be fiscally
20 disciplined while maintaining access of physician services,
21 the Chairman is proposing this 1 percent update.

22 Regarding the implications of this recommendation,

1 the spending effects are, of course, large because any
2 increase would be scored relative to the cuts that are in
3 current law. Additionally, this update would increase
4 beneficiary cost-sharing and premiums, again relative to
5 current law for 2012, and would enhance the physician
6 acceptance of Medicare patients.

7 And now this next slide here discusses a little
8 bit about some future work for the Commission. With respect
9 to payments for physicians and other health professionals,
10 the Commission will focus on two issues in future work,
11 namely, enhancing access to high-quality primary care and
12 also changing current SGR payment policies.

13 The Commission will discuss ways Medicare can
14 promote primary care to sustain beneficiary access to it.
15 Good, accessible primary care is an essential component of a
16 well-functioning delivery system, and it's also crucial for
17 patient management, especially for patients with multiple
18 chronic conditions.

19 Regarding the SGR, the Commission recognizes that
20 in addition to the budgetary implications overriding it,
21 Medicare is facing another cost -- the frustration of
22 providers and their patients stemming from the uncertainty

1 of future Medicare payments. Often referred to as temporary
2 fixes, these stop-gap measures have become increasingly
3 problematic for providers and burden CMS's resources. So we
4 can explore changes to the SGR that include options that
5 would retain the advantages of an expenditure target system
6 while making adjustments to minimize the disadvantages of
7 that.

8 So with that said, we're going to move next to
9 Ariel and his ASC.

10 MR. WINTER: Thank you. I'd like to start by
11 acknowledging the work of Dan Zabinski who did much of the
12 work involved in this presentation and the draft chapter.

13 We'll start with some basic information about
14 ASCs. Medicare paid \$3.2 billion in 2009 to ASCs, which was
15 an increase of 5.1 percent per beneficiary from 2008. ASCs
16 treated 3.3 million beneficiaries in 2009, an increase of
17 1.2 percent from the prior year. There were 5,260 Medicare-
18 certified ASCs in 2009, an increase of 2.1 percent from
19 2008.

20 In addition, about 90 percent of ASCs have some
21 degree of physician ownership. According to data from a
22 Medical Group Management Association survey, Medicare

1 payments accounted for 17 percent of ASC revenue on average
2 in 2008. CMS increased payments to ASCs by 1.2 percent in
3 2010 and will increase by 0.2 percent in 2011. PPACA
4 reduced the ASC update for 2011 and future years based on
5 the increase in multifactor productivity.

6 Now we'll turn to our measures of payment
7 adequacy, starting with access to ASC services. We examined
8 access by looking at changes in the volume of services and
9 the supply of providers. In terms of volume, there's been
10 an increase in the number of beneficiaries served and volume
11 per fee-for-service beneficiary. Although the trends in
12 volume growth moderated between 2008 and 2009, growth was
13 still positive.

14 In terms of the supply of providers, there was a
15 substantial increase in the number of ASCs from 2004 through
16 2009. The growth rate of new ASCs slowed down during 2009
17 and during the first three quarters of 2010. This slowdown
18 may reflect the economic downturn that occurred in 2008 and
19 the slow recovery from that downturn.

20 We also compared the growth rates of surgical
21 procedures in ASCs and hospital outpatient departments. We
22 found that between 2004 and 2009 the volume of procedures

1 per fee-for-service beneficiary grew much more rapidly in
2 ASCs than outpatient departments, by 6.8 percent per year in
3 ASCs versus 0.1 percent per year in HOPDs. These results
4 may reflect in part a migration of procedures from OPDs to
5 ASCs although other factors may also be playing a role.

6 A shift in services from OPDs to ASCs does offer
7 certain benefits. First, ASCs are likely to offer
8 efficiencies for patients and physicians relative to OPDs.
9 For patients, ASCs may offer more convenient locations,
10 shorter waiter times and easier scheduling. For physicians,
11 ASCs may offer customized surgical environments and
12 specialized staffing.

13 Second, Medicare's payment rates per service and
14 beneficiaries' cost-sharing are generally lower in ASCs than
15 in outpatient departments.

16 However, we are concerned that ASC growth has the
17 potential to increase the total volume of outpatient
18 surgical procedures which could lead to higher program
19 spending. Most ASCs have some degree of physician ownership
20 which creates a financial incentive to perform additional
21 procedures. Recent studies offer limited evidence that
22 physicians with an ownership stake in an ASC perform a

1 higher volume of certain procedures than non-owning
2 physicians. Moreover, there is evidence that physician-
3 owned cardiac hospitals are associated with a higher volume
4 of CABG surgeries in a market.

5 Although there are differences between specialty
6 hospitals and ASCs, the relationship between physician
7 ownership and volume in specialty hospitals may also be
8 occurring in ASCs. Therefore, the growth in ASCs may result
9 in greater overall volume of procedures and not solely
10 represent a shift of services from one setting to another.

11 This slide summarizes our findings on payment
12 adequacy for ASCs. Access to ASC services has been
13 increasing as we have just seen. Meanwhile, access to
14 capital has been at least adequate. We lack data on the
15 cost and quality of ASC services, so we are unable to assess
16 quality of care or to calculate a margin.

17 The Commission has recommended that ASCs be
18 required to submit cost and quality data. These data are
19 important to help determine the adequacy of Medicare
20 payments to ASCs, select an appropriate market basket to
21 update payment rates, and to assess and reward ASC
22 performance.

1 Overall, the measures of ASC payment adequacy are
2 positive and are similar to last year. Therefore, the
3 Chairman is proposing that we rerun last year's
4 recommendation which said that ASCs should receive a 0.6
5 percent payment update and be required to submit cost and
6 quality data. This would produce a small reduction in
7 program spending, and we do not anticipate that it would
8 reduce access to care.

9 This concludes our presentation, and we would be
10 happy to take any questions.

11 MR. HACKBARTH: Okay, thank you. So I think we're
12 starting over on this side, round one clarifying questions,
13 beginning with Karen and Scott.

14 DR. BORMAN: I think we have some pretty plain
15 data about volume of services. I recognize it's perhaps a
16 more challenging thing to get at, but in terms of the level
17 of sophistication or nature of the services because I think
18 that drives the spending part of the equation also. So, for
19 example, within evaluation and management services, it's
20 possible to code at a higher level visit whereas within
21 certain of the other procedures, just in my personal world,
22 not that it's necessarily the perfect, an appendectomy is an

1 appendectomy. So do we have anything that reflects
2 capturing that as a contributor to the expenditure growth?

3 And then somewhat analogously, things that were
4 formerly performed without imaging guidance, whether it be
5 ultrasound, CT, whatever, that now are shifting
6 predominantly to imaging guidance, do we have any way to
7 really parse out whether that's a big factor in driving up
8 the total expenditures because those potentially might
9 impact how we would recommend to deal with the problem?

10 DR. HAYES: So on the issue about changes in
11 coding patterns for E&M services, if we take office visits
12 as an example, there's a table in the chart, or a table in
13 the chapter, that kind of, if you interpret it in a certain
14 way, would get you to that answer.

15 And so if we look, and what we're talking about
16 here then is a difference between just increases in the
17 number of visits verses an increase in how visits are coded,
18 right?

19 And so if we look at -- I'm just looking here now
20 at the changes from 2008 to 2009. We saw a 2 percent
21 increase in the number of office visits, but a 2.7 percent
22 increase in volume -- volume being a measure that

1 incorporates not just the number of visits but also any
2 changes in the coding of them. So you could interpret that
3 difference of 2 to 2.7 as the effect of changes in the
4 coding.

5 DR. BORMAN: So then that point whatever, albeit
6 sounding small, is a pretty significant fraction of the
7 increase.

8 DR. HAYES: That's right.

9 MR. HACKBARTH: Kevin, just one clarification,
10 especially given that we just finished a conversation coding
11 change for hospitals, what I understand you're saying is
12 that the difference between the 2 and the 2.7 percent that
13 you just quoted was not necessarily just a coding change.
14 It could actually reflect the increased intensity of care, a
15 change in the care.

16 DR. HAYES: Oh, of course. One would hope that
17 that's what mostly what it is -- is that it's just change.

18 MR. HACKBARTH: Right.

19 DR. HAYES: So it's not a change in how the codes
20 are defined and how they're used necessarily. So there
21 would be a difference. You know. From what I understand of
22 the DCI change, there would be.

1 MR. HACKBARTH: Exactly.

2 DR. BORMAN: And do we have any ability to parse
3 out how that relates to the availability of using electronic
4 health records because electronic health records make it
5 extraordinarily easy to carry forward a lot of past
6 information that can build documentation toward documenting
7 higher levels of service, without really a change in the
8 care delivery?

9 DR. HAYES: About the only way I can -- just
10 looking at this table, the only way I could come anywhere
11 answering that question would be if we were to contrast the
12 change in 2008 to 2009 versus the average annual for 2004 to
13 2008, an earlier time period, presumably when electronic
14 health records were less prevalent, and so there we see an
15 increase. Contrasting this now with the 0.7 percentage
16 point increase that we talked about a moment ago, we could
17 look here and see 1.7 versus 3. So that's a 1.3 percentage
18 point difference.

19 So it seems like it was a bigger, you know,
20 coding.

21 The other question that you asked had to do with
22 image-guided procedures, and you know we did have occasion

1 to look at that. I'm not sure exactly why, but these things
2 come up. Anyway, the one, there is a lot of growth there;
3 you are right about that. And the other thing to note is
4 that image-guided procedures, there are different
5 technologies, different types of images that one could use
6 for these procedures. So some of it's fluoroscopy, and some
7 of it's CT, and some of it's whatever. I think PET is
8 actually used to some extent for this.

9 In any case, some of the CT changes that you see
10 on this table, for example, advanced CT, other parts of the
11 body other than the head, that would include, that's where
12 those image-guided procedures codes are -- is in that
13 category. So it's in here. It's reflected, but it's not
14 broken out as any kind of a special thing.

15 DR. BORMAN: Recognizing that some of them may be
16 wholly appropriate to do that way, and I don't mean to imply
17 that there's anything necessary inappropriate, just trying
18 to parse out that a shift in medical care has caused a
19 number of these to migrate to more resource-requiring
20 procedures than what have occurred in the past. So trying
21 to relate those to safety or quality gains obviously becomes
22 key, and our ability to do that is pretty limited.

1 So I just wanted to try and get at that point.

2 Thank you.

3 MR. ARMSTRONG: Two fairly straight-forward
4 questions and both related to some concerns about access:
5 My concern frankly is primarily around primary care, and I
6 know that's no surprise, and I realize this decision
7 structure can't really differentiate between primary and
8 specialty services. But still my experience has been that
9 when we survey physician practices they will describe
10 themselves as participating, but they have a lot of
11 discretion over how small a number of appointment slots will
12 be available for Medicare patients. Are we at all through
13 this surveying process able to judge is it either
14 participating or not, or in some way judge the impact of
15 actually narrowing the availability of a practice to new
16 Medicare patients?

17 MS. BOCCUTTI: When you have a physician survey,
18 you can ask the questions. You can be as specific as saying
19 do you limit these slots. I think when MedPAC has performed
20 this, and it has funded some of these studies in the past --
21 I think the most recent was 2006, right -- we did ask those
22 questions. And I think the Center for Studying Health

1 Systems Change asked some of those questions, right, Bob.
2 So it needs to get down to that level of survey.

3 Now the NAMCS -- that is a result that I
4 highlighted -- does not get to that, doesn't specify like
5 that, and they even say "any." It's more like "any"
6 patients rather than "some," "all" or "none." I think
7 that's as simple as some, all or none, and then you get to
8 those slots.

9 So I can go back to some of the literature, but
10 it's going to be dated.

11 MR. ARMSTRONG: Yeah.

12 MS. BOCCUTTI: And to go to those questions needs
13 to fund some -- these are expensive surveys to conduct when
14 you're looking at physician offices.

15 MR. HACKBARTH: Let me try to get your reaction to
16 this, Cristina. If in fact it were true that physician were
17 saying oh, yes, I accept Medicare patients, but they're
18 offering a shrinking number of slots for Medicare
19 appointments, what you would see over time is we'd start to
20 get divergence in our data. Presumably, that would show up
21 in the Medicare beneficiary survey as people saying I'm
22 having more and more problems getting timely appointments,

1 which we're not seeing. So you'd see that gap. So far, we
2 have not, in national surveys, have not seen evidence of it.

3 Having said that, individual markets can differ
4 markedly from the national information that we're presenting
5 here.

6 MR. ARMSTRONG: Thanks, Glenn. Actually, I
7 appreciate your saying that, and that was really the next
8 point I was going to make -- was that I presume the
9 beneficiary survey is meant to try to deal with some of
10 those issues that you come up with when you survey the
11 practices directly.

12 So my next question is actually about the
13 beneficiary survey. Are we surveying Medicare
14 fee-for-service or all Medicare beneficiaries to include
15 Medicare Advantage beneficiaries as well?

16 MS. BOCCUTTI: It's a great question, and
17 unfortunately we've tried to parse out Medicare Advantage
18 beneficiaries, and we've tried a number of ways with a
19 number of different questions. When you get the results,
20 it's clearly that a lot of the respondents are confused
21 about what's being asked. You know. Whether it's a drug
22 plan or MA, it's just too hard to definitively make that

1 separation. So that does mean that the results have both
2 Medicare Advantage and fee-for-service in them.

3 MR. ARMSTRONG: Okay.

4 MS. BOCCUTTI: We've tried to address that. It's
5 just it hasn't come out yet.

6 MR. ARMSTRONG: Okay. Good. Thanks.

7 MS. BOCCUTTI: In order to do the survey, it has to
8 be relatively quick. We have to have a quick turnaround,
9 and the survey can't be too long, to start asking multiple,
10 multiple questions. In the NCBS, they're able to do it
11 because it's a much longer survey.

12 MR. ARMSTRONG: Would it be wrong for me to be a
13 little concerned that we're actually, as a result,
14 overstating the access that we're getting back in the survey
15 results?

16 MS. BOCCUTTI: Maybe you should be more clear about
17 overstating.

18 MR. ARMSTRONG: Well, it's actually not as good as
19 our beneficiary -- not as good in fee-for-service as our
20 beneficiaries would say through the survey tools.

21 MR. HACKBARTH: Scott, we were also surveying
22 privately insured patients in the 50 to 64 age group,

1 presumably many of whom are in various types of managed care
2 plans, and they're saying their access is worse than
3 Medicare beneficiaries. So the fact that we have Medicare
4 Advantage beneficiaries in our Medicare numbers, for all we
5 know, could be pulling the numbers down.

6 MR. ARMSTRONG: Yeah, yeah.

7 MR. HACKBARTH: I'm not offering that as a
8 statement of fact, but we just don't know the direction of
9 the effect of including the Medicare Advantage enrollees in
10 the survey population. Could be up, could be down. We
11 don't know one way or the other.

12 MR. ARMSTRONG: Okay. Great. Thank you.

13 MS. HANSEN: Thank you. Thanks all for this, and
14 Cristina, I appreciate your opening that there was an
15 over-sampling of minority populations. Do other programs
16 that do surveys do that similarly, or is this something that
17 was more specifically done here?

18 MS. BOCCUTI: If any other research is examining
19 that question, they should have over-samples in order to get
20 the statistical power that you need to make assessments.
21 I'm not going to pull them out right now, but I'll be happy
22 to send you some studies. If you're going to be doing a

1 large survey, you're going to be needing to do that to draw
2 conclusions.

3 MS. HANSEN: And then just the second question, on
4 slide number 5, when we described the over 65 population for
5 access, is it usually the new Medicare beneficiary that
6 we're thinking about, or is the end divided up in a way that
7 you can see age breakdown, say the 75 plus as a different
8 cohort?

9 MS. BOCCUTI: We can look at that, and we have
10 before, where the older the beneficiary was, in general, the
11 fewer problems that they had.

12 In past research that CMS has conducted, being in
13 the group of needing to find a physician, you have a little
14 bit more propensity to be in that group of needing to search
15 if you're potentially a new Medicare beneficiary, if you
16 need to switch doctors or that situation, or you've just
17 moved. You know, so those situations. So there may be more
18 younger. It may be likely that that group is slightly
19 younger, and that again supports that we found that in
20 previous examination 85 and olders report fewer problems.

21 MR. HACKBARTH: Ron, can I just for a second go
22 back to Scott for a minute, sort of the gist of some of your

1 questions of hey, there seems to be a disconnect between
2 these numbers and what I hear in Seattle?

3 Whenever I testify on this issue, that is the most
4 common reaction I think we get from members of Congress:
5 Wait a second, I'm getting lots of letters, lots of
6 complaints. There are lots of stories in the local press
7 about the problems that Medicare beneficiaries are having.
8 How does that square with your numbers that make things
9 sound pretty good?

10 I don't know the answer to that. It's sort of
11 unknowable. But I do have a couple hypotheses. One is
12 these are national data, and individual markets can be
13 significantly different, either better or worse than the
14 national average.

15 And I think that's true where I live, in Bend.
16 We've had rapid population growth. Physicians, including a
17 lot of retirees, moving into the area, and the physician
18 supply hasn't kept pace with that and as a result access has
19 deteriorated, but not just for Medicare beneficiaries; for
20 everybody. We've got an imbalanced supply and demand.

21 Another point to keep in mind is that take the
22 issue of finding a new primary care physician. As Cristina

1 says, we're talking about 7 percent of the Medicare
2 beneficiaries looking for a new primary care physician, and
3 of those, roughly 20 percent are saying that they're having
4 a problem, a big or somewhat of a problem. So 20 percent of
5 7 percent, let's say you're talking about a percentage point
6 and a half, round numbers.

7 Well, you know we've got 45, 48 million Medicare
8 beneficiaries. That's a lot of people. You know. We're
9 talking about nationwide 750,000, 800,000 people having a
10 problem. Even when the percentage levels are low, it's
11 still a lot of people.

12 On average, that's 1,500 per congressional
13 district. That will generate a lot of mail and a lot of
14 local newspaper stories, even though at a percentage level
15 on a national basis it's quite low.

16 So those are some ideas I have about this seeming
17 disconnect between the national survey data and what people
18 experience in the local press or in congressional offices.

19 Ron.

20 DR. CASTELLANOS: Thank you. Just to carry on
21 your conversation with Scott, there's no question that this
22 is an area of concern spotty all over the country. I'm not

1 saying the survey you did was wrong because I think it was
2 right at the time you did it, but you know when you look at
3 say page 4 -- maybe just put that up -- 75 percent say they
4 never have a problem. That means 25 percent did, and 25
5 percent of let's just say 40 million is still 10 million
6 people. That's a lot of people.

7 So I don't want to jump on this, but I want to say
8 I think we don't want to underestimate that there's an
9 access problem, and I think for a lot of reasons.

10 On the access problem, I think it was a year ago
11 we had a focus group of physicians, where you had primary
12 care doctors trying to get a referral to a specialist, and
13 some of the primary care doctors had to call three or four
14 times to get the specialist. Has there been any follow-up
15 on that at all because, you know, if I call three times and
16 get a specialist, then I've made a referral? It is a
17 concern, especially a concern in my community.

18 The other issue is -- well, perhaps, Kevin, you
19 can help me on this one. You know. I don't want to dwell
20 on the SGR, and I really appreciate what the Commission has
21 done. Maybe slide 17. We all recognize these SGR problems.
22 We understand about the cuts in SGR. The main thing that I

1 can tell you is that this is the most disruptive thing that
2 I see in the medical community. I think most or all of us
3 feel that way, and I really don't want to dwell on that.

4 I want to dwell on the part that at least this
5 Commission wants to think about changing this and getting to
6 some more appropriate payment policy. I'm ripe for that. I
7 really need to consider doing that. What we're dealing with
8 now, with all these five cuts that we had this year and
9 that, is just intolerable.

10 Kevin, the question I have for you is that under
11 the new -- we just had the new payment rules that just came
12 out, and the final rule in fact just came out a couple of
13 days ago. We have a 23 percent cut, December 31st to
14 January 1st, and prior to that there was a cut that was in
15 the legislature for 6 percent, and under the final rule it's
16 now down to 2.5 percent. You know, this kind of tells me
17 there may be a change in volume or something in 2010, and I
18 wonder if you know anything about it or you could look into
19 that.

20 DR. HAYES: I don't know the answer to the
21 question, but we can look into it and see what the
22 difference is.

1 DR. CASTELLANOS: It's a significant change, and
2 it's something I think may be something that we should look
3 into.

4 As far as -- well, think I'll stop there until
5 round two. Thank you.

6 DR. BAICKER: Just a quick question about the
7 racial disparities, I was very interested in those slides,
8 and I wondered how much of that, if you know, could be
9 attributed to different characteristics of the patients that
10 happen to vary by race, like different income or illness
11 burdens, or differences in where people live. Are minority
12 beneficiaries more likely to live in underserved areas?

13 And I ask that both because I'm interested in the
14 underlying fact pattern but also because it might have
15 different implications for where we might, along which
16 dimensions we might see payments as being inadequate. Is it
17 about particular parts of the country that happen to be
18 where minorities live, so they're disproportionately
19 impacted, but we need to focus on those communities? Or, is
20 it really even within a community there's differential
21 access for those different groups?

22 MS. BOCCUTI: Yes, that is interesting. However,

1 even with these over-samples, there's just no way we can
2 make a community-based assessment from this survey. Even
3 further breakdown with any of these is going to be very hard
4 -- income and all that. It's just going to get very small
5 cell sizes to be able to look at some of that.

6 But we can keep this, and it can help us do
7 further work and talk about trends. And we can talk a
8 little bit more about the finding, but you know, offline,
9 yeah.

10 DR. STUART: A minor suggestion and then a couple
11 of questions: The suggestion is on slide 2. This comment
12 also applies to the chapter and to some of the other
13 chapters. You've denominated -- it's the second bullet.
14 You've denominated the 64 billion on fee-for-service
15 physician services to total Medicare spending. At least for
16 me I think it would be more useful to denominate it for
17 fee-for-service spending, so we have some sense of the share
18 of physician services to other fee-for-service.

19 MS. BOCCUTI: I should put that in the slide. It
20 is percent of fee-for-service. So it doesn't include MA.

21 DR. STUART: Oh, it is percent of fee-for-service
22 total.

1 MS. BOCCUTTI: No. Oh, it is total. It is total.

2 Okay, so of the total. Okay. Good. That's what

3 I thought. Both ways, I'm right.

4 [Laughter.]

5 DR. STUART: Well, you can do it both ways. That

6 would solve the question.

7 DR. MARK MILLER: Take one off the transcript.

8 [Laughter.]

9 MS. BOCCUTTI: We'll talk about that.

10 MR. HACKBARTH: I think this is a good point, and

11 I stumbled across it a couple times too. We ought to be

12 consistent across the chapters in how we're denominating.

13 DR. STUART: Right, and also with changes in the

14 fee-for-service percentage of the population being served.

15 MR. HACKBARTH: Yeah.

16 DR. STUART: You know these numbers change because

17 of that as well.

18 The questions are, first, on slide 20, and it's

19 the top bullet point. I guess I'm having trouble looking at

20 the number for hospital outpatient departments, the increase

21 of a tenth of a percent per year, and reconciling that with

22 what we heard this morning about rapid growth in outpatient

1 services.

2 MR. WINTER: Just to clarify, so that, what we're
3 measuring there is growth in surgical procedures that were
4 covered in ASCs in 2004, which is a subset of all outpatient
5 surgical procedures that were offered, performed in
6 outpatient departments in 2004. The reason for that
7 limitation is we wanted to do an apples-to-apples comparison
8 using the same set of services and OPDs versus ASCs.

9 The other piece of it that's missing is
10 nonsurgical services, things like diagnostic images, clinic
11 visits and those sorts of things, which were growing at 4.5
12 percent per year in outpatient departments over the same
13 timeframe.

14 DR. STUART: It might just be useful because
15 people are going to be going through ultimately reading
16 these chapters sequentially to refer back to the chapter on
17 hospitals, so that we can just make the comparisons, apples
18 to apples.

19 And then the final point, this is real quick.
20 This is on slide 22. I'm wondering how a positive update
21 can lead to a reduction in spending.

22 MR. WINTER: Under current law, ASCs are scheduled

1 to receive an update in 2012 equal to the CPI-U, Consumer
2 Price Index for Urban Consumers, which CMS uses to update
3 ASCs, minus the multifactor productivity. The current
4 projection -- and this could change -- for CPI for 2012 is
5 2.2 percent, and you subtract the most recent estimate of
6 multifactor productivity of 1.3 percent to get 0.9 percent.
7 So that's what we're forecasting, you know, based on the
8 most recent numbers for their update for 2012 under current
9 law. So it's a 0.3 percent difference.

10 MR. HACKBARTH: But let me just highlight again
11 here what I'm proposing, and I welcome reactions to this in
12 round two -- is that we not have a separate vote on an ASC
13 update in this year's package because we don't have any more
14 cost or quality information, in that we simply rerun last
15 year's recommendation in a text box. So there's no right or
16 wrong answer here, but I invite your reaction to that when
17 we get to round two.

18 Nancy.

19 DR. KANE: Just quick one, it looks like the 2011
20 update, even though we recommended 0.6, was only 0.2.

21 MR. WINTER: Correct.

22 DR. KANE: I guess do we have a sense of why there

1 was that difference between. Was there something also under
2 consideration, and do we think that the 0.2 versus the 0.6
3 made any difference in terms of supply adequacy or quality
4 or any of that?

5 MR. WINTER: And you're referring to the 2011
6 update, correct?

7 DR. KANE: [Off microphone.] Yeah.

8 MR. WINTER: So it was 0.2 percent because under
9 PPACA they had to subtract the estimate of multifactor
10 productivity from their market basket. The CPI for the
11 market basket on that was projected to be 1.5, I think, and
12 they subtracted a 1.3 percent for multifactor productivity,
13 yielding a 0.2 update for 2011.

14 And we don't have data yet on 2011, to answer your
15 second question.

16 DR. KANE: And any sense of why ours came out 0.6
17 and theirs came out 0.2 then because we would have -- why
18 did we differ from the update minus the multisector factor?
19 Was it just the numbers changed? The update, you know.

20 MR. WINTER: I mean last year our recommendation
21 for 2011 was 0.6 percent. The rationale was we had made the
22 same 0.6 percent recommendation for 2010, and the indicators

1 of payment adequacy -- and we recognize they are limited
2 compared to other sectors because they don't have cost and
3 quality data -- were similar last year relative to the prior
4 year. So that was part of the rationale for repeating the
5 same recommendation for 2011 that we made for 2010.

6 Glenn, if you want to add anything if I'm
7 misstating that.

8 MR. HACKBARTH: So you know, it's a historical
9 artifact, and the problem that we've had here is that in
10 this sector in particular we've been sort of flying blind
11 with not really much information.

12 DR. KANE: So can we recall our justification for
13 the 0.6? I guess I just wanted to get back to that, I mean.

14 So right now we're saying well, because we did it
15 before and then we did it last year because we did it
16 before. But what was the before? When we originally came
17 up with 0.6, what were we thinking? Do we have a sense of
18 how we got there.

19 Was it that the update factor minus productivity
20 has just -- you know. That's what it was, and now it's just
21 moving along.

22 MR. HACKBARTH: And by 2009, we have it in 2009,

1 and that goes -

2 DR. KANE: But to get the 0.6, was it a formulaic
3 thing or was it a judgment call based on something?

4 MR. HACKBARTH: Rather than our trying to, unless
5 you have a specific recollection, Mark, why don't we just
6 look that up and we can answer that question quickly? If
7 Ariel doesn't remember -- or do you?

8 MR. WINTER: It was a policy judgment. It was a
9 judgment call based on the measures, the payment adequacy
10 indicators, that they were positive, and ASCs had not
11 received an update for 6 years between 2004 and 2009, and so
12 the Commission made a judgment that it was reasonable to
13 give them a modest update of 0.6 percent for 2010.

14 MR. HACKBARTH: And how did it relate to part of
15 what Nancy's asking? Was it linked to market basket? Was
16 it the result of some market-based calculation?

17 MR. WINTER: I don't think that was mentioned as
18 the justification in the chapter. It was probably
19 discussed, you know, at one of the presentations. We can go
20 back and look at the transcript and see what transpired.

21 DR. MARK MILLER: The only reason I balked at it I
22 believe there was a discussion of CPI versus productivity,

1 and there was a talk back and forth on that.

2 MR. HACKBARTH: All right.

3 DR. MARK MILLER: And the only reason I balked is
4 you said formulaic, and I generally view the decisions that
5 come out of here as pretty much a basis of judgment in which
6 people go through and look at different numbers and then
7 reach a judgment.

8 I think the discussion of what productivity was
9 relative -

10 MR. HACKBARTH: What you say, Mark, just triggers
11 a little bit of a memory. You know part of the problem was
12 this is linked to CPI-U, a consumer price, and at the time
13 it was really fluctuating because of the recession. So it
14 was going negative or something.

15 And so we said if we use the statutory market
16 basket, which is CPI, a very volatile number, it just didn't
17 make sense to us. And so we ended up saying we're going to
18 have to choose a number for a modest update, decouple it
19 from the statutory index. We ended up at 0.6, and then
20 that, for the reasons Ariel described we carried that over
21 to the following year.

22 DR. KANE: So I guess consistency being not

1 necessarily what we have to do here, but if that's true has
2 the CPI-U stabilized enough that we want to go back to
3 saying let's do CPI-U minus market basket? Rather than the
4 number that we ended up, use the same process since we have
5 no new data, but the numbers may change.

6 MR. HACKBARTH: We specifically recommended, as I
7 recall, that we would not link any payments to CPI. It just
8 didn't make sense as the foundation for any calculation. So
9 for us to now go back and use that would be inconsistent
10 with our recommendation that we didn't think that made
11 sense. It's a volatile number, unrelated to ASC costs.

12 So, Herb, lead us on.

13 MR. KUHN: Cristina, I want to go back to the
14 issue of the patient surveys. Is there -- and I know, and
15 I've heard the conversation about these being national
16 numbers that are out there. But is there any way to
17 differentiate between urban and rural, and access in rural
18 areas?

19 MS. BOCCUTI: Yes, we have, and there's a little
20 bit of a discussion in the chapter on that. There wasn't
21 much that was statistically significantly different, but we
22 do differentiate on that. Do you want me to elaborate, or

1 do you want to look at that and we can talk later at the
2 table?

3 MR. KUHN: I saw the chapter.

4 MS. BOCCUTTI: Okay.

5 MR. KUHN: And I just wanted to see if there was
6 anything more than that that we had or if that's the extent
7 there is.

8 MS. BOCCUTTI: No.

9 MR. KUHN: Good. That's all I need to know.
10 Thank you.

11 MS. BOCCUTTI: Right.

12 DR. BERENSON: First picking up on the issue that
13 Scott got us into, regarding physician practices that don't
14 see Medicare patients, it's sort of common wisdom in what
15 I've heard from a lot of practices that don't see all
16 Medicare patients, that they will see their own age-in
17 patients -- patients who age into Medicare, where they feel
18 a commitment to the patient -- but not accept new patients.
19 Do we have from previous surveys confirmation of that? Have
20 we asked about that level of detail; do you know?

21 MS. BOCCUTTI: Well, the NAMCS -- well, the one is
22 MGMA recently came out with that kind of question. I happen

1 to have it here. And they have 92 percent of survey group
2 medical practices currently accept new Medicare patients,
3 another 6.5 accept established patients -- that's where
4 you're going -- aging into Medicare, and 1 percent do not
5 accept.

6 DR. BERENSON: That's helpful. The reason I'm
7 asking specifically is again next year is a new environment
8 with lots of age-ins suddenly starting, and it could be that
9 there will be some behavior changes, that practices that are
10 willing to accept a relatively small percentage of new
11 Medicare patients through age-in might. So I think we want
12 to keep our eye on that and look to see what develops over
13 that in the near future.

14 MS. BOCCUTTI: It's hard to get those for that
15 year, the MGMA.

16 DR. BERENSON: Yeah.

17 MS. BOCCUTTI: It's rare that we get something
18 that's that timely. The NAMCS, we just have for 2008, and
19 that does ask about new patients.

20 DR. BERENSON: Yeah. No, I mean in fact the
21 behavior change might take a few years. As there's a
22 cumulative, large number of people moving into Medicare, it

1 might cause some behavior change.

2 DR. BERENSON: Yeah. No, I mean in fact the
3 behavior change might take a few years as there's a
4 cumulative, large number of people moving into Medicare, it
5 might cause some behavior change.

6
7 The next one, last one is for Kevin. On slide 11,
8 we frequently have this information about the percentage of
9 private PPO fees that Medicare pays. In the paper, you have
10 a foot note on methodology. I just want to push a little
11 bit on that, and I guess my issue is these based -- I mean
12 the information is from a large insurer who apparently has
13 national business, et cetera.

14 DR. HAYES: [Off microphone.] Yes.

15 DR. BERENSON: Are we getting the fees from sort
16 of generic fee schedules or are we getting actual paid
17 claims.

18 DR. HAYES: Paid claims.

19 DR. BERENSON: Okay, so that's good. So the only
20 thing I would then -- because the point I was going to make
21 was there's a lot of negotiation outside of the generic fee
22 schedule, but you're capturing that.

1 The new thing that seems to be going on, which I
2 think we need to be attentive to going forward, is that a
3 lot of now practices that have an ability both to improve
4 quality and to have market leverage with plans are not
5 getting higher fees. They're getting it in
6 performance-based payments.

7 In other words, they're achieving certain
8 performance goals. They're getting significant additional
9 payments, and that won't show up as a fee schedule
10 differential, but it's actually a payment change. It might
11 not show up in claims at all. This is not a broad, national
12 thing, but I'm finding it's beginning to happen. And going
13 forward, again as you're thinking of methodologic issues to
14 stay on top of this, I would just point that out.

15 MR. HACKBARTH: So let me ask another question
16 since Bob had the microphone. Maybe even Bob is the right
17 person to answer it. So the draft chapter quotes the work
18 that Urban did saying how much would physicians be paid if
19 everybody were paid at the Medicare fee schedule, and my
20 recollection is that the answer was on average 12 percent
21 less than currently. And then we have this number that
22 Medicare pays at 80 percent, 20 percent less. I think I

1 know how you reconcile those two numbers, but it might be
2 good to explain that.

3 DR. BERENSON: Go for it.

4 DR. HAYES: I'll try it and we'll see what
5 happens. So it's a question of comparison, of the type of
6 comparison that's being made. And so in the case of the 80
7 percent number, it's pure Medicare compared to pure, in this
8 case, PPO rates; whereas, with the -- with the simulated
9 versus actual, we're talking about a simulated being pure
10 Medicare, but the actual is a mix of Medicare, private, even
11 Medicaid. Right? And so you end up with a smaller
12 percentage because of that.

13 DR. BERENSON: And there's a marginal difference
14 because the compensation includes some non-professional
15 revenues from, say, drugs and things that are not
16 comparable. So it's not an exact thing, but if you assume
17 that Medicare is about 30 percent of the average physician
18 practice and you do the calculation, they're very similar
19 numbers. The 12 percent pretty much translates into a 20
20 percent differential.

21 MR. HACKBARTH: George?

22 MR. GEORGE MILLER: I want to thank Kate for

1 teeing the question up about disparities. In the material
2 that you sent us, there was a statement that both
3 minorities, dual eligibles, and Medicaid patients are least
4 likely to go to ASCs, and I don't know if you thought about
5 a policy issue, how to deal with this. It seems to be that
6 this issue is growing over time as we have an increased
7 number of ASCs, increased number of procedures, but the
8 number of dual eligibles, minorities, and Medicaid patients
9 seem to be growing or not getting that same service.

10 I don't know if you have a policy issue,
11 particularly in the material that says the Commission
12 recognizes the benefits of the ASC offer, and I would agree
13 with that statement, but I'm a little concerned about that.
14 If those three groups we just mentioned don't have the same
15 access to that benefit, there is a disconnect, or for me,
16 it's an inequitable situation. So from a policy standpoint,
17 how would the Commission recommend we deal with this
18 disparity?

19 MR. WINTER: Yeah, we didn't attempt to lay out
20 sort of policy options. If you all want to discuss that and
21 suggest ideas for us to pursue, that's certainly in your
22 purview. We just laid out the data in response to your

1 request from last year. We did a similar discussion last
2 year in the chapter and were we could we tried to discuss
3 factors that might lead to this kind of disparity.

4 For example, in dual eligibles, it could be that.
5 Medicare beneficiaries are more likely to go to hospitals as
6 a usual source of care, or to the emergency room.

7 Therefore, when they get outpatient surgery, they go to the
8 hospital instead of the ASC.

9 It could also be linked to the decisions about
10 where ASCs tend to locate relative to hospitals. So we try
11 to explore some of the factors in terms of policy
12 alternatives that we don't go that far and we're open to
13 your suggestions.

14 MR. GEORGE MILLER: But is there evidence that
15 minorities or dual eligibles or Medicaid patients seek out
16 the emergency room or seek out hospital versus an ASC? Is
17 there any evidence that that's true?

18 MR. WINTER: They seek out? I don't have evidence
19 about that. There's one study by John Gable published in
20 Health Affairs in 2008 where he looked at referral patterns
21 for physicians who owned ASCs versus other physicians and
22 found that physician owners of ASCs were much more likely to

1 send their Medicare and commercially-insured patients to an
2 ASC than their Medicaid patients, where they're more likely
3 to send them to the hospital. So on the physician side,
4 there's some evidence there. In terms of the patient side,
5 I'm not aware of any evidence, any research.

6 MR. GEORGE MILLER: Okay. Well, that's
7 problematic to me. If that study is true

8 DR. CASTELLANOS: Can I answer that question?

9 MR. GEORGE MILLER: Sure

10 DR. CASTELLANOS: Because you put it up before. I
11 looked at my ASC and now I understand there's only one out
12 of 5,000. But Medicaid in our state, Florida, will not
13 cover any procedure in the ASC, Medicaid.

14 MR. GEORGE MILLER: Okay. That's one of three.
15 You've got minorities, you've got dual eligibles, and they
16 all seem to be, statistically, not being seen at ASCs. I
17 understand the Medicaid issue. If it's a financial issue, I
18 don't have a dog in that hunt. But if an equally qualified
19 minority who has commercial insurance, and according to this
20 statistic, they're not seen as much as in the physician
21 offices or the ASCs, I've got a problem with that.

22 MR. HACKBARTH: It could be issues of location,

1 where the ASCs are located so we can definitely dig into it
2 some more.

3 MR. GEORGE MILLER: I live in the little town of
4 Springfield. I mean, it's not that big. There's three ASCs
5 in that community, including a specialty hospital. You
6 don't have to drive that far.

7 DR. MARK MILLER: We can do some more thinking
8 about this, but to the extent that there was evidence here,
9 if it is a referral pattern issue, exactly what we're going
10 to do in terms of policy, I think, could get -- and I'd be
11 interested in your views if it comes to that point.

12 MR. HACKBARTH: Okay. Continuing with Round 1
13 clarifying questions. Cori and then Mike.

14 MS. UCCELLO: I'm just going to pick up on
15 something that Bob said about access for folks aging in.
16 The ACA could potentially, in a few years, impact access of
17 the 50 to 64 year olds, even just the privately insured. So
18 that could, in turn, have some effects as people age in to
19 Medicare. So it's a few years down the road, but it's
20 something to keep in mind.

21 Clarification for Glenn on the recommendation of 1
22 percent is, in effect, MEI plus 0.3. Right? Did that

1 factor in? I just kind of want to get more understanding of
2 where that came from.

3 MR. HACKBARTH: The 1 percent is not the result of
4 a calculation related to MEI. I think this -- how many
5 years now? It's at least a couple that we've used the 1
6 percent. We've set a modest update, the really salient
7 point being that we don't think 50 SGR cut should go into
8 effect and that a modest update would be appropriate. My
9 recollection is we've used 1 percent now for at least a
10 couple of years.

11 MS. BOCCUTI: Last year we said the 1 percent.
12 Before it calculated to become about that amount.

13 MR. HACKBARTH: Mike?

14 DR. CHERNEW: I just want to make sure I
15 understand the connection between this recommendation and
16 the SGR. So this is essentially a complete override in the
17 sense that it doesn't need to be paid back. So all the
18 other overrides they do when they go to -- say they were to
19 go to 1 percent legislatively, the standard thing would have
20 been to have to pay it off through some other mechanism.

21 When we recommend 1 percent, if we were, they
22 would still have to do that, or explicitly decide not to.

1 They can't just say, okay, 1 percent, now we don't have to
2 pay for it. So they would still have to either decide to
3 pay for this 1 percent versus the SGR baseline or not, as I
4 think the chapter and Cristina said. I just want to be very
5 clear. Our recommendation has nothing to do with paying for
6 or not paying for. So it should be 1 percent.

7 MR. HACKBARTH: So this would, in fact, be added
8 to the tab. We'd say override the gargantuan cut and
9 substitute 1 percent. That means that the unpaid balance of
10 the SGR bill, if you will, goes up by -

11 DR. CHERNEW: So that's automatic. Right. That's
12 what I'm trying to understand. So if they do that, the way
13 the SGR is written, that unpaid tab portion you just
14 described, that's automatically -- if they don't do anything
15 else, that automatically happens.

16 MR. HACKBARTH: Correct me if I'm wrong. So that
17 implies that the next time they calculate a cut to reach the
18 SGR line, it gets yea bigger.

19 DR. CHERNEW: That's what I wanted to know.

20 MR. GEORGE MILLER: But just to follow up on that
21 point, for example, we can make the recommendation of 1
22 percent and Congress, in its wisdom, could come back and

1 say, well, we're going to take that out of home health or
2 hospitals. It would be nice to know that beforehand.

3 DR. CHERNEW: Exactly, but it does affect the SGR
4 hole that we're in. I just want -- because we're going to
5 vote in this recommendation, and I just wanted to know if
6 this vote had ramifications for the SGR hole.

7 MR. HACKBARTH: It increases the hole, yeah. But,
8 George, if Congress can selectively take any of our
9 recommendations and do whatever they want, mix and match,
10 that's just the world in which we live. That's not unique
11 to this. Peter?

12 MR. BUTLER: One quick comment on this warning
13 light idea on access is a good one. I would think about the
14 survey and do it a different way. I would do a random 500
15 secret shopper. Call the doctors' offices you can. I have
16 an appointment. It would be a different way of kind of
17 surveying this to kind of say, I wonder if there really is
18 -- just a little different twist.

19 But my question relates to the MEI, because I've
20 tried to struggle with the true costs of what does it cost
21 this year versus next year to run a physician's office, and
22 obviously I'm thinking of kind of an EMN coded -- different

1 -- one part of the span. So the MEI has gone up 20 percent
2 over ten years and 0.7 in 2012 and it includes a
3 productivity adjustment for the national GDP productivity
4 growth. So just tell me a little bit more about your
5 assessment of the 0.7 and remind me of the components,
6 because you could say, hey, 1 percent, that's more than the
7 costs increase in the practice. You ought to be able to
8 live with that.

9 DR. HAYES: The 0.7 includes a productivity
10 adjustment. Otherwise, it's based on a forecast of changes
11 in input prices for all the different inputs that go into
12 furnishing physician services.

13 MR. BUTLER: And the productivity piece of it is
14 for this year coming up as what of the 0.7? In other words,
15 what would it be without the productivity adjustment,
16 because I think that's the part that -

17 MS. BOCCUTI: 1.3.

18 DR. HAYES: 1.3.

19 MR. BUTLER: That's the part that people have a
20 hard time swallowing, how many more patients can I see a
21 day. It's not easy.

22 MS. BOCCUTI: So it would be 1.3 plus the 0.7, and

1 then when you take the 1.3 out, so that comes to -

2 MR. BUTLER: So it's 2.0 without -

3 MS. BOCCUTTI: 2.0. You take out the productivity
4 adjustment. This is how CMS, the forecasters -- when you
5 take out the productivity, you get an MEI, an adjusted MEI
6 of 0.7.

7 MR. BUTLER: Right. Got you.

8 DR. NAYLOR: So thank you. A couple quick
9 questions. Do we know how increasing access to other
10 providers affects these outcomes? I know you've seen
11 between 2007 and 2009 a growth in the sense that people have
12 access to primary care practices. So of the 140,000 nurse
13 practitioners, or now we have an increasing federally
14 qualified health centers, nurse-managed health centers,
15 community-based health centers, and they are growing. So do
16 we know how increased access to team-based provided or other
17 provider services, primary care services, influence these
18 outcomes?

19 MS. BOCCUTTI: Well, the MCBS asks about a usual
20 source of care, and in that, they include doctors -- I
21 looked at doctor's offices, doctor's clinics, and thinking
22 it's hard to say what the other clinic -- those are the ones

1 that most specifically, I think -- some of that came to --
2 95 percent of beneficiaries said that that was their usual
3 source of care.

4 DR. NAYLOR: I think given the growth, and
5 especially spawned by the Affordable Care Act going forward,
6 including now. I mean, in the last five years, we've seen a
7 rapid growth of other types of primary care, and including
8 and especially in areas that are serving vulnerable
9 populations, et cetera. So I'm interested in knowing, is
10 that -

11 MS. BOCCUTI: Okay. So if we were putting this in
12 a survey, what would be the right way to characterize
13 another -

14 DR. NAYLOR: I think it's a primary care practice.
15 Even at the growth in our state in the last three years in
16 advanced medical or health homes is predicated on having
17 access to nurse care coordinators. So when people are
18 responding, we need to know what they're responding to,
19 because they would say, I have increased access to such-and-
20 such. So I think we're going to have to make sure that the
21 language of these surveys reflects -- and it might be one of
22 the reasons we're seeing, from 2007, a 70 percent sense that

1 I have access grow to 79 percent just because of how people
2 are interpreting it.

3 MR. HACKBARTH: Do you -- go ahead.

4 MS. BOCCUTTI: Would an FQHC -- and Tom, I'm asking
5 you, too. If we ask the question, and we've been thinking
6 about this, this topic specifically, so forgive me for a
7 minute here. If it was an FQHC, would they respond to that
8 as a primary care practice?

9 DR. NAYLOR: They well might. I mean, so you are
10 going to need to -- certainly if it's a nurse-managed health
11 center, which are going to grow, you need now to make sure
12 that you're distinguishing the various options. But I think
13 we do know that they are responding to access as the, I have
14 access to someone who's caring for me.

15 MR. HACKBARTH: Mary, looking at this from the
16 patient side and patient surveys, do you think that the
17 typical Medicare patient understands the term primary care
18 practice and can relate to the way we frame issues? That
19 would be a question for you. Right now we're asking them,
20 as I understand this survey, can you get to access to
21 routine care when you want.

22 MS. BOCCUTTI: And we say doctor. I don't want to

1 dumb it down so that we don't get the right information, but
2 I want to get information that we can translate clearly.
3 And we often say doctor. But I want to be able to bring
4 this in, so I equally want

5 MR. HACKBARTH: Let's flag this as an issue that
6 we can try to work through.

7 DR. NAYLOR: I was going to say the Commonwealth
8 Fund, we've spent a lot of time on their surveys and they
9 have figured out how to do this in a way that helps you to
10 understand. So I think that would be a great starting
11 point.

12 MR. HACKBARTH: Yes, good.

13 DR. NAYLOR: And the last thing quickly is, when
14 you talk about this 1 percent and it says would increase
15 Medicare spending, will increase beneficiaries' cost
16 sharing, et cetera, 16, can you help me to [off microphone].

17 MS. BOCCUTI: Sure. Oh, the increase. Okay. So
18 considering -- recall this is against a deep cut. So when
19 it just says -- Michael was talking about this is going to
20 be an increase in Medicare spending, well, that gets paired
21 with -- your cost sharing would then be different than it
22 otherwise would be if there was a cut and your premiums will

1 be higher than they otherwise would be if there was a cut.

2 Does that -

3 DR. NAYLOR: This is just directional at this
4 point.

5 MS. BOCCUTTI: Right.

6 DR. NAYLOR: So we don't know exactly what --
7 because it's all I know is depending on the whole picture.

8 MS. BOCCUTTI: Do you want to talk about the next?
9 Well, in the next session, I think we get a little bit more
10 clear. We discuss with CBO, ballpark, so we're not -- we're
11 not in the business of we don't score this, but we make sure
12 that it's in the right realm and in these buckets of what we
13 call the payment. I think Glenn will talk about that more
14 in the next session.

15 MR. HACKBARTH: This also relates back to Mike's
16 question about how the budgetary accounting works for the 1
17 percent increase, and the staff with work with CBO to come
18 up with a number. We don't put a specific point estimate
19 in, but we use sort of buckets. It will be in the biggest
20 bucket. It will be a figure in the tens of billions of
21 dollars.

22 DR. CHERNEW: It's relative to where it would have

1 been, not where it is now. Actually, I can -- say what I
2 was going to say, Mark.

3 DR. MARK MILLER: The reason why -- I know where
4 he was going to go. So in a sense, the baseline says
5 there's going to be a significant reduction in physician
6 payment and then the score is relative to that. But if the
7 Congress were going to come along and not let that happen,
8 then the difference would be much less. And so, in a sense,
9 you can get a gigantic number here and if you calculated a
10 premium increase off of that, you'd be saying, look at the
11 premium increase for beneficiaries.

12 But the difficulty here is, is would the Congress
13 have let this highly scientific cut occur. So answering
14 your question is, we will have these buckets that sort of
15 describe the cost relative to that current law baseline.
16 But you were even, I think, more specific. I'm worried
17 about the beneficiary and the premium, and calculating that
18 premium effect is really squirrely because you don't know
19 exactly what the Congress would have done.

20 DR. CHERNEW: [Off microphone]

21 DR. MARK MILLER: Then they have all that that
22 overlays it. So the kind of factual here starts to get -

1 MS. BOCCUTTI: It's not a big increase from they
2 experience now, which is really, I think, the question,
3 rather than what they would relative to current law of 2012
4 with the SGR cut.

5 DR. DEAN: Just in response to the last
6 discussion, my experience is patients don't make a
7 distinction. They see a role. In fact, most of our mid-
8 level providers get referred to as doctor and it's Dr. So-
9 and-So, even though it's a PA. And I don't know if there's
10 any way to really correct that. Like I say, I think they're
11 responding to a provider in a role and that role is a
12 doctor's role and whether the person has a degree or not
13 isn't really important to them.

14 MR. HACKBARTH: Let's move onto Round 2. Karen?
15 As before, if you could lead with your reaction to the
16 recommendation?

17 DR. BORMAN: I am in my comfort zone with this
18 recommendation with the usual caveats that we have about the
19 SGR, the propriety of it as a platform for the conversation.
20 Not trying to say that this necessarily reflects anything
21 about costs because we don't have physician cost data and so
22 on and so forth. So I'm in my comfort zone with the

1 recommendation.

2 I hope that the community targeted will understand
3 that this is a proactive outreach compared to what, at least
4 legislatively by default, exists. My comments would only be
5 a couple. I think I absolutely support that we need the
6 most sophisticated, the most high quality, most efficient
7 primary care service delivery that we possibly can for the
8 benefit of the Medicare population.

9 I would also point out that we need to just be a
10 little bit careful in understanding that the primary care
11 provider, for some other segments of our population, may, in
12 fact, not be what we typically think of in terms of, just
13 for an example, obstetrics and gynecology and midwives and
14 related other advanced nurse practitioners, oftentimes the
15 primary care provider for women of reproductive age.

16 We would not want to take moves -- we might want
17 to be careful to say, to just remind people we are speaking
18 about a population with multiple chronic diseases, multiple
19 medications and whatever, and that we are targeting some of
20 our commentary about that.

21 Similarly, in the pediatrics world, particularly
22 where there's, I believe, still something of a pediatric

1 subspecialty deficit, we would want to be careful at not
2 trying to generalize to the entire health care system.

3 And then the other piece I would say is that I
4 think coincident with having that spectacular primary care
5 service that we would want to have is we want all of those
6 practitioners, particularly my physician colleagues, to be
7 able to be at the most challenging, top of their license
8 practice environment, and similarly for our nurse
9 practitioner and PA colleagues and whatever.

10 So that coincident with thinking about that is not
11 just how do we make more widgets. It's how do we make a
12 better practice environment that retains people, that
13 leverages them to their skills set.

14 So it isn't necessarily just sort of almost a
15 tacit endorsement of how we're delivering it now, but just
16 throw more bodies at it, that it needs to make sure we're
17 framing the conversation contextually, that similar to this
18 National Workforce Commission, Health Care Workforce
19 Commission and things, we need to think about primary care
20 delivery, not just about the bodies, but also about the
21 roles and the complementary activities that lead to the
22 service that we want to deliver.

1 I think at times in the chapter, we perhaps could
2 do a little better of emphasizing sort of that that's the
3 endpoint, not just playing a number or necessarily money
4 game here. Those things are important and I don't mean to
5 say they're not important, but we have a forest and trees
6 problem potentially there. And to get where we want to go,
7 we want the right number of people, but we want them in the
8 right roles. I think as Tom has alluded to, patients don't
9 necessarily parse that piece out. Certainly my geriatric
10 relatives, who are reasonably well-educated people,
11 certainly would not.

12 MR. ARMSTRONG: I would just tell you I support
13 the direction you're heading with both sets of
14 recommendations. For the second recommendation in
15 particular, I just wanted to amplify how much I agree with
16 the requirement to submit cost and quality data. We haven't
17 really said anything about that, but I just wanted to
18 amplify that point.

19 The only other comment I would make is that the
20 SGR issue aside, it seems that this section and the
21 decisions we're making here really maybe not more so than
22 others, but remind us of all the payment reform issues that

1 we want to talk about, and they get big from bundling
2 payments and ACOs to primary care practices to how -- all
3 sorts of different things. Having said that, I support the
4 direction of these two specific recommendations.

5 MS. HANSEN: I, too, support the two
6 recommendations. I would want to underscore Scott's point
7 about the quality measures that are just going to be
8 absolutely an accountability point, because here we are
9 providing services. So I think the equality of
10 accountability for this spin should be definitely
11 underscored.

12 The second thing relative to the other
13 recommendation that I also support, again I underscore the
14 issue of just the ongoing sensitivity of the beneficiary
15 cost-sharing component, and even though we have a safe
16 harbor year, I think in this process, just our ability to
17 keep an eye on that cost element relative to, frankly, their
18 total income for the average beneficiary.

19 And then finally, as another way to think about
20 the workforce supply in the future as we do studies and,
21 Karen, to your point of having people practice to the top of
22 their preparation and their license, I wanted to just note

1 that last month, the Institute of Medicine came out with a
2 report on the future of nursing and there are 16 states
3 right now that have advanced practice nurses who are really
4 designated as primary care practice individuals.

5 So that number actually probably will continue to
6 grow. So just as we have a large N of baby boomers starting
7 on January 1, there also is a context of primary providers
8 that is beginning to shift in the country. So I think
9 noting the Institute of Medicine report would be really
10 helpful.

11 DR. CASTELLANOS: Let's go ahead and talk about
12 the ASC first. I support that. Two questions I have. I
13 don't understand why we're still using the CPIU. I know we
14 talked about that last year. CPIU has absolutely nothing to
15 do with health care and I would prefer to use the ASC market
16 basket and then we can compare apples to apples.

17 We talked about quality and cost reports. The
18 quality issue is interesting. CMS, in their report to us,
19 at least it was in the literature, saying they didn't have
20 the resources to do this at this time. That's somewhat
21 troublesome. The cost report issues, I've talked to some of
22 the ASC people and they're more than willing to do a scaled-

1 down version of the cost report. That may be something we
2 want to look into.

3 Two things on the physician side, one you can
4 really help us with. The E Prescription, that's a bonus
5 that a physician gets. We get 2 percent this year if we do
6 it by December 31st. Next year it's 1 percent, and then in
7 2012, we get minus 1 percent. CMS has stated they don't
8 have the stuff sort of together to -- and they need a six-
9 month lead time. So unless you have it up and running by
10 July, you're going to get dinged until CMS gets it together.
11 I understand they have resource problems and maybe we could
12 do something to help that.

13 The third thing is, can we have Slide 17 for a
14 second? We talked about primary care levers. That's really
15 important. One of the things we brought up last time is, I
16 think we need to just pay primary care more appropriately,
17 and we talked about care coordination. There are codes
18 there now that are not being funded and that's a big part of
19 primary care. In fact, 40 percent of what primary care does
20 they don't get paid for. So that's something we can look
21 at.

22 The other one that I really don't want to forget

1 is psychiatric care. This is probably the most vulnerable
2 portion of our population. As we discussed last year with
3 them, these doctors drop out of Medicare more than anybody
4 else, they don't participate in Medicare or anything else,
5 they have the lowest hourly wages, and it's a vulnerable
6 population they're taking care of. So I hope, when we look
7 at levers for primary care, we don't exclude psychiatric
8 care. Last year it was excluded under the recommendation we
9 had for primary care.

10 DR. BAICKER: I feel comfortable with the
11 recommendations with the small addition that I think it
12 would be helpful to have a little more information about the
13 carry-forward motivations so that we're sure that the same
14 conditions that generated that apply now.

15 DR. STUART: I support the recommendations.

16 DR. KANE: Yeah, I support the physician one and
17 agree with Kate that it would be helpful to have some sense
18 of what we considered when we first came up with the 0.6 and
19 possibly if there is a better -- I thought we looked at the
20 MEI. I can't remember. If there's a better index that we
21 look at and then if that's been changing in the last two
22 years, that we think about what that implication is. But I

1 like the -- I think the physician one is the best we can do.

2 MR. WINTER: I think my recollection is that we
3 recommended that CMS develop a new appropriate index, or did
4 we recommend a specific alternative? We analyzed this issue
5 last year and presented the results to you. It's in the
6 chapter for March 2010, and in the end, we recommended that
7 CMS collect cost data and use those both to help us evaluate
8 the adequacy of payments, but also to examine whether an
9 existing Medicare market basket or price index would be
10 appropriate for ACS services, the primary candidates being
11 the MEI or the hospital market basket, or whether an ASC
12 specific market basket should be developed. That was our
13 recommendation from last year.

14 DR. KANE: Well, I think if we're throwing out the
15 CPI one, it might be nice to put a different one in and just
16 sort of see if that's changed and if that might change it
17 from 0.6 to something else. I just don't know.

18 MR. HACKBARTH: Well, let me just seek a
19 clarification on ASC. Again, what I have proposed is that
20 we not have a specific recommendation on which we vote on
21 ASCs, because we have no new data to bring to bear on the
22 subject. So in the portion of the chapter that we have on

1 ASCs, we would provide the information in written form that
2 Ariel just summarized in his oral presentation, and then we
3 would have a text box that says, last year this is what we
4 recommended. This year we have no basis for changing that
5 recommendation and so we are not voting on a new
6 recommendation.

7 DR. KANE: Yeah, but that's the question. Is it
8 true that nothing's changed? And if we had been considering
9 some type of market basket something and that's changed, we
10 should take that into account. And it's a really minor
11 thing.

12 DR. MARK MILLER: Where we ended up in that
13 discussion is, the reason that we said this needs to be
14 developed is, is went through and we looked -

15 DR. KANE: I'll go back.

16 DR. MARK MILLER: That's right. We got some cost
17 data and there was some difficulty in how extensive that
18 cost data was, and to the extent that we can compare it, we
19 compared it to the hospital market basket, the practice
20 expense component of the physician and the CPI. And there
21 were sort of parts of it that looked like it kind of behaved
22 like hospital, parts of it that kind of said it behaved like

1 physician, and we said we really didn't have the information
2 to say okay, this is the right measure.

3 So the reason that I think your request is hard is
4 you're saying, tell us whether that thing changed, and we
5 never settled on the thing.

6 DR. KANE: I'll go back and read how we came up
7 with .6 and then I'll decide whether I think there's nothing
8 that's changed. I just can't remember enough how we came up
9 with .6.

10 DR. MARK MILLER: And just to be clear, we have
11 walked through and presented here the data that we do have
12 that has changed in terms of volume and that type of thing,
13 and we can tell you what the change is in the MEI, the
14 hospital market basket, the CPI. It's just your point of
15 like I'm riding one of these horses. We sort of decided we
16 didn't have enough information to pick the horse. That's
17 where we ended up in that discussion.

18 DR. BAICKER: Just to clarify that, I'm totally
19 comfortable saying, here's what we recommended before, we
20 have no better information now. It's different from saying,
21 here's what we recommended before, we have no information
22 that suggests changing that recommendation, implying, so we

1 recommend it again. In that stuff has changed, all the
2 inputs have changed, and there was an update last year that
3 was different from what that update was recommended. So if
4 we really thought that was right last year --

5 MR. HACKBARTH: So it's A that I'm suggesting -

6 DR. BAICKER: And I'm good with that. That's
7 great.

8 MR. HACKBARTH: -- is that we made a
9 recommendation, we really have an inadequate factual
10 foundation to make a recommendation this year, so we're just
11 saying -- we're not even saying roll it over. We don't have
12 the information on this. This is what we recommended last
13 time. We're not voting on it again.

14 DR. KANE: If we're not voting on it, then this is
15 not a big deal.

16 MR. HACKBARTH: Right. We are not voting on it.
17 It's just in a text box that says, this is what we
18 recommended before.

19 MR. KUHN: I support the recommendations.

20 DR. BERENSON: I was going to be that simple, but
21 then I wanted to endorse what Ron just said. In the
22 simulation, the MGMA Urban Simulation, psychiatry, I think,

1 was at the very bottom in simulated income. And it actually
2 does raise the issue of what we used to call cognitive
3 specialties. There was an interesting Wall Street Journal
4 piece a couple years ago about the demise of neuro-
5 ophthalmology. It's a specialty that does sophisticated
6 diagnostic evaluations. They don't have tests. They just
7 get paid for their time and they're going out of business.
8 They're taking out cataracts now.

9 So I think as we do our micro-work on repricing,
10 we should be looking not just around primary care, but at
11 specialties that rely disproportionately on their time and
12 skills, rather than on procedures or tests or things like
13 that.

14 MR. GEORGE MILLER: I support the recommendation
15 for the physician piece. Could you put up Slide 6, please?
16 I'm still a little concerned about the ASCs, particularly as
17 my previous discussion, if you look down at the bottom where
18 you see the minorities, almost three to one, have a big
19 problem finding specialists, and then primarily ASCs are
20 driven by specialists, so that still is a concern to me.
21 Not sure how to address that specifically except for, I
22 think disparity should be a quality of care issue.

1 I don't have a specific recommendation around how
2 to make that quality of care issue, but it seems to me it
3 should be a quality of care issue.

4 Then you have the notion that if both dual
5 eligibles, minorities, and understand Medicaid are going to
6 hospital versus ASC, then that's a cost of care issue
7 because that means that beneficiary is paying more out of
8 pocket to go to a hospital versus an ASC, which we are
9 saying is a lower cost. So that's a double issue, not only
10 a quality of care issue, but they're paying more out of
11 pocket.

12 Again, I think it should be a quality -- disparity
13 is a quality of care issue. I'm not sure how specifically
14 to recommend, but I do want to address that. I think a lot
15 has been said about the outpatient piece. I'm not sure I
16 want to say more, except for remembering the discussion
17 about the hospital portion we had talked about earlier
18 today, tying that somehow or making similar or aligning it
19 similarly with the ASC model. I'm not sure I understood the
20 connection now that we did not have a connection for the
21 recommendation last year or going forward this year.

22 MR. HACKBARTH: I'm not 100 percent sure --

1 MR. GEORGE MILLER: Right.

2 MR. HACKBARTH: -- on quality of care. We said 1
3 percent for hospital outpatient departments.

4 MR. GEORGE MILLER: Right.

5 MR. HACKBARTH: There are two other locations
6 where some of the same services are provided. One is
7 physician offices. The other is ASCs. The physician update
8 recommended is also 1 percent.

9 MR. GEORGE MILLER: That's on the physician side.
10 Right. I got that. The ASC side.

11 MR. HACKBARTH: And there we're not making a new
12 recommendation.

13 MR. GEORGE MILLER: Okay. So we won't vote on
14 anything.

15 MR. HACKBARTH: Cori?

16 MS. UCCELLO: I support the physician
17 recommendation and the non-recommendation for the ASCs, and
18 I look forward to our exploring more of the issues related
19 to SGR, primary care, disparities, and that kind of stuff in
20 the future.

21 DR. CHERNEW: I also support the physician
22 recommendation, although again, like everybody, I think it's

1 difficult to support or even think about in the context of
2 what's either an absurd or shameful way we've treated the
3 physician payment lately. But that's, I guess, not our axe
4 to grind here.

5 I'm going to go against the grain here and say I
6 would rather make a recommendation about ASCs than not, and
7 I think, in fact, we do have new information. We have
8 information about the continued growth in the ASCs and the
9 lack of problems for access to the ASCs. So I don't think
10 the lack of cost data precludes me from thinking about what
11 a reasonable recommendation would be.

12 I guess my preference would be to think through
13 this issue about where payment is relative to the
14 alternative places. You mentioned in an earlier discussion
15 about not wanting to make things worse. This actually does,
16 if I understand correctly, make -- we're not making a
17 recommendation, but if they just continued last year's, that
18 would be a little bit worse because it's 6.6 as opposed to
19 0.1 and 0.1.

20 Incidentally, I would be fine with that because I
21 think these are growing rapidly and I think it's an issue.
22 I think I'm not sure how silence would be taken. So the

1 lack of information doesn't bother me that much, and having
2 a recommendation that's in the range of -- you know, I'm
3 easy enough. You could probably get me to support a wide
4 range of things that are reasonable, but --

5 DR. MARK MILLER: 0.6.

6 DR. CHERNEW: -- 0.6. If you would have come in
7 here -- in all honesty, if you would have come in here and
8 said, we're going to vote on 0.6 and here's why, I would
9 have said that seems reasonable and I would have supported
10 that recommendation. I guess I tend to think that I'd
11 rather have a recommendation than not.

12 MR. BUTLER: Actually, I agree with Mike. I don't
13 feel strongly about it. This isn't the biggest service that
14 we have, but it would be better to formalize it. If we
15 don't -- by the way, I'm okay with the 1 percent on the
16 physician side. The way that the language reads now in the
17 text, it kind of reads, maybe if these guys will behave and
18 give us some data, we might give them an increase. Then the
19 last paragraph says, these things are really vital. And it
20 ends, you know, the last sentence, it is vital that ASCs be
21 paid adequately to ensure the beneficiaries have access to
22 this option.

1 So in the absence of a recommendation, at least
2 the language, you read into this, well, what do you want us
3 to do. So that's what kind of tips me more.

4 DR. CHERNEW: Yeah.

5 MR. BUTLER: Even if it's 0.6, this is what we
6 recommended last year, I think it's a little better than
7 having a hanging text box chad.

8 DR. CHERNEW: Right. I agree with that.

9 DR. NAYLOR: It's always hard to follow these two.
10 Anyway, I support the physician recommendation. I hope the
11 language will continue to reinforce how important primary
12 care is to our future. And I look forward, like Cori and
13 everybody else, to the conversation about the future around
14 SGR and primary care. I would go for a 0.58 increase in
15 this so it appears that we actually knew.

16 MR. HACKBARTH: All right. We're clearly into
17 silly time.

18 DR. NAYLOR: Right.

19 DR. DEAN: I support the recommendations. I tend
20 to agree with Mike and Peter that I think it would be useful
21 to state it explicitly about the SGR -- no, not the SGR.
22 Sorry. I would also support what Ron and Bob have said

1 about being sure that we don't get too locked into a narrow
2 interpretation of where our needs really are. Certainly the
3 most overwhelming, biggest, most frightening shortage is in
4 primary care. Everybody agrees with that.

5 But there are other important shortages, and there
6 are some places where you simply cannot get appointments
7 with psychiatrists, and we need them. And there are others.
8 I mean, that's just an example. So I think we wouldn't lose
9 sight of that.

10 I would also comment just briefly on the working
11 to the top of the license issue, which is clearly an
12 attractive concept, but if it's going to work, we really
13 need to make sure that the options are there so that when
14 one reaches the point, we have an easy transition to the
15 next step, whatever that next step may be. And the Fee-For-
16 Service structure really puts a barrier in place.

17 People are oftentimes, whether it's mid-levels or
18 primary care docs or whoever it is, are oftentimes, or maybe
19 I shouldn't say oftentimes, sometimes reluctant to make
20 those connection for fear that patient won't come back,
21 won't be -- they'll lose, they'll be out of the loop, or
22 whatever, and this, I think, speaks really strongly to the

1 whole idea of payment reform that would help to eliminate
2 some of these barriers that I see really interfering,
3 whether -- and it happens at various levels, like I say,
4 whether it's with mid-level providers or primary care docs
5 or whoever.

6 So I think I would just say, as we've all said,
7 that we desperately need payment reform.

8 MS. BEHROOZI: Oh, boy. I wanted to make some
9 points, I guess, out of my lawyerly head, but being at silly
10 time and layering lawyerly on top of that, I risk really
11 losing everybody. But maybe you and I can talk about this
12 offline.

13 But as far as the physician update recommendation,
14 I'm fine with that. But I don't really understand then.
15 We're picking 1 percent, not with any different empirical
16 basis than we had last year for picking 1 percent. Right?
17 So I don't really see the difference between that and
18 recommending that for the year 2012. Right? That's what
19 this is for? And recommending 0.6 on the ASCs for 2012.
20 You can't really carry, you know, just restate last year's
21 recommendation because it actually says for 2011. So you
22 really do have to say we want to say 0.6 for 2012.

1 And I agree with everybody who says the cost and
2 quality data need is so important. Why would we give up the
3 opportunity to actually make a definitive statement by
4 making it a recommendation again, second year in a row, as
5 opposed to just carrying it forward in a text box? So
6 that's, like I said, maybe a little lawyerly approach to it.

7 And the other comment I would make, some of the
8 data that you referred to in the report but wasn't in the
9 charts in terms of the survey of beneficiaries is about
10 people who have not accessed care. Not just who said, oh, I
11 had no trouble getting an appointment or I had a little
12 trouble getting an appointment, but I didn't go the doctor
13 because I couldn't get an appointment or because I couldn't
14 afford it.

15 I think that it's really important, even though it
16 looks, apparently from the way you describe it, it looks
17 like it's looked before in prior years. I think it's really
18 important information to keep front and center as we're
19 looking at racial disparities and economic disparities go
20 hand and hand and are only going to grow as people are
21 retiring with relatively less retirement -- or more people
22 are retiring with relatively less retirement income.

1 Jeff Colgrin and other's study out of U-Penn that
2 looked at low income beneficiaries with high deductible
3 health plans in Massachusetts showed what a huge deal it is,
4 economic barriers to care are for lower income people. And
5 when you talk about the Deficit Reduction Commission or
6 whomever, whichever one them, talking about unified
7 deductibles and things like that, I mean, there are just too
8 many issues that it implicates, I think, to leave it out.
9 So I'd really suggest putting it into the paper. Thanks.

10 MR. HACKBARTH: Thank you. So based on this
11 conversation, Bob, Mark, and I will talk for sure some more
12 about how to handle ASCs, and then I'll be back in touch
13 with you individually about that.

14 As my Round 2 comment, I just wanted to raise the
15 issue of how we portray the Commission's view of the SGR
16 situation; namely, the repeated, very short term extensions
17 and their implications for Medicare beneficiaries and
18 physicians. As I recall the chapter, and help me out, I
19 remember there's a passage where that is mentioned, but my
20 recollection is you have to read pretty far into the section
21 to get to that point.

22 MS. BOCCUTI: It's in the executive summary. We

1 try to pull it out in the executive summary, but yes, it's
2 down closer to the recommendation.

3 MR. HACKBARTH: Yeah, so what we're thinking is,
4 if we can think about how to make that message as prominent
5 and clear as possible. Based on our previous discussions of
6 this, I think that we're in unanimous agreement that this
7 one-month extension thing is a real problem and a growing
8 problem for the program. Given that, I'd like that message
9 to come through clearly and strongly. Okay. Thank you very
10 much.

11 Moving onto the next area, which is outpatient
12 dialysis services, and I was hoping that we would start to
13 close the gap and get closer to being on schedule, but alas,
14 we are falling further and further from the pack. So we've
15 got a new chance to shine here with our next session and we
16 will really be focused and disciplined in our comments. And
17 if we do them when half the Commissioners have gone to the
18 restroom, we will be really -- right.

19 Okay, Nancy, whenever you are ready.

20 MS. RAY: Good afternoon. Outpatient dialysis
21 services are used to treat most patients with end-stage
22 renal disease. In 2009, there were about 340,000 Medicare

1 fee-for-service dialysis beneficiaries, and total fee-for-
2 service spending was about \$9 billion.

3 My presentation today is composed of two parts.
4 First, I'm going to briefly describe the new payment method
5 for dialysis services that begins in 2011. Then we will
6 proceed with our payment adequacy analysis. At the end of
7 today's presentation, I will present the Chairman's draft
8 recommendation about updating the payment rates for calendar
9 year 2012.

10 So MIPPA mandated that CMS modernize the
11 outpatient dialysis payment method. The statute implements
12 a longstanding MedPAC recommendation to broaden the dialysis
13 payment bundle. In 2011, the payment bundle will be
14 expanded from the treatment itself to also include dialysis-
15 related drugs and labs, laboratory services.

16 Your mailing materials include a table that
17 compares key features of the new payment method with the
18 current payment method. I'm going to summarize some of the
19 key features of the new payment method, but I'm happy to
20 answer any specific questions you might have.

21 The new payment method increases the number of
22 patient-level adjustors and there are one set of adjustors

1 for adult and another set for pediatric patients.

2 The new payment method also includes a low-volume
3 adjustment. This adjustment is expected to help rural
4 facilities.

5 The new system makes outlier payments and the
6 outlier payments are applicable to the portion of the
7 broader bundle that was previously separately billable, that
8 is, dialysis, drugs, and labs.

9 There is a four-year transition into the new
10 payment method. As I said, the first year is 2011. The
11 last year is 2014. By November 1 of this year, facilities
12 had the option to opt into the new payment method
13 completely.

14 Now, there are two budget neutrality factors under
15 the new payment method I want to point out. First, MIPPA
16 requires that estimated total payments for dialysis services
17 be 98 percent of the estimated total amount if the new
18 payment method had not been implemented in 2011.

19 Second, to ensure budget neutrality during the
20 first year of the phase-in, again, because facilities are
21 choosing whether or not to opt into completely the new
22 method or to transition in over the four years, CMS has

1 finalized a 3.1 percent transitional budget neutrality
2 adjustment, and this is applied to all payments, both for
3 the facilities completely opting into the new payment method
4 as well as those transitioning in, and I'm going to talk
5 about this a little bit more in a few minutes.

6 MIPPA includes an annual update for the dialysis
7 sector, and this is new for this sector.

8 And finally, the ESRD Quality Pay for Performance
9 begins in 2012. This is Medicare's first P4P program and it
10 is consistent with our 2004 recommendation. In 2012, it
11 will use three clinical performance measures, one on
12 dialysis adequacy and two on anemia, and facilities submit
13 these clinical outcomes on their claims. There is a two
14 percent withhold for this P4P program.

15 So your briefing papers included some potential
16 issues about the new payment method. I want to highlight
17 three in today's presentation.

18 First, there is limited facility-level information
19 on Dialysis Compare. The Commission has previously stated
20 the importance in monitoring the use of services and quality
21 of care under the new payment method. The new payment
22 method might create incentives for facilities to under-

1 furnish care, including therapies used to treat renal-
2 related comorbidities. CMS's Dialysis Compare website could
3 be expanded to include, for example, information that is
4 readily available to CMS, including additional ESRD clinical
5 outcomes, rates of ESRD hospitalizations, and NED visits.
6 CMS through the ESRD networks already provides facilities
7 how they fare in terms of these measures compared to other
8 facilities in their region and nationally.

9 The second issue I want to discuss with you is
10 this 3.1 percent transitional budget neutrality adjustment.
11 Some stakeholders are concerned that this has been set too
12 high. Remember I said that facilities could make a one-time
13 election to opt into the new payment method. Assuming --
14 CMS assumed that the facilities' decision would be based on
15 what resulted in the greatest revenues, which would not be
16 budget neutral, and that is why CMS is making this
17 transitional budget neutrality adjustment. In CMS's
18 projection, they projected that 43 percent of facilities
19 would opt into the new payment method. However, based on
20 the survey conducted by an industry stakeholder group, it
21 may be that 90 percent of all facilities have opted into the
22 new payment method, suggesting that CMS may have taken out

1 more than was needed. CMS has yet to formally announce how
2 many facilities have opted into the new payment method.

3 The last issue I want to talk about concerns the
4 price proxy used in the market basket index for updating the
5 payment rate. The OIG raised concerns about using the PPI
6 as a proxy for the growth in dialysis drug prices. The OIG
7 contends that this will result in updating the payment rate
8 more than it should be, increasing the gap between payment
9 and cost and affecting price accuracy. CMS disagreed with
10 the OIG recommendation for using a different index, stating
11 that the PPI is best as the new payment method moves
12 forward. At issue here is whether the PPI will accurately
13 capture price changes for injectable dialysis drugs that
14 were previously separately paid for under Part B using ASP
15 and drugs that were previously paid for under Part D.

16 So now I'd like to shift gears and I'd like to
17 move to our payment adequacy analysis. Similar to previous
18 years, there's been a net increase in the number of
19 facilities, and over time, the number of freestanding and
20 for-profit facilities has increased. Of the 5,400 dialysis
21 facilities, about 90 percent are freestanding and about 80
22 percent are for profit, and about 60 percent are affiliated

1 with two large national chains.

2 Here, you can see that both the number of rural
3 and urban facilities continues to grow. Urban facilities
4 have been growing by about 3.7 percent per year since 2005
5 and rural facilities at about 3.2 percent per year.

6 We look at several measures to examine access for
7 beneficiaries. One measure we look at is the capacity of
8 facilities by assessing whether the growth in the machines
9 where people are dialyzed tracks dialysis beneficiary
10 growth. For the past five years, dialysis treatment
11 stations have increased by about four percent per year,
12 while all dialysis patients -- and I want to be specific
13 here, that means both Medicare and non-Medicare -- have
14 increased by about four percent per year.

15 There are few facility closures. Between 2008 and
16 2009, there was a net increase of more than 250 facilities.
17 The facilities that closed, which were about 60, are smaller
18 and less profitable. Our preliminary findings suggest a
19 greater representation of African-Americans in these closed
20 facilities. We estimate that this affects about one percent
21 of African-American beneficiaries.

22 That being said, we did look at all facilities,

1 those that remained in business as well as new facilities,
2 and we see that there is little change in the mix of
3 beneficiaries in terms of their age, sex, and race by type
4 of provider, that is, freestanding versus hospital-based, et
5 cetera.

6 This year, we looked at whether or not there were
7 any changes in the driving distances in miles for
8 beneficiaries and we looked at it in 2004, 2006, 2008.
9 Longer distances -- researchers have shown that longer
10 distances can affect beneficiaries' adherence with their
11 treatment. And this is also another measure to look at the
12 effect of facility closures. So between 2004 and 2008, we
13 see very little change in the distance that beneficiaries --
14 between beneficiaries' residence and the dialysis facility
15 overall and across the demographic groups.

16 We look at changes in the growth of volume of
17 services, and one item we track each year is the growth in
18 the number of dialysis treatments provided to fee-for-
19 service beneficiaries. And as you can see from this chart,
20 these measures closely track between 2004 and 2009. There's
21 about a two percent increase per year change in both of
22 these measures, and that's what you would want to see.

1 We also look at changes in the volume of dialysis
2 drugs furnished, and recall under the current method,
3 providers receive separate payment for dialysis drugs.
4 First, we look at erythropoietin stimulating agents. ESAs
5 manage patients' anemia, which is a common renal
6 comorbidity. ESAs account for about 70 percent of dialysis
7 drug spending. So between 2005 and 2008, there was a
8 decline in per capita use. This decline was driven by new
9 research that showed cardiovascular risks. However, between
10 2008 and 2009, per capita use increased by about two percent
11 -- there was about a two percent increase in ESA epo units
12 per treatment.

13 We also look at changes in the volume of other
14 leading dialysis drugs. Here, we don't look at the per
15 capita use because of the difference in units between drugs,
16 but we look at aggregate volume and we hold price constant,
17 and here, we see a steady increase since 2004 of about six
18 percent per year.

19 We look at a variety of measures to assess changes
20 in dialysis quality. Quality is moving in the right
21 direction for hemodialysis adequacy. This measures how well
22 the dialysis procedure cleans the patients' blood. A high

1 proportion of patients are receiving adequate hemodialysis
2 and that's good. Quality is moving in the right direction
3 for anemia management. The proportion of patients with
4 their anemia under control, that is, with their hemoglobin
5 between ten to 12, the range recommended by the FDA, is
6 increasing. And more patients are being dialyzed with an AV
7 fistula, and that's the recommended type of vascular access,
8 the site on the patient's body where blood is removed and
9 returned during hemodialysis.

10 That being said, improvements are still needed in
11 other parts of care, and this finding is similar to last
12 year's assessment. Patients' nutritional status has shown
13 little improvement over time. This is of concern because in
14 dialysis patients, researchers have linked this measure to
15 higher rates of hospitalization and mortality.

16 Overall rates of hospitalization are not
17 declining. They have remained steady at about two
18 admissions per year.

19 Overall and first year adjusted mortality rates
20 have decreased during this time. Nonetheless, mortality is
21 relatively high among dialysis patients, particularly
22 compared to international comparisons, even after adjusting

1 for case-mix differences.

2 Finally, the proportion of all dialysis patients
3 registered on the kidney transplant waiting list remains
4 low. Rates of renal transplant between 2007 and 2008
5 dropped across all demographic groups.

6 Regarding access to capital, indicators suggest it
7 is adequate. As mentioned earlier, an increasing proportion
8 of facilities are for-profit and freestanding. And there is
9 an increase in the number of facilities, a net increase in
10 the number of facilities. Analysts remain positive about
11 the two largest dialysis providers. Remember I told you
12 that these facilities account for about 60 percent of all
13 facilities. Our assessments suggest that providers, even
14 the smaller chain providers, have access to private capital
15 to fund acquisitions. Investor analysts appear not to be
16 worried about the effect of the new PPS in 2011.

17 Here is the Medicare margin. This is for both
18 composite rate services and dialysis drugs for 2009. The
19 aggregate margin is 3.1 percent. As in previous years, it
20 is higher for urban facilities than rural facilities and it
21 is higher for facilities affiliated with the two largest
22 chains versus those not affiliated with the two largest

1 chains.

2 We project the 2011 margin at 1.3 percent. This
3 includes the MIPPA two percent reduction, the 3.1
4 transitional budget neutrality adjustment, and the 2.5
5 percent 2011 payment update. This projection also includes
6 a conservative behavioral offset to account for efficiencies
7 expected under the new payment method. There is an
8 expectation by investor analysts that providers will become
9 more efficient with respect to their use of drugs and labs.
10 There is also research that suggests that improvements in
11 efficiencies in drug use and lab use can be made.
12 Currently, there are differences across types of providers
13 in the use of drugs and labs. And other research has shown
14 efficiencies if some providers adhered more closely to
15 national clinical guidelines.

16 So we have arrived at the second part of the
17 update process. The Chairman's draft recommendation reads
18 as follows: The Congress should update the composite rate
19 by 1.5 percent for calendar year 2012.

20 In terms of spending versus current law, this is
21 nearly the same as current law. It's actually a slight drop
22 from current law.

1 And I want to just explain that in terms of the
2 beneficiary copayment effect, what we mean here is that any
3 increase in the payment rate increases beneficiary
4 copayment, but no more than current law.

5 That concludes my presentation and I'll try to
6 answer your questions.

7 MR. HACKBARTH: Thanks, Nancy.

8 Could you put up Slide 10 for a second. So the
9 second bullet, that the closures disproportionately affected
10 selected beneficiary groups, I think that's the first -- is
11 this the first time that we've had that finding?

12 MS. RAY: No. Actually, we had that finding
13 several years ago. I'd have to go back and look up --

14 MR. HACKBARTH: Okay.

15 MS. RAY: Not in the past two or three years, but
16 going back further than that, we've had this before.

17 MR. HACKBARTH: Okay. Mitra, Round 1 clarifying
18 questions, Tom, Mary, Peter.

19 MR. BUTLER: A quick question. We get cost
20 information for this. Is there any lesson learned for our
21 previous discussion about the kind of costs that, you know,
22 on ASCs where we may be looking for cost information? What

1 led to us to gather cost information in outpatient dialysis
2 where we haven't, for example, in ASCs?

3 MS. RAY: Oh, well --

4 MR. BUTLER: Or is the amount that's requested
5 something we can learn from so that we can --

6 MS. RAY: I mean, HCFA has --

7 MR. HACKBARTH: From the beginning, almost, of the
8 --

9 MS. RAY: Yes.

10 MR. HACKBARTH: -- the ESRD program, to my
11 recollection, they've collected it right from the outset.

12 MS. RAY: I mean, dialysis facilities -- I hope
13 I'm not misspeaking here -- dialysis facilities, I mean, are
14 an institutional provider, so like hospitals and SNFs, they
15 submit cost report information. So going back through, I'd
16 say at least 1981, 1982 --

17 MR. HACKBARTH: I can't remember.

18 MS. RAY: Yes --

19 MR. HACKBARTH: I've been doing this for a while.
20 I can't remember -- back to 1981, and I can't remember a
21 time that we didn't have cost information on dialysis.

22 MS. RAY: I mean, that's how the original

1 composite rate was set back for 80 --

2 MR. KUHN: And the big distinction, if you
3 remember, from ASCs, there were eight different buckets that
4 basically ASC pricing went into. So to a degree, there
5 wasn't any need to collect that cost information because it
6 was a very crude, antiquated payment system under the old
7 ASC model, and that was another reason why they just didn't
8 collect cost information there.

9 MR. HACKBARTH: Round 1 clarifying questions,
10 Mike, Cori.

11 MS. UCCELLO: Just a quick question, and this may
12 be in the paper but I can't remember. This issue of the, I
13 think it was the change that had the better -- was it the
14 better margins? And so is it because of cost, lower cost
15 due to economies of scale or is something else going on?

16 MS. RAY: There is an economies of scale issue,
17 for sure.

18 MR. HACKBARTH: A purchasing power advantage for
19 the large chains, yes.

20 George?

21 MR. GEORGE MILLER: Thank you for this report.

22 You said that CMS estimates about 50 percent of the dialysis

1 centers would choose to take a new system, but did I hear
2 you say that actually, or the industry reports about 90
3 percent?

4 MS. RAY: CMS estimated 43 percent --

5 MR. GEORGE MILLER: Forty-three percent, okay.

6 MS. RAY: -- and industry estimates about 90
7 percent.

8 MR. GEORGE MILLER: Okay. So what does that mean?
9 I mean -

10 MS. RAY: What that -- if that number holds out to
11 be true, with -- well, it means a couple of things. It
12 means, number one, that facilities feel like that they can
13 operate under the new payment method.

14 MR. GEORGE MILLER: Yes, sooner.

15 MS. RAY: I mean, that's what it means.

16 MR. GEORGE MILLER: Right.

17 MS. RAY: With respect to the transitional budget
18 neutrality factor, it could mean that it has been set too
19 high.

20 MR. GEORGE MILLER: Okay. So do you have the
21 magnitude of that number? What do we -- if it's set too
22 high, how are we going to address that?

1 MS. RAY: I have not estimated -- because CMS has
2 not released the number of facilities that have opted into
3 the new payment method, I have not estimated what that
4 number should be. I know that there was an industry report
5 of what they thought it should be, and I think it was a
6 little less than one percent, but that was from the
7 industry.

8 MR. GEORGE MILLER: Okay.

9 MR. HACKBARTH: I think the inference we can draw
10 from the number of facilities choosing not to go through the
11 transition but to skip over it --

12 MR. GEORGE MILLER: Right.

13 MR. HACKBARTH: -- is that those facilities or
14 chains -- I assume the chains may be a big part of that.

15 MS. RAY: The two large chains have opted into the
16 new payment method.

17 MR. HACKBARTH: Yes. They see opportunities here
18 under the new payment structure to significantly lower their
19 costs.

20 MR. GEORGE MILLER: Their costs, yes. And a
21 follow-up question. Under the bundling of the new payment
22 system that would include all drugs, what happens if a new

1 drug comes online down the road and provides tremendous
2 savings? Under the new payment method, how will that new
3 drug be paid for or accounted for?

4 MS. RAY: That's a good question --

5 MR. GEORGE MILLER: Thank you.

6 [Laughter.]

7 MS. RAY: I want to go back and look at the
8 specific MIPPA provision. The best I can recollect -- I
9 will get back to you on that. I want to just go back and
10 look at the specific MIPPA provision and whether -- I mean,
11 I know it includes the Part B injectables, ESAs -

12 MR. GEORGE MILLER: Right.

13 MS. RAY: I just want to see the language, the
14 other language with respect to that.

15 MR. GEORGE MILLER: Okay. I will save the rest
16 for Round 2.

17 DR. BERENSON: Yes. Can you go to Slide 14,
18 please. I just want to talk a little bit about the quality
19 areas. It strikes me, not being a particular expert in this
20 area but pretty knowledgeable anyway, that the first
21 nutritional status, phosphorous and calcium management,
22 proportion of patients registered on a kidney transplant

1 list, are quality metrics that are proximately related to
2 whether a dialysis center really can have some impact on.
3 When you're talking about mortality rates for a patient with
4 diabetes, almost by definition, have four or five or six
5 chronic conditions. It's really hard for me to understand
6 sort of the causal relationship or what the control that a
7 dialysis unit would have. I guess, is anybody thinking
8 along my way or are they prioritizing into the areas? I
9 mean, the reason I like urea clearance and anemia management
10 as wonderful measures and where we should be starting pay-
11 for-performance is that those are directly related to what
12 the center has control over. So let me ask that question.

13 MS. RAY: Well, I think others do look at the
14 infection-related hospitalizations, again, because that is
15 related to the vascular access, and more use of AV fistulas
16 should reduce infections and therefore reduce
17 hospitalizations --

18 DR. BERENSON: So specific hospitalizations --

19 MS. RAY: Right, right --

20 DR. BERENSON: -- but not just overall
21 hospitalization rates.

22 MS. RAY: And again, that would translate into the

1 mortality, as well. And I think, also, cardiovascular-
2 related hospitalization rates. Again, some would view that
3 -- that has been pulled out separately, for example, like in
4 the U.S. Renal Data System books, looking at that over time.

5 MR. HACKBARTH: And that is something, I think,
6 related. So put up the graph that has the adequacy of
7 analysis, the bar graph. Adequacy of analysis -- adequacy
8 of dialysis. So what was that number again, like 80-some
9 percent?

10 MS. RAY: For what?

11 MR. HACKBARTH: For adequate dialysis.

12 MS. RAY: Oh, that's in the 90s.

13 MR. HACKBARTH: In the 90s.

14 MS. RAY: I'm sorry --

15 MR. HACKBARTH: So is that a function -- and
16 maybe, Bob, you can answer this -- is that a function of the
17 number of treatments per week or the duration of treatments
18 or still other factors?

19 MS. RAY: I would, again, speaking as a non-
20 clinician, I would probably say both the number of
21 treatments as well as the duration.

22 MR. HACKBARTH: Under the payment system,

1 including the new payment system, it's a bundle per
2 treatment --

3 MS. RAY: Yes.

4 MR. HACKBARTH: -- and so there's still an
5 incentive from the facility's perspective to do more
6 treatments. So it would be surprising, given that
7 incentive, to see people not getting enough treatments, and
8 I'm sort of curious as to why --

9 DR. BERENSON: I mean, I think Ron might be able
10 to help here. My understanding is that urea clearance is
11 measuring the success of an individual dialysis and it is
12 not measuring the -- like a hemoglobin A1C is a measure of
13 adequacy of diabetes control over a six-month period, a
14 random blood sugar is just where that patient is at that
15 moment. That urea clearance is really the adequacy of that
16 particular dialysis. That's correct?

17 DR. CASTELLANOS: [Off microphone.] That's right.

18 DR. BERENSON: And so we actually don't have a
19 good measure -- I think the literature is beginning to show
20 that more frequent dialysis gets you better outcomes. We
21 don't have an equivalent of a hemoglobin A1C, I believe, so
22 that we can reward those who are doing more frequent

1 dialyses, but I'm a little out of my league at this point.

2 MR. HACKBARTH: Okay.

3 DR. CASTELLANOS: This is something I deal with or
4 have dealt with in the past and it is a function of the
5 duration of the dialysis and the frequency of the dialysis.
6 It's also a function of the type of dialysis. Peritoneal
7 has less adequacies compared to hemodialysis. But it is
8 related to the duration of dialysis and the time and the
9 frequency.

10 MR. HACKBARTH: Okay. Round 1 clarifying
11 questions. Herb?

12 MR. KUHN: Just, Nancy, one question following up
13 back on this issue of the migration to those that went into
14 the PPS system in the first year versus those that went
15 through the three-year transition. And I appreciate the
16 explanation to George's question. It obviously says that
17 there's plenty of adequacy here, and perhaps as you
18 indicated, the budget neutrality adjustment might be off as
19 a result of that.

20 So my question is this. As new PPS systems come
21 online, there's always a look-back to go back and refine
22 them, because obviously you can't project all the marks out

1 there. And generally, most PPS systems go through a three-
2 or four-year transition and then perhaps a couple of years
3 running them and then it's six years out before the
4 refinements come in place.

5 But this one, with so many of the providers
6 getting in on the first year, what would be the first year
7 we might have data that we could begin to do the look-backs
8 and start to see -- time the refinements? Obviously, I
9 think that would be a much truncated process since so many
10 jumped in the first year. But would it be three years from
11 now when we would have data that we could look at the
12 adequacy of this? Is it something sooner? Is it something
13 later?

14 MS. RAY: I think we won't have data until 2012
15 for the 2011 payment system, and -- yes.

16 MR. KUHN: Okay. So it'd be 2012?

17 MS. RAY: Yes.

18 MR. KUHN: Okay. Thank you.

19 MR. HACKBARTH: This would hardly be the first
20 time that Medicare changed the payment system and evoked a
21 more dramatic response than was anticipated. That was true
22 with the hospital PPS. The changes in patterns of care were

1 quicker and stronger than people anticipated. True in home
2 health and some others, as well. So the good news here is
3 changing the payment methods to encourage efficiency, it
4 works, and obviously we have to take care to make sure we
5 properly measure and reward quality, but this stuff works.

6 DR. KANE: Yes. In the interest of trying to
7 think of measures besides just the clearance for the day of
8 quality, weren't there some kind of before they hit the
9 Medicare level, Medicare eligibility, there's a window of
10 time and how well they're taken care of has an impact on how
11 well their subsequent Medicare period is? I remember this
12 discussion a while back, that there's a period before they
13 go on dialysis, or before they go on Medicare that they're
14 ill and how that gets managed has a big effect on how sick
15 they are when they finally show up for Medicare and whether
16 there's some way to link that to these centers. And I don't
17 know if the centers are the place to look or it's the
18 doctors who are managing them.

19 DR. CASTELLANOS: [Off microphone.] You have to
20 look at the hospitals.

21 DR. KANE: The hospitals that are managing them
22 before they go on dialysis? Just remind me, how long does

1 it -- once a person has end-stage disease, what's the
2 progression between there and when they get on Medicare and
3 start getting treatment?

4 MS. RAY: A person who is under 65 with end-stage
5 renal -- whose doctor certifies that the patient has end-
6 stage renal disease, there's a three-month waiting period
7 and then Medicare -- as long as that individual meets the
8 Social Security, you know, whatever requirements, there's a
9 three-month waiting period unless the patient chooses to
10 undergo self-dialysis training or if the patient is
11 transplanted.

12 DR. KANE: I just seem to remember that we had
13 some concern about what was going on before they ended up in
14 the Medicare program and what happened made a big difference
15 in how well their subsequent Medicare experience was.

16 MR. HACKBARTH: If they're covered by employer-
17 sponsored insurance, then there's a longer period, what, 33
18 months --

19 DR. KANE: Thirty-three months. That's what I
20 remember --

21 MR. HACKBARTH: -- where they're covered.
22 Medicare is secondary --

1 MS. RAY: Yes.

2 MR. HACKBARTH: -- and the employer is primary.

3 MS. RAY: Yes.

4 DR. KANE: And I guess one question is, are the
5 dialysis centers at all places of accountability for that or
6 is it really much more the doctor-hospital? Is there a way
7 to look at that pre-Medicare period when they are most --
8 they can be quite vulnerable to the condition that they end
9 up in when they finally go onto Medicare.

10 MS. RAY: I think some of what you're talking
11 about, the notion that pre-ESRD care, that if a person who's
12 in the Stage IV approaching Stage V of chronic renal failure
13 sees a nephrologist, a specialist, earlier on, that when the
14 person -- if the person eventually ends up to ESRD, that the
15 person won't crash, that there will be a smoother transition
16 and there will be reduced hospital spending. So that's more
17 -- for the under 65 who's not on disability, so not on
18 Medicare, that would be whether they're on other commercial
19 payer or Medicaid and having access -- gaining access
20 earlier on to the appropriate specialty care.

21 MR. KUHN: And even a little further downstream
22 from there, I know CMS is running some demonstrations now.

1 I think the high-cost beneficiary demonstration is looking
2 at CKD or chronic kidney disease and ways to forestall or
3 create the prevention of moving into full renal failure. So
4 there is some better work going on there.

5 DR. KANE: Just in thinking about -- I don't know
6 if you can link it to the quality of the dialysis itself or
7 whether that center's coordination with the other providers
8 is a part of what we want to encourage, but thinking about
9 measures that might also go into this -- again, I'm back on
10 my mode of value and integration and pushing people to look
11 outside their immediate silos to improve the quality -- it
12 might be useful to explore those types of quality measures
13 going forward, and if we ever get to see P4P type things
14 here, that that should be some of it.

15 DR. BORMAN: Just one question. In the materials
16 and in your presentation, Nancy, you mentioned a falling
17 listing on the transplant list, and as a proponent of
18 someone, that that is something that we should look at. My
19 question, however, would be does that reflect a growing
20 shortage of organ donors relative to the number of people on
21 dialysis, or is it that fewer ESRD participants were simply
22 getting evaluated as a potential transplant recipient,

1 because we wouldn't want to say that it's a measure of
2 quality that went down if what it's really reflecting is
3 that there's fewer available organ donors.

4 MS. RAY: Right. That's a good point. And let me
5 be clear that there was -- the percent of people on the wait
6 list -- I mean, I think there was just a -- I mean, it's
7 pretty low, but there was a slight increase. The rate of
8 kidney transplant, there was a decrease in the most recent
9 two-year period. And my recollection is that there was a --
10 I know between 2006 and 2007, there was a drop in the live
11 donor procedures, and I think that partly may be reflecting
12 the 2007 to 2008 numbers.

13 DR. BORMAN: And also a drop in deceased donor --

14 MS. RAY: I need to go back and double-check that.

15 DR. BORMAN: Okay.

16 MS. RAY: There was also between 2007 and 2008 a
17 decline in the rate of newly diagnosed ESRD folks due to
18 diabetes, and that -- again, you don't know how that's
19 playing into everything.

20 DR. BERENSON: I mean, I don't have -- I heard a
21 presentation from a transplant surgeon at Hopkins who feels
22 he's out there suggesting a lack of appropriate referral and

1 that it is a real problem, partly from financial incentives
2 not to refer was his -- I mean, I'm not saying he is right,
3 but there is at least some published literature suggesting
4 that's a problem.

5 DR. BORMAN: And that was the reason that I
6 originally brought it up in a discussion a couple of years
7 ago about ESRD. I just want to make sure that if we're
8 going to stake a statement that it's a quality metric, that
9 we just be sure that we're reflecting those kinds of data as
10 opposed to just mere shifts in the number of people on ESRD
11 versus the number of available organs, because there is a
12 chronic organ shortage, as everyone knows.

13 DR. DEAN: A couple of things. First of all, just
14 a quick thing on the driving distance.

15 MR. HACKBARTH: Could I remind people to say what
16 they think about the draft recommendation as we go through
17 Round 2.

18 DR. DEAN: I'm comfortable with the draft
19 recommendation.

20 On the driving distance, it would be helpful to me
21 to have the range. A lot of things get hidden in an
22 average, and it would be really helpful to know what

1 percentage of people have to go more than 20 miles or 50
2 miles or whatever, because I think that's significant. And
3 you're right, there's a lot of data to say it does affect
4 behavior quite significantly.

5 On the quality issues, as I read through this and
6 also some of the stuff in Tab A about the problems and
7 concerns, it seemed to me that it would really be beneficial
8 to have a much broader-based quality measurement along with
9 some of the things that were listed as hospitalizations,
10 nutrition, I guess, because I think those really are direct
11 things, and there are things that will get missed. I mean,
12 the three that are up there are certainly all reasonable
13 things, but, for instance, hospitalizations due to
14 infections are something that really should be looked at.

15 And the other concern that I have is that the
16 things that get attention are the things that get measured
17 and the worry is that if you have too narrow a measure --
18 too narrow an index of quality, those are the things that
19 are going to get attention and there's a real risk that
20 other things may get pushed aside. So I would really urge
21 that we support a broader-based measure of quality, and I
22 think there are a number of things in the chapter that are

1 actually relatively easy to measure and it would seem to me
2 to be fairly easy to construct a broader-based index,
3 because, I mean, whether it's the albumen levels or numbers
4 of hospitalizations, those are things that are easy to
5 count.

6 DR. NAYLOR: I support the recommendation.

7 MR. BUTLER: I support the recommendation and
8 would, for Glenn's benefit, to make sure that he feels like
9 we're making progress, we've now opined on \$224 billion of
10 expenditures, which is 77 percent of the total. So we're
11 actually three-quarters of the way done.

12 [Laughter.]

13 MR. BUTLER: It just doesn't feel like it.

14 [Laughter.]

15 DR. CHERNEW: If that were only our metric.

16 So I look at the physicians that got one percent
17 update and the hospitals got one percent update and I'm very
18 worried about access in all of those areas, and there's a
19 lot of stuff in here that makes me think I'm not so worried
20 about access. For-profit facilities are entering. There's
21 maybe some efficiencies when we bundle the payment that we
22 haven't figured out if they're exploited. The margins seem

1 sort of to be reasonable, at least -- now, the challenge is
2 this is almost all Medicare in ways, I think, that some of
3 the other ones aren't, so there's some tricks going in
4 there.

5 But I guess I look forward to our call when we get
6 to talk broadly about what this is, but I suppose --

7 [Laughter.]

8 DR. CHERNEW: I'm not not supportive of this
9 recommendation, if everyone supported this recommendation.
10 I think I could have probably seen a lower recommendation
11 and been supportive of that, too.

12 MR. HACKBARTH: [Off microphone.] That's
13 important. As a matter of fact, let me just give people who
14 have already gone an opportunity to react, if they wish --
15 I'm sorry -- give people who have already gone an
16 opportunity to react to what Mike says, if they want to.

17 MS. BEHROOZI: Yes. Actually, being first or last
18 has its problems, and I felt like I didn't really hear
19 enough about why 1.5, why that was the number. So I wasn't
20 quite ready to say, sure, that's great, but I don't know
21 enough to be against it, either, and so -- yes, I guess I --

22 MR. HACKBARTH: Does anybody else want --

1 MS. BEHROOZI: -- why it's different than the
2 others.

3 DR. NAYLOR: I just understood from the
4 presentation and the report about all of these other changes
5 that are going into place at the same time and assumed that
6 this was -- maybe not a good assumption, but because of the
7 two percent reduction by MIPPA, all of this going into play
8 at the same time, that that was the basis. So I could be
9 persuaded --

10 MR. HACKBARTH: Peter?

11 MR. BUTLER: I could be persuaded on one, but at
12 the same time thought that this one did have some careful
13 thought, ended up about where the law is now, and it kind of
14 felt a little bit more sophisticated in terms of how it
15 looked at it than maybe some of our others. So I'd still
16 land on 1.5, but if everybody went with one, I could go with
17 that way.

18 DR. CHERNEW: [Off microphone.] I'm not pushing -
19 - I just want to be clear. I'm not pushing strongly one way
20 or another --

21 MR. HACKBARTH: No --

22 DR. CHERNEW: -- these other areas that --

1 MR. HACKBARTH: This is exactly the process that
2 we need to do, is not just think about the individuals, but
3 also think across the silos and how they relate to one
4 another. So a good comment, and -

5 MS. UCCELLO: Yes, I kind of share some of Mike's
6 thoughts on this, and maybe I need to get over this, but
7 when I look at these, I need to know -- understand a little
8 more where these numbers come from, and looking over --

9 MR. HACKBARTH: Are you talking about the update
10 number?

11 MS. UCCELLO: The 1.5, yes.

12 MR. HACKBARTH: Okay.

13 MS. UCCELLO: And you probably know this, Glenn,
14 but looking at the past recommendations are one, but then
15 the minus two that was in effect -- looking at the projected
16 lower margin, you know, I can see how all of this came
17 about, but, you know, I think there's a range that I could
18 be made comfortable on.

19 MR. HACKBARTH: That's my sense of all the
20 recommendations. There is not a point -- a right number for
21 all of these. For all the years that I have been doing
22 this, it always seemed to me that there was sort of a range

1 of reason that you could be within for any given
2 recommendation. This isn't an arithmetic exercise. This is
3 really about judgment and -- go ahead.

4 MS. UCCELLO: So take that for what it's worth --

5 MR. HACKBARTH: Okay.

6 MS. UCCELLO: -- but I think I also want to echo
7 Tom's comment/concerns about some of these quality issues.
8 I'm concerned about some of these, and to the extent that we
9 can figure out more measures, I think that would be a good
10 thing.

11 MR. GEORGE MILLER: Yes. I want to appreciate and
12 thank Tom for raising the quality issue, because I think
13 between Tom and the statement about why it should be 1.5, I
14 think we should try in the recommendation is to maybe marry
15 those two together, particularly, and Tom mentioned it, in
16 Tab A, there was some angst about the quality in American
17 dialysis centers around America. I'm not saying that's the
18 end-all because the industry came back and pushed back very
19 hard and said all the numbers are wrong, but quite frankly,
20 I remember when the IOM report came out and the hospitals
21 pushed back and said those numbers weren't correct, but from
22 a quality standpoint, when that IOM report came out, the

1 number, rather you debated the number should be zero. There
2 should be zero deaths in America at hospitals, and
3 therefore, I think we had the opportunity here to raise the
4 quality issue, as Tom talked about.

5 And in the chapter, we talked about appropriate
6 dialysis being between 93 and 95 percent, and we thought
7 that was good. Why shouldn't it be at 100 percent? And the
8 same thing for hemodialysis and peritoneal dialysis. Why
9 shouldn't that be the quality goal, to be at 100 percent?

10 So I'd like to make this a pay-for-performance
11 issue around quality, particularly with the margins and the
12 fact that the industry -- if the 90 percent number is
13 correct, they migrated very, very quickly to the additional
14 payment method and this is a good time to put in quality
15 issues, at least in my view.

16 Because I am also then concerned -- the reason I
17 want the quality issues there is, first, because I'm still
18 concerned about the rate of -- the high percentage of
19 Medicare, the high percentage of dual eligibles, and the
20 high percentage of minorities in this group. I'm concerned
21 about the percentage of, for example, African-Americans who
22 are on the renal transplant list and the percentage who are

1 waiting for a kidney transplant. They're both low on the
2 transplant list and yet they make up 32 percent of all
3 patients in end-stage renal dialysis. I find that
4 incredible. There may be good reasons. I haven't read them
5 yet. But I think this is a good time to push the quality
6 issue.

7 So from a policy standpoint, I'd like to see us
8 try to improve the quality standards and then tie them to an
9 improvement, and I, quite frankly, I just don't understand
10 why, as a percentage, African-Americans do not get on the
11 transplant list. I just don't understand that. I think we
12 should set a standard of about a year. It takes time to
13 work them up, but that should be a quality goal, to increase
14 that number, as an example.

15 MR. HACKBARTH: So Nancy --

16 MR. GEORGE MILLER: That's a policy issue --

17 MR. HACKBARTH: -- it may be helpful -- it
18 certainly would be helpful for me if you would just remind
19 us of the link of the new payment system to quality
20 measures. We're going to a new bundle. There is a quality
21 -- a pay-for-performance element in it. Remind us of what
22 the measures are in the pay-for-performance system and how

1 does that work. What are the goals? In order to do well in
2 pay-for-performance, do you have to -- is it an aspirational
3 goal, or is it beat the average, or how does that aspect of
4 it work?

5 MS. RAY: Okay --

6 MR. HACKBARTH: Or hasn't that been decided yet?

7 MS. RAY: Okay. What's been decided is that --
8 okay. The P4P begins in 2012. That's been decided, and it
9 is a two percent withhold. That's been decided. And it
10 uses three measures.

11 MR. HACKBARTH: Right.

12 MS. RAY: It uses a dialysis -- well, I'm sorry.
13 It uses a dialysis adequacy measure, and then it uses an
14 anemia measure of how many are over 12 -- whose hemoglobin
15 is over 12, which is too high, and then under ten, which is
16 too low.

17 MR. HACKBARTH: Right. Then what's the third
18 measure?

19 MS. RAY: I'm sorry, it's -- well, it's one
20 measure on adequacy and two measures on anemia.

21 MR. HACKBARTH: Oh, okay.

22 MS. RAY: Okay?

1 MR. HACKBARTH: Yes.

2 MS. RAY: All right. All right.

3 MR. HACKBARTH: So on adequacy, part of the
4 message I hear George sending is we shouldn't be too easily
5 satisfied --

6 MR. GEORGE MILLER: Right.

7 MR. HACKBARTH: -- with numbers like 90 percent
8 for adequacy.

9 MR. GEORGE MILLER: Right.

10 MR. HACKBARTH: We ought to be really pushing for
11 100. So on the adequacy measure, how is that going to work?
12 If you're at the national average, are you going to do well
13 and get your P4P money for adequacy, or do you have to
14 really excel?

15 MS. RAY: So that's the part that's still -- CMS
16 has issued a proposed rule. The comments have been
17 submitted. A final rule has not been issued on that yet.

18 MR. HACKBARTH: Okay.

19 MS. RAY: And I can come back with you -- come
20 back to you in January with just a little bit more of the
21 specifics, but it's measured against either the -- for each
22 measure, it's measured against either the national average

1 or the facility performance for the first year of the
2 program. And each of the three variables is -- you can get
3 up to ten points. But what CMS has proposed is a higher
4 weight for the anemia under ten than the other two measures.

5 MR. HACKBARTH: Okay.

6 MR. GEORGE MILLER: But nothing addressed the
7 disparities.

8 MR. HACKBARTH: Not in the current set --

9 MS. RAY: Not for 2012, but for beyond, that's
10 something we may want to opine on.

11 DR. BERENSON: First, on the issue that Mike
12 raised, I'm somewhat sympathetic to the point he made. On
13 the other hand, this is a provider who's pretty dependent on
14 Medicare revenues. The margins, the projected margin is 1.3
15 percent, is that what we've got here, and so there's fewer
16 safety valves here. So I'm sort of conflicted. I see your
17 point, and at the same time it may well be that 1.5 is right
18 because of these other factors.

19 Let me -- on the quality, I just would make the
20 following point. I initially was surprised that only, I
21 think, 25 percent of the weight in the pay-for-performance
22 was based on the adequacy of dialysis, but it is over 90

1 percent, whereas the other two measures are down around 60.
2 So I think it sort of makes some sense to emphasize areas
3 where there's more potential gain to be made, so I'm not
4 going to micromanage that decision.

5 With Tom, I would be for more measures. My point
6 earlier, though, is that I would have them be related to
7 what dialysis units do, not to sort of be sort of a global
8 measurement of hospitalization or of mortality, but
9 specifically those related. Now, if we want dialysis units
10 to be medical homes, which in some ways they -- if they had
11 the right personnel, some nurse practitioners, a couple of
12 internists floating around, they could -- and they see a
13 patient three times a week -- they could well become medical
14 homes, in which case we would want to have a different
15 accountability framework. But right now, that's not how it
16 works.

17 Most -- virtually all, I would say, dialysis
18 patients -- well, I'll just -- from my own experience, I had
19 a lot of patients in dialysis, but I was the doctor who was
20 managing their diabetes and their hypertension and their
21 congestive heart failure and it would be hard, I think, to
22 attribute to the dialysis center what was going on with all

1 the other care. If we have ACOs, then the ACO would be
2 responsible to coordinate all of that. So I think we may
3 need a fuller discussion of it. I'm generally in favor of
4 expanding the measurement set, but I know Tom wants to
5 respond.

6 DR. DEAN: It's sort of like the same situation as
7 holding a hospital responsible for readmissions in that the
8 administrators argue, it's outside of our control. I guess
9 my argument would be that, first of all, some of this is
10 under the dialysis center's control, the infections and
11 those kind of things, maybe not total control, but they do
12 have an influence on it.

13 And I think -- I mean, it's an excellent point
14 that this would be a great place for the total care of the
15 patient to be monitored and maybe we could push things in
16 that direction. Maybe we could help with coordination. I
17 don't know. But anyway, I would still argue for a broader
18 index.

19 MR. HACKBARTH: On the first issue of the
20 magnitude of the update and Bob's pointing to the projected
21 1.3 percent margin, Nancy, my understanding -- when you say
22 that's based on conservative behavioral assumptions,

1 conservative in this context means that we may have
2 underestimated how quickly dialysis organizations will
3 respond to the new incentives, so we've been pretty cautious
4 in saying how much they'll change their cost structure?

5 MS. RAY: Yes.

6 MR. HACKBARTH: And on the other hand, we have the
7 evidence that they seem to be leaping at this opportunity,
8 which may suggest that 1.3 is on the -- could be on the low
9 side at the end of the day. Is that a fair -- Nancy?

10 MS. RAY: Yes.

11 MR. HACKBARTH: Okay. Round 2 comments on the
12 recommendation --

13 MR. KUHN: Yes. Just on the recommendation, I
14 think the range we're talking about of one to 1.5 is a good
15 place for us to be discussing this and I'm fine with that.

16 One thing, Nancy, on the quality measures, I'm
17 just curious. Has there been any discussion about a set of
18 CAPS measures for dialysis?

19 MS. RAY: That's still under development, for many
20 years.

21 MR. HACKBARTH: [Off microphone.] So yes.

22 MS. RAY: But it's -- yes. It definitely has not

1 moved as quickly as one might like.

2 DR. KANE: Well, I'm with Mike. I kind of think,
3 given that they're bundling and they see opportunities to
4 create cost savings here, I think I would be more
5 conservative with my update, relatively more conservative.
6 I'm not sure quite where it falls, but I don't know why they
7 would get a better update than a hospital.

8 DR. STUART: If I recall, though, that the
9 hospitals are paying back some of the overpayment. So I
10 think we have to put it in that context.

11 I'm generally comfortable with the recommendation,
12 and if there's further information that comes up before the
13 next meeting, then obviously I'll take that into
14 consideration.

15 I do have a question, though, about the incidence
16 of the disease itself. If you could look at Slide 11, I
17 mean, that looks really steep, but then partly because
18 there's no zero. But if you look at the rate of increase
19 between 2004 and 2009 in terms of the number of people who
20 are on this benefit -- remember, this is just fee-for-
21 service -- the increase is about ten percent over that five-
22 year period. But it's also worth noting that this is a time

1 when there was a dramatic reduction in the total number of
2 fee-for-service beneficiaries because of the increase in MA
3 enrollment. And so it would look as though the -- if you
4 take that into consideration, it could be a much higher rate
5 of incidence if individuals that have this disease stay in
6 fee-for-service.

7 And so my question is, is there any evidence, or
8 do we know the proportion of MA enrollees who are ESRD,
9 because I think we need that information to understand what
10 that rate of increase really is.

11 MS. RAY: So first of all, to be clear, this is
12 the total population, not just incident cases.

13 There has --

14 DR. KANE: [Off microphone.]

15 MS. RAY: Fee-for-service beneficiaries, total --

16 DR. KANE: [Off microphone.]

17 MS. RAY: This is the prevalent population. Okay.
18 All right. And we have seen, according to CMS, an increase
19 in the number of ESRD beneficiaries in MA plans in recent
20 years.

21 DR. STUART: Equivalent to this?

22 MS. RAY: Uh -- I have to go back and calculate

1 the rate of growth. I don't have it for this complete time
2 period. I believe I have it for 2005 to 2008, and I think
3 it -- it's in the paper. It went from something like 22,000
4 to about 43,000. So that's ESRD patients. That can include
5 both dialysis as well as transplant. CMS doesn't break it
6 out just for dialysis versus transplant. There's other
7 measures that suggest that some of that growth is dialysis,
8 though. And I also -- okay. And that's it.

9 DR. STUART: I was going to say, I'd like to see a
10 little bit more on this, because I used the term "incidence"
11 and it well could be that it's because if there's more
12 transplantation and the mortality rate is lower, more people
13 are living longer, and so over time, you get that increase.
14 So trying to understand the underlying nature of this
15 disease within this population, I think, would help us to
16 better understand what the implications of payment are.

17 DR. BAICKER: The general ballpark seems very
18 reasonable to me, but I do -- I am somewhat persuaded by
19 people's thoughts on being a little more conservative,
20 especially in the absence of knowing about selection issues
21 between the plans and what's the differential --

22 MR. HACKBARTH: Conservative being one -- lower or

1 higher?

2 DR. BAICKER: Lower.

3 MR. HACKBARTH: Lower.

4 DR. BAICKER: Lower always seems more
5 conservative, doesn't it? Especially not being sure about -

6 MR. HACKBARTH: [Off microphone.]

7 DR. BAICKER: That's true.

8 [Laughter.]

9 DR. BAICKER: More information on the relative
10 illness and the attractiveness of enrolling diabetic
11 enrolles in Medicare Advantage relative to fee-for-service
12 might be helpful in gauging the magnitude of this update
13 relative to the update for other types of services.

14 DR. CASTELLANOS: I'm going to take a little
15 different approach as far as quality goes. You know, what
16 we're paying for -- what Medicare is paying for is dialysis.
17 They're not paying for management of that patient. They're
18 only paying for management of that patient while he or she
19 is in dialysis. And that's why you have somewhat limited
20 quality measures, hemoglobin, hematocrit, and the
21 effectiveness of appropriateness in the treatment and the
22 dialysis.

1 Now, if you want to increase that bundle and you
2 want to put nephrologists in there or put internists in
3 there that are managing the diabetic patient, then I think
4 we have something else to look at. But we are really paying
5 just for the dialysis. We are not paying for -- we are
6 paying for the management of that patient during dialysis.

7 So I would be a little hesitant before jumping
8 into increasing quality issues. I don't know if -- this
9 bundle just covers dialysis.

10 MR. GEORGE MILLER: How about infections?

11 MR. HACKBARTH: Dialysis special needs plans, any
12 special needs plans that are focused on this population.
13 That is sort of what you would want, is here is a
14 challenging population with a lot of health issues and
15 somebody taking the overall responsibility and looking for
16 all the opportunities --

17 DR. CASTELLANOS: Absolutely, and that's where we
18 should go. I don't want to throw the baby out with the
19 bathwater because there's a lot of good things that we're
20 beginning to see in one of the Medicare programs, and this
21 is the first time we're seeing pay-for-performance as an
22 issue. You don't want to throw that out of the water until

1 you really want to see how it goes.

2 And the other thing is this is the first time we
3 have seen appropriateness criteria applied to anemia
4 management with drug management. This is the first time
5 they've used appropriateness, and this is -- we've talked
6 about this before. I think that's where we have to go in
7 Medicare.

8 MR. GEORGE MILLER: Yes, but Ron, I'm not a
9 physician, but it is the dialysis that causes the anemia,
10 and so shouldn't that be a quality measure and --

11 DR. CASTELLANOS: It's not the dialysis that
12 causes anemia. It's the chronic renal failure.

13 MR. GEORGE MILLER: Well, right, but the dialysis
14 is a function of that, and should --

15 DR. CASTELLANOS: No. The dialysis --

16 MR. GEORGE MILLER: Should not the physician who
17 is managing that dialysis --

18 DR. CASTELLANOS: No, dialysis does not cause --

19 MR. GEORGE MILLER: Well, I shouldn't say cause --

20 DR. CASTELLANOS: It helps getting rid of the
21 byproducts. What happens is the kidneys don't function --

22 MR. GEORGE MILLER: Function, right.

1 DR. CASTELLANOS: -- and that's why you have the
2 anemia. The dialysis doesn't help the anemia at all.

3 MR. GEORGE MILLER: Okay. So that should not be
4 the place where it should be. What you're saying is that
5 should not be the place where it should be monitored.

6 DR. CASTELLANOS: No, I didn't say that.

7 MR. GEORGE MILLER: Okay.

8 DR. CASTELLANOS: I said, this can be one criteria
9 that you measure during dialysis.

10 MR. GEORGE MILLER: Okay.

11 DR. CASTELLANOS: But if you're going to hold
12 somebody responsible for total care, then you really have to
13 go into a special needs program or do something with the
14 total -- these people are train wrecks.

15 MR. HACKBARTH: Yes. So --

16 DR. CASTELLANOS: I mean, Bob, you've seen this.
17 These people have -- comorbidities, 20 percent of them die
18 in the first year.

19 MR. HACKBARTH: So for purposes of this chapter
20 and this report, we can flag the issue of getting the right
21 -- the importance of getting the right quality measures, but
22 deciding exactly how to do that is well beyond the scope of

1 what we can do for this report. So we can come back to it,
2 but we probably need to move on right now.

3 DR. CASTELLANOS: Can I make one more point?

4 MR. HACKBARTH: Sure.

5 DR. CASTELLANOS: And Peter, I was surprised that
6 Peter hasn't picked this up. Five percent of these patients
7 don't have any insurance at all and they're managed in the
8 hospital and the hospital is getting dinged like anything on
9 these patients, okay. So they're providing the total care,
10 and I don't know if that's recognized on the hospital side,
11 but we see very few hospital-based dialysis centers and the
12 ones that you see in the hospital are the train wrecks or
13 the acutes or people without insurance.

14 MR. HACKBARTH: Okay. Jennie?

15 MS. HANSEN: Yes. Sorry I had to step out for a
16 few minutes, so I have just two clarifying questions, back
17 to stage one. What is the average length of time that
18 people are in dialysis? I know people are on a wait list
19 for transplant, but what is the -- is there an average
20 length of time that has been quoted for dialysis users?

21 MS. RAY: You mean before they get a kidney
22 transplant?

1 MS. HANSEN: No, just in general, the average
2 length of stay, so to speak.

3 MS. RAY: Umm -

4 MS. HANSEN: Ron just said, for example,
5 oftentimes if you're very complicated, your survival rate is
6 very short, a year. But on the average?

7 MS. RAY: There is survival -- there's one-year
8 and five-year survival data and I will get back to you on
9 that. I just don't have that right here with me.

10 MS. HANSEN: Sure. That's fine. And then the
11 second clarifying question has to do with the draft
12 recommendation in terms of increased beneficiary cost
13 sharing. Whatever the increase is going to be, there's a
14 correspondence. Is there any information on the fact that
15 cost sharing affects this population more
16 disproportionately, because it's one thing to miss a primary
17 care visit because of the copay, but it's quite different to
18 miss a dialysis treatment because of the copay. Is there
19 any data on that?

20 MS. RAY: So you're -- so let me make sure I
21 understand your question in terms of does the 20 percent
22 affect patients' adherence to coming in for treatment three

1 times a week? Is that what you're getting at?

2 MS. HANSEN: I guess it's actually maybe even a
3 broader question. Is cost of cost sharing an impediment of
4 getting dialysis treatment for this population, because
5 there are -- many people tend to be economically poor, or
6 does Medicaid kick in because it's a dual eligible, in which
7 case it's covered?

8 MS. RAY: I mean, a higher proportion of dialysis
9 patients are dually eligible for Medicare and Medicaid than
10 across -- than compared to all Medicare beneficiaries. That
11 is the case.

12 MS. HANSEN: Okay. Could we have a chart next
13 time just to kind of say what the proportionality is?

14 MS. RAY: Sure.

15 MS. HANSEN: Thank you. And then otherwise, the
16 1.5 to one percent, again, I will wait to hear a little bit
17 more, but it seems within the range.

18 MR. ARMSTRONG: Yes. I would also just agree that
19 that seems like the right range. You know, given how much
20 experience we have with reporting on -- I mean, real
21 information for this population on these services, the
22 relatively sophisticated approach now we're taking to

1 bundling services, given that these programs, these
2 organizations are highly dependent upon Medicare as a source
3 of revenue, relative to some of the other sections and rates
4 we have set, I could make the argument that I would go more
5 toward 1.5 rather than one percent on this particular rate.
6 But I think anywhere in that range seems fine with me.

7 DR. BORMAN: I'm generally comfortable with this
8 range, although I was taken by Mike's points, I think are
9 well taken ones. I do think this is a heavily Medicare-
10 dependent area and so I think we do have to consider that.

11 Just a couple of things. I think that, as Bob has
12 pointed out, the primary manager of the overall individual
13 may vary. It may be someone separate from their
14 nephrologist. In some cases, it is, in fact, a nephrologist
15 who's serving in a dual role, the manager of the dialysis
16 and providing that service, and then the nephrologist who
17 may, in fact, be caring for many things about the patient
18 because their diabetes may, in fact, be the primary thing
19 behind their ESRD and so on and so forth. So I think that's
20 a little bit hard to tease out. I think that if we needed
21 to precisely clarify what's in the service on the physician
22 side, I might suggest going back to the CPT descriptor and

1 what the professional association described as the services
2 that were provided under that.

3 I would say that perhaps it would be fair to
4 consider something like missed dialysis treatments as a
5 quality measure because I think the dialysis center is a
6 part of encouraging the individual to come on a regular
7 basis, and perhaps that might be something in my own
8 experience with patients I would say that they do
9 periodically, opt out of treatment for a variety of reasons,
10 and I think that that potentially could have some use as a
11 measure.

12 I also think that there might be some
13 opportunities relative to monitoring fistula flow rates and
14 how soon intervention happens when abnormal flow rates are
15 detected. So I think as the P4P evolves on this, there will
16 be opportunity for additional dialysis-specific measures.

17 And then, finally, and it's certainly not
18 necessarily a piece of the update, but since we talked about
19 it in terms of the ASCs, we may want to explore a little bit
20 over time whether there are any disclosure issues here. I
21 understand that a goodly chunk of this market is related to
22 publicly-traded companies, but I think a moderate chunk of

1 the remaining market may, in fact, have provider investment
2 and whether or not we should in fairness, since we examine
3 that for other areas, whether we should ask that question
4 here, and it may be that it's a non-issue. But I would just
5 throw that out as part of the future work.

6 MR. HACKBARTH: All right. Thank you, Nancy.

7 So I just looked down at the schedule and I see a
8 session scheduled to end at 4:15 and we're about 4:15. The
9 problem is that it's the next session that was supposed to
10 end at 4:15. So we are just about an hour behind, so I'm
11 going to exhort all of us to be really efficient and let's
12 see if we can close the gap a little bit here.

13 Our next topic is hospice, and, Kim, whenever
14 you're ready.

15 MS. NEUMAN: Good afternoon. We're now going to
16 focus on Medicare hospice services.

17 Before we look at the data, some background on
18 hospice. The Medicare hospice benefit provides
19 beneficiaries with an alternative to intensive end-of-life
20 care. The benefit includes a broad set of palliative and
21 supportive services for terminally ill beneficiaries who
22 choose to enroll. By enrolling, a patient agree to forgo

1 curative care for their terminal condition.

2 More than 1 million Medicare beneficiaries
3 received hospice service in 2009, with total spending of \$12
4 billion. About 42 percent of Medicare decedents in 2009
5 used hospice, with this use rate increasing substantially
6 over the last decade. This growth in hospice use is a
7 positive indicator of increased awareness of and access to
8 hospice services.

9 The hospice benefit was implemented in 1983 on the
10 presumption that it would be less costly to Medicare than
11 conventional end-of-life care. Two major constraints were
12 placed on the benefit:

13 First, to be eligible, a beneficiary must have a
14 life expectancy of six months or less if the disease runs
15 its normal course. Two physicians must initially certify
16 this, and then at specified intervals a hospice physician
17 must recertify this

18 Congress also placed an aggregate cap on the total
19 payments an individual hospice can receive in a year. If
20 the hospice cap amount [about \$22,000 in 2008] multiplied by
21 the number of beneficiaries enrolled by the hospice exceeds
22 total payments to the hospice in that year, the hospice must

1 repay the excess to Medicare.

2 In the past few years, the Commission has spent a
3 fair amount of time on hospice. To recap briefly where
4 we've been, our prior analyses showed rapid growth in the
5 number of hospice providers, mostly among for profits; the
6 number of hospice users has increased; average length of
7 stay has increased, driven by longer lengths of stay among
8 patients with the longest stays. We noted concern about the
9 growth in very long stays because it appeared in part to be
10 driven by incentives in the hospice payment system that make
11 very long hospice stays more profitable than shorter stays.

12 We also identified weaknesses in the
13 accountability of the hospice benefit, including reports of
14 some physicians certifying patients who may not meet the
15 hospice eligibility criteria and questionable relationships
16 between some nursing homes and hospices.

17 To address this, in March 2009 the Commission made
18 recommendations to: reform the hospice payment system to
19 make it better align with hospices' level of effort in
20 providing care throughout an episode; to increase
21 accountability within the benefit; and to collect more data
22 for administration and oversight of the benefit.

1 The Patient Protection and Affordable Care Act
2 includes provisions related to hospice, including some areas
3 touched on by the Commission's recommendations. PPACA
4 allows the HHS Secretary to reform the hospice payment
5 system, as the Secretary determines appropriate, no earlier
6 than fiscal year 2014. PPACA also requires that CMS begin
7 collecting data to inform payment system reform by January
8 2011.

9 In addition, PPACA includes two hospice
10 accountability measures, which are consistent with
11 Commission recommendations. Effective January 2011, a
12 hospice physician or nurse practitioner will be required to
13 have a face-to-face visit with a hospice patient prior to
14 the third benefit period recertification, which is usually
15 180 days, and each subsequent recertification. CMS is
16 required to conduct medical review of hospice claims
17 exceeding 180 days for hospices that have many patients with
18 very long stays.

19 PPACA also includes additional hospice provisions
20 in several areas, such as quality reporting, testing pay for
21 performance, a concurrent care demonstration, and beginning
22 in 2013 adjustments to the market basket updates. I will

1 discuss some of these provisions later in the presentation
2 and would be happy to address others on question.

3 So now we'll take a look at the most recently
4 available hospice data. The number of hospices has
5 increased substantially in the last decade, growing 50
6 percent from 2000 to 2009. This reflects average annual
7 growth of 4.6 percent over the decade and about 2.8 percent
8 growth from 2008 to 2009. The increase in the number
9 hospices has been driven largely by growth in for-profit,
10 free-standing providers. Not shown in the chart, we have
11 seen a modest increase in nonprofit free-standing providers.

12 Hospice use among Medicare decedents has grown
13 substantially in recent years. The percent of decedents
14 using hospice grew from 23 percent in 2000 to 40 percent in
15 2008 and 42 percent in 2009. While hospice use rates vary
16 by demographic and beneficiary characteristics, hospice use
17 rates grew substantially from 2000 to 2008 for all groups we
18 examined: age, race, ethnicity, rural, urban, gender, fee-
19 for-service, managed care, and dual eligibles. From 2008 to
20 2009, use continued to grow among all these groups except
21 Native Americans, whose use in 2009 edged downward one-tenth
22 of a percentage point.

1 Between 2000 and 2009, Medicare hospice spending
2 quadrupled as the number of hospice users and average length
3 of stay increased. In the most recent two years, between
4 2008 and 2009, Medicare spending increased 7 percent, the
5 number of hospice users increased 3 percent, and average
6 length of stay among decedents grew from 83 to 86 days.

7 The increase in average length of stay reflects
8 largely increased lengths of stay for patients with the
9 longest stays. There has been substantial growth in hospice
10 length of stay at the 90th percentile, with an increase from
11 141 days in 2000 to 237 days in 2009. Growth in length of
12 stay at the 90th percentile slowed somewhat in 2009 compared
13 with the more rapid pace seen earlier in the decade. In
14 contrast, the median length of stay has held steady at 17
15 days since 2000, and the 25th percentile is five days.

16 Both the growth in length of stay for very long
17 stays and the persistence of very short stays are a concern.
18 With short stays, there is a concern that beneficiaries may
19 enter hospice too late to receive all the benefits hospice
20 has to offer. With the increase in length of stay among
21 patients with the longest stays, there is concern that
22 financial incentives in the payment system may be driving

1 some hospices to admit patients before they are eligible for
2 the benefit. In fact, there's a group of hospices -- those
3 that exceed Medicare's aggregate payment cap -- that have
4 very long stays across all diagnoses.

5 In 2008, the share of hospices exceeding the cap
6 was roughly 10 percent. Between 2007 and 2008, the share of
7 hospices hitting the cap increased slightly, while the total
8 dollars exceeding the cap declined.

9 Looking at cap hospices, we see that they are
10 almost all for-profit; they have long lengths of stay, even
11 after taking into account patient diagnosis. For example,
12 in 2008, about 47 percent of patients with chronic
13 obstructive pulmonary disease, COPD, had stays exceeding 180
14 days in above-cap hospices compared to 24 percent in below-
15 cap hospices. Hospices exceeding the cap also have a much
16 higher rate of patients being discharged alive than below-
17 cap hospices. In 2008, 44 percent of the discharges from
18 above-cap hospices were live discharges, compared with 16
19 percent in below-cap hospices.

20 The longer lengths of stay and high discharge
21 alive rates for above-cap hospices compared with other
22 hospices may suggest that above-cap hospices are enrolling

1 beneficiaries before they're ready for the Medicare hospice
2 benefit.

3 Currently, there are no publicly available quality
4 data covering all hospices. PPACA requires CMS to publish
5 quality measures by 2012, and beginning in 2014, hospices
6 that fail to report quality data will have their payments
7 reduced 2 percentage points. CMS recently completed testing
8 12 hospice quality measures in seven hospices in New York.
9 The measures tested are generally obtained through
10 abstraction from medical records. Some examples of measures
11 include the percentage of patients with certain symptoms
12 [such as pain, anxiety, or nausea] who received treatment or
13 experienced symptom relief within a specified time period.
14 It remains to be seen whether these or other quality
15 measures will be selected for the public reporting.

16 Now taking a look at access to capital, hospice is
17 less capital intensive than some other provider types. In
18 terms of access to capital among free-standing hospices,
19 publicly traded hospice chains are reporting strong
20 financial performance and likely have solid access to
21 capital; robust entry of for-profit, free-standing providers
22 and modest growth in nonprofit free-standing providers also

1 suggests availability of capital. Hospital-based and home
2 health-based providers have access to capital through their
3 parent providers.

4 Now on to costs. This slide shows the costs per
5 day by provider type. We see that costs per day vary by
6 different provider characteristics. Free-standing hospices
7 have lower costs per day than provider-based hospices. For-
8 profits have lower costs than nonprofits. Above-cap
9 hospices have lower costs than below-cap hospices. Ad rural
10 hospices have lower costs than urban hospices.

11 Length of stay and indirect costs are two factors
12 that contribute to the cost per day differences across
13 provider types. Hospices with longer lengths of stay have
14 lower costs per day. This is consistent with our work
15 showing patients with longer stays receive fewer visits on
16 average per week than patients with shorter stays. Free-
17 standing hospices have longer lengths of stay than provider-
18 based hospices and, consequently, lower costs per day. But,
19 after taking into account differences in length of stay,
20 free-standing hospices still have lower costs per day. This
21 is because free-standing hospices have lower indirect costs
22 than provider-based hospices, which suggests that the costs

1 for provider-based hospices may be inflated by the
2 allocation of overhead from the parent provider.

3 The next slide shows our estimates of aggregate
4 Medicare margins for hospices over time. From 2002 to 2008,
5 the aggregate hospice Medicare margin has fluctuated between
6 4.5 and 6.5 percent. In 2008, the aggregate margin was 5.1
7 percent, down from 5.8 percent in 2007.

8 A couple points about how we estimate margins.
9 Like last year, on the revenue side we exclude Medicare
10 overpayments to cap hospices. On the cost side, consistent
11 with our methodology in the other sectors, we exclude
12 Medicare nonreimbursable costs. This means we exclude
13 bereavement costs and volunteer costs.

14 The exclusion of bereavement and volunteer costs
15 raises an issue. The statute requires that hospices offer
16 bereavement services to the family members of a deceased
17 Medicare beneficiary, but the statute also specifies that
18 bereavement services are not reimbursable. The statute also
19 requires that hospices use volunteers to provide a certain
20 percentage of services. The costs of bereavement and
21 volunteer services are not insignificant. If they were
22 included in our margin calculations, the margins would be

1 1.8 percentage points lower. So in developing his draft
2 recommendation for the hospice update, the Chairman has
3 contemplated this issue.

4 The next slide shows hospice margins overall and
5 by type of provider. Again, the aggregate margin is 5.1
6 percent. You'll notice this is a 2008 margin, whereas we
7 have 2009 margins for other providers. This one-year lag
8 occurs because we get information on hospice revenues from
9 the Medicare claims data, and the claims data have time
10 lags. For 97 percent of hospices, we do have claims data
11 for the 2009 cost reporting year, and margins for these
12 providers increased from 2008 to 2009 by 1.1 to 1.5
13 percentage points.

14 In terms of hospice margins by type of provider,
15 in 2008 free-standing hospices had a margin of 8 percent
16 compared with 2.7 percent for home health-based hospices and
17 -12.2 percent for hospital-based hospices. Part of the
18 reason for these margin differences is the higher indirect
19 costs among provider-based hospices. If home health- and
20 hospital-based hospices had indirect cost structures similar
21 to free-standing hospices, we estimate it would increase
22 their margins by 8 to 11 percentage points. And it would

1 increase the overall industry-wide Medicare margin by 2
2 percentage points.

3 In terms of margins by type of ownership, for-
4 profit hospices had margins of 10 percent compared to 0.2
5 percent for nonprofit hospices. Focusing on free-standing
6 nonprofits whose costs are not be affected by allocation of
7 overhead from a parent provider, margins are higher -- 3.8
8 percent. Urban hospices have more favorable margins than
9 rural hospices. And we also see that margins increase with
10 average length of stay.

11 Looking at providers by average length of stay
12 quintiles, margins increase for each successively higher
13 average length of stay quintile, until the highest quintile
14 where margins dip slightly. The dip in the highest quintile
15 reflects the fact that some hospices in this group exceed
16 the cap and must return overpayments. Above-cap hospices
17 had margins of 19 percent before the return of overpayments
18 and 1 percent after the return of overpayments. Below-cap
19 hospices had margins of 5.5 percent, higher than the 5.1
20 percent industry-wide Medicare margin.

21 Finally, hospices with a high share of patients in
22 nursing facilities and assisted living facilities have

1 higher margins than other hospices. Hospices in the top
2 quartile in terms of percent of patients in nursing and
3 assisted living facilities had a margin of about 13.7
4 percent compared to -3.3 percent for hospices in the bottom
5 quartile.

6 The projected 2011 hospice margin is 4.2 percent.
7 To make this projection, we start with the 2008 margin and
8 take into account the following: full market basket updates
9 to the payment rates for 2009 to 2011; cost growth generally
10 in line with projected input price increases; small changes
11 to the wage index values in 2010 and 2011; a reduction in
12 the hospice wage index budget neutrality adjustment in 2010
13 and 2011, which reduces payments by about 1 percent;
14 additional costs related to the face-to-face recertification
15 visit requirement beginning in 2011.

16 With regard to 2012, there is one additional
17 policy to note. Hospices payments will be reduced an
18 additional 0.6 percentage points in 2012 due to the
19 continued phase-out of the wage index budget neutrality
20 adjustment.

21 So, in summary, the supply of providers continues
22 to grow, driven by for-profit hospices; number of hospice

1 users has increased; length of stay has increased among
2 patients with the longest stays; access to capital appears
3 adequate; the 2008 margin is 5.1 percent; and the projected
4 2011 margin is 4.2 percent; these margin estimates do not
5 include bereavement and volunteer costs, about 1.8
6 percentage points.

7 Taking into account all of these factors, the
8 Chairman has developed the following draft recommendation:
9 "The Congress should update the payment rates for hospice
10 for 2012 by 1.5 percent."

11 The implications of the recommendation would be a
12 decrease in spending relative to current law. We expect no
13 adverse impact on beneficiaries' access to care or
14 providers' willingness and ability to care for Medicare
15 beneficiaries. As you know, this draft recommendation would
16 affect aggregate payments, not the distribution of payments
17 across providers.

18 The Commission has made a recommendation to revise
19 the hospice payment system, which would affect the
20 distribution of payments across providers. In March 2009,
21 the Commission recommended that hospice per diem payments be
22 relatively higher at the beginning and end of the hospice

1 episode and lower in the middle period to better align
2 payments with hospices' level of effort throughout an
3 episode. These reforms would have the effect of changing
4 the distribution of payments across hospices, moving some
5 revenues from hospices that are more profitable to hospices
6 that are less profitable. We plan to re-run this
7 recommendation in the March 2011 report since the Secretary
8 has been given discretion on the structure of a revised
9 payment system.

10 We also plan to re-run a recommendation in the
11 March report for OIG studies of a number of issues, such as
12 hospices/nursing home financial relationships and
13 differences in patterns of nursing home referrals to
14 hospices; enrollment practices of hospices with unusual
15 utilization patterns, and hospice marketing practices. The
16 OIG has work underway in several of these areas,
17 particularly with regard to hospice and nursing facilities.
18 Since many but not all aspects of the recommendation are
19 under study, we plan to repeat the recommendation.

20 With that I conclude my presentation and look
21 forward to your discussion and any questions.

22 MR. HACKBARTH: Thank you, Kim.

1 So round one clarifying questions, starting on my
2 right-hand side.

3 MR. ARMSTRONG: You expressed concern about the
4 cost of volunteers. I thought volunteers were free, so I
5 just didn't understand what that would be.

6 MS. NEUMAN: There is the cost of recruitment of
7 the volunteers and training of volunteers, things of that
8 sort. So the volunteers themselves are free, but the costs
9 associated with getting them and having them do things is
10 not.

11 MR. ARMSTRONG: Okay. In that area, you implied
12 that this cost had some influence over the final
13 recommendation. Did it have very much influence? It was
14 hard to tell from the comments that you made.

15 MR. HACKBARTH: Yeah, I would say it did have some
16 influence. So why don't you put the relevant numbers up
17 there.

18 MR. ARMSTRONG: Slide 17.

19 MR. HACKBARTH: Yeah.

20 MS. NEUMAN: This here?

21 MR. HACKBARTH: Actually, the numbers with the
22 projected margins is the one I was thinking of.

1 MS. NEUMAN: So the 4.2?

2 MR. HACKBARTH: Yeah, so 4.2 percent and the
3 combined bereavement and volunteer expenses were 1.8, as I
4 recall, so these are things that they're required to do but
5 by law aren't -- not by law, but are not counted as
6 allowable costs. And so I'm saying since they're required
7 to do them, it seems to me that they are real costs, and we
8 may want to think about what the margin would be taking them
9 into account, and so we would be down from 4.2 to 2.4.

10 MR. ARMSTRONG: Thank you. That answered my
11 question.

12 MS. HANSEN: This is great. I just wanted to ask
13 the second aspect of the unpaid-for service, which is the
14 bereavement services. I was trying to recall the
15 description. Have we had a description as to what that
16 profile is of the activity around bereavement, what that
17 service amounts to, the frequency? Or did I recall that it
18 goes for an entire year?

19 MS. NEUMAN: I believe it's 13 months after the
20 patient is deceased, and it's for the family members of the
21 Medicare beneficiary. And I don't believe that we have data
22 that gives us a sense of how many visits or what kinds of

1 services that the family members are receiving. But that's
2 something that I can do some more looking at.

3 DR. CASTELLANOS: Good presentation. The
4 concurrent demonstration project, is there any follow-up on
5 that that you know of at this time?

6 MS. NEUMAN: My understanding is that that project
7 is still in development. They have not yet released a
8 timeline for implementation. It's supposed to be up to 15
9 sites where they're going to test what the effect is of
10 allowing folks to elect hospice and continue curative care
11 at the same time. And so it would be a three-year project
12 in up to 15 sites.

13 DR. CASTELLANOS: Any follow-up on the fraud and
14 abuse that was discussed, that issue?

15 MS. NEUMAN: As I stated at the beginning of the
16 presentation, the Congress adopted the recommendation that
17 the Commission made for the medical review of the long stay
18 claims. So we'll see as the year goes forward how that
19 goes. I don't have any additional updates for you right now
20 on fraud and abuse.

21 DR. CASTELLANOS: Hospice excludes some of the
22 Medicare nonreimbursed costs. Does any other provider have

1 that? In other words, they're excluding some of the
2 nonreimbursable charges, you know, the volunteer costs --

3 MR. HACKBARTH: Yeah, there are for other
4 providers costs that providers incur that are not counted as
5 allowable costs. The one that always sticks in my mind is
6 TVs and the hospital cost report and things like that. The
7 difference here, I think -- and people can correct me on
8 this -- is that hospitals are not required to provide TVs,
9 and it's not allowed as a cost. Here hospices are required
10 to provide the volunteers and bereavement services, and then
11 we say it's not allowable. And it's that juxtaposition that
12 makes me think, well, maybe we want to take that into
13 account in our recommendation.

14 DR. CASTELLANOS: Okay. And the last is a
15 rhetorical question. The base rate and the payment rates
16 have really not been recalibrated for almost 37 years. I
17 know we've made some recommendations. Can you give me a
18 good explanation why that hasn't been done?

19 MS. NEUMAN: That's a difficult question to
20 answer. We can refer back to our discussions last year when
21 you made the recommendation to revise the hospice payments.
22 There was some discussion back and forth about aggregate

1 payment levels, and a decision was made to recommend
2 something budget neutral at that time. So to the extent --
3 and that's what the Congress, in fact, put into the law. If
4 the Secretary does change the payment system in 2014 or
5 thereafter, it will be budget neutral. And, you know, there
6 is a question about aggregate payments that we go through
7 every year. That's sort of kind of two separable things.

8 MR. HACKBARTH: Ron, part of what motivated our
9 originally taking a look at the hospice payment system was
10 that it was a system that was developed a long time ago and
11 never really looked at or refined or improved. And as we
12 began to look at it, we thought, hey, it is ripe after 30
13 years for some changes.

14 DR. CASTELLANOS: Thank you.

15 DR. STUART: I have a couple of questions on Slide
16 18. First is a math question, and maybe I'm missing
17 something here, but when I add up the number or the percent
18 of hospices that are for-profit and nonprofit, that's 52
19 percent, if I've got this right, and 35 percent. I end up
20 with 87 percent. Do we have some sort-of-for-profits that
21 are not allocated here?

22 [Laughter.]

1 MS. NEUMAN: There's government and other
2 ownership structures that are missing.

3 DR. STUART: Okay. So they're not included in the
4 not-for-profit.

5 MS. NEUMAN: Correct.

6 DR. STUART: Right, okay. And then remind me, in
7 terms of these profit margins, why do we exclude the cap
8 overpayments? I think what that means is that the real
9 profit that a hospice earns after they pay it back is lower
10 than what we have indicated here. Is that correct?

11 MS. NEUMAN: So if a hospice exceeds the cap, they
12 have to repay the excess back to Medicare. So in our
13 margins, that excess that they have to repay, we don't count
14 that as revenues to them.

15 DR. STUART: Oh, okay. So it's a question about
16 what exclude means here. So when you say that --

17 DR. BAICKER: [off microphone] It's net effect.

18 DR. STUART: -- it excludes the cap overpayments,
19 it means that those are reduced -- those are taken into
20 account in terms of the revenue side.

21 MS. NEUMAN: They're subtracted from the revenue
22 side.

1 DR. STUART: They're subtracted.

2 MS. NEUMAN: Yes.

3 MR. HACKBARTH: [off microphone] -- cost side.

4 MS. NEUMAN: It doesn't affect the cost side.

5 MR. HACKBARTH: Because those aren't allowable --

6 MS. NEUMAN: If they've exceeded the cap, then the
7 policy is that Medicare has paid too much for the care that
8 they've provided, and so they repay some of that money to
9 the government. It doesn't change the amount of costs they
10 incurred to provide that care.

11 MR. HACKBARTH: Okay.

12 MR. KUHN: Kim, just a quick question. If I
13 remember right, those institutions that exceeded the cap are
14 kind of clustered in a set of six or seven states. Is that
15 correct?

16 MS. NEUMAN: Yes, there's definitely a clustering
17 of states, yes.

18 MR. KUHN: And how about the growth? Is that also
19 a clustering, or are we seeing that nationwide?

20 MS. NEUMAN: No, it remains relatively clustered.

21 MR. KUHN: So if that's the case -- and when we
22 measure access, adequacy and access to care, because of that

1 clustering in those states, do we feel pretty confident that
2 we are seeing good access in those areas where we're not
3 seeing as high growth as those in those cluster areas?

4 MS. NEUMAN: There is a chart in your mailing
5 materials that shows the ten states with the highest use of
6 hospice among decedents, so the highest percent of Medicare
7 decedents using hospice. And when we look at the percent of
8 hospices in those states exceeding the cap, we see the whole
9 gamut, from a couple states that have high rates of hospices
10 exceeding the cap to a number of states that have none or
11 very low amounts of hospices exceeding the cap. So we don't
12 think that the cap is what's sort of driving our hospice use
13 rates. It's kind of unrelated.

14 MR. KUHN: I was just thinking more of the growth
15 of new hospices and just making sure that if we are
16 clustered, if those areas where we're not seeing such high
17 growth, that we do have good access in those areas as well.

18 MS. NEUMAN: I think that we have seen -- there
19 are a couple states where we have seen some declines in the
20 number of hospices, and we can look at that issue again to
21 sort of check that out. Something that's not in this year's
22 mailing materials but we had last year that sort of speaks

1 to this issue of number of providers and access is that if
2 you plot the number of providers per beneficiary or per
3 thousand beneficiaries in the hospice use rates, it's a
4 complete scatter. There is no relationship between the
5 number of hospices per beneficiary and how many people
6 enroll, because unlike something that has a fixed, like
7 facility, hospice could be big or little. So the number
8 doesn't necessarily reflect capacity to serve.

9 So I will definitely take a look and see if there
10 are a few states where we could have concerns about the
11 growth, but overall we haven't seen a relationship between
12 numbers and access.

13 MR. HACKBARTH: My recollection is that Oregon is
14 a high-use state but a low-growth state, for example.

15 MS. NEUMAN: Yes.

16 DR. BERENSON: I have read elsewhere that there
17 have been legal challenges to the way CMS has administered
18 the cap with something about them allocating into a single
19 year's spending that occurs over two years and, therefore,
20 artificially having a cap, and that courts have upheld the
21 challenge. Could you sort of elucidate for us?

22 MS. NEUMAN: Sure. The crux of the issue is that

1 the way the statute is written, if a beneficiary switches
2 providers, they need to be able to allocate the
3 beneficiary's time in hospice, days in hospice across those
4 providers. And the way CMS does the calculation is they
5 count the beneficiary in the calculation in the first year
6 they enroll. So CMS is not allocating exactly as the
7 statute says. But if you took the statute to the extreme,
8 it's really impossible to do it exactly as the statute says
9 because you would literally have to wait until every person
10 who was in the hospice passed away before you could know for
11 sure what their total hospice use was over their lifetime
12 and how to allocate appropriately across those years.

13 So what has happened is a number of hospices have
14 challenged the way CMS is doing it, and a number of courts
15 have found against CMS saying that they're not doing it as
16 the statute has suggested. So in most of those cases, what
17 has happened is it has been remanded back to CMS to do a
18 recalculation, and in some cases, hospices have owed more,
19 not less, and vice versa.

20 So this is still going on. There's still a fight
21 going on about how this is being done, but it hasn't negated
22 the cap in most cases. It has just -- it's an agency about

1 the amount, at least as the court has seen it. The court
2 has not said that --

3 DR. BERENSON: So this doesn't have a prospect
4 then of basically negating the cap such that there would be
5 more money flowing to those high-cost hospices and higher
6 net total margins that we should be considering in the near
7 future? You don't think it's relevant to our discussion?

8 MS. NEUMAN: It's possible that our estimates of
9 the amount of cap overpayments could be incorrect. We could
10 have too high an estimate. Maybe they don't have to repay
11 all of it. So it is an issue to consider.

12 If you look at the margins for below-cap hospices,
13 we see about 5.5 percent in 2008. So if you were really
14 worried about this, you could think about as one option
15 focusing on those folks because that would take this issue
16 off the table.

17 MR. GEORGE MILLER: I'm trying to get my hands
18 around the growth in the for-profit and the length of stay
19 versus not-for-profit. Am I correct in that most of the
20 growth in hospice over the last several years has been in
21 for-profits and that they have the longest length of stay?
22 Which generates more profit for them because they're able to

1 spread their costs.

2 MS. NEUMAN: Right, so most of the growth in
3 providers is for-profit, and length of stay is higher in
4 for-profit than nonprofit, even within diagnoses.

5 MR. GEORGE MILLER: And then the cap overpayments
6 have been mostly in for-profits.

7 MS. NEUMAN: Right. But, again, for-profit is 50-
8 some percent of providers, and the folks who are hitting the
9 cap is 10 percent, so just as a frame of reference.

10 MR. GEORGE MILLER: Right, right. Thank you.

11 MS. UCCELLO: I'm just thinking through some of
12 the issues related to the short stays, because these are
13 just as troubling. But it's not necessarily the facilities'
14 or the hospices' fault that people are coming to them too
15 late. But that said, I'm still interested in what -- and
16 it's probably small just because by definition we're talking
17 about smaller dollars because they're shorter stays. But if
18 we took out these low 20 or 25 percent of stays from our
19 margin calculation, how much would that kind of increase the
20 margin?

21 MS. NEUMAN: Is what you're saying that if there
22 was a different sort of distribution of length of stay among

1 people who are in hospice, what would the margins look like
2 today?

3 MS. UCCELLO: In effect, yeah. If you just take
4 out those low folks, or maybe bump them up. I don't know.
5 But I'm just trying to get a feel for how much that's
6 driving some of the margin versus not. Again, I think it's
7 probably small just because -- in terms of dollars it's a
8 disproportionately smaller share.

9 MR. HACKBARTH: So if you them out, that would
10 drive up the average margin. But I'm not sure where you go
11 with it.

12 MS. UCCELLO: Well, I'm just --

13 MR. HACKBARTH: What's the policy implication? I
14 can understand the math that you're thinking about.

15 MS. UCCELLO: Yeah, well, and I think I'm just
16 thinking through it because you don't want to penalize the -
17 - but if you had a policy or if there were policies that
18 could help get people in there sooner, then that itself is
19 helping the margins of the hospice. I'm just thinking out
20 loud, but, you know, just -- I'll just stop.

21 MR. HACKBARTH: Presumably hospices have an
22 incentive to reach out and be available in the community and

1 get patients early, at an appropriate time when they can
2 help.

3 MS. UCCELLO: So then it is as much as --

4 MR. HACKBARTH: It's not that there's not an
5 incentive to do that. But apparently there are other
6 barriers that stand in the way.

7 MS. NEUMAN: We had a expert panel about a year
8 and a half ago, and we talked about this issue, about the
9 short-stay patients, and sort of what kinds of things could
10 be done to facilitate a more timely entry for those folks
11 who were interested in hospice. And, you know, our expert
12 panelists from the hospice industry cited a lot of issues
13 that, you know, really are outside of the hospice payment
14 system, things like, you know, social and cultural issues,
15 the sort of school of thought in medical practice about
16 trying to cure, you know, sort of very acute care-focused
17 kinds of practices. And, you know, the other thing that
18 people talk about is sort of the fact that you have to give
19 up -- you know, you have to give up curative cure to elect
20 hospice. So the demo that's going to happen will give us
21 some sense of, you know, what the impact of a change like
22 that might be.

1 MR. BUTLER: I'm trying to come to grips with
2 whether I'm going to support 1.5 or 1.0. It's tipping my
3 hand, but it's based on a little bit of a question here.

4 Go back to 18 now, and the nonprofit is sitting at
5 -- the free-standing, for example, is 3.8. And I notice in
6 the chapter the bereavement cost, for example, of nonprofits
7 is 2 percent and for-profits is 1.1 percent, which makes me
8 a little worried or concerned, you know, different levels of
9 service. And I'm suspecting -- and this is a question --
10 that our recommendation to the Secretary to ask the
11 Inspector General to look at the bad behaviors would be more
12 likely to be skewed to the for-profit side than the
13 nonprofit side. And I don't know that, but if that were the
14 case, that would tend to pull that margin down, if they
15 follow through on it. And if all that is true, then I would
16 kind of think, well, the rest probably needs the full 1.5
17 percent, as I'm looking at this. But unless, you know -- so
18 if the Inspector General really was successful, I have no
19 idea about the potential size of the impact and where it may
20 land in this profile.

21 MS. NEUMAN: It's really hard to predict. You
22 know, for-profit providers have longer stays than

1 nonprofits, but we see long stays among both categories.
2 There are providers in both categories that have very long
3 stays that could be, you know, sort of looked at and, you
4 know, it's hard to know what would happen of any kind of
5 looking. But I can't really predict for you. It's pretty
6 hard to predict what will come of that.

7 DR. MARK MILLER: I don't know why I'm compelled
8 to say this, but the other thing that we are going to re-run
9 is the change in the payment, the underlying payment system,
10 and I need some help to remember here. That does
11 redistribute from high profit to lower profit. It's sort of
12 the other side of your coin, like if they were to do that,
13 that would shift money in the other direction from high
14 profit to low profit, from longer stay to shorter stay, from
15 it turns out for-profit to not-for-profit. I think I said
16 most of that right.

17 MR. HACKBARTH: Yeah, and if that were to happen,
18 then you might say with that redistribution then you can
19 have a lower update because now the hospices at the low end
20 of the distribution would be paid more and lifted up, and it
21 would be financed out of lower payments at the long end of
22 the distribution. And you could say with that

1 redistribution, oh, we can live with a smaller increase in
2 the pie, but so long as you have a severe maldistribution,
3 then, you know, that may incline you to say that we need a
4 little bigger number for the people at the low end.

5 This is something that comes in a lot of different
6 sectors. What do you do when you've got this really broad
7 distribution of margins and you're not confident in how the
8 money's distributed?

9 DR. NAYLOR: I may tip my hand the other way in
10 this world. I'm wondering -- you know, data has just come
11 out from many sources about the rehospitalization rate,
12 hospitalization rate and rehospitalization rate of people
13 with cognitive impairment, multiple functional deficits, and
14 48 percent of the people in the Medicare beneficiaries are
15 people over 85 that are receiving hospice. So I'm trying to
16 put together, then, what are the data for the 40.9 percent
17 in the hospice benefit in terms of their cost, Medicare cost
18 in the last six months of life versus the other than 50 --
19 whatever they are, the remaining, who are not in this
20 service? I mean, because you start at the beginning saying
21 this is something we want to encourage, so I'm wondering can
22 you give us a sense of what are the costs for the people

1 that are not accessing this service relative -- Medicare
2 costs relative to those?

3 MS. NEUMAN: So we have not done our own estimate
4 of the costs of people who enroll in hospice at the last six
5 months of life, over the last year of life compared to folks
6 who do not. There is research looking at that, and what I
7 can tell you is that whether hospice saves money or costs
8 more money depends on a number of things.

9 For the first month or two -- the last month or
10 two months of life, hospice saves money because you reduce
11 high-cost inpatient care in those time periods. The
12 research is less clear on exactly where, but maybe at the
13 third month, fourth month, hospice starts to -- before the
14 third or fourth month before the time of death, hospice
15 starts to cost more money than it saves. So you're saving
16 more money in the last two months of life. As you get out
17 further, you're costing more, and at some point the savings
18 from the last two months will be outweighed by the cost as
19 length of stay gets longer and longer. And it also depends
20 on diagnosis. Certain diagnoses use inpatient services more
21 than others.

22 So there's not a strict hospice saves money or

1 doesn't and this is how much. It really depends on a lot of
2 characteristics: how long you're in hospice, you know, what
3 your condition is, the practice patterns in an area, all of
4 that.

5 DR. NAYLOR: And so the projected recommendations
6 will help address that in terms of the readjustment of
7 payments, more here, more here, and not as much here. I'm
8 really talking about the concern of this rapidly growing
9 population that might be negatively affected in whom we are
10 seeing a great rise in hospital and rehospitalization use.
11 So that's why I'm concerned about the rate. And I guess I
12 would -- 1.5 to 2.

13 MR. HACKBARTH: We are finishing round one.

14 MS. BEHROOZI: So the costs associated with
15 volunteers are the training and recruitment and all of that,
16 but you don't pay them for the work that they do, right?
17 But according to your paper, it says that hospices are
18 required to use volunteers to provide services to at least 5
19 percent of total paid patient care time. So the hospice
20 gets paid for the work that volunteers do? Is that what
21 that means?

22 MS. NEUMAN: So the hospice gets a per diem

1 payment regardless of what services are provided on a day,
2 and the hospice is required to use volunteers to provide
3 services or to do functions that amount to in a time
4 perspective equal to 5 percent of the paid time that they
5 expend in providing services.

6 MS. BEHROOZI: Right, but it's not like the
7 bereavement services that the hospice is not otherwise
8 compensated for, right?

9 MS. NEUMAN: Right. I mean --

10 MS. BEHROOZI: It's the services encompassed
11 within the per diem.

12 MS. NEUMAN: Yes.

13 MS. BEHROOZI: Are there any limitations on the
14 type of work that volunteers can do?

15 MS. NEUMAN: They don't count for things like
16 fundraising. It either has to be direct patient care or --
17 and I'll get back to you on the specifics, but I feel like
18 there is some administrative things that they can do. But
19 like fundraising and things like that, that's a no. That
20 doesn't count.

21 MS. BEHROOZI: But they can do patient care.

22 MS. NEUMAN: Like visiting a patient, yeah, yeah.

1 MS. BEHROOZI: Could you have a nurse volunteer?

2 MS. NEUMAN: Hospices do have some nurse
3 volunteers, physician volunteers, yes.

4 MS. BEHROOZI: And it says at least 5 percent of
5 the time. Is there any limit?

6 MS. NEUMAN: Not that I'm aware of.

7 MS. BEHROOZI: And does this distinguish between
8 for-profit and not-for-profit agencies?

9 MS. NEUMAN: As far as the rule or --

10 MS. BEHROOZI: Yeah.

11 MS. NEUMAN: No.

12 MS. BEHROOZI: I just have to say that that seems
13 very weird to me. This is a round two question, but, you
14 know, you're talking about profit-making entities making
15 their income based on people not getting paid. Aren't there
16 laws about that? Oh, I'm a labor lawyer, yeah. I think
17 there are. Maybe we could talk off-line a little bit about
18 whether there are some kind of protections or exemptions or
19 something. That's very strange to me, especially when you
20 see the margins, the extreme margins in some cases, of for-
21 profit agencies using, you know, unpaid labor. It's kind of
22 weird.

1 MR. HACKBARTH: It is anomalous, and I think part
2 of the reason that we got to this place -- correct me if I'm
3 wrong, Kim -- is I think the volunteer piece has been in
4 since 1983 when this was overwhelmingly a not-for-profit
5 enterprise.

6 MS. BEHROOZI: Yeah, I get, you know, the
7 admission-driven --

8 MR. HACKBARTH: And we just haven't changed
9 anything despite the fact that now it has become a largely
10 for-profit enterprise.

11 MS. BEHROOZI: Yeah, so I would really encourage
12 that we put that at the top of the list for policy
13 modification.

14 MR. HACKBARTH: Okay, round two, and please be
15 economical in your comments.

16 DR. BORMAN: I'm generally in a comfort zone with
17 this recommendation. I have one question, Kim. What
18 percentage of this market is Medicare? Could you remind of
19 the ballpark?

20 MS. NEUMAN: It's like the high 80s.

21 DR. BORMAN: Okay. I think that there are any
22 number of unknowns here. Particularly, we've spent a lot of

1 time in the past trying to make some comprehensive comments
2 about this, which the Congress in its wisdom will consider
3 whether to do or not. Making our best educated guesses
4 about the factors, I think we're in a landing zone that is
5 reasonable.

6 MR. ARMSTRONG: I agree. I would just say, as
7 reflected by several of the comments I, too feel like I have
8 two points of view on this. On the one hand, I'm working
9 very hard in a system that looks at the overall cost of care
10 and health outcomes, and we're investing like crazy in more
11 and more hospice services right now because there's a great
12 return on investment in that. And I think the Medicare
13 program is well served through what we spend on hospice.

14 On the other hand, in the context of the specific
15 rate decision that we're making right now, these are strong
16 margins relative to margins being made by other sectors in
17 the Medicare program. And I think closer to 1 percent than
18 1.5 percent is not going to slow the growth of hospice
19 services.

20 MS. HANSEN: I would just affirm what Scott said.

21 DR. CASTELLANOS: I second that.

22 DR. BAICKER: Agreed.

1 DR. STUART: [off microphone].

2 DR. KANE: I agree, and I also wonder if we can't
3 have the difference attributed to offset the SGR.

4 MR. KUHN: I'm fine with that range of discussion.

5 DR. BERENSON: So everybody's freed up a little
6 time for me to tell --

7 [Laughter.]

8 DR. BERENSON: I know it's late in the afternoon,
9 but sometimes an anecdote is so perfect that you got to do
10 it. I will be very fast on this one, I promise.

11 A couple weeks ago, I was at a social event and
12 met a woman who knew me as a doctor who did health policy.
13 She said, "I have something I just have to tell somebody.
14 Who should I tell about this?" She proceeded to tell me
15 that her mother, 95-year-old mother who had been in a life
16 care community for a number of years, about 15 months before
17 we were talking had been transferred to what she called
18 skilled nursing and I interpreted it as assisted living
19 within that facility. And at that moment, her hospice
20 benefit kicked in, and she said, "It's nice to have these
21 folks coming by, but it's perfectly redundant care." I
22 don't know what they're doing that she's not getting with

1 her \$6,000-a-month payment to the assisted living. And she
2 thought it was a terrible waste, but basically she wasn't
3 out-of-pocket anything and just thought as a good citizen
4 she should tell somebody. I told her I thought she had told
5 somebody who might have something to be able to do about it.

6 I guess two points I want to make. One, I think
7 we do really want to -- I mean, we've said it before, but I
8 think there is a real issue about nursing home/assisted
9 living being places where there may be inappropriate use of
10 hospice and sort of relationships established that are
11 generating referrals. She was in her 15th month, and she
12 said, "I have no reason to believe my mother's going to die
13 anytime soon. She's got dementia. That's the reason she's
14 in assisted living. But she's not declining in particular.
15 She's just getting her hospice benefit into her 15th month."

16 And the second thing, tomorrow we're going to be
17 talking about home health co-payments, and I think a similar
18 argument could be made here. I mean, she basically said
19 that, "If I were paying for anything, I probably would have
20 been doing something sooner than this. But, you know, it
21 doesn't affect my mother's payment. I'm just doing this as
22 a Good Samaritan, basically trying to find out who I should

1 talk to."

2 So I don't think we're do anything definitive on
3 the home health tomorrow on the co-payment, but I think when
4 we consider rationalizing cost sharing across the program,
5 I'd consider hospice with home health as two places that
6 maybe should have some form of co-payment -- not large co-
7 payment but something that gives everybody -- I won't use
8 the term "skin in the game."

9 MR. GEORGE MILLER: Yeah, in principle, I agree
10 with what Scott said and everybody around there, until I
11 heard Bob's anecdote. And I guess I got to reflect on the
12 hospital outpatient margins about a negative 10 percent, and
13 we gave them a 1-percent update. The hospice margins are
14 10, 11 percent for for-profits. They're the reason for the
15 major growth from \$2 billion to \$12 billion recently. They
16 had the length-of-stay problem. They had the issue that Bob
17 just brought up. I'm not even so sure that I'm going to
18 agree with even the 1 percent, quite frankly, but in
19 principle, I'll agree with Scott.

20 MS. UCCELLO: Yeah, I agree with Scott, and I'd
21 probably lean more toward 1.

22 DR. CHERNEW: I think it's important when looking

1 at these margins to realize that many of the lower ones in
2 some of these groups have the indirect rate in. So other
3 things are being added in there that aren't necessarily the
4 direct costs of the hospice in ways. So that said, this is
5 a particularly labor-intensive procedure, so it's hard to
6 get some of the productivity gains. And I do agree that,
7 when done right, it can have some advantages in terms of the
8 efficiency of care.

9 All of that said, I guess I am closer to
10 Scott's/last George in where I would come out on the
11 recommendation, recognizing how important and valuable this
12 service is.

13 MR. BUTLER: That's where I am, too, but I'd just
14 one quick thing. I do feel it's probably the most
15 underutilized of all of the services in Medicare and
16 probably the most misutilized at the same time, and that's
17 kind of the dilemma.

18 DR. CHERNEW: Right.

19 MR. BUTLER: Misutilized and underutilized, and
20 how we can really target this so it lands in the right place
21 as a very, very important tool is something that I think we
22 can contribute to, because the staffing so far, I think, on

1 all of this has been really good, and I think we can make a
2 unique contribution.

3 DR. NAYLOR: First, I am looking at the not-for-
4 profit margin here, but I obviously could be persuaded by
5 this group. I'm new here, and I think that I'll pay
6 attention closely to what they said. And I'm heartened by
7 the fact that this will be a focal point, palliation and end
8 of life and hospice going forward. So I can land where you
9 are.

10 DR. DEAN: I guess as far as the update I tend to
11 have the same concerns that George and several others have
12 voiced. This is so difficult because here we have an
13 extremely valuable service that we fail to be able to
14 define. And, you know, the six-month criteria is just
15 totally arbitrary. It got pulled out of mid-air. It's hard
16 to quantify. It's hard to predict. And yet I think we
17 really need to give some serious thought to trying to
18 further clarify the eligibility criteria, although I don't
19 know -- I don't certainly have any better ideas, but, you
20 know, Bob's anecdote is very relevant. I just struggle with
21 it. It's an important -- I mean, the Gawande article I
22 think was a powerful statement about how valuable this is,

1 but at the same time it's clearly being misused.

2 MS. BEHROOZI: In the discussion about the ASC
3 recommendation, the level of the recommendation, I was
4 thinking that if we're not going to be using strict failures
5 or empirically derived numbers, we should instead use a
6 principle, and if that principle is 1 percent because of
7 some reason -- because we think 1 percent will help do
8 something to constrain overall costs, or maybe it's Nancy's
9 principle that it's not the most important thing anyway and
10 it seems not unfair -- so it's 1 percent unless -- unless
11 there's some good reason to make it more or there's some
12 good reason to make it less.

13 So I'd say 1 percent just, you know, to kind of
14 introduce some kind of consistency and something -- a tool
15 for us to use to aggregate ourselves around. But I would
16 say for hospice -- and I'm just thinking about this now, so
17 this is like a very preliminary thing. I think for-profits
18 should pay their workers.

19 [Laughter.]

20 MS. BEHROOZI: And that would, you know, compress
21 these margins a little bit and compress the spread between
22 the costs of the for-profits and not-for-profits. And I

1 don't know, you have to -- obviously not-for-profits should
2 pay their workers, too, but, you know, you can have some
3 different kinds of constraints around the nature of the
4 volunteering in a not-for-profit. But I don't see how you
5 do it in a for-profit, especially when you've got this
6 margin that's clearly being made off the backs of human
7 beings doing the work.

8 MR. HACKBARTH: Okay, Kim. Well done. Thank you.

9 As we transition to our last presentation of the
10 day on skilled nursing facilities, I think the point that
11 Mitra just made is well taken, and so one of the things that
12 we will do as we go back through review of the conversation
13 is look at that horizontal, you know, really emphasize the
14 horizontal approach and maybe decision rules of the sort
15 that Mitra suggests. I'm just thinking aloud about this.
16 But when you cut loose from the market basket-based
17 calculation, it does increase the importance and the focus
18 that you put on the horizontal and how we're treating the
19 different sectors equitably. So we will emphasize that as
20 we go through this, and then I'll talk to each of you about
21 it.

22 Okay, Carol. You are up.

1 DR. CARTER: I am. Okay. I want to just start
2 with a thumbnail sketch of the industry and remind you that
3 there are about just over 15,000 providers and about 1.6
4 million beneficiaries. That's about five percent of
5 beneficiaries use SNF services. Program spending in 2010
6 topped \$26 billion. And I wanted to remind you that most
7 SNFs are parts of nursing homes that furnish long-term care,
8 which is a service that Medicare does not cover. Medicare
9 makes up about 12 percent of facility days, but about 23
10 percent of their revenues. And Medicare pays for this
11 service on a per day basis. That's described in the paper.

12 We'll be using the same framework that we've been
13 using for the rest of the update discussions. I wanted to
14 point out that there's an appendix in this chapter. PPACA
15 required MedPAC to examine trends in Medicaid utilization,
16 spending, and financial performance for providers where
17 Medicaid is a large share of either revenues or services,
18 and so we've done that for this provider, and that
19 information -- I won't be going into it here, but if you
20 have questions, I can answer them.

21 Okay. In fiscal 2010, spending for SNF services
22 was over \$26 billion. That's the yellow line. Growth in

1 total spending slowed to about two percent between 2009 and
2 2010, and this, in part, reflects the beneficiary enrollment
3 in MA plans whose spending is not included, and also a small
4 decline in use. Increases in spending on a fee-for-service
5 basis -- that's the pink line -- were also lower, reflecting
6 a slowdown in the growth in the intensification of the
7 highest payment rehabilitation case-mix days.

8 Access appears stable for most beneficiaries. We
9 don't have direct measures of access but instead use several
10 indirect measures to gauge it. First, supply has been
11 steady, with a small increase in the providers since 2000.
12 About three-quarters of beneficiaries live in counties with
13 at least five providers, and less than one percent of
14 beneficiaries live in a county without a SNF. There has
15 been a steady growth in the number of bed days available.
16 These increased four percent between 2008 and 2009.
17 Occupancy rates declined slightly, indicating that there was
18 space to admit beneficiaries. There was a small decline in
19 covered days and admissions, reflecting lower hospital use,
20 and Jeff talked about that this morning.

21 Two indicators of use concern us. First, the
22 number of SNFs treating medically complex patients continues

1 to decline, even though provider supply is stable.

2 Second, racial minorities had lower admission
3 rates than whites, but longer stays. Differences in SNF use
4 is consistent with other studies that generally have found
5 that minorities were more likely to use home health care and
6 informal care and less likely to use institutional care.
7 Lower use rates may also reflect differences in
8 hospitalization rates for racial minorities, and that's
9 required for a covered service under Medicare. And finally,
10 the longer stays for racial minorities may also reflect
11 differences in patient comorbidities, which are not
12 reflected in those use rates.

13 The two trends in service use discussed in the
14 paper underline the importance of previous MedPAC
15 recommendations. First, as I just mentioned, fewer SNFs
16 admit medically complex patients. Revisions to the
17 classification system will make these patients more
18 financially attractive to SNFs. However, payments for non-
19 therapy ancillary services, and those are largely drugs and
20 respiratory therapy, continue to be tied to nursing
21 payments. MedPAC recommended creating a separate payment
22 for NTA services, and his still needs to be done.

1 A second trend is the continued intensification of
2 therapy services. MedPAC recommended replacing the current
3 therapy component with one that bases therapy payments on
4 patient characteristics. CMS has not acted on this.

5 Last, the SNF PPS is one of the few prospective
6 payment systems without an outlier policy. This change
7 requires Congressional action. CMS does not have the
8 authority to create an outlier policy.

9 Turning to quality, we use two measures to assess
10 the quality, risk-adjusted rates of community discharge and
11 potentially avoidable rehospitalizations for five
12 conditions. Here, we see a mixed story for SNF quality.
13 Since 2000, the community discharge rate -- that's the top
14 line -- has increased slightly, indicating improved quality,
15 while the rehospitalization rate is about the same. And
16 between 2007 and 2008, both measures were virtually
17 unchanged.

18 We looked at differences in quality measures by
19 race and found that the observed differences were not
20 statistically significant once other patient characteristics
21 and comorbidities were considered.

22 We do see quite a bit of variation in quality

1 measures across facilities, and here you can see the 10th
2 and the 90th percentile along with the medians. I should
3 point out that the 10th and 90th, these are large samples
4 and they each include over 1,200 facilities. So they're not
5 just small tails. There are a lot of facilities in each of
6 them.

7 You can see that the community discharge rates
8 vary by more than threefold and the rehospitalization rates
9 vary twofold. And over the next year, we plan to examine
10 policy options to lower the variation across facilities.

11 Turning to access to capital, because SNFs are
12 parts of larger nursing homes, we assessed the capital for
13 nursing homes. Lending to nursing homes has improved since
14 last year. Despite the condition of many State budgets and
15 the poor economy, this sector is fairly resilient. Even
16 though Medicare is a small share of most homes' revenues, it
17 is seen as a generous payer that homes rely on financially.
18 Medicare continues to be a preferred payer.

19 Comparing payments and costs, the aggregate
20 Medicare margin was 18.1 percent in 2009. This is for free-
21 standing facilities. This is the ninth year in a row that
22 aggregate margins were above ten percent. There continues

1 to be variation in the financial performance across location
2 and ownership. Rural facilities had slightly higher margins
3 than their urban counterparts, and for-profit facilities
4 continued to have considerably higher margins than
5 nonprofits, though the difference was smaller this year than
6 in previous years.

7 Here's a snapshot of the distribution. About half
8 of freestanding SNFs had margins at or above 18.7 percent.
9 One-quarter of SNFs had margins at or below 8.8 percent,
10 while one-quarter had margins over 26 percent. About 14
11 percent of facilities had negative margins, and this was a
12 smaller share than in 2008. The most rural of SNFs, those
13 in areas with populations under 2,500 and not adjacent to a
14 metro area, had higher-than-average margins.

15 Not shown in this table, hospital-based facilities
16 continue to have very negative margins, negative 66 percent.
17 We have discussed in previous years the reasons for these
18 large differences in per day costs between hospital-based
19 and freestanding, including their higher staffing levels and
20 the fact that physicians appear to treat SNFs as extensions
21 of their inpatient stays. These factors result in much
22 higher routine and ancillary costs per day.

1 Our recommendations to revise the PPS would
2 redirect payments from freestanding facilities to hospital-
3 based facilities based on the mix of patients that they
4 treat.

5 To provide some context for the margins, we
6 compared freestanding SNFs in the top and bottom quartile of
7 Medicare margins. We find the cost differences were much
8 larger than the differences in revenues. Low-margin SNFs
9 had costs per day that were 41 percent higher, in part
10 explained by their lower average daily census and their
11 shorter stays over which to spread their fixed costs. On
12 the revenue side, low-margin SNFs had payments that were
13 seven percent lower than high-margin SNFs, reflecting a
14 smaller share of the more profitable therapy days. Low-
15 margin SNFs also had smaller Medicare shares of days.

16 We also looked at the performance of relatively
17 efficient SNFs, and like Jeff presented this morning, we
18 looked at -- we used both cost and quality measures to
19 define these. And like the definitions they use in the
20 hospitals, SNFs had to be in the top third for one measure
21 and not in the bottom third for any measure for three years
22 in a row. So they had to have consistent performance both

1 on quality and cost measures. And nine percent of SNFs, and
2 that was about 800 facilities, met these criteria.

3 Comparing the efficient SNFs to others, we found
4 that they had costs per day that were nine percent lower
5 after adjusting for differences in case-mix and wages,
6 community discharge rates that were 29 percent higher, and
7 rehospitalization rates that were 16 percent lower, and they
8 had higher margins.

9 Looking at trends since 2000, although efficient
10 SNFs made up nine percent of the study sample, they made up
11 11 percent of facilities with low-cost growth and of the
12 facilities with high-revenue growth. It is clear that it is
13 possible to furnish relatively low-cost, high-quality care
14 and do very well financially.

15 We project the SNF margin for freestanding
16 facilities to be 10.9 percent in 2011. The margin goes down
17 because payments were reduced in 2010 and 2011. In 2010,
18 payments were lowered to more accurately account for the
19 impact of the new case-mix groups that were implemented in
20 2006. In 2011, CMS reduced the update to account for a past
21 forecasting error.

22 In addition, SNF costs have been increasing faster

1 than the market basket. This projection assumed that costs
2 will increase at the actual average cost growth over the
3 past five years. This may be a conservative assumption
4 because cost growth may slow due to broad economic
5 conditions. And we did not factor in any behavioral
6 changes, such as shifts in case-mix that could change
7 payments.

8 In summary, the factors indicate that payments are
9 adequate, access and quality are stable, capital is
10 available, the Medicare margin was 18.1 percent in 2009, and
11 the projected margin for 2011 is 10.9 percent.

12 In 2012, the current law calls for payments to be
13 updated by a combination of the market basket increase and
14 the productivity adjustment as required by PPACA. The
15 market basket for SNFs is projected to be 2.6 percent and
16 the productivity adjustment is 1.3 percent. So net payments
17 are slated to increase by 1.3 percent.

18 The high aggregate margins indicate that Medicare
19 payments are high enough to accommodate a zero update, and
20 here is the Chairman's draft recommendation. It reads, "The
21 Congress should eliminate the update to payment rates for
22 skilled nursing facilities for fiscal year 2012." This

1 recommendation would lower program spending relative to
2 current law and it is not expected to impact beneficiaries
3 or providers' willingness or ability to care for Medicare
4 beneficiaries.

5 The update is not the only tool to help improve
6 the accuracy and incentives of the payment system. Past
7 recommendations have sought to improve the payment system
8 and to increase the value of the program's purchases.
9 Related to the payment updates, MedPAC recommended revising
10 the SNF PPS to add a separate NTA component to base therapy
11 components on predicted patient care needs and to add an
12 outlier policy. MedPAC also recommended linking program
13 payments to beneficiary outcomes by establishing a quality
14 incentive payment policy, and PPACA requires the Secretary
15 to develop an implementation for value-based purchasing by
16 October 2011.

17 If implemented, the Commission's recommendations
18 would narrow the differences in financial performance across
19 facilities and we will be rerunning these recommendations in
20 the chapter. And with that, I look forward to your
21 discussion.

22 MR. HACKBARTH: Thank you, Carol.

1 Could I ask you to put up Slide 11, please? I
2 want to pick up with the theme where we just left off, that
3 being the importance of treating similar situations more or
4 less the same as we look across the various provider groups.

5 Now, when I first saw these numbers, Carol, they
6 surprised me how high they were. You know, for a number of
7 years now, we've had both SNF and home health with quite
8 high margins compared to all of the other provider groups in
9 Medicare. My recollection of the history -- and I may well
10 be wrong, and so please, if I am wrong, correct me. But my
11 recollection is that mostly the SNF margins have been in the
12 10-, 11-, 12-, 13-percent range, and home health have been
13 usually 4, 5, or 6 percent higher than that, up in the mid-
14 to high teens. And so both have been high, both have been
15 double digits for a long time, home health sort of a notch
16 higher than SNF.

17 And so when I saw the 18-plus percent -- 18.1 is
18 the median -- or 18 --

19 DR. CARTER: Yeah, 18.1 for an aggregate.

20 MR. HACKBARTH: Yeah, in the aggregate. Again, I
21 was surprised. That seemed higher than I remembered. So
22 let me stop there. Are these numbers higher than they have

1 been --

2 DR. CARTER: They are higher. Last year we
3 reported for 2008 it was 16.6, and the year before that it
4 was 14.7.

5 MR. HACKBARTH: Yeah, so they have been sort of
6 creeping higher.

7 DR. CARTER: They're creeping up, and they do
8 reflect the increasing share of case-mix days in the highest
9 payment groups.

10 MR. HACKBARTH: Right, right.

11 DR. CARTER: So something like 90 percent of days
12 are now rehab, and 70 percent of those are in the two
13 highest case-mix groups.

14 MR. HACKBARTH: Right, right. So here's where I'm
15 going with this. We recommended rebasing of the home health
16 system, which is another way of saying actually cutting the
17 rates. We have not gone to that point in the past with
18 skilled nursing. We've had zero update recommendations for
19 a large number of years now, but have never gone the
20 additional step of saying the rates ought to be rebased and
21 even lowered.

22 In my mind, part of the difference between the two

1 have been, A, that -- my recollection of the history was
2 that the home health margins were always somewhat higher,
3 but in addition to that, I've always been concerned about
4 the medically complex skilled nursing patient where we've
5 actually consistently said, you know, there are some
6 potential access problems for the medically complex skilled
7 nursing. And so the way my mind has worked on this is we
8 really needed to fix the case-mix problems that are in SNF
9 before going the additional step of potentially recommending
10 a rebasing. So that has sort of been where my mind has
11 been. But even with that, in my mind, when I saw 18-plus
12 percent is the median margin, I must say I was a little
13 taken aback. We've sort of jumped up there, it sounds like,
14 in two-percentage-points increments the last several years.

15 So there's not an answer at the end of that, but
16 in keeping with the earlier conversation about, you know,
17 being consistent across sectors, I wanted to offer that for
18 people to chew on.

19 I think we're starting on Mitra's side, so round
20 one clarifying comments?

21 MS. BEHROOZI: [off microphone].

22 MR. HACKBARTH: Okay. Tom? Mary? Peter? Mike?

1 Cori? I think you're tired.

2 [Laughter.]

3 MR. HACKBARTH: George isn't tired.

4 MR. GEORGE MILLER: No. I am. But you raised a
5 very good point. What would that rebasing look like?

6 Because I think you're right on point.

7 MR. HACKBARTH: You know, I don't have a rebasing
8 proposal to offer. What we have said in home health is that
9 they ought to go back and look at the average cost -- the
10 product has changed -- and rebase the rates on up-to-date
11 costs as opposed to old patterns of care. How it would be
12 done in SNF I have not even begun to think about.

13 MR. GEORGE MILLER: But one point that you brought
14 up, if I remember correctly from the presentation, and the
15 medically complex patients have gone down, so that's even,
16 it seems to me, more of a reason. I don't know where those
17 patients are --

18 MR. HACKBARTH: What do you mean when you say
19 they've come down?

20 MR. GEORGE MILLER: Fewer medically complex
21 patients. They're treating fewer. Do I have that correct?

22 DR. CARTER: No. What I said was there were fewer

1 SNFs treating them, so they're increasingly concentrated at
2 the SNFs that do treat them.

3 MR. GEORGE MILLER: Okay. All right.

4 MR. HACKBARTH: So the number of patients isn't
5 shrinking.

6 MR. GEORGE MILLER: Right.

7 MR. HACKBARTH: It's just they're more
8 concentrated, which incidentally, to the extent that that's
9 true and you don't have an appropriate payment system for
10 them, and if they're concentrated in a few facilities and
11 you rebase, those people who've been picking up the slack in
12 the system, as it were, and caring for the really difficult
13 patients really get whacked.

14 DR. CARTER: I would want to just put a couple
15 more pieces of information -- and it's in your chapter. The
16 revisions to the case-mix groups that CMS plans to implement
17 with RUGs-IV really is going to make a big difference for
18 both expanding the number of groups for medically complex
19 cases but also redirects money towards medically complex
20 patients because of the way it moved money from the therapy
21 component to the nursing component.

22 MR. HACKBARTH: This is probably a question that

1 is unanswerable, but my impression has been that we've said
2 to CMS, oh, this is a step in the right direction, the
3 changes that they've made, but you've not gone far enough.
4 And so we keep insisting there needs to be a separate non-
5 therapy ancillary payment and, you know, get away from the
6 therapy-based payments.

7 So if they've gone in the right direction but not
8 far enough, how much of the distance in the right direction
9 have they gone with these changes? How much are they
10 improving the situation for the medically complex?

11 DR. CARTER: Well, we can't model that because we
12 can't -- there aren't the data to replicate the new
13 classification group, so that has been the problem;
14 otherwise, we would have modeled that. I think they will
15 make a big difference, but I don't know how much.

16 MR. HACKBARTH: Okay.

17 DR. BERENSON: I was going to be asking -- I want
18 to pursue this just a little more. When I was at CMS, I
19 visited a SNF that basically only did very complex patients,
20 and I guess my first question is: When you say they tend to
21 be concentrated, are there SNFs that don't have long-term
22 residents that only do skilled nursing for that period of

1 time?

2 DR. CARTER: Certainly hospital-based tended --

3 DR. BERENSON: Hospital-based, yeah, by definition
4 would.

5 DR. CARTER: I don't know. I haven't looked at
6 that, so I'm not sure.

7 DR. BERENSON: And do we know if some of those
8 kinds of SNFs are LTCs, also? Can they be both?

9 DR. CARTER: I don't think they can be both.

10 DR. BERENSON: Okay. So they can be one or the
11 other.

12 DR. CARTER: Right.

13 DR. MARK MILLER: I think on that there may be a
14 couple of exceptions, but generally no.

15 DR. BERENSON: But the patient population is often
16 similar, right?

17 DR. MARK MILLER: See, you said this in passing,
18 but I wanted to kind of track on it. You said long-term
19 residents.

20 DR. BERENSON: I was talking about a long --
21 nursing home patients, you know.

22 DR. CARTER: So like a ventilator patient that

1 might be, right.

2 DR. BERENSON: I'm talking about ventilator
3 patients, is who I'm talking --

4 DR. MARK MILLER: And I just want to quickly
5 delineate a couple of things. So long-term-care hospitals,
6 I mean, one of the requirements is -- we'll talk about this
7 tomorrow -- a 25-day length of stay, and so that tends to be
8 people who are in for a long period of time. Then you have
9 the nursing facility which you can -- and I'm sure I'm not
10 doing it justice, but think of it as two ways. There is the
11 residential beneficiaries there and then this group, the
12 skilled nursing facility, which tends to be shorter stay.

13 DR. CARTER: The average length of stay is about
14 23 days.

15 MR. KUHN: One thing, Carol, just to make sure I
16 heard you right. In the current RUGs, 54 RUGs, there's nine
17 that are therapy RUGs, correct? Or rehab --

18 DR. CARTER: You're thinking about -- there are
19 nine -- the new rehab plus extensive services.

20 MR. KUHN: Right.

21 DR. CARTER: There are many more rehab --

22 MR. KUHN: Right, there's three that are the

1 rehab, but you said of those RUGs right now that -- what
2 were the percentages that were falling in kind of those
3 upper reaches of those RUGs? Can you just say that one more
4 time?

5 DR. CARTER: About 92 percent of all days are
6 classified into a rehab RUG, and of those, about 70 percent
7 are in the ultra high and very high.

8 MR. KUHN: Okay, thanks. And the other quick
9 thing, in the chapter I noticed there was the appendix that
10 talked about that new section of PPACA that asks us to look
11 at Medicaid utilization. Under the statutory reading, this
12 would satisfy the needs for our requirements under the law,
13 this appendix in our annual chapter. Is that our
14 understanding?

15 DR. MARK MILLER: That is our understanding, and
16 what we're doing is trying -- I'm trying not to laugh as I'm
17 giving --

18 [Laughter.]

19 DR. MARK MILLER: We're trying to meet the
20 statutory requirement; you know, we're starting here with
21 skilled nursing facility to try and work up the data as best
22 as we can. There may be some other areas that we'll add as

1 we go. We are trying to meet it, and, yes, that is our
2 attempt to take the first step in that direction.

3 DR. KANE: My only question is: If you
4 redistribute this more toward the medically more complex,
5 the aggregate margin would still be 18 percent, or not? I'm
6 just trying to figure out what a redistribution towards --

7 DR. MARK MILLER: Yeah [off microphone].

8 DR. KANE: So you would still have an aggregate at
9 18 percent because the revenue and the costs are still
10 aggregate.

11 DR. CHERNEW: [off microphone] Unless they change
12 behavior.

13 DR. KANE: Yes, right. Unless they change
14 behavior in what way? Like --

15 DR. CHERNEW: [off microphone] more or less
16 profitable.

17 DR. KANE: Yeah, toward more or less --

18 DR. CHERNEW: If you make one group relatively
19 more profitable or not and they move around, the costs and
20 the revenues would change.

21 DR. KANE: Yes, but it's kind of hard to know --
22 yeah, right.

1 DR. CHERNEW: Yes, it is.

2 DR. KANE: Yes, okay. That was my question.

3 That's what's built in right now, and a new case-mix system
4 will just redistribute but -- and assuming not a big
5 behavioral change.

6 DR. STUART: Yeah, I'm curious in terms of how
7 well we were able to predict margins back in 2007 and 2008.
8 Did we predict that margins would go up even with a zero
9 update?

10 DR. CARTER: You know, we've never tried to model
11 a behavioral reaction.

12 DR. STUART: But that's what I'm wondering,
13 because we're projecting that the margins for 2011 are going
14 to drop to 10.9 percent. Now, that's a huge drop from 18.7.
15 But maybe there's this behavioral thing in there, and then
16 next year it will be 19.8 percent.

17 MR. HACKBARTH: Just a point of clarification. We
18 have been recommending zero updates for a long time, but
19 that's not what skilled nursing facilities have gotten
20 historically.

21 DR. CARTER: No, they've been getting, you know,
22 market basket minus sometimes --

1 MR. HACKBARTH: Yeah, so this growth in margins
2 that Carol described going up a couple percentage points is
3 not in a zero update environment.

4 DR. STUART: The question remains about how well
5 we are able to project what the margin would be given an
6 update, and if there is a strong behavioral response and
7 it's a negative response from the standpoint of access to
8 care, particularly for the kind of person that you would
9 think would need this kind of service, then I think that's
10 something that we should take into consideration.

11 MS. HANSEN: Well, yes, it's not a question but a
12 quick comment. Just again affirm how we assure this, the
13 access to complex patients. So if the new RUGs system will
14 perhaps provide sufficient incentives for that, that's
15 great. The concentration in certain places, on the one hand
16 I can really understand from an operational standpoint
17 because then you'll have more competently prepared people
18 maybe focused to do that. But as the volume grows, I think
19 as Mary has pointed out, in terms of population, just, you
20 know, assuring that other facilities will be available to do
21 this in a more distributive basis.

22 MR. HACKBARTH: On to round two [off microphone].

1 MS. BEHROOZI: Yeah, I like taking a deeper look
2 than just the payment update, as you suggested.

3 MR. HACKBARTH: So you are saying that you would
4 be open to going below zero?

5 MS. BEHROOZI: In the result, yes, but doing it in
6 an intelligent way that addresses some of the -- I mean,
7 we've made recommendations. I don't know if they were all
8 adopted whether it would address all of the issues since we
9 have seen margins growing. But, yeah, margins -- I mean, in
10 two years it sounds like margins at the median increased by
11 four points over 14 points, which is a lot in two years.

12 MR. HACKBARTH: Right, right.

13 MS. BEHROOZI: That's close to 30 percent, or
14 whatever.

15 MR. HACKBARTH: I don't want to create
16 expectations or fears in the audience that may not come to
17 pass. I'm surprising Carol and Mark in talking about
18 rebasing, but this is just something that comes to me as --
19 you know, I've listened to the discussion all day long and
20 the emphasis on, you know, equity, and so an obvious
21 question is, Why are we rebasing home health and not these
22 folks?

1 DR. KANE: In home health, I recall an exhibit
2 that actually showed the percentage of nursing and therapy
3 and aide visits back whenever it was -- 1998 -- was very
4 different than what is now being visible. But it's hard to
5 tell what's different here in terms of the inputs. There
6 were very different inputs.

7 MR. HACKBARTH: Yeah, excellent point. That is
8 one of the distinctive characteristics of home health. And
9 as I said earlier, part of my own thinking about this has
10 been that you wouldn't want to do rebasing given our
11 concerns about access to care for medically complex until we
12 felt like the case-mix system had been sufficiently
13 improved.

14 So, again, you know, let me talk to Mark and Bob
15 and Carol about this, and then I'll talk to each of you
16 after that. Tom, any thoughts to offer?

17 DR. DEAN: No. I'm comfortable with where we're
18 at [off microphone].

19 DR. NAYLOR: As am I.

20 MR. BUTLER: I am okay, too, but I do have an
21 overnight assignment for you because I like your episodes of
22 care so much. I just had a thought, though. This will just

1 take a second. As we look at all these -- it helps me
2 integrate the day, too. If you take a look at all these
3 silos, particularly all the post-acute, if you had the
4 aggregate dollars at the bottom and you had all of the
5 diseases that we're treating in Medicare, whether it's
6 episodes or the -- and you could look at where all of our
7 dollars are being spent, it would give an interesting
8 profile of the trade-offs between these various post-acute
9 sectors that would kind of give a scorecard that we could
10 kind of say, oh, that's where we're spending the dollars to
11 treat neurological diseases or congestive heart failure or
12 whatever it is. It might be a nice analytical tool, so when
13 we have the trade-offs between rehab versus home health
14 versus hospice, it might help some of our thinking. But you
15 don't have to do it overnight, but in the future.

16 [Laughter.]

17 MR. HACKBARTH: Yeah, this is important [off
18 microphone] look at the data in different ways, for example,
19 on a disease basis as opposed to by --

20 DR. CHERNEW: And, I mean, our push for
21 productivity would involve substituting appropriately across
22 these settings, and that's really hard to encourage in this

1 silo-based exercise that we march through every winter, and
2 it really emphasizes the lack of integrated policy.

3 I guess there's just two things I wanted to say
4 before my quick comments on the recommendation. The first
5 one is these are Medicare margins, and there's a huge cross-
6 subsidy. And I know that Glenn has said our job is not to
7 subsidize Medicaid, and I agree with Glenn's point that our
8 job is not to subsidize Medicaid. But I think that we do
9 care about access of the beneficiaries, and so we just have
10 to be cognizant of the connections, whether we want to or
11 not. And given the fiscal situations that the states face,
12 if we do this all based on just Medicare, we might be
13 ideologically pure, which won't really be worth a lot to the
14 beneficiaries who face problems. So I worry a lot about
15 that, just as sort of a sleep-at-night kind of thing.

16 Secondly, I think we want to move to this sort of
17 long-term care bundling thing, and there's going to be
18 hopefully a lot of demonstrations, not just about looking at
19 it episode-wise, but changing the related incentives. And
20 that will affect how all of this plays out. And so Bob made
21 a point in a previous meeting about fee-for-service in
22 general and how the rates will be set. And so when we make

1 our recommendations now for a number of these things, we're
2 not just making recommendations in the fee-for-service
3 system going forward, but it has ramifications for how
4 things like bundled -- the level that bundled payments would
5 be at and stuff, and we need to think through that and the
6 ramifications of that.

7 So the bottom line is I'm comfortable with the
8 recommendation as given. I'm open to the idea of doing
9 something more. But if you're going to do something more, I
10 think it has to be done in this broader context of
11 integration, a cross-subsidy, and the states' Medicaid stuff
12 and all of those things. So it's actually, I think, harder
13 to do -- I might say this again when we get to home care,
14 incidentally, but I think it might be harder to do than it
15 otherwise might have been given all of the complicated
16 moving pieces in this area that's fraught with difficulty.

17 MS. UCCELLO: I'd agree with that.

18 DR. BERENSON: Yeah, I'll agree with that.

19 MR. KUHN: I'm fine [off microphone].

20 DR. KANE: I'd believe in anything to get up and
21 go home.

22 [Laughter.]

1 DR. KANE: But I guess my only thought was -- and
2 I know this is just too complicated, but I am worried a
3 little bit about the high Medicaid places where the Medicare
4 is holding them up. But I'm wondering how hard it would be
5 -- since I see we have total margins, we must have total
6 revenues -- to look at these margins in relationship to the
7 percentage of the total business that's Medicare. And then
8 I don't know if we have Medicaid, but it just would be
9 interesting to see if that's the case, that the high
10 Medicaid places have the highest Medicare margins or not. I
11 don't know if that's truly -- if the high Medicaid places
12 are the places where there's really high Medicare margins,
13 then you'd worry about cutting the Medicare margin. But if
14 the high Medicaid places have relatively low Medicare
15 margins, you're not doing that much more damage to them than
16 they already have done to themselves.

17 MR. HACKBARTH: In addition to that --

18 DR. KANE: Does that make sense?

19 MR. HACKBARTH: I think so. But the other way of
20 looking at this which I have tended to emphasize is that
21 using Medicare rates, high Medicare rates to subsidize low
22 Medicaid rates is problematic because the nursing homes that

1 need the money most are the ones with high Medicaid shares
2 and low Medicare shares.

3 DR. KANE: And that's why I want to see if the
4 margins correlate to that at all. I don't know.

5 DR. STUART: The only thing that I would add to
6 the cross-subsidy issue is that it's really quite different
7 than when we're talking about hospital payment Medicare
8 margins being negative and being offset by private-pay
9 patients. The Medicaid patients are also Medicare, and so
10 trying to figure out what's going to happen to the same
11 patient -- I mean, not during the same stay, obviously, but
12 it's very common for Medicare patients to stay beyond the
13 SNF stay and then become, you know, ultimately Medicaid
14 patients. So I would just add that caution in here in terms
15 of trying to understand what the implications of that are.
16 Otherwise, I support the proposal.

17 DR. BAICKER: I support it, and I liked Mitra's
18 framing of things as starting with a basic default of
19 something like 1 percent and justifying based on
20 observations like this.

21 DR. CASTELLANOS: [off microphone] I agree.

22 MS. HANSEN: I agree, but with a question. It

1 just struck me, something that Bruce just said. I just
2 wonder how many of the people who end up being Medicaid
3 start off as Medicare. So, in other words, they start off a
4 private-pay or post-acute and then they end up custodially
5 staying for a long time and then ending up Medicaid. And
6 how often does that happen? So just if you know that.

7 MR. ARMSTRONG: So I agree that in this section
8 we're overpaying for what we're getting, and that to -- the
9 recommendation is to hold payment flat. I think we should
10 consider some kind of rebasing. I don't really fully
11 appreciate the implications of that.

12 To this whole point about, you know, there are
13 boundaries that get broken between Medicare and other payers
14 and margins and so forth, it happens in all of these
15 different sectors. I think we're here in one sector where I
16 think we're generally believing we're paying more than we
17 should be. But if that's the case, then I wouldn't use the
18 overpayment to subsidize Medicaid programs necessarily. I
19 think we should consider whether we should be subsidizing
20 other parts of the Medicare program as an alternative. And
21 so I don't know what you do with that.

22 Also, just to Peter's point earlier, you know, at

1 the end of the morning tomorrow it will be very interesting
2 to have a chance just to talk a little bit about how this
3 along with some of the other sectors really get all kind
4 intermingled in some of our work going forward after January
5 to look at some kind of bundling or other reform ideas that
6 just might make some of these silo decisions a little bit
7 more sensible.

8 DR. BORMAN: Intellectually, I'm fine with where
9 we are now. I have a little bit of Mike's visceral reaction
10 of concern.

11 MR. HACKBARTH: Let's see here. 5:50. We made up
12 some ground. So now we'll have our public comment period.

13 Seeing none, we are -- oh, Marianne.

14 Is that on?

15 MS. LOVE: Sorry to be the person who keeps you
16 here late.

17 I appreciated your comments, Glenn, this morning
18 about trying to work towards harmonizing the updates for
19 settings that are providing the same service. I think from
20 the ASC setting perspective -- I'm sorry, I'm Marianne Love
21 from the ASC Association.

22 The savings to the Medicare program and the

1 efficiencies of the ASC setting are baked into the rate
2 differential already. Medicare is paying 44 percent less
3 for a service done in an ASC than in a hospital. So I think
4 moving towards a system that, on an annual basis, is
5 updating things at the same rate is a good step in the right
6 direction.

7 So we would actually like to see the Commission
8 move towards an affirmative recommendation that is
9 consistent with the hospital outpatient recommendation.

10 We think the slightly higher recommendation than
11 what you discussed earlier today is warranted. The data
12 that you're looking at for 2009 is the second year of a new
13 payment system in which rates for many common ASC services
14 are being substantially reduced. We know that 2010 is on
15 track to be the lowest growth rate of ASCs probably in the
16 history of the program for the ASC payment setting. And the
17 largest public operators of ASCs are reporting flat or
18 negative same store growth for their centers, Medicare and
19 commercial.

20 These things, I think, are all important signals
21 that should be considered. One of the things that we're
22 seeing is an increasing number of hospitals buying ASCs,

1 buying out the physician owners, converting those ASCs to
2 the hospital license. This comes at great expense to the
3 Medicare program and the taxpayers that support it.

4 So we think an affirmative update recommendation
5 sends a very strong and positive signal to the industry that
6 they'll be on stable ground going forward and continue to
7 provide those savings to the program.

8 Thank you.

9 MR. HACKBARTH: Okay, we are adjourned until 8:15
10 tomorrow morning.

11 [Whereupon, at 5:53 p.m., the meeting was
12 recessed, to reconvene at 8:15 a.m. on Friday, December 3,
13 2010.]

14

15

16

17

18

19

20

21

22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 3, 2010
8:17 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
ROBERT BERENSON, MD, FACP, Vice Chair
SCOTT ARMSTRONG, MBA
KATHERINE BAICKER, PhD
MITRA BEHROOZI, JD
KAREN R. BORMAN, MD
PETER W. BUTLER, MHSA
RONALD D. CASTELLANOS, MD
MICHAEL CHERNEW, PhD
THOMAS M. DEAN, MD
JENNIE CHIN HANSEN, RN, MSN, FAAN
NANCY M. KANE, DBA
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
BRUCE STUART, PhD
CORI UCCELLO, FSA, MAAA, MPP

AGENDA	PAGE
Assessing payment adequacy: home health care services - Evan Christman	5
Assessing payment adequacy: inpatient rehabilitation facility services - Christine Aguiar, Craig Lisk	90
Assessing payment adequacy: long-term care hospital services - Dana Kelley	120
Public Comment	167

1 P R O C E E D I N G S [8:17 a.m.]

2 MR. HACKBARTH: Okay. Good morning. So this
3 morning, we continue our discussion of our update
4 recommendations for fiscal year 2012. We have three
5 presentations today.

6 For those of you in the audience who were not here
7 yesterday, yesterday and today, we are discussing draft
8 recommendations for updates for each of the provider groups
9 serving Medicare beneficiaries. These are draft
10 recommendations that I have prepared and am offering to the
11 Commission for discussion. We will have final votes on
12 recommendations at the January meeting. The final
13 recommendations that we vote on may be the same as the draft
14 or they may be modified as a result of the conversations
15 that we've had yesterday and today.

16 Since the last time we did update recommendations
17 a year ago, obviously, there's been a major legislative
18 change in PPACA. Among other things, what it did was
19 establish a new budgetary baseline for all of the updates.
20 Obviously, that's very important. However, the task that
21 we've been assigned by the Congress is to provide our best
22 assessment year by year on the level of payment that is

1 appropriate for the efficient delivery of services in a
2 given provider group, a level of payment that will assure
3 adequate access to high-quality care for Medicare
4 beneficiaries by efficiently managed organizations. So,
5 obviously, the recommendations we make could be different
6 than what is in current law, and if it's higher, that would
7 entail a budgetary cost. If it's lower, it would be a
8 savings.

9 As always, in talking about the update
10 recommendations, we use a multi-part framework. Where
11 available, one piece of that is information on financial
12 performance, on margins, but that's not the only part of the
13 framework. Other considerations are access for patients and
14 what's happening there, access to capital for the
15 organizations, and the like.

16 Anything else?

17 DR. MARK MILLER: [Off microphone.] Updates and
18 distribution under --

19 MR. HACKBARTH: Oh, yes. Another critical piece
20 is as we conceive of the update process, the update simply
21 establishes the size of the pool of dollars available for a
22 particular provider group. Often, there are important

1 issues about how that pool of dollars, whatever it might be,
2 are distributed and whether the money is distributed in a
3 way that is fair, equitable, and rewards effective,
4 efficient delivery of care, and so sometimes, not for every
5 provider group, but sometimes in addition to making an
6 update recommendation, we will also make a recommendation
7 about the distribution of those dollars, and in fact, when
8 we proceed with the home health presentation discussion,
9 there are issues about how the existing case-mix system
10 distributes the dollars.

11 So with that as background, let me turn it over to
12 Evan for the home health presentation.

13 MR. CHRISTMAN: Good morning. Today, we are going
14 to cover the payment framework as it pertains to home
15 health. We will also review draft recommendations that
16 provide policy options to improve payment accuracy,
17 strengthen patient safeguards, establish beneficiary
18 incentives, and advance program integrity.

19 I am going to start with the framework. As in
20 previous years, the supply of providers and access to home
21 health continues to increase. Ninety-nine percent of
22 beneficiaries live in an area served by one home health

1 agency. Sixty percent live in an area served by ten or
2 more. While there are some areas that lack home health
3 agencies, they are relatively few in number. Our measure of
4 access is based on ZIP code-level data which tracks the
5 areas served by a home health agency in the last year. This
6 data may overstate access for some areas because agencies
7 need not serve the entire ZIP code to be counted as serving
8 it. On the other hand, the data may understate access if
9 agencies are willing to serve a given ZIP but did not
10 receive any requests from those areas.

11 Turning from access to supply, the number of
12 agencies was over 11,300 by the end of 2010, a number that
13 exceeds the peak level of supply reached in the 1990s when
14 Congress significantly changed the benefit to address fraud
15 and problematic payment incentives. The growth in 2010 is
16 consistent with prior years. For example, over 1,000
17 agencies entered the program in 2009. And while the growth
18 has been significant, for the last few years, it has been
19 concentrated primarily in Texas and Florida.

20 Next, we look at volume. Use of the benefit has
21 increased significantly in the last seven years. The number
22 of users has increased to 3.3 million in 2009, or over nine

1 percent of fee-for-service beneficiaries. The number of
2 episodes has risen to 6.6 million in 2009, a growth of more
3 than 50 percent since 2002. The episodes per user has also
4 increased, from 1.6 to two episodes per user in 2009,
5 implying that beneficiaries are staying on service for
6 longer periods.

7 The 50 percent rise in total episode volume has
8 been accompanied by an increase in episodes serving patients
9 admitted directly to home health from the community. In
10 2001, home health episodes were split about evenly between
11 patients admitted after a hospital or PAC stay and episodes
12 where the beneficiary was admitted directly from the
13 community. In the years since, episodes for community-
14 admitted patients have increased by over nine percent a
15 year, faster than the rate of growth for all episodes.
16 Because of this fast growth, in 2008, episodes for
17 community-admitted patients were about two-thirds of home
18 health episodes, and post-hospital or PAC episodes
19 represented only about 36 percent of episodes.

20 At the last meeting, some Commissioners asked
21 whether some of the growth in community-admitted patients
22 was due to beneficiaries using home health after receiving

1 outpatient surgery. Our review of outpatient surgery claims
2 suggested this was not a major factor, as about 4.5 percent
3 of community-admitted patients in 2001 had outpatient
4 surgery prior to home health and the share for 2008 is
5 slightly lower, at 4.3 percent.

6 Other shifts in volume which have occurred are
7 related to how CMS changed therapy payments in 2008. In
8 that year, CMS implemented a new system that dropped payment
9 for episodes in the ten to 13 therapy visit range and
10 increased it for episodes above and below this range. If
11 you look at the green bar of the middle graph, you will see
12 that a significant number of episodes were clustered in the
13 ten to 13 therapy visit range in 2007. In 2008, when
14 Medicare reduced its payments for these episodes, they
15 declined. The red bar in each part of this graph shows how
16 agencies reacted after this change in 2009. Visits
17 increased for the two groups with higher payment and
18 decreased for the group with lower payment.

19 The timing and nature of the change in episode
20 volume suggests that the use of therapy visits as a payment
21 factor may permit payment incentives to trump patient
22 characteristics in setting therapy plans of care. Later, we

1 will discuss a predictive approach that uses patient
2 characteristics to set therapy payment that would be less
3 prone to manipulation.

4 This next table shows risk-adjusted quality
5 measures for home health. For the first five measures, all
6 measures of a beneficiary's functioning, the steadily rising
7 line indicates there has been consistent increase in the
8 number of beneficiaries who improved. The bottom blue and
9 green lines show adverse events, such as hospital admissions
10 or the use of urgent care. A decline would indicate
11 improvement for these measures. However, the rate of
12 adverse events has not changed significantly.

13 Last year, the Commission expressed concern that
14 the current measures were too broad and did not necessarily
15 measure outcomes related to the need for skilled care. We
16 have launched a project to develop clinically-focused
17 measures and expect to report them when they are complete.

18 Next, we look at capital. It is worth noting that
19 home health agencies, even publicly-traded ones, are less
20 capital intensive than other health care providers. Also,
21 few are publicly traded. Financial analysts have concluded
22 that for those publicly-traded ones, they have adequate

1 access to capital, though because of the payment reductions
2 in the PPACA and several Federal investigations into
3 industry billing practices, the terms are not as favorable
4 as prior years. For agencies not part of publicly-traded
5 companies, the continuing entry of new agencies reflects
6 that smaller entities are able to get the capital they need
7 to expand. As I mentioned earlier, over 1,000 new agencies
8 entered Medicare in 2009, and so far, over 500 have entered
9 in 2010.

10 Next, we turn our attention to margins for 2009.
11 You can see that overall margins for freestanding providers
12 in 2009 are 17.7 percent. However, there is variation in
13 the margins. For example, the agency at the 25th percentile
14 had a margin of 2.2 percent while the agency at the 75th
15 percentile had a margin of over 26 percent. Margins for
16 providers that serve mostly urban patients were 17.9
17 percent, while they were 16.6 percent for agencies that
18 serve mostly rural patients. For-profit margins equal 18.7
19 percent. Nonprofit margins were 14.4 percent.

20 These numbers highlight two concerns that the
21 Commission has had for many years, that home health margins
22 have been excessive and that the wide variance in margins

1 may reflect inaccuracies in the case-mix.

2 I would note that we only report margins for
3 freestanding providers in this presentation. Hospital-based
4 providers, whose margins were included in those reported
5 during the review of hospital payments, averaged a margin of
6 negative-5.4 percent in 2009.

7 Since 2001, home health margins for freestanding
8 providers have averaged 17.5 percent. The high margins are
9 the result of at least two factors. The first factor is
10 that home health agency cost growth has been lower than the
11 payment update in most years. Because actual inflation has
12 been lower than market basket inflation, payment increases
13 have exceeded the growth in providers' costs.

14 The second factor is that the number of visits in
15 an episode has always been lower than what Medicare assumed
16 when it initially set home health rates. Medicare assumed
17 the average episode would include 32 visits, while under PPS
18 the average has been about 22 visits. As a result, Medicare
19 rates assumed more costs in the average episode than
20 providers actually incur.

21 We estimate margins of 14.5 percent in 2011. This
22 is the result of several payment and cost changes. Agencies

1 received a two percent update in 2010, offset by a 2.75
2 percent reduction for coding. In 2011, the PPACA reduced
3 the payment update to 1.2 percent and included a base rate
4 reduction of 2.5 percent. The PPACA also includes a three
5 percent rural add-on. And in addition, CMS reduced payments
6 by 3.89 percent in 2011 for changes in coding.

7 We expect case-mix to increase by another two
8 percent in 2010 and 2011 and assumed cost growth of one
9 percent in 2010 and a higher rate of 1.7 percent in 2011.

10 Here is a summary of our indicators.
11 Beneficiaries have good access to care in most areas. The
12 number of agencies continues to increase, reaching over
13 11,000 agencies in 2010. The number of episodes and rate of
14 use continues to rise. Quality shows improvement on most
15 measures. Access to capital is adequate. Margins for 2011
16 are projected to equal 14.5 percent. And margins, again,
17 for 2009 were 17.7 percent. These findings are very similar
18 to prior years.

19 Next, we will turn to recommendations. Before I
20 do that, let me remind Commissioners of changes in the PPACA
21 that have some relation to our draft payment adequacy
22 recommendation for 2012. Recall that in last year's March

1 report, we recommended that home health payments be rebased
2 to equal costs in 2011. The PPACA implements a phased
3 rebasing which begins in 2014 and is phased in over four
4 years. The reductions would be limited to no more than 3.5
5 percent a year, and this reduction would be offset each year
6 by the payment update. Given the positive indicators for
7 the industry, the delay seems unnecessary. In addition,
8 including the market basket update as an offset makes these
9 reductions similar and in some cases smaller than those that
10 industry has weathered in the past, so it would likely
11 result in agencies maintaining high margins.

12 Here is a draft recommendation for 2012. It calls
13 for an acceleration of the rebasing already in law and the
14 elimination of the market basket update. It reads, "The
15 Congress should direct the Secretary to begin a two-year
16 rebasing of home health rates in 2012 and eliminate the
17 market basket update for 2012." This would be a decrease
18 relative to current law, and in terms of beneficiary and
19 provider implications, we expect that some providers may
20 choose to withdraw from the program but that remaining
21 supply should be adequate to provide adequate access to
22 care.

1 In addition to concerns about high margins, there
2 has also been concern about the distribution of payments and
3 whether the payment system provides appropriate incentives.
4 First, as shown earlier, the inclusion of the therapy visits
5 as a factor in setting payments allows agencies to follow
6 financial incentives when determining the number of therapy
7 visits provided. In addition, a review of the payment
8 system indicates that it overpays for high case-mix
9 episodes, which are predominately therapy, and underpaid for
10 low case-mix episodes. For example, in a review of data
11 from 2007, high-margin agencies had a case-mix that was
12 seven percent higher than low-margin agencies.

13 An analysis by the Urban Institute found that the
14 current system is highly dependent on the use of therapy as
15 a predictor for its accuracy. With therapy as a predictor,
16 the system could explain 55 percent of costs. Without it,
17 the explanatory value dropped to 7.6 percent. Perhaps most
18 importantly, the case-mix explains one-tenth of one percent
19 of the variation in non-therapy costs, meaning the system is
20 weakest in explaining the services that are most commonly
21 provided. And notably, the case-mix properly identified
22 only 15 percent of high-cost non-therapy episodes.

1 All of these factors suggest the case-mix system
2 needs to change. If the current system remains in place,
3 agencies will have an incentive to avoid non-therapy cases,
4 base the amount of therapy provided on payment incentives
5 and not patient characteristics, and also to avoid high-cost
6 non-therapy cases.

7 Urban developed a revised system that did not use
8 therapy visits as a factor in setting payments and relied
9 solely on patient characteristics. The revised system they
10 developed explained about 15 percent of costs, or about
11 double the explanatory power of the current system when its
12 therapy thresholds are removed. Please note that the
13 prediction estimates for the revised system have been
14 updated and the numbers on the slide here are slightly
15 different from those in the paper we sent you.

16 The improvement was better at the service level.
17 For non-therapy services, the explanatory value of the
18 revised model was 15 percent compared to eight percent for
19 the current case-mix without its therapy thresholds. For
20 therapy services, the revised model had an explanatory value
21 that was more than double the current system without therapy
22 thresholds. The revised system was also more accurate in

1 identifying high-cost non-therapy cases, identifying about
2 28 percent of them, or nearly double the current system.
3 This analysis suggests that an alternate case-mix which
4 drops the therapy thresholds would have better accuracy and
5 better incentives than the current system.

6 This leads to a draft recommendation. It would
7 urge the Secretary to develop a revised case-mix system
8 similar to the one I just described. It reads, "The
9 Secretary should revise the home health case-mix system to
10 rely on patient characteristics to set payment for therapy
11 and non-therapy services and no longer use the number of
12 therapy visits as a payment factor." This would be a budget
13 neutral change. It would increase access to care for
14 therapy patients. Payments will be redistributed to
15 providers that focus on non-therapy services from those that
16 are more focused on therapy services.

17 Now, we have a preliminary model of the impact,
18 and generally, payments would increase for providers that
19 deliver more non-therapy and decrease for those that deliver
20 more therapy. Payments would increase for dual-eligibles,
21 severely ill patients who receive high amounts of nursing
22 and aide services, and at the provider level, it would

1 increase payment for patient-based nonprofit, rural, and
2 small providers.

3 We also plan to reprint the third recommendation
4 from last year's report that sets up a framework for
5 Medicaid safeguards. This recommendation addresses concerns
6 that providers may stint on care when the rebasing is
7 implemented. It reads, "The Congress should direct the
8 Secretary to expeditiously modify the home health payment
9 system to protect beneficiaries from stinting or lower
10 quality of care in response to rebasing. The approaches
11 should include risk corridors and blended payment that mix
12 prospective payment with elements of cost-based
13 reimbursement." And this would be budget neutral and it
14 should maintain beneficiary access to care and provider
15 willingness to serve beneficiaries.

16 Another issue is ensuring appropriate use of the
17 home health benefit. Today, physicians and home health
18 agencies are principally responsible for following
19 Medicare's enrollment and coverage standards, but several
20 studies have raised questions about how effectively they
21 serve this role. Many reports suggest that physician
22 oversight can be weak and the locus of control with agencies

1 which have a financial interest in eligibility -- excuse me,
2 and the locus of control remains with agencies which have a
3 financial interest in eligibility and plan of care
4 decisions.

5 Concerns about overutilization are further
6 exacerbated by the lack of cost sharing in home health.
7 Studies have generally found that beneficiaries consume more
8 health care services when they have limited or no cost
9 sharing and that these additional services do not always
10 contribute to better health. The rapid rise in home health
11 volume suggests that at least some of this growth may be
12 increasing Medicare's costs without improving beneficiaries'
13 health.

14 Adding a copay requirement would permit patient
15 choice to serve as an offset to the incentives in the home
16 health PPS which reward additional volume. However, the
17 copay needs to set appropriate incentives. It should not
18 drive beneficiaries to other high-cost settings and it
19 should minimize negative impact for high-need and low-income
20 patients.

21 One approach is to establish a fixed per episode
22 copay that applies to episodes for community-admitted

1 patients. As pointed out earlier, these are the majority of
2 episodes and one of the fastest growing category of
3 episodes. A copay could be charged at the per visit or per
4 episode level, but given the incentive that providers have
5 to deliver more episodes, a per episode copay seems most
6 appropriate.

7 To protect low-income beneficiaries, dual
8 eligibles could be exempt from the copay. The copay could
9 also exclude episodes with few visits. With this design,
10 about 32 percent of episodes in 2008 would have been subject
11 to the copay.

12 The amount of the copay depends on the minimum
13 value you would want a beneficiary to place on an episode
14 and how strongly you want them to consider alternatives. An
15 amount equal to ten percent, or \$300 per episode, might be
16 an example of an initial value that is appropriate. For a
17 typical episode, this amount would average out to about \$17
18 per visit, roughly in the middle range of the cost sharing a
19 beneficiary would pay for an evaluation and management
20 office visit covered under Part B.

21 To ensure that the incentives of this copay are
22 not diminished by secondary insurance, Medicare could

1 require that beneficiaries pay this out of pocket similar to
2 the true out-of-pocket feature in the Part D benefit.
3 Excluding home health cost sharing would avert an increase
4 in secondary insurance premiums that would result if it was
5 permitted to cover these costs.

6 With these parameters, here is a draft
7 recommendation which would establish a copay as I just
8 described. "The Congress should establish a per episode
9 copay for home health episodes that are not preceded by
10 hospitalization or post-acute care use. To protect access
11 for low-income beneficiaries, dual eligible Medicare and
12 Medicaid beneficiaries should be excluded from the
13 requirement. The copay should be exempt from first-dollar
14 coverage." And this would decrease spending. Some
15 beneficiaries would have to seek outpatient or ambulatory
16 care as a substitute, and providers would experience some
17 decline in demand.

18 And finally, we turn to program integrity. This
19 slide lists the 25 counties with the highest frequency of
20 home health use in 2008. If you compare the share of users
21 and the episode per user for each county to the national
22 average listed below and to the left in yellow, you will see

1 that these counties are well above average in home health
2 utilization. Note that the share of beneficiaries using
3 home health is two to four times the national average, while
4 the average number of episodes per user is also
5 significantly greater than the national average. Five of
6 these counties have more episodes than fee-for-service
7 beneficiaries.

8 Differences of this magnitude raise concern that
9 fraud may be an issue in some areas, particularly because
10 some of these areas, such as Miami, have already seen
11 significant program integrity activities. We cannot make
12 definitive judgments about the role of fraud in high-use
13 areas from this data, but differences of this magnitude
14 suggest a need for closer inspection, and if fraud is
15 revealed to be a factor, swift action.

16 Medicare has new authorities to fight fraud in the
17 PPACA and home health may be an appropriate place to use
18 these new authorities. Specifically, in areas where the
19 Secretary concludes there is widespread risk of fraud, she
20 can implement local moratoria on the enrollment of new
21 providers and suspend payments for services in areas that
22 appear to have widespread fraud.

1 This brings me to a draft recommendation. "The
2 Secretary, with the Office of the Inspector General, should
3 conduct medical review activities in counties that have
4 aberrant home health utilization. The Secretary should
5 implement the new authorities to suspend payment and the
6 enrollment of new providers if they indicate significant
7 fraud." And this could potentially decrease spending, and
8 appropriately targeted reviews should not significantly
9 affect beneficiary access to care or provider willingness to
10 serve them.

11 This completes my presentation and I look forward
12 to your discussion.

13 MR. HACKBARTH: Okay. Thank you, Evan. Well
14 done.

15 Today is a new day for the timekeeper and I'm
16 under pressure today because people have plane reservations
17 and train reservations, so we're going to adhere closely to
18 the schedule.

19 Before we launch into our round one clarifying
20 comments, I want to raise a couple issues that I'd like
21 people to think about and ask clarifying questions about
22 during round one and make comments on in round two.

1 Evan has laid out a package of recommendations,
2 five in total, plus re-running last year's recommendation
3 with regard to looking at modifying the payment system using
4 risk corridors or blended payment. So there are a lot of
5 moving parts here.

6 One of the issues that I'd like you to react to is
7 the sequencing of these different recommendations. So, for
8 example, obviously one of the recommendations is to rebase
9 the rates, but we're also talking about changing the case-
10 mix system in order to redistribute the dollars. We're also
11 talking about potentially moving away from fully prospective
12 payment to one that is blended payment or at least includes
13 risk corridors. The sequencing of those things could
14 matter, and I want you to think about that and react to that
15 when we get to the round two comments.

16 DR. CHERNEW: Do you mean the sequencing in the
17 chapter --

18 MR. HACKBARTH: No. Operationally -- the policy.
19 The policy. Does the order in which we do these policy
20 changes matter? So food for thought there.

21 DR. DEAN: Evan, as you know, I've been concerned
22 about this area for some time. You said that the case-mix

1 changes would be beneficial, you thought, to smaller
2 providers, if I heard that right. Do you have any idea of
3 the magnitude? Because I think in my area that's the major
4 concern. We've got a whole lot of very small providers,
5 many of which are marginal or non-existent at this point.
6 And there's obviously a huge variation across the country in
7 terms of Medicare expenditures per beneficiary.

8 Without getting into a lot of detail, is it
9 anticipated that this change would even out some of that?

10 MR. CHRISTMAN: I guess I'll start with the small
11 providers comment, and the boost they get, it's real but
12 it's not big. It's about 2 percent. And that's principally
13 -- you know, there's nothing in the model that specifically
14 is geared to an agency size. It's just that they're doing a
15 little bit more of the non-therapy, and the payments for
16 those episode types go up. And so that's why they come out
17 ahead.

18 In terms of the spending, I think it would have
19 some effect nationwide, but I don't know that there would be
20 a huge shift in what you see from the per capitas today.
21 But we haven't really looked at that.

22 DR. DEAN: The other issue, of course, in rural

1 areas is travel time, and that can probably double the cost
2 of the visits. Is any of that involved in this new
3 adjustment?

4 MR. CHRISTMAN: This does not. This looks simply
5 at patient severity. You know, travel time is something
6 that is a very difficult issue for us to look at because,
7 frankly, we hear that concern from providers in all
8 settings.

9 DR. DEAN: Yeah, well, I understand that.

10 DR. MARK MILLER: Can I ask a couple things?
11 There was a rural effect as well, right?

12 MR. CHRISTMAN: Yes, the rural does go up. If I
13 try and do the number off the top of my head, I won't say it
14 right.

15 DR. MARK MILLER: And also hospital-based?

16 MR. CHRISTMAN: Right.

17 DR. MARK MILLER: And the reason I bring that up
18 is because, Tom, you've raised both of those issues before
19 in your comments.

20 Then on the travel point, is there a change in law
21 that addresses that?

22 MR. CHRISTMAN: No. Well, it's one of the issues

1 that CMS is charged with studying --

2 DR. MARK MILLER: That was it.

3 MR. CHRISTMAN: -- as a part of their look at
4 potential refinements.

5 DR. MARK MILLER: All right.

6 MR. CHRISTMAN: But I guess, you know, on this
7 front we've had people from very urban areas come and tell
8 us the same thing, that because of congestion or what-not
9 that their areas are difficult to get around and they have
10 higher travel costs. And so it's something that may deserve
11 some attention, but whether we'll be able to find relative
12 differences I think is an interesting question.

13 DR. NAYLOR: Thank you for this great paper. On
14 the case-mix refinement, proposed refinement, to what extent
15 is comorbidity being captured? It wasn't captured in
16 earlier OASIS, the extent to which having multiple complex
17 conditions affect outcomes. And cognitive impairment, to
18 what extent is that -- you lay out here some of the areas,
19 but I was wanting to make sure that those factors were...

20 MR. CHRISTMAN: We haven't done anything
21 explicitly going down the comorbidities alley too far, and
22 that's because we were sort of starting from scratch and

1 rebuilding a whole system. I think we could think about
2 that. You know, when CMS did its refinements in 2008, they
3 added some comorbidities. And I think the difficulty is
4 that overall we find that diagnosis isn't as limited in how
5 correlated it is with home health use. So you can add some
6 of those comorbidities. How much additional explanatory
7 value you really get is -- go ahead. I'm sorry.

8 DR. NAYLOR: I was just going to say across our
9 work, which has now spanned a long time, the sheer presence
10 of multiple comorbidities, reinforced by Gerry Anderson and
11 others, really impacts the care needs and complexity. And
12 that's been absent in case-mix for home health, and I think
13 if we're moving forward, it would be great -- cognitive
14 impairment adds greatly to the complexity of the care needs
15 in the face of these, and I think it would be great to
16 consider.

17 MR. CHRISTMAN: I'm sorry. I can't recall off the
18 top of my head, but there are some cognitive things in the
19 model.

20 DR. NAYLOR: Okay. The second thing, which goes
21 to the threshold for co-pay and dual eligibles would be
22 exempt, but how did you arrive at that threshold?

1 MR. CHRISTMAN: Of \$300?

2 DR. NAYLOR: Yeah.

3 MR. CHRISTMAN: We started off thinking, you know,
4 normally co-payments in Part B, for example, coinsurance
5 runs 20 percent, and that would result in a co-pay of \$600.
6 And we just felt that that was probably a bit of a big jump
7 to go from zero to \$600, and so, you know, 10 percent, \$300,
8 became I think what we were just offering as, you know, a
9 discussion target. It just comes out arithmetically also.
10 That's kind of in the range of what a beneficiary would pay
11 for some types of outpatient physician visits. And that's
12 offered just as a comparator, not as something that's
13 instructive. You know, it really comes down to the two
14 points that I mentioned, which is sort of what's the minimum
15 value that you'd want a beneficiary to place on these
16 services and how much do you want them to think about
17 alternatives. I think from at least my perspective, I don't
18 have more guidance to offer than that.

19 DR. NAYLOR: Thank you.

20 MR. BUTLER: On page 23, the one that gets your
21 attention, I'd like to understand not just the fraud and
22 abuse piece but the variation question just in general and

1 how significant it is. These numbers suggest about at least
2 twice as much number of episodes per users and two to four
3 times as many -- so maybe six times the national average in
4 utilization, if you'd kind of do the simple math. But these
5 are small number accounting.

6 So at the two ends of the spectrum, do you have
7 any sense, like, you know, 10 percent of the counties use 50
8 percent of the home health, or any other -- a number of
9 counties have almost none? So, you know, what's the
10 variation whether or not it's due to fraud and abuse?

11 MR. CHRISTMAN: Okay. So in terms of the percents
12 in counties like you talked about them, I haven't racked it
13 up that way, so I don't know. The variation that we've seen
14 in home health among counties is greater than any of the
15 individual payment systems we've looked at. So there's more
16 variation in home health than hospice, than physician
17 services, and other things. And as I recall, the variation
18 between sort of the price-adjusted and health status-
19 adjusted variation is about twofold between the CBSA at the
20 75th percentile and the CBSA at the 25th percentile, so in
21 the interquartile range there. And it goes to sort of
22 threefold if you look at the 10th and the 90th.

1 In Hildalgo County, there's McAllen, Texas, and
2 that variation is about, I believe, six or seven times the
3 national average -- again, at the per beneficiary level in
4 health and price adjusted.

5 DR. MARK MILLER: We can also come back with, you
6 know -- what you asked is doable. We can come back with a
7 more specific statement about this many counties account for
8 this much of the spending, that type of thing.

9 MR. BUTLER: My interest is not just, you know,
10 the obvious targets, but what is the variation and
11 ultimately how is it complemented by SNFs or the presence of
12 other services? Just to get a sense of what's going on in
13 the communities.

14 DR. MARK MILLER: We can speak to some of that.
15 There was a presentation, I want to say either in September
16 or October -- I can't remember right at the moment -- and we
17 continued to do some work. When you look at variation
18 across the country, a lot of the variation does seem to be
19 driven by differences in post-acute care. And, two, there
20 is some assumption, but, yeah, doesn't one of these things
21 substitute for the other? Not so much. You're high, you're
22 high.

1 MS. UCCELLO: I'm thinking about the co-pay and
2 the incentives to drive people into other services,
3 especially if supplementary coverage fills in the cost
4 sharing for these other services.

5 MR. HACKBARTH: Could I suggest we come back to
6 that in round two? I think that's a really important issue.

7 MS. UCCELLO: Okay.

8 MR. HACKBARTH: Unless there's just --

9 MS. UCCELLO: My question was just how
10 substitutable are these. Is that two?

11 MR. HACKBARTH: Yeah. You know, I don't think
12 that there's a simple answer to that, and it's going to take
13 some discussion. So let's come back to it.

14 MR. GEORGE MILLER: Yes, I want to address that
15 issue but will do it in round two.

16 Slide 5 and Slide 12, I've got the same question
17 for both of those slides. That is, the increase in admitted
18 patients from the community increased by more than 10
19 percent annually. Do you have that broken down for for-
20 profit and not-for-profit for that increase? And on Slide
21 12, the same question, number of home health agencies
22 continue to grow. Do you have the growth for for-profits

1 and not-for-profits?

2 MR. CHRISTMAN: The growth in agencies has been
3 predominantly for-profits, so I'm going to say 80 to 90
4 percent has been for-profit. But, you know, with that said,
5 I would just remind you that the financial performance
6 differences between the for-profits and the nonprofits is a
7 very small sector.

8 MR. GEORGE MILLER: I saw that. Very well taken.
9 But still the predominance of the growth and the explosion,
10 and in McAllen, Texas, is for-profit. Okay.

11 DR. BERENSON: Could you go back to 23 again where
12 Peter was? I want to just pick up that substitutability
13 question. I'm interested in the interaction between the
14 home health in Medicare and home and community-based
15 services in Medicaid. Well, first, just a simple question.
16 What's the percentage who are duals, do you know?

17 MR. CHRISTMAN: It's between 35 -- episodes,
18 between 35 and 40 percent.

19 DR. BERENSON: 35 and 40. In general, are home
20 and community-based services provided by Medicaid through
21 sort of waivers and home health complementary services? Or
22 is there a substitutability component? I mean, do they work

1 together or do they work as substitutes, I guess is my
2 question.

3 MR. CHRISTMAN: My understanding of this is not
4 very strong, but it's sort of similar to the SNF world. I
5 think whenever they can move folks into the Medicare
6 benefit, they do, you know, if they qualify. But whether
7 they function in a complementary manner the way you're
8 describing, I'm couldn't -- I'm not sure I can --

9 DR. BERENSON: I mean, because it's striking. I
10 mean, there's other hypotheses, but when you're looking at
11 Texas and Mississippi and Louisiana and states like that, I
12 mean, I just raise the question of whether they're not
13 really providing an alternative in Medicaid, and so at least
14 there's some attempt to use Medicare as the source of care.
15 I mean, also personally having visited some parts of Texas
16 and seen that there were six home health agencies in a town
17 of 2,000 people, I don't think that's the whole issue. But
18 I'm wondering whether it is playing a part, and I think we'd
19 want to look into that.

20 MR. CHRISTMAN: There are a number of areas on
21 that chart that are areas that have seen lots and lots of
22 growth in agencies. And so, you know, you have a concern

1 that's part of the story. But there are a few that are as
2 you're laying out. You know, I believe it's either
3 Louisiana or Mississippi, for example, that has certificate
4 of need and just hasn't seen a lot of growth in agencies,
5 but we still see a lot of growth in volume and growth in
6 high use.

7 MR. KUHN: Evan, one issue didn't come up, and I
8 just want to check and see. The issue of the outlier, the
9 kind of charging that we saw a couple years ago that CMS
10 tamped down, has that issue been pretty much dealt with? Or
11 is there going to be needed an additional policy work in
12 that area?

13 MR. CHRISTMAN: They made a number of changes that
14 I think we kind of have to see how they work. The two
15 changes they made were -- just briefly, there were agencies
16 that were manipulating their billing to charge for outlier
17 episodes and get high payments for services that either
18 weren't covered or were much cheaper than what Medicare
19 assumed they cost. So they were able to make money on
20 outliers, and CMS took two actions. One is they shrank the
21 size of the outlier pool; it puts fewer dollars at risk.
22 They went from a 5-percent pool to a 2.5-percent pool. And

1 they implemented an agency cap such that for no individual
2 agency no more than 10 percent of their Medicare payments
3 could be outlier payments. So if they exceed that cap in
4 outlier payments, they have to give it back.

5 So, you know, I think that will have a significant
6 effect. There are agencies that had very high rates of
7 outliers. My understanding, you know, one home health
8 executive told me -- an association executive told me that
9 their phone was ringing off the hook because some agencies
10 felt that their business plans had been exploded, and they
11 were trying to figure out how to function in this new world.

12 So that change went into effect, if I'm counting
13 my years right, in the 2010 payment year. So I think we're
14 kind of waiting to see what happens there, and right now
15 we're kind of just focused on fixing the core case-mix.

16 DR. STUART: My question regards the
17 interpretation of the data on Slide 7. We've seen this
18 before, and the question I have is that the interpretation
19 of the rise in the proportion of the population that meet
20 these criteria and the expression both here and in the
21 chapter is that this represents an increase in quality of
22 care. But my understanding is that these are unadjusted

1 rate. Is that correct?

2 MR. CHRISTMAN: They're adjusted.

3 DR. STUART: They are adjusted.

4 MR. CHRISTMAN: They are adjusted.

5 DR. STUART: For?

6 MR. CHRISTMAN: Differences in, changes in
7 comorbidities, functional characteristics, demographics.

8 DR. STUART: They are adjusted okay. All right.

9 Thank you.

10 MR. HACKBARTH: On that same issue, in previous
11 discussions the question that has come up about these
12 measures is are they truly objective measures. Do you want
13 to address that, Evan?

14 MR. CHRISTMAN: Sure. If I'm following you,
15 there's probably two sets of concerns. One has been that
16 these aren't based on claims data. These is the self-
17 reported information from the industry.

18 And a second concern has been sort of this
19 divergence between the adverse event rates and the
20 functional rates. The functional rates show improvement.
21 The adverse event rates kind of stay steady.

22 You know, a third concern has been that these are

1 sort of broad measures of quality, so, for example, they
2 show improvement in walking even for people who may not have
3 shown up at home health with a walking dysfunction.

4 So we have some work underway that addresses some
5 of these things where we can. We're looking at clinically
6 focused measures that look at improvement in walking for
7 patients that just received a hip and knee replacement, and
8 we are looking at claims-based hospitalization rates so
9 that, you know, we can use that data and see how it compares
10 to the self-reported data.

11 I think that sort of describes the past concerns
12 and sort of what we're doing to come up with alternative
13 measures.

14 DR. BAICKER: Just a brief follow-up on that. I
15 would think the risk adjusters are unlikely to be perfect,
16 and so this is also consistent with the story where as you
17 just start getting more people enrolled, you're marching
18 down the distribution, so it's a selection story even with
19 the adjustment. You're getting healthy people in and they
20 can walk real well.

21 My other question may be in the category of round
22 one and a half, but it does have a factual nub, which is,

1 I'm really interested in the interaction of Recommendations
2 2 and 4, which both seems like great ideas, to foreshadow
3 round two. But what I'm not clear on is how we would expect
4 them to interact if they were deployed together. For
5 example, are the services where you want people -- when
6 people are paying more, you expect some services to get cut
7 back. Are those the services that are being overcompensated
8 now? So how would you expect introducing this co-payment to
9 affect your ability to go back and do the better payment
10 system? That's a question in the long run about the
11 elasticities of different kinds of consumption, but in the
12 short run, the models are all based on the behavior from the
13 previous pricing regime. You introduce a co-payment, all
14 sorts of things shake out differently. How do you build
15 that into the model of what the right risk adjuster should
16 be?

17 MR. CHRISTMAN: Sure. I haven't thought too much
18 about this question, but I guess what I would say is, you
19 know, the case-mix adjustment, the purpose of that is to pay
20 more accurately for services, and it will increase payment
21 for the non-therapy and decrease payment for the therapy.
22 And that has definitely been one driver of volume, people

1 favoring those therapy cases. But whether that would affect
2 the number of patients coming from the community, I don't
3 think it would and here's why. I think that it comes down
4 to the fact that about 10 percent of beneficiaries go to the
5 hospital at all during the year, and so from the agency
6 perspective, the pool of potential patients that they've
7 sort of been expanding it to in the community-admitted is
8 just so large. Whether they're going to offer them therapy
9 or non-therapy services, you know, I think that the factors
10 driving in that direction aren't going to be changed by the
11 change in the case-mix. What they may offer or favor may
12 change, but, you know, we've had this situation where
13 hospital discharges have been flat or declining and agency
14 census has been increasing. And so, in some sense, there's
15 got to be -- I think the hypothesis is that there's at least
16 some supply-induced demand in there, and what they offer may
17 change, but the fact that the community-admitted patients is
18 just such a larger potential market that many agencies will
19 continue to look there.

20 DR. CASTELLANOS: First of all, good presentation.
21 In your discussion, you mentioned that physician oversight
22 was weak. I know in the material that you sent you

1 discussed that wide window of 90 days ahead of time and 30
2 days afterwards, and there was no discussion at all
3 concerning recertification. I know we had briefly talked
4 about this before. Has there been any more discussion as
5 far as maybe tightening that up from the physician or
6 physician-extended side, similar to perhaps what we've tried
7 to accomplish with hospice?

8 MR. CHRISTMAN: Part of the struggle is that
9 there's already, I think, some measures that are somewhat
10 similar to what we've done in hospice in place and home
11 health, not the exact same, and there's a couple of
12 different questions in there. One is the window, and under
13 the PPACA a beneficiary is supposed to have a prior
14 encounter with a physician or a nurse practitioner before a
15 physician can certify for home health. And out of concerns
16 of maintaining access to care, CMS settled on a window that
17 permits that prior encounter to occur up to 90 days before
18 or 30 days after the physician certifies home health.

19 MR. HACKBARTH: Evan, is there a recertification
20 required for each new episode?

21 MR. CHRISTMAN: Yes, there is. There's a
22 recertification. The physician has to basically sign a

1 legally binding attestation that has False Claims Act and
2 all that good stuff attached to it. And so the wrinkle is
3 that the face-to-face encounter requirement right now only
4 applies to initial certifications of home health. So when
5 they're being recertified, the physician still has to fill
6 out a legal attestation and all that good stuff.

7 MR. HACKBARTH: But no face-to-face for the --

8 MR. CHRISTMAN: No face-to-face.

9 DR. CASTELLANOS: Is there any more discussion as
10 to our tightening that up, specifically recertification,
11 face-to-face and cutting down on the window?

12 MR. CHRISTMAN: It's certainly something that we
13 could consider. I don't remember exactly what we thought it
14 has established for a window in hospice. And I think my
15 opinion is that a more timely evaluation would be valuable,
16 and just in the interest of balance -- I mean, they did it
17 out of concern of access to care, so there are folks on the
18 other side --

19 MR. HACKBARTH: As I recall, in a comment letter
20 we suggested a narrower window, recognizing that it would
21 require a legislative change, but a narrower window may be a
22 good thing.

1 The other time we discussed this, though, Ron --
2 and you'll remember -- we had a draft recommendation to
3 increase physician involvement in this. And I can't
4 remember all the specifics of it, but ultimately we dropped
5 it because we couldn't quite figure out how to make it work.
6 I'm not going to be able to remember all the issues, but I
7 remember well Tom saying that he was uncomfortable with the
8 ability of physicians to monitor the use of the benefit,
9 that they don't have the knowledge.

10 So it's definitely an area of interest, and we can
11 go back to it. We need to bring forward that past
12 discussion and see if we can use it as the foundation.

13 DR. CASTELLANOS: Thank you.

14 MS. HANSEN: Evan, you said something actually in
15 response to one of the questions just asked. Did I hear you
16 say that 10 percent of the Medicare beneficiaries have a
17 hospital episode in any given year? Or did I mishear?

18 MR. CHRISTMAN: I hope I said that, yes, and I
19 hope it's right. But that's the number --

20 [Laughter.]

21 MR. CHRISTMAN: I mean, if you know something
22 different, please tell me. But I believe that's the number.

1 I make it a point of having this conversation with the
2 hospital folks, and I believe that's what we landed on last
3 time we had the conversation.

4 MS. HANSEN: I actually would like to follow up on
5 that just so that we get a sense so that if there are about,
6 say, just on the average, for the Medicare beneficiaries who
7 are 65 and older, it's under 40 million, so that would be --
8 potentially 10 percent of that population would go. So if
9 we could just verify that number, that would be good.

10 MR. CHRISTMAN: Sure.

11 MS. HANSEN: And then, secondly, back to Slide 23,
12 this is just more of -- it just ticked my curiosity of the
13 previous work on, say, the more efficient areas of services
14 in communities that are -- use of Medicare services is on
15 the opposite side, so it would be -- and I saw the earlier
16 chart about the fact that some of the quality indicators of
17 rehospitalizations or other things don't change. But is
18 there a little bit more descriptive sense of the more --
19 kind of almost the -- whether it's the 10 percent that was
20 brought up earlier, but just the more efficient Medicare use
21 counties with good outcomes on the part of beneficiaries.

22 MR. CHRISTMAN: I think we could definitely pull

1 up areas that meet some sort of national average and what
2 they look at. I think the difficulty is that, you know,
3 even this data is a county-level average, and it's going to
4 consist of providers who are really doing the right things
5 and providers who are practicing in the wild, to use the
6 term that's been used before. So really saying that, you
7 know, this county looks good and this may represent some
8 sort of optimum of home health I think would be difficult to
9 conclude.

10 DR. MARK MILLER: The only thing I will add to
11 this is you remember the conversation yesterday, we're also
12 trying to get some data from Managed Care Plan to see what
13 their patterns are like. But each of these always have
14 compromises. Whether you're able to link that to quality
15 outcomes is more difficult. I'm just trying to run this
16 fact to ground. It's about 10 million admissions, but it's
17 closer to 20 percent, I think, of beneficiaries. And I
18 think that was...

19 MR. HACKBARTH: Clarifying questions?

20 DR. BORMAN: Evan, could you put up Slide 14?
21 And, Glenn, this is really a clarification for you, and if
22 you want to defer it to the next round, I understand.

1 This is a compound sentence here, so it's really
2 two things. It's begin the two-year home rebasing and
3 eliminate the market basket. In terms of us thinking to the
4 next part of your question for sequencing, could you share
5 the strength of the linkage? The "and" there, is this
6 something that "if" and "and" together needs to stay
7 together or is this something that we need to consider
8 separately?

9 MR. HACKBARTH: I think the reason -- and, Evan,
10 jump in if I'm off the mark here. But I think the reason
11 for structuring it this way is that PPACA actually says go
12 forward with rebasing, but then also give updates, which has
13 the effect of undoing some of the rebasing. So, you know,
14 if your goal is to bring the rates closer into line with the
15 underlying costs, to go down and then up doesn't seem to
16 make a lot of sense. And so this just makes it clear that
17 we think that there ought to be rebasing and don't turn
18 around and offset part of that through a market basket
19 increase.

20 DR. BORMAN: Thank you.

21 MR. HACKBARTH: Round 2 now. We've got 45 minutes
22 left in this session and, unfortunately, we've also got a

1 lot of different recommendations, so we're going to have to
2 be really disciplined in how we go through this. Let me
3 just also raise one other issue that I'd like people to
4 react to. I raise the question of the sequencing of the
5 recommendations that would influence the rates and the
6 distribution of the dollars.

7 Another issue that I'd like you to react to
8 relates to the recommendation on the co-pay. We have
9 planned for the spring another discussion on restructuring
10 of the Medicare benefit package, and the reason I wanted to
11 offer this here, the home health co-pay is, this is one of
12 the few services where there's zero co-pay today.

13 So one train of thought would be, well, a major
14 overhaul of all of the structure is down the road and may
15 take a long time. A more focused recommendation in one of
16 the areas where we have zero may move more quickly. But
17 again, that's an issue I'd like you to react to. Mitra?

18 MS. BEHROOZI: So on the sequencing question,
19 which I hadn't thought about it at all until you raised it
20 so this is off the top of my head, I mean, what I have
21 thought about since the prior presentation that Evan did
22 about this is that one of the big concerns is not the level

1 of -- is in addition to the level of the margins is the wide
2 variability.

3 So I love the redistributive effect of the case-
4 mix index adjuster, and I think that that's the priority
5 just because that is so much more dramatically worse than in
6 other payment systems, and because we don't want to do harm
7 where there are providers who are trying to do the right
8 thing and provide the non-therapy services. So that would
9 not only protect them, but reward them in a way that they
10 haven't been rewarded and take some of the money away that's
11 not being spent appropriately at the high end.

12 I think consistent with that, then risk -- the
13 whole risk corridor recommendation moves in the same
14 direction of sort of bringing the ends closer to the middle.
15 And then that middle being too high, you know, is what, I
16 guess, would be addressed by rebasing. So while I
17 understand that in current law, the way it's set out, it
18 would take a long time to get there. I don't know that it's
19 so important to necessarily move that up so fast and hard,
20 and that's not really going to solve, I think, the worst
21 problems because, you know, payments have been cut before
22 and volume continues to grow and payments continue to grow.

1 I mean, rates have been cut before.

2 So I think that's, to me, the third in the line of
3 three. Certainly, the final recommendation on doing more to
4 combat fraud I totally support and would go farther
5 probably.

6 On co-payments, I certainly like -- I think that
7 what we need to do, and as you said, Glenn, this is an
8 opportunity to do it in a targeted way, but we need to be
9 consistent with what we want to do on the broader scene,
10 which is to encourage the use of high value services and
11 discourage the use of low value services.

12 So I appreciate that you wouldn't be proposing
13 using -- applying a co-payment to post-acute services after
14 a hospital or a post-acute stay. But then when it comes to
15 the co-payment on the second or from the community episodes,
16 I have some issues with imposing the co-pay as proposed
17 here.

18 First, I think that having it be a flat co-payment
19 doesn't relate it to the value of the services to the
20 beneficiary. I mean, we're starting with the payment system
21 structure to address provider incentives. Right? So we're
22 talking about a 60-day bundle and we're talking about

1 adjusting the case-mix index within that bundle. But to the
2 beneficiary, the 60 days is not relevant to how many
3 services or what type of services they might be receiving
4 within that bundle.

5 So for everybody to pay \$300, or whatever that is,
6 for that same period of time within which they might get 30
7 aide visits or 50 nurse visits is not very targeted in terms
8 of the value to them, unless I'm misunderstanding it. I do
9 note, though, that you said that we could also exempt
10 episodes with very low numbers of visits, and I think that's
11 a good approach.

12 But I think it would be helpful to, I don't know,
13 allow the Secretary or somebody to develop a more targeted
14 or more nuanced kind of approach that addresses it from the
15 beneficiary value standpoint. I think there's also a
16 potential that it doesn't relate to value to the program
17 because if you treat all community admissions the same way,
18 then you might be missing some opportunities to incent the
19 utilization of home care that would avoid a hospitalization
20 or something like that. I know you looked at the post-
21 outpatient surgery category, but again, it might be useful
22 to be more nuanced in the approach.

1 I also think -- and I said this the last time --
2 that a number like \$300 is too high. It's too high for low-
3 income people who are not dual eligibles, and I say this all
4 the time, I know. Sorry. I'm a broken record. Dual
5 eligible is not coextensive with low income. It's really
6 not.

7 Again, if it's the same number for all people who
8 are not dual eligibles, then you're going to have a lot of
9 people at the lower end of the income scale making a
10 decision based on the \$300 that has nothing to do with,
11 really, the value of the services to them. It will just be
12 about the \$300. Again, I think there's evidence that shows
13 us a lot smaller number can be used to drive behavior while
14 mitigating the potential effect of being too high a barrier
15 that will make people avoid needed care.

16 I think, again, we need to look at it from the
17 beneficiary perspective rather than the program perspective,
18 starting with the 20 percent because that's what the program
19 does in other areas. And here's the cost to the program of
20 the benefit just is not looking at it from the beneficiary
21 perspective. If you want to look at driving behavior, I
22 don't think you need to start with, well, 20 percent of the

1 cost of the benefit to the program. You look at what would
2 drive beneficiary behavior in a constructive way, again.

3 But on the point of exempting duals, this is more
4 of a question and relates to what Bob raised about the state
5 interplay. If you exempt duals, wouldn't that mean that
6 you're exempting the state from covering the co-payment and
7 then encourage a little bit more about what Bob brought up
8 about possible shifting of what might otherwise be a state
9 program?

10 And then the substitutability, that kind of also
11 relates to what Cori was raising about would this not only
12 possibly drive people to more expensive post-acute care, but
13 even to hospice, I guess, right, where we see evidence that
14 that's sort of growing into a long-term home care benefit.
15 So I think taking those considerations into account is
16 important.

17 DR. DEAN: Where to start? Just in response to
18 the question about recertification, I guess it is true that
19 we get forms stuck in front of us to sign about which we
20 know very little as to what's actually happening. That
21 isn't necessarily an argument against the concept.

22 I guess, Evan, I'm still not really clear as to

1 what the criteria for recertification is. Does it require
2 that progress be demonstrated? I mean, for instance, when
3 we're using, for instance, physical therapy and their swing
4 bed program, that is the main criteria, that they have to
5 demonstrate progress, and if they do, they can continue. If
6 they hit a plateau, then not. What are the criteria for
7 continuation?

8 MR. CHRISTMAN: As I understand it, really it's
9 the two keys are the same as in initial certification,
10 broadly. Is the patient still home-bound? And they still
11 have a need for skilled care so they still need the physical
12 therapy. Do they still need the nursing service.

13 DR. DEAN: Is need defined?

14 MR. CHRISTMAN: You're wading into waters I just
15 don't know as well.

16 DR. DEAN: And that may be an issue in and of
17 itself, if the criteria for continuing are very imprecise,
18 it certainly --

19 MR. HACKBARTH: So right now, we don't have a
20 recertification draft recommendation on the table for
21 consideration, and there are issues that we would need to
22 think through. Ron has asked that we consider that in the

1 future and we will, but right now, that is not one of the
2 draft recommendations.

3 DR. DEAN: I understand, and I guess I would just
4 say, I would agree with Ron. I think it deserves some
5 exploration.

6 MR. HACKBARTH: What about the existing draft
7 recommendations? What are your thoughts?

8 DR. DEAN: Well, I certainly agree with the
9 direction of them. As far as prioritizing or sequencing,
10 I'm not quite sure. Certainly the fraud issue probably
11 ought to be number one, I would think, and then if the case-
12 mix adjustments and rebasing is -- if there's an expectation
13 that that will result in a more reasonable distribution of
14 the resources, I'm certainly supportive. I guess I'm not
15 sure I understand them well enough to really comment on
16 that.

17 Looking at the data, the wide variation in
18 resources expended per beneficiary is disturbing. The data,
19 I think, that we saw that you folks sent me a while back
20 there's a tenfold difference between expenditures per
21 beneficiary across states, from the lowest users to the
22 highest users. There just isn't anywhere near that much

1 variation in terms of clinical justification or clinical
2 need.

3 So we clearly have a problem. Obviously, it's a
4 complex one to know how to get a handle on it, but obviously
5 I think these are a start.

6 So I guess, you know, how or what the strategy of
7 the sequence should be, I think those are right moves. I
8 guess I still am concerned about the low volume providers
9 that I'm not sure are going to do well in any of these
10 things.

11 The example in the written material of the fact
12 that there's an area where Medicare payments were judged to
13 be adequate, but there wasn't enough Medicare patients to
14 support an agency, and so the agency went out of business,
15 and how we respond to that I'm not quite sure except the
16 bottom line is you have beneficiaries that don't have a
17 service.

18 So I think it still is a worry even though it
19 isn't -- Medicare may be approaching it in a reasonable way,
20 and yet, still -- and that's certainly the case in the areas
21 where I'm at. You have, admittedly, not large numbers, but
22 you certainly have beneficiaries that just don't have access

1 to this service. So obviously I'm concerned. I don't know
2 exactly what the response is.

3 MR. HACKBARTH: In a way, this relates to the
4 rural report.

5 DR. DEAN: Yeah -- [off microphone.]

6 MR. HACKBARTH: Right. The question you and I
7 have discussed via email is when there are situations like
8 this, take the example of home health, Medicare is paying
9 well. There just aren't enough Medicare patients to make
10 the home health agency viable. Is the best way to solve
11 that problem through still higher Medicare rates, or should
12 the Federal Government provide support through some other
13 channel to assure adequate access to essential health care
14 services? So that's a question, I think, is better
15 discussed not in the home health update, but in the broader,
16 what should our policy be towards rural issues.

17 DR. DEAN: And I accept that. I think it is -- I
18 mean, it's an outlier issue and how we respond to it. And
19 like I've said, it's not huge numbers of people. I
20 acknowledge that. And yet, at the same time, there are
21 folks that could benefit. I mean, in our setting, there are
22 other services that fill part of these gaps. That didn't

1 answer any of your questions probably.

2 MR. HACKBARTH: Sort of like I've got the drift.

3 Mary?

4 DR. NAYLOR: So my recommendations in terms of
5 sequencing would be that we would proceed immediately with
6 efforts around the case-mix. I think that there are really
7 important questions about whether or not the right set of
8 people are getting to home care from hospital to post-acute.
9 We still have no change in the needle on readmission rates
10 in 30 days from hospitals, et cetera, and that they're
11 getting to the right and most efficient services.

12 There are some issues around that. So I think
13 that this case-mix work is going to help, really help in
14 helping us to get that path much clearer, right people to
15 the most effective and efficient sets of services which --
16 so I really think that's important.

17 I think this movement around the quality measures,
18 which is not an explicit part of the recommendation, but
19 part of the report, is also equally important, that we get
20 the right set of measures to help us to understand that
21 we've done that.

22 I was also immediately moved on number five, on

1 their review of the Office of Inspector General. Putting
2 back lower and not immediately the recommendations related
3 to rebasing, and then obviously protecting beneficiaries
4 from possible stinting from rebasing, it seems to me, would
5 -- they go together, but I would not put them immediately.

6 I would recommend that we recommend testing the
7 impact of co-pay. I do agree with earlier comments that low
8 income and dual eligibles are not the same, so we would
9 really want to make sure that we were not in any way hurting
10 low-income beneficiaries who absolutely need access to these
11 services and who will absolutely look at that \$300 as just a
12 barrier that they can't overcome.

13 And finally, since it was raised on the
14 certification, I would say this is also an opportunity for
15 us to look at consistencies across the policies in hospice,
16 advance practice nurses, certify, recertify. Here, I would
17 think that we would also want to look at the capacity of
18 advance practice nurses to participate as active players in
19 that process.

20 MR. HACKBARTH: So let me just clarify on thing,
21 Peter, before you go. So, Evan, briefly describe the timing
22 of rebasing as it exists in current law and PPACA.

1 MR. CHRISTMAN: Sure. It would start in 2014 and
2 starting in that year, the Secretary could begin to dial
3 down payments by 3.5 percent in that year and each of the
4 three following years. And then in each year, that 3.5
5 percent would be offset by the market basket update that
6 year, which will be around 1 or 2 percent.

7 MR. HACKBARTH: And so the length of the rebasing
8 process is stretched out by the fact that they're going down
9 and then increasing by the market basket. So to get to the
10 ultimate goal takes more years. Is that right? So you
11 start in 2014 and you have a rather protracted process to
12 get to the destination.

13 So one of the things that I feel pretty strongly
14 about is that we need to rebase and we need to do it and at
15 a pace significantly faster than that. I offered let's do
16 it starting in 2012. We don't need to resolve it today, but
17 even if we were to change the sequencing and say, oh, we've
18 got to do the case-mix thing before we rebase, I would like
19 to still be clear that oh, we're not talking about start in
20 2014 and do it over the next ten years or something.

21 DR. NAYLOR: I totally agree with that.

22 MR. HACKBARTH: Okay.

1 DR. MARK MILLER: Can I get just one other
2 clarification? It starts in '14 or it can start in '14?

3 MR. CHRISTMAN: I believe it's required to start
4 in '14.

5 DR. MARK MILLER: Okay.

6 MR. BUTLER: So just to clarify, I guess, if we
7 had the right system case-mix today, coupled with a good co-
8 pay and you could extract all of the targeted dollars
9 through that means as opposed to rebasing, that would be my
10 preference. So in other words, let's pretend we have the
11 case-mix system done today and we were ready to go with co-
12 pays, I would try to get to the spending target through
13 those two means and not rebasing at all, if there was a way
14 to do it. In other words, redistribute the dollars at a
15 lower amount using the case-mix, and also have a co-pay. We
16 just practically can't do that.

17 DR. MARK MILLER: Can I just ask, and just for
18 clarification, the case-mix, as discussed, is a budget
19 neutral transaction. So what I'm ask --

20 MR. BUTLER: See, I would marry it with the budget
21 goal.

22 DR. MARK MILLER: So I'm going to restate. This

1 is exactly what I'm trying to draw out. You're almost
2 saying something -- I'm asking. You're saying the case-mix
3 would have the effect of leveling out payments. We were
4 seeing that as a budget neutral transaction. Are you
5 suggesting you would say no, you take the payments out of
6 this side? Is that conceptually what you're saying?

7 MR. BUTLER: I think so, yes.

8 MR. HACKBARTH: So a non-budget neutral case-mix?

9 MR. BUTLER: Case-mix. In other words, I'm trying
10 to get the rebasing done in combination. Throw it into the
11 case-mix equation so it's not a budget neutral. I don't
12 think we could do that given that we don't have the case-mix
13 done in a timely fashion. But you said if it had been.

14 MR. HACKBARTH: Yeah.

15 MR. BUTLER: So I don't have an answer to how to
16 do that. But in the end -- my point is, and everybody
17 else's is, you're trying to affect individual behaviors in
18 how the services are delivered at the local level, and
19 rebasing is a blunt instrument that just takes money out of
20 the system and it doesn't do anything about underlying
21 delivery of services and behaviors of the individuals using
22 them, I don't think.

1 MR. HACKBARTH: At the patient level or the --

2 MR. BUTLER: Yeah, or even in the -- let me --

3 MR. HACKBARTH: Well, rebasing. I'm sorry. Go
4 ahead, Peter.

5 MR. BUTLER: It takes profits out of the system.

6 MR. HACKBARTH: Yes.

7 MR. BUTLER: I understand that. It doesn't
8 necessarily change incentives for the home health to do
9 things anything differently.

10 MR. HACKBARTH: Well --

11 MR. BUTLER: Except cheaper.

12 MR. HACKBARTH: For hospitals. We talk about
13 pressure on the rates being an important force in improving
14 efficiency. And so, I think the level of the rates matters
15 a lot. If you have a base rate that is well above the cost
16 of delivering the service, I think that's a problem.

17 MR. BUTLER: It doesn't do anything about the
18 therapy services though, the way the system is skewed.

19 MR. HACKBARTH: And I agree and that's why I
20 haven't said, oh, rebasing is the only thing we need to do
21 in home health. Unfortunately, we've got a lot of things
22 that we need to do in home health. That's why we've got so

1 many recommendations. So rebasing isn't a panacea, but I
2 don't see if we did everything else but rebasing, that would
3 solve the problem either. I think we need to do it all.

4 MR. BUTLER: Right. It's tricky. The other thing
5 I would say, Mitra brings up an interesting point on the --
6 I think you're almost suggesting means testing at a co-pay
7 level, which is, I think you're almost suggesting, at least
8 you said \$300 is too much. You didn't go as far as saying
9 maybe it's \$100 for this group and \$400 for this group. But
10 it's an interesting question because we have limited means
11 testing at the premium level now at Part B and it does have
12 implications.

13 How would you begin to think about it? Because
14 you might have some kind of means testing, but in a
15 consistent way across the various services, I don't know,
16 but it's something that we should think about when we think
17 about the \$300.

18 MR. HACKBARTH: Yeah. And again, it goes back to
19 the question of whether to think about the home health co-
20 pay in isolation or as part of a broader redesign of the
21 benefit structure. Mike?

22 DR. CHERNEW: So first let me say I find these an

1 absolutely wonderful set of recommendations and I'm rarely
2 that positive as an economist. So first --

3 MR. HACKBARTH: I'm worried. What comes next?

4 DR. CHERNEW: My goal is three minutes so I'm
5 going to talk quickly. First let me point out that if
6 someone is unfortunate to get stricken with cancer, they
7 have a huge set of co-pay requirements. Is someone,
8 unfortunately, has a heart attack, they'll pay hospital co-
9 pay requirements that dwarf any of the things we're talking
10 about here. That said -- so I'm very supportive of the co-
11 pay. I think \$300 is too high for the reason Mitra said. I
12 think you can much of the bang for a substantially lower
13 number, so we'll have to discuss what the number is.

14 But the idea of not having a co-pay, I think, is
15 incredibly inequitable to people that have -- we basically
16 tax poor and rich people who have things that there's no
17 behavioral thing that they can do to get around it. There's
18 no evidence of fraud. There's none of these other
19 beneficial things that this co-pay might do. So I think
20 relatively speaking, the co-pay one is very important.

21 I want to say that it's very important that we do
22 this in a way that doesn't make the admin part really

1 burdensome. So while I think it will be nice if we could
2 have physicians certify people, I hardly think that's
3 costless.

4 So I think some of these other tools, before I
5 went through all these administrative things where I have
6 people having to do this and you have to fill out that
7 paperwork and you're going to have to do this thing with
8 this oversight, I think a lot can be done if you try and get
9 some of the payment and incentives right before you layer on
10 a bunch of administrative things.

11 So that's why I really like the attitude behind
12 many of these proposals, which I think go in the spirit of
13 setting payment incentives right. So I think, for example,
14 the case-mix stuff is extremely important. I'm worried
15 about saying to order that first. I think we need to start
16 on it immediately, but I think we can do things.

17 I would have put first, honestly, the fraud. The
18 fraud stuff undermines support for the program. We will not
19 have this program, we will not have rates that make this
20 program viable if we can't control the spending. Everybody
21 wants to control the spending that's fraudulent, let alone
22 not valuable. Let's ignore the not valuable but not

1 fraudulent stuff because otherwise we're not going to be
2 able to preserve the care that is so important for everybody
3 else to get -- that we all agree on. So I think the fraud
4 has to be done immediately in practice as we work on the
5 case-mix stuff.

6 I think the co-pay stuff should go in as soon as
7 we could do it. I would like to make it part of a broader
8 benefit design thing, but I wouldn't want to hold it up to
9 wait for that. I think the rebasing part is important. The
10 one that I would put last, if I was doing all of these ones,
11 is the blended payment recommendation three, and the reason
12 is, I find it sort of goes everywhere with we're going to do
13 some of this, some of that, with these corridors.

14 So unless I learn more and think more about just
15 the implementation speed with which one can do all of those
16 various things, it strikes me as taking Peter's basic view
17 of we do the case-mix stuff and the co-pay stuff, the
18 rebasing is important. I'm very supportive of the
19 recommendation three on the blended payment amounts and
20 corridors and all of that stuff, but I think we might not
21 need it quite as badly as we got some of the other things
22 done. So I might make that one last, if you asked us to

1 prioritize these, which you did.

2 MR. HACKBARTH: It occurs to me now that maybe the
3 new Commissioners, this recommendation about corridors and
4 blended payment may just be way too abstract, and so let me
5 just really briefly recount the history here.

6 This was an issue that over time Bill Scanlon
7 persuaded me was an important problem. And Bill's argument,
8 which I ultimately found compelling, was that to have a
9 prospective payment system you need a well-defined product,
10 and home health is not a well-defined product. It's quite
11 amorphous and malleable depending on how people want to use
12 it.

13 And so, he thought it was ill-suited to a fully
14 prospective payment. That's one of the reasons that you
15 have (a) very high profit levels, and (b) a really wide
16 range of profitability. And so, Bill said, in recognition
17 of how ill-defined this product is, we should move away from
18 fully prospective payment and use a system like blended
19 payment or risk corridors that would, as Mitra pointed out,
20 narrow the distribution. Take some money away from the very
21 high profit agencies and maybe put a floor under some of the
22 low profit and just really tighten up the distribution of

1 financial performance.

2 The language here is carried over from our last
3 discussion of this. We stopped short of saying, we know
4 exactly which to use, risk corridors versus blended payment.
5 We thought it required more study. So that's where this
6 comes from. Cori?

7 MS. UCCELLO: I am generally supportive of all of
8 these recommendations. I agree with a lot of what Mike
9 said. In terms of the sequencing, you know, I'm not sure I
10 really have much to add on that. I think the case-mix -- I
11 think rebasing before the case-mix could just exacerbate the
12 problems of some of the inequities there.

13 In terms of the co-pay, in general I am very
14 supportive of co-pay mechanisms. Clarification, I mean,
15 we've been talking about this \$300 number, but we don't have
16 a number in the recommendation. Are we explicitly kind of
17 leaving that or implicitly leaving that to the Secretary?
18 Or do we really want to come up with a number? Just with
19 respect to that, too, I agree that \$300 gut-wise just seems
20 high, especially if I think about this, you know, no-first-
21 hour coverage and the substitutability and other kinds of
22 things. But if that were \$100 instead, I think you would

1 still get -- I mean, it still serves as a signal to people,
2 and then I would be less concerned about some of these other
3 issues.

4 MR. CHRISTMAN: Could I just say -- and this is
5 just a point of clarification. You know, the co-pay amount,
6 it is just sort of a stalking horse we put out there. But
7 the point I guess I would just make is that as you go below
8 \$300, on a per visit amount home health is going to be
9 cheaper than going to the doctor when it's more expensive
10 for Medicare. So --

11 MS. UCCELLO: So you get substitution the other
12 way.

13 MR. CHRISTMAN: Yeah, and again, there's a lot of
14 factors you're going to weigh when you do the co-pay, and
15 the optics of \$300 is a lot. And so I don't want to
16 dissuade anybody, but I just want to --

17 MS. UCCELLO: But it's also \$300 -- that's also,
18 you know, 17 if you're at the average, and even -- you know,
19 what if you're at five, which is higher than visits, which
20 is -- you know, where do you set that? So I just -- you
21 know, signal-wise, just trying to get that right place.

22 MR. GEORGE MILLER: Yes, I agree with Mike that we

1 should address the fraud issue first, and in general, I'm
2 comfortable with most of these recommendations. The one I
3 have a little bit of trouble with that everybody's
4 discussing is the co-pay. Had you come and said we need to
5 redefine benefits because this particular product line, home
6 care, needs to have a co-pay, I would be fine with that
7 separately.

8 My problem is that we're trying this in an
9 industry where apparently there's a lot of fraud, and one
10 solution -- and these are my words -- seems to be there's
11 fraud here and so how to solve the problem is we should have
12 a co-pay and have people help pay for services and benefits
13 they may not necessarily need. You take that aside, then I
14 don't have a problem with the co-pay, but I agree that it
15 should be probably, like Peter, means-tested to have that
16 co-pay.

17 One thing that could be -- since we're talking
18 about redistributing some of these services and
19 reallocating, maybe instead of talking about a co-pay but
20 maybe a beneficiary sharing I helping to reduce some of the
21 costs in some way. I don't know the answer to that. I
22 don't have a solution. And maybe co-pay is a better

1 solution, but if we try to achieve some savings in this
2 market, maybe having the beneficiary share in some of that
3 savings may be a way to think about it.

4 So, in general, I support the recommendations. I
5 think fraud should go first. I could be persuaded about the
6 co-pay, but it depends on what order and the sequencing.

7 DR. BERENSON: I support a co-pay, although this
8 discussion suggests the need for quickly having that spring
9 conversation because while I think \$300 may be too much --
10 and yesterday it was noted again that the SNF after 20 days
11 is \$141 a day, that can add up to lots of barriers to
12 access. The hospital first stay is over a thousand hours,
13 something like that. So it's hard to have this discussion
14 without having the bigger discussion, but I think it's
15 reasonable to do it and to make the recommendation.

16 As I said yesterday, I think I would use the same
17 argument to have a co-pay in hospice as well. I didn't
18 quite follow Mitra's logic as to why you want to not pay on
19 the per episode basis. You know, some patients go into the
20 hospital for two days or three days and have the same first-
21 day co-pay as somebody in the ICU for three months. Maybe
22 that's not the right way. I'm not sure what marginal

1 decision you want the beneficiary to make based on the
2 latter days, but this is not the time to have that
3 conversation, I think. I think we do need to have a good,
4 robust discussion of this in the spring.

5 On sequencing, I'm not sure I see much need for
6 sequencing. The rebasing, as I understand it, it's in law
7 to begin in 2014, and we're suggesting we move it up. So I
8 think that if we're going to do it, it has to go right away,
9 and Congress will either do it or they won't do it. The co-
10 pay is another thing that Congress has to do, and we want to
11 recommend that.

12 If it's the Secretary who has to do the case-mix
13 work and then sort of the more complicated risk corridors,
14 that kind of thing, that latter is going to take awhile. I
15 mean, that's not going to be anything they're going to do
16 right away. If, in fact, the rebasing, Congress does pass
17 that, moves it up, then I think CMS takes that into account
18 with any transition they do in the case-mix. I mean, I just
19 think that we want to push all of this stuff out quickly,
20 and I don't see any sort of logic that you have to wait for
21 one to be done before you can propose the next one. I just
22 think you just -- I don't think we have that kind of control

1 over the different actors and to how they're going to do all
2 of this stuff.

3 So I would be for making these recommendations
4 without a recommendation on sequencing.

5 MR. KUHN: As I think about the sequencing issue,
6 I really want to -- where I'm thinking about it is a little
7 bit where Mary was. What are the items that are going to
8 accelerate and help us get to -- or create a better platform
9 for hospitals and other health care organizations to deal
10 with readmissions, ultimately get to ACOs, et cetera? What
11 if any of these things could help accelerate towards that
12 integration and create that platform? Particularly when you
13 look at the data on page 7 and you look at the final two
14 things, any hospital admission and any urgent care, we're
15 not making any progress in those areas. And any of these
16 recommendations that can help accelerate us in that
17 direction to move forward would be where I would think on
18 the sequencing. And of all the things that we have before
19 us, I think the case-mix probably does the best or probably
20 would be the one that would help us create that better
21 platform and improve the system that would make it easier to
22 implement the readmission issues, those kinds of things that

1 are out there.

2 So I would think we would go there as we go
3 forward, although I think Bob makes some pretty persuasive
4 arguments that it's just kind of all in.

5 On the issue of the co-pays, to help me kind of
6 think this one through -- and I do think \$300 is very high.
7 But what would help me to think this one through a little
8 bit is to look at little bit more at the underlying bad debt
9 policies that we see with other providers out there. We've
10 talked about hospitals, but hospitals, there is a bad debt
11 provision in current Medicare law which I think covers up to
12 70 percent of the bad debt after due diligence in trying to
13 collect. But there's no bad debt opportunities for Medicare
14 to recover for other provider types out there, and it would
15 be interesting to see for physician offices these other kind
16 of settings out there, what's the absorption rate of the
17 providers on the bad debt side of this and to see what's out
18 there.

19 One could argue that with the kind of margins
20 we're seeing here with home health, there's plenty of room
21 to absorb some bad debt here, and it shouldn't create an
22 access issue. But I'd like to kind of understand a little

1 bit what goes on in the other provider areas. Are we seeing
2 bad debt go up because of the economy going down? Would
3 that create a barrier? So that would help me kind of think
4 that one through a little bit more.

5 DR. KANE: Well, I think since a 17-percent margin
6 kind of gives you -- it attracts a lot of people that you
7 don't necessarily want to have in the business since it has
8 no capital requirements. I mean, they might need a little
9 bit of IT, a little bit of a management control system, a
10 little bit of worker training, and then it's like gravy. So
11 I think my first priority would be to get rid of the 17-
12 percent profit margin because it's just attracting in a lot
13 of people who are not necessarily there for the right
14 reasons. And I'm not talking for-profit or not-for-profit.
15 I just think that's just way too much. So, therefore, the
16 rebasing -- by the way, as I recall, there was something
17 like double the number of visits in the old system, in the
18 old episodes, upon which the current rates are based, as
19 there are now -- change in skill mix but also like double
20 the number of visits.

21 So let's just get down to the right amount, and I
22 think that will solve some of the problems and who's in this

1 business and who's doing the stuff they shouldn't be doing.

2 MR. HACKBARTH: I really agree with that point.

3 You know, it's an invitation to fraud to have huge profits.

4 But on the declining visits, I think it was from the low 30s
5 to low 20s.

6 DR. MARK MILLER: Correct.

7 MR. CHRISTMAN: Right. It was 32 to 22.

8 DR. KANE: 32 to 22, and then a change in mix that
9 goes with higher skill.

10 MR. CHRISTMAN: Right.

11 DR. KANE: But, still, that's a big chunk of --
12 you know, what are we doing paying for that? I do think the
13 case-mix is a no-brainer. Why not? You know, it obviously
14 does the right things and rewards the right kind of
15 behavior. And I do think that the fraud deterrent -- I
16 mean, is there any way we can, you know, pay home health
17 people -- Medicare beneficiaries who get approached with
18 inappropriate marketing, I mean, I just think there's all
19 kinds of reasons we should try to get rid of the bad actors
20 in this business.

21 And on modifying the system with corridors and all
22 that, I know I must have voted for that recommendation, but

1 I guess I'd rather see that energy spent towards, you know,
2 what Herb was just talking about. What kind of outcome
3 measures should we be focusing on and trying to encourage
4 and build into the payment system rather than, you know,
5 making sure that everybody -- from a financial way that they
6 all get -- I'd rather say let's do it more from the outcome
7 measure, that people don't get stunted because they had
8 better outcomes because they're using the hospital, they're
9 not being admitted to the hospital or urgent care.

10 On the co-pays, I'm very conflicts on this. I
11 think picking one group that has to pay and another group
12 that doesn't gets a little dicey because we've been trying
13 to push substitute of inpatient care with outpatient care,
14 and, you know, there's ambulatory surgery. So, you know,
15 are they going to have to pay the co-pay, but if you had
16 your surgery inpatient, you know, you don't.

17 There's also all the chronic disease management
18 programs we're trying to see get going where home care is a
19 central part of some of them, home monitoring systems,
20 intervention. So I'm kind of not sure we know where to put
21 the co-pay to encourage value as opposed to discouraging
22 inappropriate utilization. So I kind of think that's

1 something we should recommend that we should maybe study,
2 but I'm not sure we're ready to make that kind of a broad-
3 based recommendation. I'm all for co-pays, but I think we
4 should try to think about how to structure it to encourage
5 more appropriate utilization, but when we don't know what
6 that is, it's a little awkward to just say, well, because
7 you came in from the hospital but you didn't. You know, I'm
8 not comfortable with that. I think that's the one I'm the
9 most uncomfortable with.

10 DR. STUART: I strongly support Recommendations 1,
11 2, and 5, and I think that order is fine. I don't support
12 number 3. I understand Bill Scanlon's arguments on this,
13 but the arguments are based on frustration, I think, rather
14 than based upon any empirical evidence that this thing would
15 actually work. And I'm really impressed with the analysis
16 that Urban did regarding the case-mix, and so I would say,
17 you know, before we say anything about bring cost
18 reimbursement back, "Ahhh," I just don't want to do that. I
19 would put my nickels on the case-mix. So I would get rid of
20 number 3.

21 I'm also not at all sanguine about number 4 on co-
22 pay, and part of that -- there are two basic reasons why.

1 I'm not opposed to cost sharing, but if you think about it,
2 co-pays are generally applied to relatively low-cost -- not
3 always but relatively low-cost services that are provided in
4 some kind of a sequence. And so the question is, well, do I
5 want to continue to use this brand-name drug or am I going
6 to use a generic drug, or do I continue to go to the
7 physician or maybe I visit some other type of practitioner.
8 So it has to do with what the margin is, and the margin
9 here, as I understand it, is a \$6,000, approximately, cost
10 of an episode. So the question that would be relevant to
11 the beneficiaries is, Well, do I have the whole episode or
12 do I have none of it? And I'm just uncomfortable about
13 that, and I think that Nancy has raised that.

14 I don't know of any evidence base that would be
15 relevant to understanding what a co-pay, whatever the level
16 is, would actually have in terms of numbers of episodes.
17 And, in fact, is that something that we really want
18 beneficiaries to do? Or does it get back -- and I don't
19 want to raise this as a large issue, but it comes back in.
20 Is it really the definition of the episode that we're
21 concerned about? Maybe the episodes shouldn't be as long as
22 they are. Maybe they should be shorter. Maybe there should

1 be fewer resources within the episode. The co-pay wouldn't
2 affect that at all. And so I'm not opposed to cost sharing,
3 but I don't think co-pay is necessarily the right way to go
4 about this.

5 The second piece, I think I heard you say, Evan,
6 that -- maybe it was just in those counties, but that home
7 health is heavily used by duals. Was it 35 --

8 MR. CHRISTMAN: That was a nationwide number.
9 That was not just in those counties.

10 DR. STUART: Okay. Well, whatever the number is,
11 it's high. And if we're not going to apply any type of cost
12 sharing for dual eligibles, then logically we have to come
13 up with some other mechanism to deal with the potential
14 overuse or misallocation of resources for that very large
15 proportion of the population. And so if you follow the
16 logic that you have to come up with some other tool to
17 address the issue for 35 percent of the users of this
18 benefit, then the question is, Well, that tool, if it's
19 going to be effective for the dual eligibles, might that be
20 better than a co-pay or other form of cost sharing for the
21 non-duals? And that's something that comes up again and
22 again here, and I think we just kind of shovel it under the

1 rug and assume that, well, you can't charge duals anything
2 and so we have to have some other kind of tool, but we don't
3 spend a whole lot of time on what those tools are.

4 So I think that item 4 is -- that we're not ready
5 for prime time on making a recommendation for a specific
6 kind of change in policy. I really do think that we need to
7 think this thing through more carefully. In the perfect
8 world, I agree with Mike, this is something that you'd like
9 to do in terms of looking at the broader structure for the
10 program as a whole. I'm not opposed to going in for
11 something else if we had a strong consensus that we knew
12 what the something else is, and I just don't hear that
13 consensus.

14 And then, finally, I'd like to come back to this.
15 Evan, the reason I raised the question about improving
16 quality -- because I think quality of care really is at the
17 heart of this -- is that there's nothing on the slide -- and
18 I checked and I didn't see anything in the text -- about
19 what the case-mix -- in fact, whether it was case-mix-
20 adjusted at all or what that case-mix adjustment looked
21 like. So what I'd like to see is I'd like to see this chart
22 reproduced for values that are not case-mix-adjusted.

1 Kate followed up and raised the issue that I had,
2 which is a selection issue. If we think about the
3 population growing who are getting this benefit and it
4 starts from a very frail population becomes less frail, we
5 have the selection issue, you'd expect that all of these
6 indicators would be higher, and so if we were to compare the
7 adjusted and non-adjusted and see that we have very
8 different trends for the adjusted, then I'd be more sanguine
9 about saying, yeah, well, there really is improvement in
10 quality. But I'm not convinced on the face of it yet that
11 we know enough to say that there really is an improvement in
12 quality of care.

13 MR. HACKBARTH: Let me just pick up on Bruce's
14 comments about the co-pay. As I hear this conversation,
15 there are different potential rationales for looking at a
16 co-pay. One, and the reason that this is being discussed at
17 all, is that there are indications of potentially
18 significant overuse of the benefit, and having some amount
19 of co-pay might address that -- maybe not without collateral
20 problems, but that's the potential rationale.

21 As a number of people have pointed out, then you
22 start thinking about substitution questions and whether, you

1 know, we want people to go to the most efficient, and if you
2 put in the co-pay are we going to steer people away from a
3 potentially low-cost service into a higher-cost service, as
4 Mary was indicating. And, you know, that's a really
5 complicated question, and I'm not sure that any benefit
6 design can perfectly address the issues of substitution.
7 Those are really clinical judgments that, you know, you need
8 to make working with real live patients on the ground. No
9 benefit structure is going to be tweaked to the point where
10 you can get people making exactly the right decisions. You
11 can maybe get better, but it's going to be elusive.

12 The third rationale for looking at a co-pay for
13 this is it's one of the only services that doesn't have a
14 co-pay. We've got finite resources in Medicare, and as Bob
15 was pointing out, there's not a whole lot of rhyme or reason
16 to the way we distribute the burden among Medicare
17 beneficiaries, impose very heavy co-pays on hospitalized
18 patients that may have very little control over their
19 ability to use the services. And just as a matter of
20 equity, if we've got a finite amount of resources, we ought
21 to think about restructuring the benefits so that the burden
22 is shared more equitably at a high level, and in the

1 process, you know, introduce protections for low-income
2 beneficiaries and the like.

3 So, you know, we sort of bounce around among
4 potentially competing rationales for restructuring. The
5 more I listen to the conversation, the more I think that
6 maybe we need to talk about this as part of, you know, a
7 bigger discussion about the benefit package as opposed to in
8 isolation, even though I think we've got a serious problem
9 with overuse.

10 I'll just stop there.

11 DR. STUART: I just want to make clear: I am not
12 opposed to cost sharing.

13 MR. HACKBARTH: Yes.

14 DR. STUART: So my concern is more on the
15 technical grounds of whether this is going to have the
16 effect in terms of patient behavior that you want it to
17 have.

18 MR. HACKBARTH: Right.

19 DR. BAICKER: Yes, separating this out into the
20 patient side things and the provider side things, the co-
21 payment is the odd man out. And being the only one on the
22 patient side -- and in some ways you could unbundle that

1 into the same set of issues we're talking about on the
2 provider side. There's the level of co-payment. There is
3 the tilt in who should be paying more, who should be paying
4 less, which services, et cetera. And I'm strongly in favor
5 of co-payments. It seems both inefficient and inequitable
6 to have zero co-payment on this highly malleable service
7 when there are co-payments on things that are less
8 discretionary. And for all those reasons, I'd very much be
9 in favor of it, but I do think we probably need to unbundle
10 it into those different components the same way we're doing
11 on the provider side.

12 On the provider side things, I join everyone in
13 being firmly anti-fraud, so let's certainly do that first.

14 [Laughter.]

15 DR. BAICKER: That's right. I'm going to take a
16 bold stand here. Fraud is bad. And then thinking about --

17 DR. STUART: A tough decision.

18 DR. BAICKER: Yes. -- rebasing versus the
19 changing in case-mix, I was a little unclear on the
20 distinction that Peter was making in that I think of
21 rebasing plus change in case-mix as non-budget neutral
22 change in case-mix. You know, we're saying, okay, we're

1 going to tilt things and we're going to let the overall
2 level be dialed up or, in this case, down. And I'm favor of
3 both, and I don't know whether there's any advantage of
4 doing one first versus the other if the case-mix isn't quite
5 ready and the rebasing is. But I think of those together as
6 changing the mix of payments to people and changing the
7 total amount of money in the system at the same time. And
8 treating them as separate recommendations just seems like
9 decomposing that a little bit based on the availability of
10 the measures, and that seems fine to me.

11 As for the risk corridor one, it is a little
12 abstract for me to think about the particulars right not.
13 It seems to warrant further discussion.

14 DR. CASTELLANOS: Quickly, I'm in favor of all of
15 them. I strongly recommend the fraud and rebasing.
16 Rebasing is already in law for 2014.

17 Like Mike and like a lot of us, I like the concept
18 of co-pay. I'm a provider and I realize the value of co-pay
19 in the provider community. I think it needs a lot of work.

20 Like Bob, I think we should push on all five of
21 them at this time.

22 MS. HANSEN: Yes, I think the combination of the

1 rebasing, the case-mix, and the fraud are kind of a
2 coordinated campaign that can be done, and I think as
3 everybody is saying, the obvious one is the fraud one,
4 especially since we can work with the -- or really refer
5 this to the OIG, which actually gives a real important
6 signal, you know, to the broader community.

7 The co-pay discussion I think merits the kind of
8 discussion that other people have focused on. I am
9 definitely also supportive of some sense of co-pay.

10 And then it sounds to me that Recommendation 3,
11 which is the repeat or the Scanlon aspect, does really take
12 a lot of intellectual rigor and complexity of doing it. So
13 it's still worthy of doing it, but it just will require
14 perhaps some other people in the broader field to perhaps
15 focus on this kind of work that can inform us over time.
16 But bottom line, I think it's still very merit worthy but
17 very complex and requires a great of rigor to that.

18 MR. ARMSTRONG: Glenn, I just briefly would affirm
19 I support the direction for all five of the recommendations.

20 With respect to the sequencing question, I, too,
21 am like Bob. I'd do all five of them tomorrow if we could.
22 I recognize there are some issues that have been raised, in

1 particular on the co-pays, but I'm not uncomfortable with a
2 \$300 co-pay, but I recognize it's complicated issue. And I
3 really appreciated the way that you asked us to be cognizant
4 of the fact there are several different, sometimes
5 overlapping goals for implementing co-pays, and I think
6 clarity around that is good. But I just think the risk is
7 low enough that we shouldn't be too cautious about that in a
8 world where there are such -- where we're paying so much
9 more than what we're getting for through this program.

10 Then finally, to the point that was made by a
11 couple of people earlier about the supervision and the
12 recertification, I really believe that is worth some follow-
13 up discussion at some point, partly because -- actually,
14 probably mainly because I do see investments in home health
15 and the value of home health and the return to the Medicare
16 program at least to -- well, to a fairly large degree as an
17 investment in advancing the health of the patients as part
18 of a care system. And to the degree clinicians are
19 accountable for the patient's care, at least at some point
20 through that process or at various points through that
21 process, it increases the likelihood that their care in home
22 health is connected to a broader care plan for their health

1 in the broader sense.

2 So I know that's really not our topic for today,
3 but I think both Tom and Ron said that this would be a
4 worthy conversation for the future, and I would agree with
5 that.

6 DR. BORMAN: I'm generally supportive of the
7 package, and I share Bob and Scott's thoughts about moving
8 forward expeditiously. I do think that some -- more than
9 one of them raise issues -- or fall into the camp of the
10 more complicated vertical and horizontal and generational
11 and all inequities that we've talked about at points in the
12 past. I do think that I'm comfortable with carrying forward
13 number 3 because, as we carry forward many of our
14 recommendations that don't get implemented, I think there's
15 still a great deal of thought behind that. Nothing that we
16 do here particularly changes the somewhat vague nature of
17 what can be wonderful services under this umbrella, but it's
18 a very broad basket of services and not uniformly applied.
19 None of that changes that, and number 3 does speak to trying
20 to deal with that in the context of improving this.

21 So I think rebasing is going to happen. I think
22 the margins here suggest that it can happen sooner rather

1 than later without distinct harm to most, if not all,
2 beneficiaries. So that I think those things go together,
3 and if you have the rebasing -- I think the case-mix needs
4 to happen additionally, so no reason not to proceed forward
5 with that now. Number 3 is a carry forward. I think we do
6 need to endorse a co-pay. Frankly, it sounds almost to me
7 like it's a little bit -- what we've suggested is a little
8 bit more like a deductible because it isn't indexed to the
9 number of services and whatever. You know, but not being an
10 insurance glossary person, I may be out of my depth there.
11 But I think that we have endorsed the issues -- understand
12 the issues with first-dollar coverage. Our own work that
13 we've contracted out certainly supports some of those
14 issues. And I think we can make a recommendation with being
15 able to say that the specifics may require more work, that
16 we ourselves may want to commit that we will examine this in
17 this time frame; we may want to advocate some outsource or
18 whatever for that. But I think not to go on record as part
19 of this package that there should be a co-pay would be a
20 mistake, or whatever we want to call it. So, in general,
21 I'm supportive.

22 MR. HACKBARTH: We're at 10:12 right now, so we're

1 12 minutes behind. We've got to leave time for two more
2 presentations, so thank you, Evan.

3 Now we need to move on to inpatient rehab
4 facilities.

5 Christine, are you going first? Okay. Whenever
6 you're ready.

7 MS. AGUIAR: During this presentation, we will
8 discuss the adequacy of Medicare payments to inpatient
9 rehabilitation facilities, also referred to as IRFs. IRFs
10 provide intensive rehabilitation services, such as physical
11 and occupational therapy, to patients after an injury,
12 illness, or surgery. IRFs may be specialized units within
13 an acute care hospital or freestanding hospitals. About 80
14 percent of IRFs are hospital-based and 20 percent are
15 freestanding.

16 Medicare fee-for-service is the principal payer
17 for IRF services, accounting for about 60 percent of total
18 cases in 2009 and \$6 billion in spending. Since 2002, IRFs
19 have been paid on a per discharge basis, where rates vary
20 based on patients' conditions, wages, and certain facility
21 characteristics.

22 To qualify as an IRF, facilities must meet certain

1 criteria. IRF patients must require at least two types of
2 therapy, one of which must be physical or occupational
3 therapy. The patients must also generally need to tolerate
4 three hours of therapy per day for at least five days per
5 week. The facilities must meet the Medicare Conditions of
6 Participation for acute care hospitals and satisfy
7 additional criteria, such as having a medical director of
8 rehabilitation on a full-time basis, having a pre-admission
9 screening process for patients, and using a coordinated
10 interdisciplinary team approach led by a rehabilitation
11 physician.

12 In addition to the above criteria, IRFs must also
13 meet the compliance threshold, also known as the 60 percent
14 rule. The compliance threshold is important to understand
15 because of the impact that it had on many of the measures of
16 payment adequacy, so I will spend a few minutes to go over
17 it.

18 The compliance threshold is a requirement that
19 stipulates that no fewer than 60 percent of all IRF patients
20 have at least one of 13 conditions. The purpose of the
21 compliance threshold is to distinguish IRFs from acute care
22 hospitals, and the 13 conditions are diagnoses that

1 typically require intensive in-hospital rehabilitation.

2 Enforcement of the compliance threshold was renewed in 2004.

3 Also in 2004, CMS limited the types of major joint
4 replacement patients that counted toward the threshold.

5 Major joint replacements, such as hip and knee replacements,
6 were commonly treated in IRFs before 2004. The combination
7 of most of those patients not counting towards the threshold
8 and renewed enforcement of the threshold resulted in a
9 substantial decline in volume after 2004. As volume
10 declined, occupancy rates and the number of rehabilitation
11 beds fell, as well. Case-mix increased as the IRF patient
12 population shifted to more severe patients that counted
13 towards the threshold. Growth in cost per case also
14 increased, as fixed costs were spread across fewer patients.

15 The compliance threshold was originally set at 75
16 percent. However, it was permanently capped at 60 percent
17 in 2007. Since then, the industry has begun to stabilize in
18 its response to the compliance threshold, as we will see in
19 the following slides.

20 Just as a quick reminder, we use the same
21 framework for payment adequacy as we use in other sectors.

22 I will now begin discussing our measures of access

1 to care. On this chart, you see the supply of IRFs from
2 2002 to 2009. Supply peaked in 2005 and decreased after
3 that. In 2009, changes in supply varied by category of
4 provider, with the overall picture suggesting that the
5 supply of IRFs is stabilizing. The categories with the
6 highest growth are freestanding and rural IRFs. Growth in
7 rural IRFs occurred among hospital-based IRFs. There is at
8 least one IRF located in every State, although IRFs are not
9 evenly distributed among States. However, because other
10 Medicare providers, such as skilled nursing facilities and
11 home health agencies, also provide rehabilitation services,
12 it is unlikely that many areas exist where IRFs are the only
13 therapy provider available to beneficiaries.

14 Occupancy rates are one measure of provider
15 capacity. Occupancy rates have been falling since 2002 and
16 fell at a higher rate in 2004 when enforcement of the
17 compliance threshold was renewed. In 2009, occupancy rates
18 remain relatively stable, increasing slightly for both
19 freestanding and hospital-based IRFs, although occupancy was
20 higher for freestanding IRFs. The occupancy rate across all
21 IRFs was 62.8 percent in 2009, which indicates that capacity
22 is adequate to handle current demand and IRFs can likely

1 accommodate future increases.

2 The number of rehabilitation beds is another
3 measure of capacity. The number of IRF beds declined by an
4 average of 1.1 percent each year between 2004 and 2008, as
5 IRFs adjusted to a decrease in cases due to renewed
6 enforcement of the compliance threshold. In 2009, the total
7 number of IRF beds decreased slightly, by 0.3 percent, the
8 result of a decrease in hospital-based IRF beds and an
9 increase in freestanding IRF beds.

10 This chart presents fee-for-service spending on
11 IRFs, the number of fee-for-service cases, and fee-for-
12 service payment per case from 2002 through 2009. As you can
13 see, the number of IRF cases declined after 2004 when
14 enforcement of the compliance threshold was renewed.
15 However, volume began to stabilize in 2008 after the
16 compliance threshold was capped at 60 percent. In 2009,
17 volume remained relatively stable, with the number of cases
18 increasing by 1.5 percent. The increase in the number of
19 cases from 2008 to 2009 was due to an increase in both the
20 number of unique beneficiaries receiving IRF care and an
21 increase in the number of beneficiaries with more than one
22 IRF stay in a year. The average fee-for-service payment per

1 case declined by half-a-percent between 2008 and 2009
2 because payments in 2009 were held at 2007 levels.

3 We also analyzed IRF patient mix, which has
4 changed since 2004 as IRFs adjusted to meet the compliance
5 threshold. As expected, the share of cases with conditions
6 that count towards the compliance threshold has increased.
7 For example, the share of stroke patients, shown on the
8 graph in orange, increased by 3.9 percentage points between
9 2004 and 2010. Also, as expected, the share of major joint
10 replacement cases, shown here in red, have fallen since 2004
11 when CMS limited the types of these cases that count towards
12 the compliance threshold. Case-mix also increased as the
13 patient mix increased, and between 2008 and 2009, case-mix
14 grew by 2.3 percent.

15 We also analyzed changes in acute care hospital
16 discharge destinations from 2004 to 2010 for hip and knee
17 replacement patients to assess whether the compliance
18 threshold impacted these beneficiaries' access to care. As
19 you can see, acute care discharges to IRFs for hip and knee
20 replacements declined by 15 percentage points between 2004
21 and 2009. However, discharges to skilled nursing facilities
22 and home health agencies increased over the same period by

1 four and ten percentage points, respectively. Beneficiaries
2 with hip and knee replacements that were previously treated
3 in IRFs were able to receive rehabilitation services in
4 other settings.

5 Now we will move on to two more payment adequacy
6 measures, quality of care and access to capital. We measure
7 quality by the difference between functional status from
8 admission and discharge. Between 2004 and 2010, the gain in
9 functional status increased 3.3 points for all fee-for-
10 service patients. However, over the same time period, the
11 functional status at admission declined because IRFs
12 admitted more severely impaired cases that met the
13 compliance thresholds. Currently, we cannot conclude
14 whether the gain in functional status between admission and
15 discharge is due to an improvement in quality or due to the
16 declining functional status at admission.

17 Also, with respect to IRF quality measurement, the
18 Patient Protection and Affordable Care Act requires IRFs to
19 begin submitting quality measures in fiscal year 2014. We
20 recently held a meeting with rehabilitation clinicians,
21 researchers, and IRF medical directors to discuss the types
22 of measures that IRFs should be required to report. I will

1 present the results of that meeting during the January
2 presentation.

3 Access to capital is another measure of payment
4 adequacy. Hospital-based units have access to capital
5 through their parent institution, and as we heard during the
6 inpatient hospital presentation yesterday, hospitals' access
7 to capital appears adequate. Therefore, it is likely the
8 hospital-based IRF units have adequate access to capital.

9 To measure access to capital for freestanding
10 facilities, we review access to the credit markets for two
11 major national chains. These chains continue to experience
12 positive revenue growth and are able to access the capital
13 markets.

14 We will now move on to measures of Medicare
15 payments and providers' costs. This graph displays growth
16 in payments and costs per case since 2002. Payments per
17 case have grown faster than cost per case since the
18 implementation of the PPS in 2002. In 2004, the gap between
19 the growth of payments and costs began to close when volume
20 declined due to renewed enforcement of the compliance
21 threshold and the limitation on the major joint replacement
22 patients that counted towards the threshold. With the lower

1 volume of fee-for-service patients, fixed costs were spread
2 over a smaller number of cases and growth in cost per case
3 accelerated.

4 Adjusting IRF costs per case for differences in
5 wages, case-mix, and outlier payments permits a standardized
6 comparison of costs across different types of IRFs. This
7 table displays the characteristics of IRFs in the low- and
8 high-cost quartiles of adjusted cost per case. This data
9 permits us to begin constructing the profile of efficient
10 IRF providers. While we cannot identify efficient providers
11 without risk-adjusted quality measures, we can begin to see
12 patterns in efficiencies with costs.

13 Larger bed size and higher occupancy rates are
14 characteristics of IRFs in the low-cost quartile. The
15 median bed size decreased from 37 beds in the low-cost
16 quartile to 18 beds in the high-cost quartile. Occupancy
17 rates also decrease across quartiles, with the average
18 occupancy rate for IRFs in the low-cost quartile approaching
19 70 percent, while IRFs in the high-cost quartile are, on
20 average, at half occupancy. Given that freestanding IRFs
21 are more likely to be larger facilities and to have higher
22 occupancy rates, it is not surprising that these facilities

1 are more likely to be in the low-cost quartile.

2 Case-mix does not vary by much across quartiles,
3 suggesting that it is not case-mix but rather bed size and
4 occupancy rates that are more indicative of lower cost per
5 case.

6 This chart shows the Medicare margins for IRFs.
7 IRF margins declined between 2008 and 2009, but remained a
8 healthy 8.4 percent across the industry. The margin decline
9 in 2009 is expected because 2009 payment rates were frozen
10 at 2007 levels.

11 Margins vary across providers. Urban IRFs have
12 higher margins than rural IRFs. However, the 18.4 percent
13 rural adjustment factor contributes to the close margins for
14 urban and rural providers.

15 Freestanding IRFs have substantially higher
16 margins than hospital-based IRFs, and the difference between
17 freestanding and hospital-based IRF margins grew larger in
18 2009. While freestanding IRF margins increased in 2009 to
19 20 percent, despite not having a payment update for that
20 year, hospital-based IRF margins declined to point-five
21 percent. The difference in margins between freestanding and
22 hospital-based IRFs is likely due to the ability to manage

1 costs, which we will see on the next slide, and due to
2 economies of scale. Hospital-based units, in general, have
3 fewer beds than freestanding facilities and have lower
4 occupancy rates.

5 To illustrate the difference in freestanding and
6 hospital-based IRFs' abilities to manage costs, this graph
7 shows the growth in cost per case for hospital-based IRFs,
8 represented in the red bars, and freestanding IRFs,
9 represented in the yellow bars. Growth in average cost per
10 case for freestanding and hospital-based IRFs peaked in
11 2005, as the industry managed a decline in volume due to
12 renewed enforcement of the compliance threshold. However,
13 after 2005, freestanding IRFs were able to lower the growth
14 in cost per case while cost per case continued to grow at
15 higher rates for hospital-based IRFs.

16 As we have seen, aggregate Medicare margins for
17 IRFs in 2009 were 8.4 percent. To project the aggregate
18 Medicare margin for 2011, we modeled the following policy
19 changes for 2010 and 2011. Market basket minus 2.5 percent,
20 as specified in PPACA, for 2010 and 2011, and an adjustment
21 to the outlier threshold in 2011 that CMS estimated will
22 slightly reduce IRF payments. We estimate that Medicare

1 margins for 2011 will be 8.1 percent.

2 In summary, our indicators of payment adequacy for
3 IRFs are generally positive. Supply and capacity are stable
4 and adequate to meet demand. With the compliance threshold
5 permanently set at 60 percent, the decline in volume since
6 2004 tapered off, and volume remains stable in 2009. We
7 have seen an increase in functional gain, which suggests
8 improved quality. However, we cannot conclude definitively
9 without risk adjustment. Access to credit appears adequate
10 for hospital-based and freestanding IRFs. Finally, we
11 project the 2011 aggregate Medicare margins to be 8.1
12 percent, down slightly from the 8.4 percent margins in 2009.
13 To the extent that IRFs restrain their cost growth, the
14 projected 2011 margin could be higher than we have
15 estimated.

16 The Chairman's draft recommendation for your view
17 is: "The Congress should eliminate the update to the
18 payment rates for inpatient rehabilitation facilities for
19 fiscal year 2012." On the basis of our analysis, we believe
20 that IRFs could absorb cost increases and continue to
21 provide care with no update to the payments in 2012. We
22 estimate that this recommendation will decrease Federal

1 program spending relative to current law. We do not expect
2 this recommendation to have adverse impacts on Medicare
3 beneficiaries. This recommendation may increase the
4 financial pressure on some providers, but overall, a minimal
5 effect on providers' willingness and ability to care for the
6 Medicare beneficiaries is expected.

7 This concludes the presentation and I welcome any
8 questions.

9 MR. HACKBARTH: Thank you, Christine. Well done.

10 We have 35 minutes for discussion, and so I think
11 we're starting with Karen this time. Clarifying questions.
12 Scott?

13 MR. ARMSTRONG: In some of the other sections,
14 we've seen margins for hospital-based programs lower in part
15 because of the higher overhead expenses, the burden that
16 they're carrying. Is that part of what explains the
17 differential margins for the hospital-based IRFs?

18 MS. AGUIAR: Sure. I'll take a crack at it, and
19 then Craig, who's more familiar with the margins, could
20 elaborate. I believe, especially with the hospital-based
21 margins, we see a relationships with bed size which
22 indicates that there is an economy of scale. And so of the

1 providers that have the bed size in the one-to-ten range,
2 about 99 percent of them are hospital-based. The majority
3 of hospital-based have between -- have less than 60 beds,
4 whereas the higher percent -- about half of freestanding
5 facilities have 60 or more beds. So there is that
6 relationship in the margins there with economies of scale.

7 MR. LISK: Yes . You have to think the economies
8 of scale is really the major factor here rather than the
9 overhead is. You have to think as one of the requirements
10 is having a full-time director of rehabilitation. So you
11 divide that over ten beds, your cost is going to be a lot
12 higher per bed for that expense versus a place with 60 beds,
13 which may have more than just one person related to that.

14 But the other thing is when you look at the
15 occupancy rate, too, is there are differences, the lower
16 occupancy rate in the hospital-based versus the
17 freestanding, too.

18 DR. CASTELLANOS: I'm not sure if this is
19 appropriate at this time, but first of all, I support this.
20 I think there's a real value. One of the criteria to get
21 into the rehabilitation for the patient is he or she must be
22 able to undergo three hours a day, right. Why is that just

1 for five days a week and not on weekends?

2 MS. AGUIAR: I'm not sure that it's not on
3 weekends. I believe it's three hours a day for five days
4 per week, and when you have -- do you want to elaborate on
5 this?

6 MR. LISK: It was clarified more recently that
7 it's for five days a week, and in fact, sometimes people
8 need rest for their therapy, so they need some break. But
9 it is -- I think that's something that has been, like,
10 clarified recently. We can get back to you more
11 specifically on that, but --

12 MS. AGUIAR: Yes --

13 DR. CASTELLANOS: I'd really like you to get back
14 to me.

15 MS. AGUIAR: Yes, we will get back, and what it is
16 is that therapy has to begin, I believe, within 36 hours,
17 depending -- even if that person started on a weekend. So
18 when they were admitted to the IRF is when that sort of
19 clock starts, and then it has to begin, I believe, within 36
20 hours from them and then has to be at least, you know, three
21 hours a day for five days. But we'll get back to you --

22 DR. CASTELLANOS: Thank you.

1 MR. LISK: The other thing, I think, is it's not
2 35 hours a week, and I think there was some indication from
3 the industry that it wants to go to it being 35 hours a
4 week, or maybe I did my math wrong, but -- but anyway --

5 DR. CASTELLANOS: Get back to me.

6 MR. HACKBARTH: Jennie, did I skip over you?
7 Okay. Kate, clarifying question, Bruce, Nancy.

8 DR. KANE: Yes. It would be -- I know we had
9 something in the paper about the MA plan use of IRFs. It
10 would also be interested to look at the non-Medicare margins
11 for this sector, just to get a sense of how far differently
12 Medicare is to others, because this is an -- unlike home
13 health, it actually has capital requirements, and so when
14 you look at a profit margin, it's not the same kind of
15 profit margin as when you're looking at home health and it
16 would be better -- it would be kind of good to see how far
17 off or close we are as we start to say, let's get those
18 profits down. Now, I don't think they had a big problem
19 when it was up around 14 percent, or even maybe eight
20 percent. I don't know. But not having any sense of what
21 the overall profitability is or the capital requirements
22 means we're just picking a number for the profit side. So

1 do we have any sense of their non-Medicare profitability?

2 MR. LISK: If I look at the total margin for the
3 freestanding facilities, because it's more difficult to
4 separate that out on the hospital-based, the total margin on
5 the freestanding is a little bit lower than what it is for
6 what Medicare is paying --

7 DR. KANE: So we're overpaying relative to what
8 the private sector and Medicaid might be paying.

9 MR. LISK: That --

10 DR. KANE: Or Medicare is paying.

11 MR. LISK: -- might be the implication on the
12 freestanding. I don't know what it comes out to on the
13 hospital-based side.

14 DR. KANE: Okay. My only other question is, do we
15 have a sense -- in 2009, I notice the freestandings actually
16 lowered their cost per case. Do we have a sense of how they
17 did that?

18 MS. AGUIAR: I have asked one of the
19 representatives who sort of was doing exceptionally well
20 with their margins, but I do think I should probably go back
21 and ask more providers to get sort of a broader -- I would
22 rather go back and ask them again before I report back to

1 you on that.

2 DR. KANE: If there are any quality measures, it
3 would be kind of nice to see how that goes along with what
4 happens with the cost changes.

5 MS. AGUIAR: Yes.

6 DR. BERENSON: Yes. I have a data question and
7 the easiest way to deal with it is to read two sentences
8 from the paper. It wasn't in your presentation here. "In
9 the first three years of renewed enforcement of the
10 compliance threshold, 2004 to 2006, the aggregate percent of
11 Medicare cases meeting the threshold increased rapidly from
12 45 to 60.1 percent. However, when Congress capped the
13 threshold permanently at 60 percent in 2007, the compliance
14 rate began to level off and it has remained between 61 and
15 63 percent."

16 I find it remarkable that the threshold level is
17 the same as the average. I would have thought that a bunch
18 would have rates at 70 or 75. Is this, one, correct, and
19 two, are IRFs able to titrate their admissions so that
20 they're all coming in at 60 percent?

21 MS. AGUIAR: We do get this data from eRehabData,
22 and unfortunately, they don't have a complete sample of all

1 of the IRFs. Specifically, they're missing the largest
2 freestanding IRF provider, which accounts for 20 percent of
3 total revenues and 50 percent of all freestanding and for-
4 profit revenues. So there is somewhat of a limitation.
5 That aside, this data -- it has been consistent. We've been
6 seeing this consistent trend previously, so we don't have
7 any reason to think that that's not true.

8 What it indicates, sort of what it suggests is
9 that they were reaching -- they were going towards having to
10 comply for a 75 percent threshold, because originally when
11 CMS -- in 2004, when they renewed enforcement of the
12 compliance threshold, it was set at 75 percent and there was
13 a four- or five-year, I believe, phase-in period to that.
14 Then in 2007, it was capped permanently at 60 percent. So
15 it seemed like they were reaching to meet that 75 percent
16 threshold, and then once it was stuck at 60 percent, their
17 compliance rate has been hovering around there.

18 DR. BERENSON: It wasn't clear. What happens to
19 an IRF that doesn't meet the compliance rate?

20 MS. AGUIAR: I believe that they are not allowed --
21 they don't receive payment, I believe --

22 MR. LISK: They become no longer an IRF and they

1 become a PPS hospital --

2 MS. AGUIAR: Yes.

3 MR. LISK: -- and so they would be paid under PPS,
4 which --

5 DR. BERENSON: The incentive is to make 60
6 percent, but not more than 60 percent.

7 MS. AGUIAR: Right. Exactly.

8 DR. CHERNEW: Can you just remind me what the
9 copay is on an IRF stay?

10 MS. AGUIAR: It's the hospital inpatient copay. I
11 believe it's \$1,200, and it's only for patients that are
12 admitted from the community, the community admits.

13 MR. HACKBARTH: So somebody is transferred after
14 an acute inpatient stay, it's zero.

15 MS. AGUIAR: Right. Exactly. But they do have,
16 after a certain number of days, they have a copay.

17 MR. LISK: Yes, if they exceed the Medicare limits
18 on stays, then there is those --

19 DR. CHERNEW: Right.

20 MS. AGUIAR: Right.

21 DR. CHERNEW: But if you had a hip or a knee
22 replacement and you were deciding between an IRF or home

1 care, the IRF copay is \$1,200, or you might not be in the
2 community, so I'm not sure exactly how this would work, but
3 just conceptually. The home care, which you showed on one
4 of your slides the substitutability --

5 MS. AGUIAR: Right.

6 DR. CHERNEW: -- it now would be zero. Home care
7 would be free and the IRF would be \$1,200.

8 MS. AGUIAR: Right --

9 MR. HACKBARTH: [Off microphone.] -- patient
10 surgery.

11 MS. AGUIAR: Exactly.

12 DR. CHERNEW: [Off microphone.]

13 MR. HACKBARTH: So if they had a knee replacement
14 or a hip replacement, that would be -- I think it's still
15 inpatient --

16 MS. AGUIAR: Exactly.

17 MR. HACKBARTH: -- and so when they were
18 transferred to the IRF, the copay would be zero.

19 MS. AGUIAR: Right. They wouldn't have the copay --
20 -

21 MR. HACKBARTH: And if they went home, it would be
22 zero.

1 DR. MARK MILLER: And what's happening here is
2 there's a \$1,000 copayment on hospital -- or deductible on
3 hospitalization, right?

4 MS. AGUIAR: Yes.

5 DR. MARK MILLER: That's what we're talking about
6 here. And this is considered a continuation of the
7 hospitalization, is that the point?

8 MS. AGUIAR: Yes. Exactly.

9 MR. BUTLER: All right. I have several slides to
10 walk through to see if I can understand --

11 DR. MARK MILLER: [Off microphone.] I'm sorry.
12 Just to stay on his point for one second, in the
13 circumstances where somebody comes from the community,
14 however --

15 MS. AGUIAR: Yes, that's correct.

16 DR. MARK MILLER: -- it's as if they pay a \$1,000
17 deductible on a hospitalization, except they would be going
18 to the IRF. And so in that instance, your point --

19 DR. CHERNEW: I don't mean to go across
20 presentations, recognizing that would be too silo-breaking,
21 but --

22 [Laughter.]

1 DR. CHERNEW: -- we were talking about a copay in
2 the other one --

3 DR. MARK MILLER: I know.

4 DR. CHERNEW: -- and this is a substitute service,
5 as you can see from Slide, whichever one -- Slide 10 shows
6 you there's some substitutability between home health, up
7 ten, IRF, down 15 percent. And so it strikes me as a
8 potential thing that someone might be interested in, the
9 copay symmetry. That was the only reason why I wanted to
10 know.

11 MR. HACKBARTH: Absolutely. Do we know -- do you
12 know off the top of your head what the percentage of
13 admissions to IRFs come after an acute in-hospital stay as
14 opposed to from the community?

15 MS. AGUIAR: I could get you the exact number. I
16 believe it's less than three percent that come from the
17 community to the IRFs.

18 MR. HACKBARTH: Right. So typically, it's going
19 to be zero.

20 DR. STUART: But I believe the law on episode of
21 illness would allow up to a 30-day or 29-day gap between the
22 discharge from a hospital and an admission to an IRF would

1 be a continuous stay. So it might not -- so it depends on
2 how you've looked at the relationship between discharge and
3 admission. I mean, there could be a gap and it still would
4 not generate the deductible.

5 MR. HACKBARTH: Okay. Peter, you're up.

6 MR. BUTLER: So I've understood in the past the
7 differences in the hospital-based SNFs and home health and
8 why the numbers don't add up here, and I understand the
9 baseline on this and the different -- the economies of scale
10 question. I clearly understand why there could be a
11 difference. What I don't understand is the trend. One of
12 your slides, and you're going back to 2004, so there's been
13 relatively stable occupancy for both the freestanding as
14 well as the hospital-based, modest declines in both. But
15 the headlines is stable occupancy rate. So it's not like
16 one has declined and the other hasn't.

17 So now go to Slide 16 and you say the main reason
18 for the decline of 12 percent down to point-five percent in
19 the hospital-based profitability, which has not occurred on
20 the other side, is the growth in cost, and this slide
21 clearly demonstrates that. It shows, though, in those
22 earlier years that apparently the hospital-based folks could

1 manage the costs as well as the freestanding and suddenly
2 they lost their -- they couldn't do it anymore, even though
3 their occupancy didn't decline. It just -- it doesn't kind
4 of make sense to me that this is just a, suddenly, something
5 happened there.

6 So I come back to, do we have a change in the mix
7 of patients, which is always Glenn's argument. If you can
8 say that, then you can justify a difference in a rate
9 increase or a rate amount.

10 So now go back to Slide 9, and I realize we're
11 sitting here with one month before we're going to vote on
12 something, so I don't know that we can get answers to this
13 trend, but it is pretty striking that one would go up so
14 much more than the others. I kind of wonder if this profile
15 would look different in the hospital-based versus the
16 freestanding, so that the mapping -- not that stroke, and
17 these are measures of case-mix, but it would tell something
18 about the underlying trend that would help explain the --
19 because I don't think management of the costs is
20 significantly different in the two enterprises. I think we
21 do have a mix thing going on. I don't know that we can
22 quantify it, but I wanted to highlight that and see if

1 there's some way to kind of, just as the earlier question
2 was how did they reduce their costs, I'm skeptical something
3 else is going on.

4 MR. HACKBARTH: Interesting question, so
5 Christine, have you looked at this? Have you done this
6 graph for hospital-based versus freestanding?

7 MS. AGUIAR: No, I haven't, and I have to look to
8 see if we are able to with this data source.

9 MR. HACKBARTH: Okay.

10 MS. AGUIAR: I have to look into it, and if we can,
11 then I'll definitely produce that for you.

12 MR. HACKBARTH: Okay. So then turn to the graph
13 on page 16. Do you have any hypotheses in response to
14 Peter's question about why the marked difference in the
15 trend on hospital-based versus freestanding?

16 MS. AGUIAR: So, I mean, I'm speculating at this
17 point. What it seems to me is that both hospital-based and
18 freestanding were both under some of the same pressures and
19 responding to the 60 percent rule -- I'm sorry, to the
20 compliance threshold, which was reinforced in 2004, and so
21 which is why I think you saw a volume decline and a decline
22 in occupancy rates and beds across for both.

1 And then it seems to me what this sort of implies
2 is that the freestanding, which do tend to be larger and to
3 have higher occupancy rates in general than the hospital-
4 based facilities, were more able to control their cost
5 growth, were more able to respond to the compliance
6 threshold and therefore were just more effective at doing
7 so.

8 The question of whether or not the patient mix and
9 the case-mix is different, we haven't looked at that. So
10 I'm going to check back to see if we can check into that. I
11 think the one thing to keep in mind here is that the
12 freestanding is dominated by one chain in particular who has
13 50 percent of freestanding revenues, and that chain, their
14 margins are even higher. They're about 25 percent margins.
15 So they are doing exceptionally well. They're doing better
16 even sort of than you would expect if there was no payment
17 cut in 2008 and 2009. So the freestanding numbers are also
18 brought up by that company specifically.

19 MR. HACKBARTH: Yes.

20 MS. AGUIAR: And I think, you know, when we
21 stratified the results of cost per discharge by the low cost
22 -- when we standardized them, looked at low cost and high

1 cost, you sort of saw some of the same story. It's, like,
2 higher occupancy rates, higher number of beds, of course,
3 more likely to be freestanding is what sort of pushes you in
4 the efficiency with managing your costs category.

5 MR. HACKBARTH: Yes. So let me ask this. I think
6 that the decline in admissions was similar between the
7 hospital-based and freestanding -- I'm a lawyer, I'm not a
8 mathematician. Because of the smaller size of the hospital-
9 based, any given decline in occupancy would have more of an
10 effect on their year-to-year change in costs than it would
11 for a larger institution, is that right?

12 MS. AGUIAR: Right, I think.

13 MR. BUTLER: The Slide 4 shows that the declines
14 in occupancy was very modest and similar. I mean, it's not
15 -- I wouldn't think it would explain all of that.

16 MR. HACKBARTH: Okay.

17 DR. MARK MILLER: The other thing here is we've --
18 and I don't know at least half of what I'm going to suggest,
19 but there's also we've been tracking hospital cost growth
20 and during that period it was a lot more rapid than the
21 market basket. That's some of the discussions we've had in
22 the hospital world about their cost relative to their input

1 cost. And I don't know what the cost growth has been on the
2 IRF side. mean, we've been sort of making this argument
3 that the hospital cost growth is not under the same kind of
4 pressure because of the payment on the private sector side,
5 and so I'm trying to figure out whether freestanding IRF
6 cost growth is slower than the cost growth we've seen in the
7 hospital sector.

8 MR. HACKBARTH: So you --

9 MR. LISK: Actually, can I add a piece of
10 information that may be somewhat helpful? We can try to see
11 whether we can go back and do what Christine is talking
12 about in the analysis, but again, it's one large chain. So
13 they're freestanding, so this will be a differential. But
14 they did indicate they weren't as impacted as much by the 60
15 percent rule or the 75 percent rule because they did not do
16 as much on the hip and knee replacements, for instance. And
17 I think hospitals had a lot -- many hospitals had a lot more
18 of those and had to adjust for those. So there could have
19 been a bigger shift and change in the case-mix there, but
20 that's what we need to go back and check. But that is one
21 possibility, what we're seeing there. It's one reason for
22 the differential.

1 MR. HACKBARTH: So you understand the gist of the
2 issue that Peter is raising.

3 MS. AGUIAR: Yes.

4 MR. HACKBARTH: Let's see if we can bring some
5 analysis to bear.

6 Mary, any clarifying? Tom? Mitra?

7 Okay. Round 2 comments. Karen?

8 DR. BORMAN: I generally support the
9 recommendation.

10 MR. ARMSTRONG: I also support the recommendation.

11 MS. HANSEN: I support.

12 DR. CASTELLANOS: I'd support.

13 DR. BAICKER: I support it, as well.

14 DR. STUART: I support it.

15 MR. GEORGE MILLER: Aye.

16 DR. CHERNEW: Aye.

17 MR. BUTLER: Subject to understanding if there's a
18 case-mix change or not, I would like to understand that.

19 DR. NAYLOR: [Off microphone.] Aye.

20 DR. DEAN: Yes, I would support the
21 recommendation. It just strikes me, to compare this
22 discussion and these data with the ones we saw previously,

1 it seems to me that in this situation and this service, we,
2 correctly or incorrectly, we've been able to define the
3 benefit in a more precise way and it looks like utilization
4 is under reasonable control. I think there's maybe a lesson
5 there for our previous discussion.

6 MS. BEHROOZI: Starting with the one "unless," the
7 margins are high enough, so I support the recommendation.

8 MR. HACKBARTH: All right. Thank you very much.

9 [Pause.]

10 MR. HACKBARTH: So we are now to our final
11 presentation on long-term care hospital services. And,
12 Dana, you can start whenever ready.

13 MS. KELLEY: Good morning. So turning to our
14 long-term care hospital update, you are well familiar with
15 the update framework by this point, so I'll just start with
16 a little bit of background on LTCHs to refresh your memory.

17 Patients with clinically complex problems who need
18 hospital care for relatively extended periods are sometimes
19 treated in LTCHs. To qualify as an LTCH under Medicare, a
20 facility must meet Medicare's conditions of participation
21 for acute care hospitals and have an average length of stay
22 greater than 25 days for its Medicare patients.

1 Due to these long stays and the level of care
2 provided, care in LTCHs is expensive, averaging \$37,500 per
3 case in 2009. Medicare pays LTCHs under a per-discharge PPS
4 and the LTCH PPS uses the same MS DRGs as are used in the
5 acute care hospital PPS, but with weights that are specific
6 to LTCHs.

7 For some patients, payments are adjusted to be
8 more in line with those for similar patients in acute care
9 hospitals, and I'll talk a little bit more about that in a
10 minute.

11 Following implementation of the PPS in fiscal year
12 2003, Medicare spending for LTCH services grew rapidly,
13 climbing an average of 29 percent per year between 2003 and
14 2005. This growth prompted concerns about the demand for
15 LTCH care, patient selection, and the possible unbundling of
16 services from the acute care PPS.

17 As a result, CMS implemented regulations such as
18 the 25 percent rule, which reduces payments for hospitals
19 within hospitals if they admit a certain share of their
20 patients from their host hospitals. Between 2005 and 2008,
21 growth in spending slowed to less than 1 percent per year.

22 After Congress rolled back or delayed

1 implementation of some of CMS's regulations in the Medicare,
2 Medicaid, and CHIP Extension Act of 2007, spending for LTCH
3 services began to climb again, as you can see here, rising
4 6.4 percent between '08 and '09, to reach \$4.9 billion.

5 I'm going to quickly review changes to LTCH
6 payment policies that were wrought by MMSI and subsequent
7 amendments as well as by the Affordable Care Act, because so
8 many of them affect factors we consider in our update
9 framework.

10 First, as I mentioned, Congress delayed the phase-
11 in of the 25 percent rule, as well as reductions in payment
12 for LTCH cases with the very shortest lengths of stay.
13 Second, in exchange for this regulatory relief, the industry
14 faces a moratorium on new LTCHs and new LTCH beds through
15 December 2012.

16 Third, Congress mandated that CMS report on the
17 use of facility and patient criteria for LTCHs. You'll
18 remember that this is something the Commission recommended
19 back in 2004. The report from CMS was due July 2009, but as
20 of today is still pending.

21 The fourth bullet here refers to PPACA as mandated
22 reductions and updates to the LTCH payment rates. PPACA

1 required CMS to reduce the update by a quarter point for the
2 second half of fiscal year 2010 and by a half point for
3 fiscal year 2011. And then finally, PPACA mandates that CMS
4 implement a pay-for-reporting program for LTCHs by October
5 2013.

6 You'll recall that LTCHs don't submit any quality
7 data to CMS. In October, staff convened a panel to provide
8 input on the development of quality measures, and I'm going
9 to go ahead and present our update findings, and then report
10 on the findings from the panel.

11 So turning now to our update framework, our first
12 consideration is access to care. We have no direct
13 indicators of beneficiaries access to LTCH services, so we focus on
14 changes in capacity and use. But it's important to keep in
15 mind that, as a previous service we've discussed this
16 morning, the product is not well-defined.

17 There are not established criteria for admission
18 to an LTCH so it's not clear whether the patients treated
19 there require that level of care. And remember that many
20 Medicare beneficiaries live in areas without LTCHs and so,
21 presumably, are receiving similar services in other
22 facilities.

1 So to gauge access to services we'll first look at
2 available capacity, and you can see here the number of LTCHs
3 in the U.S. From the early '90s, which isn't shown in this
4 slide, but up until 2005, the number of LTCHs quadrupled.
5 Growth in the number of LTCHs leveled off between 2005 and
6 2008, that period when CMS implemented the payment
7 regulations that limited the growth in the spending.

8 As we've seen, spending began to climb again
9 between '08 and '09, and the number of LTCHs did as well,
10 rising 6.6 percent. This was surprising to some observers
11 because the moratorium Congress imposed -- because of the
12 moratorium that Congress imposed beginning in July 2007.
13 But exceptions to the moratorium were made for LTCHs that
14 were already in the construction pipeline and that exception
15 allowed this influx in facilities that we've seen.
16 Preliminary analysis suggests that far fewer LTCHs opened in
17 2010.

18 The rate of growth in the number of LTCH beds
19 picked up between '08 and '09 as well, and nationwide, in
20 2009, there were about 27,000 certified LTCH beds. This
21 shows growth in the number of cases per 10,000 fee-for-
22 service beneficiaries and we can see a slight increase over

1 the past few years after a period of rapid growth. So taken
2 together, these trends suggest to us that access to care has
3 been maintained during the period.

4 Turning now to quality, as I said, LTCHs don't
5 submit quality data to CMS so we rely on trends and in-
6 facility mortality, mortality within 30 days of discharge,
7 and readmission to acute care to assess gross changes in the
8 quality of care in LTCHs. In 2009, these rates were stable
9 or declining for most of the top 20 diagnoses.

10 Access to capital, as you know, allows LTCHs to
11 maintain and modernize their facilities. If LTCHs were
12 unable to access capital, it might, in part, reflect
13 problems with the adequacy of Medicare payments since
14 Medicare provides about two-thirds of LTCH revenues,
15 typically.

16 In 2010, the three largest LTCH chains, which
17 together own slightly more than half of all LTCHs, continued
18 with construction of new LTCHs that were already in the
19 pipeline, and thus exempt from the moratorium on new
20 facilities. In addition, these chains acquired other LTCHs
21 and other PAC providers.

22 According to the chains' filings with the SEC, all

1 three have access to revolving credit facilities that
2 they've tapped to finance these acquisitions. LTCH
3 companies are increasingly diversified, both horizontally
4 and vertically, which may improve their ability to control
5 costs and better position the companies for payment policy
6 changes.

7 Nevertheless, policy makers' increased scrutiny of
8 LTCH spending and quality has heightened investor anxiety
9 about the industry, and some analysts consider it to be one
10 of the most risky of the health care provider settings.
11 Smaller chains and non-chain facilities have more difficulty
12 accessing capital, but also are more likely to be limited by
13 the moratorium.

14 How have LTCHs per case payments compared to per
15 case costs? In the first years of the PPS, LTCHs appeared
16 to be very responsive to changes in their payments,
17 adjusting their costs per case when payments per case
18 changed. Payment per case increased rapidly after the PPS
19 was implemented, climbing an average of 16.6 percent per
20 year between '03 and '05.

21 Much of this growth was due to improvements in the
22 documentation and coding of patients following the

1 implementation of the new classification system. During
2 this early period, cost per case also increased rapidly,
3 albeit at a somewhat slower pace.

4 Between '05 and '08, growth in cost per case
5 outpaced that for payments as regulatory changes slowed
6 growth in payment per case to an average of 1.5 percent per
7 year. After Congress delayed the implementation of some of
8 CMS's stringent payment policies, growth in payments per
9 case began to pick up again, and between '08 and '09, per
10 case payments climbed 6.4 percent. Cost per case rose less
11 than 2 percent.

12 Consistent with this pattern of payment and cost
13 growth, margins for LTCHs rose rapidly after the
14 implementation of the PPS, rising from a bit under zero
15 under TEFRA to a peak of 12 percent in 2005. At that point,
16 margins began to fall as growth in payments leveled off.
17 However, in 2009, LTCH margins began to increase again,
18 reaching 5.7 percent.

19 This next slide shows 2005 and 2009 Medicare
20 margins for different LTCH groups as well as the share each
21 presents -- each represents of total providers and total
22 cases. You'll remember that '05 was the peak in LTCH

1 margins.

2 As you can see, there's a wide spread in margins,
3 similar to what you've seen in other settings with a quarter
4 of LTCHs having margins of minus 6.4 percent or less, and
5 another quarter having margins that are 14.1 percent or more
6 in 2009.

7 Margins for for-profit LTCHs are quite a bit
8 higher than those for non-for-profits. We haven't broken
9 out margins by urban and rural area here because there are
10 so few rural LTCHs, about 21 or so. Margins for rural LTCHs
11 are negative, which because of their small size, may
12 reflect, in part, a lack of economies of scale.

13 We looked more closely at high and low-margin
14 LTCHs to get a better idea of what's driving the margins.
15 Because LTCHs often operate in the red when they first open,
16 in this part of the analysis we included only LTCHs that
17 filed cost reports in 2008 and 2009.

18 This slide compares LTCHs in the top quartile of
19 margins with those in the bottom quartile. We found that
20 lower standardized costs, rather than higher payments, drove
21 the differences in financial performance between LTCHs with
22 the highest and lowest margins.

1 High-margin LTCHs also care for more patients with
2 mean total discharges of 533 compared with 410 for low-
3 margin LTCHs. High-margin LTCHs have far fewer high cost
4 outlier cases and lower outlier payments. In addition, they
5 have a lower share of short stay cases, and you'll recall
6 the facility's margins may be negatively affected by both
7 these types of patients. Finally, high-margin LTCHs are
8 much more likely to be for-profit.

9 So for purposes of projecting 2011 margins, we
10 modeled a number of policy changes. First we included
11 updates in 2010 and 2011. For both years, the update was
12 the market basket less adjustments for documentation and
13 coding improvements and the PPACA-mandated reduction for the
14 applicable year. This resulted in a small but positive
15 update in 2010 and an update for 2011 of minus .49 percent.

16 We also made an adjustment for changes to outliers
17 in both years which we estimate will increase aggregate
18 payments. Altogether, these effects will result in somewhat
19 greater growth in provider costs than in aggregate payments.
20 Assuming provider's costs go up at the projected market
21 basket levels, we've projected a margin of 4.8 percent in
22 2011. You'll note that that's a positive margin in spite of

1 the negative update that facilities receive that year.

2 So to sum up our update analysis, the number of
3 facilities and beds are up in 2009. We're seeing stability
4 in the use of services. We've little information about
5 quality in LTCHs, but mortality and readmission rates appear
6 to be stable. LTCHs appear to have access to the capital
7 they need, although the moratorium should now begin to limit
8 opportunities for expansion.

9 Our projected margin for 2011 is 4.8 percent, and
10 our projected decline in the aggregate margin is consistent
11 with expected effects of Congressionally-mandated reductions
12 and updates to payments.

13 We make our recommendation to the Secretary
14 because there's no legislated update to the LTCH PPS. Our
15 draft recommendation reads that the Secretary should
16 eliminate the update to payment rates for long-term care
17 hospitals for rate year 2012.

18 CMS historically has used the market basket as a
19 starting point for establishing updates to LTCH payments.
20 So eliminating the update for 2012 will produce savings
21 relative to a market basket. We do not anticipate any
22 adverse impact on beneficiaries or on providers' willingness

1 and ability to care for patients.

2 Before I turn it over to you, let me fill you in
3 on the findings from our recent panel discussion on quality
4 measurement in LTCHs. As I mentioned, PPACA requires CMS to
5 implement a pay-for-reporting program by October 2013. To
6 help us provide input to CMS on measures that can yield
7 meaningful information about LTCH quality, and hopefully
8 influence the provision of care, staff convened a panel of
9 clinicians, LTCH administrators and medical directors,
10 quality measurement analysts, and researchers with knowledge
11 of best practices in caring for post-ICU patients in LTCHs
12 and other settings.

13 Our panel suggested that CMS begin with a starter
14 set of measures building on those that LTCHs are already
15 using for internal quality measurement purposes. One of the
16 challenges for CMS will be to determine national
17 specifications for the measures, consistent definitions of
18 numerators and denominators, patient inclusion and exclusion
19 criteria.

20 Panelists discussed several outcome measures.
21 These three were considered to be the most basic. Panelists
22 noted that many readmissions to acute care hospitals are

1 planned so that any measure of readmission should focus on
2 unplanned readmissions. However, they cautioned that there
3 are facility characteristics that can affect the rate of
4 unplanned readmissions such as the presence of an ICU in the
5 LTCH. So that will be something that CMS will need to keep
6 in mind.

7 We asked the panel what patient safety issues were
8 prevalent in LTCHs and what measures could be used to track
9 trends in this area and encourage best practices. These
10 measures that I've outlined here are discussed in detail in
11 the paper and I can take any questions you have during our
12 Q&A.

13 I do want to note that the general consensus among
14 our panelists is that most, if not all, LTCHs are already
15 collecting these types of measures internally.

16 Panelists also discussed some process measures
17 that can help to improve quality of life for LTCHs patients.
18 These include a meaningful use of the Electronic Health
19 Record, advanced care planning and end of life discussions,
20 measures that monitor polypharmacy and its affects, and the
21 use of a ventilator weaning protocol.

22 Finally, panelists discussed the issue of risk

1 adjustment of quality measures in LTCHs. There was
2 agreement that risk adjustment was generally not appropriate
3 for patient safety measures as long as present on admission
4 indicator was used. The consensus was that the development
5 of a pressure ulcer was a bad outcome, no matter how complex
6 the patient.

7 Panelists agreed that risk adjustment was
8 necessary for outcomes measures, but the consensus was that
9 risk varies less in LTCHs than in other settings, and many
10 in the group argued that the issue of risk adjustment should
11 not be an impediment to moving forward. There was also
12 general agreement that until a common assessment tool is
13 available, CMS's starter set of measures should be ones that
14 can be collected from administrative data.

15 The findings from our panel meeting are summarized
16 in the paper and will be shared with CMS staff. You may
17 want to discuss whether MedPAC should make a formal
18 recommendation on the development of a pay-for-reporting
19 program for LTCHs. Such a recommendation might include
20 encouragement to move to pay-for-performance as soon as
21 possible.

22 A recommendation could also outline some guiding

1 principles for choosing the starter set of measures, such as
2 that the number of measures should be relatively small,
3 claims-based, and focused on outcomes and patient safety.
4 A MedPAC recommendation could also suggest future directions
5 for quality measurement in the LTCH setting, such as the use
6 of an assessment tool and the types of measures that might
7 be included in an expanded measure set.

8 So now I'll turn back to the draft update
9 recommendation and turn the discussion over to you, and I
10 look forward to your questions.

11 MR. HACKBARTH: Thank you, Dana, well done. So
12 let's see. Which side are we starting on this time for
13 Round 1 clarifying questions? Mitra, that would be you.

14 MS. BEHROOZI: Just being from a state where we
15 don't have LTCHs, is it unique to New York? There are
16 places that don't have LTCHs, right?

17 MS. KELLEY: Yes. New York is, I think, one of
18 the few places that actually does this.

19 MS. BEHROOZI: And do you know anything about the
20 characteristics of the places where it's not du jure but
21 it's defacto that there aren't LTCHs? This might be too big
22 a question for the first round.

1 MS. KELLEY: Much of the growth, for example, has
2 been in the south, in Texas, Louisiana are standard places.
3 And in places where there is not such a strict certificate
4 of need.

5 MS. BEHROOZI: So where you don't find LTCHs where
6 it's not forbidden, where it's not prohibited?

7 MS. KELLEY: What's been very interesting about
8 the growth in LTCHs and the lack of growth in other places
9 is that in recent years, we've seen most of the growth in
10 areas that already have LTCHs. So there appears to be a
11 concentration on duplicating services in particular areas
12 rather than kind of dispersing them.

13 Rural areas typically do not have LTCHs and from a
14 policy perspective, one would suspect that that's because
15 the population simply doesn't support that many critical
16 care patients in the area. Other than that, I don't have --

17 MS. BEHROOZI: Do you have a sense of where the
18 services are provided? I mean, can you --

19 MS. KELLEY: When they're not in an LTCH?

20 MS. BEHROOZI: Yeah.

21 MS. KELLEY: Sure. Generally, patients are -- not
22 all, but many patients stay in the acute care hospital for

1 longer and then they generally go to other types of post-
2 acute care providers, particularly SNFs after the longer
3 hospital stay.

4 MR. HACKBARTH: Mitra's questions make me think it
5 might be useful for the new Commissioners to just spend
6 another minute on sort of the context for this particular
7 discussion. One feature of it Mitra has put her finger on
8 which is the distribution patterns of LTCHs is interesting
9 at least. They are concentrated in, as Dana just pointed
10 out, rather than spreading. A lot of the new development is
11 in areas where there are already LTCHs. So there are large
12 swaths of the country dealing with, presumably, very similar
13 sort of patients but doing it in other types of settings.

14 Related to that, of course, is that LTCHs are a
15 relatively expensive setting. And so, four years ago, was
16 it, Dana, the Commission recommended that in order to make
17 sure that this very expensive resource was used for the
18 patients who could best benefit from the level of care and
19 cost of care, there ought to be facility and patient
20 criteria on who's eligible for a Medicare payment.

21 Congress asked CMS to do a report on that, which
22 is, as Dana said, is still pending. Could you put up Slide

1 10 for a second, Dana? Another interesting facet of the
2 history here, and Nancy has often remarked on this. So here
3 we have the advent of a prospective payment system. Usually
4 the idea for doing prospective payment is it's going to help
5 make the system more efficient and lower cost.

6 Well, we did prospective payment and cost growth
7 and revenue growth took off. It became an attractive
8 business opportunity for some people and we had rapid growth
9 in the number of LTCHs, but again with this peculiar pattern
10 of only in some parts of the country, which is, in part, a
11 function of regulatory restrictions, but not entirely, and
12 then sort of piling on in select markets, all of which led
13 us to be concerned, again, about whether we have a sensible
14 payment system, whether the criteria of who's going in are
15 proper, and also concern about the payment levels.

16 Some of these issues have been dealt with by CMS
17 and the Congress through ways that, at least to me, are
18 cruder than I would like. The restrictions on the referral
19 patterns that CMS instituted by regulation, four or five
20 years ago, to me is a cruder approach than facility and
21 patient criteria.

22 And then most recently, Congress has come in with

1 an absolute moratorium, which is sort of the ultimate crude
2 tool. But there's some really unique dynamics at work in
3 this field. I just wanted to highlight some of that history
4 for the new Commissioners.

5 Okay. Continuing with Round 1 clarifying
6 questions, Tom?

7 DR. DEAN: Yeah, just to follow up on Mitra's
8 question, I suspect it's beyond any information you have,
9 but this is a sort of unique model of care and it would seem
10 -- are you aware of any comparative studies?

11 I mean, we know these patients get taken care of
12 in places where these facilities don't exist, obviously, and
13 through other means. It would seem that there would be a
14 real value in trying to track patients that have roughly
15 equivalent problems through different routes of care and see
16 if we can come to some indication about both cost and
17 outcome.

18 MS. KELLEY: The Commission took a look at that
19 back -- we reported on it in 2004. We used 2001 data. So
20 it's dated. But we looked at areas without -- what we tried
21 to do was look at patients who looked similar to LTCH
22 patients, but who did not use LTCHs, and to see how their

1 episode costs compared to LTCH patients.

2 The problem in our analysis and that has affected
3 subsequent research also, is that we don't have any outcome
4 data or quality measures. So we have no way to decide
5 whether maybe it does cost more in an LTCH, but they may be
6 getting much better care or much more appropriate care
7 having better outcomes.

8 What we found and what other researchers have
9 found as well is that the episode costs for LTCH patients
10 are generally higher, and in some cases much higher, than if
11 patients don't use LTCHs. But that cost difference really
12 narrows if you focus on the most complex patients with the
13 highest severity levels and, I think, declines to sort of
14 statistical insignificance. That's also especially true for
15 ventilator-dependent patients who are cared for in LTCHs.

16 DR. DEAN: Do you know what proportion of the
17 patients admitted to LTCHs meet those criteria, the most
18 complex?

19 MS. KELLEY: I can dance around that one a little
20 bit. About 12 percent of patients have been -- in
21 aggregate, have been on a ventilator for more than 96 hours.
22 That percentage differs across different facilities. One of

1 the national associations did a study recently looking at --
2 trying to look at the cost of LTCH care, and they found that
3 LTCH care was a savings for about, I want to say, 40 percent
4 of patients. Those again were the sickest patients.

5 So there do seem to be, shall we say, a
6 substantial number of patients that probably are not of the
7 highest acuity.

8 MR. HACKBARTH: Round 1 clarifying questions.
9 George?

10 MR. GEORGE MILLER: The staff has done an
11 excellent job of providing demographic information in most
12 of the other presentations to date, but I didn't see --

13 MS. KELLEY: I'm sorry about that. I can speak to
14 that.

15 MR. GEORGE MILLER: Okay.

16 MS. KELLEY: And also, we'll make sure that that's
17 included in the chapter as well.

18 MR. GEORGE MILLER: Yes.

19 MS. KELLEY: The use of the services is pretty
20 much in line with demographics, with the general
21 demographics of the program. Slightly more minority use,
22 but not -- I wouldn't say an alarming difference. What is

1 very interesting is that other researchers who have looked
2 at the use of LTCH care following discharge from an ICU with
3 ventilator dependency, they have found a fairly significant
4 difference in LTCH use among African-American patients, and
5 the research that I've seen has not been able to tease out
6 whether that's a referral issue, whether that's a family
7 preference.

8 The mortality rate for patients who are
9 ventilator-dependent, when they leave the acute care
10 hospital, is very, very high. And so, there are patients
11 who go to hospice and there are differences in patient
12 election of those services across demographic groups. I
13 will definitely refer to this in the paper.

14 MR. GEORGE MILLER: And a follow up to that, 70
15 percent of this is paid by Medicare. Do you know what the
16 breakdown of the rest of the 30 percent would be?

17 MS. KELLEY: Off the top of my head, I'm going to
18 get it wrong, so I will also include that.

19 MR. GEORGE MILLER: Okay. Do you know if Medicaid
20 is a large --

21 MS. KELLEY: Medicaid is not large there.

22 MR. GEORGE MILLER: So this is not a dual eligible

1 issue as well, or would it be?

2 MS. KELLEY: I'm not sure.

3 MR. GEORGE MILLER: Okay. Thank you.

4 DR. BERENSON: I missed any discussion on what the
5 cost-sharing obligations of beneficiaries.

6 MS. KELLEY: Well, this is the hospital service.
7 You know, generally, an acute hospital service. So it's the
8 same premium and cost-sharing as in the acute care hospital
9 and as with as Cristina was talking about, with IRFs, if the
10 patient comes directly from the hospital they've already met
11 that obligation.

12 DR. BERENSON: With Bruce's notion of the 30-day
13 episode.

14 MS. KELLEY: Yes.

15 DR. BERENSON: So, theoretically, but these are
16 very sick patients, or many are. Okay.

17 MS. KELLEY: These are. I would say in most cases
18 home health care is probably not the substitute if that's
19 the question.

20 DR. BERENSON: Yeah, and so that's where I was
21 going next. In the work you did five or six years ago,
22 whenever it was, the alternatives where you don't have LTCH

1 presumably would be either a continued long stay in an acute
2 care hospital or in some cases the SNF --

3 MS. KELLEY: Yes.

4 DR. BERENSON: -- the complex SNF patients.

5 MS. KELLEY: Yeah. Some areas do have very high
6 complexity SNFs where patients are cared for.

7 DR. BERENSON: And there, we would then have a
8 very significant incompatibility of cost-sharing obligations
9 between the patient, the beneficiary who's in a SNF and
10 after day 20 is facing a daily significant out-of-pocket,
11 whereas here they're not.

12 MS. KELLEY: True.

13 DR. BERENSON: Okay.

14 MR. KUHN: Two quick questions: One on page 18,
15 when you were talking about the suggested outcome measures,
16 and I was particularly interested in the one in the in-
17 facility mortality. I remember looking at some data several
18 years ago where it appears that mortality rates for short-
19 stay patients was much higher than for longer-stay. One of
20 the policy assumptions people were drawing from that is that
21 these individuals perhaps maybe should have been more
22 directed to hospice rather than admission to a LTCH.

1 When you had this conversation with the community,
2 is there a discussion of differentiating on the inpatient
3 mortality in terms of short stay, long stay?

4 MS. KELLEY: One of the things we heard loudly and
5 clearly from our panelists was that often patients end up in
6 the LTCH because physicians in the acute care hospital want
7 to shift a patient elsewhere, and either the family or the
8 physician wants to avoid difficult decisions. There was a
9 consensus that patients come to the LTCH sometimes who
10 should not come. Their survival, expectations for survival
11 are quite low, and it's probably not the most appropriate
12 place for them to be cared for. On the other hand,
13 sometimes there aren't easy decisions about where else they
14 should go.

15 MR. KUHN: Thank you. And in that regard,
16 obviously, a facility or patient criteria would probably
17 help in some of the decision-making as we go in that
18 direction. So I know CMS has a report pending, but I also
19 understand the industry has put together some pretty
20 thoughtful recommendations of some criteria. Have we all
21 reviewed their recommendations, and do we have a pretty
22 favorable view of those, or what's the --

1 MS. KELLEY: I think the criteria that the
2 industry has developed, or has recommended, is similar to
3 the types of criteria that the Commission recommended back
4 in 2004 -- setting up parameters for staffing
5 qualifications, and also sort of some patient criteria that
6 can help sort of narrow the patient population a little bit.
7 RTI did the work for CMS on criteria, and they had very
8 similar recommendations as well.

9 DR. MARK MILLER: This may be dated, but at the
10 time that the two associations developed their criteria
11 there was some difference between the two of them.

12 MS. KELLEY: Yes.

13 DR. MARK MILLER: Is that still true?

14 MS. KELLEY: The industry, I think, has been
15 working together, increasingly working together on coming to
16 consensus on these issues, but I think that there is sort of
17 a general waiting to see what CMS is going to say.

18 DR. MARK MILLER: Yeah, and I just tease this out
19 because I think perhaps behind your question is if the
20 industry has criteria and we've suggested criteria, and I
21 think there is some static between the two --

22 MS. KELLEY: There was --

1 DR. MARK MILLER: -- associations for a while,
2 which may be working its way out. And then there's this
3 issue of where the circumstance stands with CMS.

4 And I just want to make this conceptual point just
5 to make sure. When we talk about the criteria here, we're
6 talking about the criteria for this level of care --

7 MS. KELLEY: Right.

8 DR. MARK MILLER: -- as opposed to this is what it
9 takes to get into an LTCH. I mean, as Bob is pointing out,
10 a person like this can be treated in other settings. So
11 when we spoke to the criteria, what we meant was a level of
12 care that's needed as opposed to you have to go to an LTCH
13 when you meet these criteria.

14 MR. HACKBARTH: I would think that the moratorium
15 is a reason for the associations to sort of get together and
16 say --

17 MS. KELLEY: Well, there's -- I would say that
18 there are disagreements in the industry about the pros and
19 cons of the moratorium.

20 MR. HACKBARTH: So my recollection, Dana is that,
21 and this is going to be a gross oversimplification, but
22 there's sort of a group of LTCHs that have been around for a

1 long time --

2 MS. KELLEY: Yes, that's right.

3 MR. HACKBARTH: -- that are largely or exclusively
4 not for profit.

5 MS. KELLEY: That's correct.

6 MR. HACKBARTH: And then there are the newer ones.

7 MS. KELLEY: Yes.

8 MR. HACKBARTH: Are the associations divided along
9 those lines?

10 MS. KELLEY: Not perfectly, but yeah.

11 MR. HACKBARTH: Okay. Nancy.

12 DR. KANE: Yeah, a couple questions. One is
13 something just to link up something I've been working on.
14 Are the staff required to get vaccinated for the flu season?

15 MS. KELLEY: The staff have to meet all the
16 qualifications that acute care hospitals have to meet. So
17 if the answer there is yes --

18 DR. KANE: That they don't have to.

19 MS. KELLEY: -- then they don't here either.

20 DR. KANE: Because I was reading that CDC was
21 pointing out that they really should, but in long-term care
22 facilities there's a much lower staff influenza vaccination

1 rate, and I just wondered if that would be one of the
2 criteria we'd want to put in there since these people seem a
3 pretty vulnerable to --

4 MS. KELLEY: These people are very vulnerable,
5 yes.

6 DR. KANE: Then on slide 13, on the differences
7 between the high margin and low margin I'm wondering two
8 things. One is do we know if there are any quality
9 differences even in mortality and discharge?

10 MS. KELLEY: Not really significant ones.

11 DR. KANE: So they look the same.

12 And do we know for the high-margin ones whether
13 there' are any physician ownership issues around who goes,
14 whether there's physician ownership of the high-margin ones
15 that's any different than the low-margin ones?

16 MS. KELLEY: I don't know the answer to that.

17 DR. KANE: Because I think we're starting to
18 collect that data. I thought we were. I'm not sure if
19 that's actually happening. I'm wondering if it might be
20 useful to get a sense of whether there is some selection
21 going on in that referral that has to do with physician
22 ownership issues.

1 MS. KELLEY: Okay.

2 MR. HACKBARTH: Clarifying questions? Kate.

3 DR. BAICKER: Just a quick one, I was very excited
4 about all the different outcome measures you were talking
5 about. To what extent are those measurable in other
6 populations, so that we could get a better answer to the
7 comparability of treatment in different settings? Do we
8 have the data we would need to compare different settings?

9 MS. KELLEY: CMS has been working on a
10 demonstration of the post-acute care tool that they tested
11 in a variety of post-acute care settings including LTCHs,
12 and the report on that demonstration is due in June or --
13 June? July?

14 June. So we're very much looking forward to the
15 results of that, and CMS's goal has been to try to develop a
16 tool that can be used across the post-acute care settings.

17 What we won't have is a similar kind of tool in
18 the acute care hospital, and of course that's a place of
19 overlap here too. But you know it certainly moves us in the
20 right direction, and it would provide a lot of information
21 about the care that's provided inside LTCHs, much more than
22 we currently have.

1 MR. HACKBARTH: Round one questions?

2 [No response.]

3 MR. HACKBARTH: Round two comments, reactions to
4 the recommendations? Mitra.

5 MS. BEHROOZI: I would support the recommendation,
6 and certainly the concerns about quality are well placed.
7 But just the concerns about having a payment system that
8 seems to incent, I don't know whether it's building
9 facilities or selection of patients or whatever, that we
10 just seem to be paying too much for.

11 You said it, Dana. I'll just repeat it. The
12 industry's own study showed that there was an efficiency
13 gain or whatever, a savings, in a minority of the cases that
14 we're paying them too much for is of real concern. So with
15 that, I support the recommendation.

16 DR. DEAN: Yeah, I'd support the recommendation.
17 I would also support Mitra's comments. It seems to me that
18 sitting here with a kind of unique model of care for which
19 we have a moratorium on is not a very satisfactory
20 arrangement. I mean if this is a good way to do things, we
21 should take off the moratorium; if it's not a good way to do
22 things, then we should get much more aggressive in the other

1 direction.

2 So the quality issues I think are crucial, and the
3 comparative, some sort of comparative information about how
4 this approach relates to the other alternatives and whether
5 or not the patients that are entering these facilities
6 really are the ones that stand to benefit from this type of
7 care are questions we don't really have answers to, it
8 doesn't sound like right now. And I think we really need
9 answers if we're going to come up with a logical approach.

10 MS. KELLEY: I think I have just one response to
11 that. I think this was suggested in one of the earlier
12 presentations today. I think in home health. I think we've
13 got a lot of good actors here and then perhaps other
14 providers who are not performing the way we would like. So
15 I think the challenge is to try and direct the care in the
16 way that we want as opposed to in a way that sort of is a
17 financial performance issue.

18 DR. DEAN: Sorting out the good guys from the bad
19 guys has always been a challenge.

20 DR. NAYLOR: I also support the recommendation and
21 strongly endorse Tom's recommendation about comparative
22 effectiveness work. I don't know that we do that, but

1 studies that would help us to uncover how similar
2 populations are being served, how well and what are the
3 costs associated with it. It's a great opportunity, and I
4 think we need to encourage it.

5 MR. HACKBARTH: One of the reasons that this
6 demonstration project and developing common information
7 tools across the different post-acute settings is so
8 important, that's the raw material with which you can begin
9 to look at oh, these patients require this resource and
10 other patients can be cared equally well for in another
11 setting. So we're making progress towards that.

12 Peter.

13 MR. BUTLER: I support the recommendation and
14 would like a short editorial as I reflect over our decisions
15 over the last day and a half. We have again supported the
16 migration of post-acute care to free-standing for-profit
17 entities in a fairly rapid way and pretty much locked in, in
18 many cases, double-digit profit levels.

19 This is nothing against for-profits. I think they
20 manage costs well. They often add discipline to the market.
21 So that's not the point. But we have kind of -- that's what
22 we've in effect done, embraced that.

1 My second point, so what are the implications? It
2 runs maybe, or maybe not, counter to the bundling that we
3 need to get on with. At least it is posing either greater
4 barriers or greater facilitations, and I think we need to
5 worry about that.

6 Secondly, we really never talk about the
7 willingness of the for-profits in the post-acute world to
8 accept the charity care. We are just focusing on the
9 Medicare access. So I'm a little concerned for those post-
10 acute care providers that are in the non-Medicare business,
11 the potential implications.

12 Finally, I think that we do need to think about
13 again for-profits aren't bad, but who really do we want to
14 be the assemblers of the bundles. We know the MA plan
15 should do it. I think we need -- I'm not sure hospital-
16 centric bundling is any better, and I'm not sure that
17 multispecialty physician group bundling is necessarily
18 better. We need patient-centric bundling, and I don't know
19 how we have that discussion so that you really kind of --
20 otherwise, everybody is trying to be the bundler, and we're
21 kind of letting it happen in ways potentially that I think
22 we could be a more proactive voice in thinking about how

1 this happens.

2 MR. HACKBARTH: Peter, when you say your first
3 point, when you say that the recommendations we've discussed
4 encourage the growth of a for-profit, free-standing, post-
5 acute industry, I take it what you mean by that is because
6 the hospital-based services in the post-acute area typically
7 have much lower or negative margins and we're not making any
8 payment adjustment for that, which is causing them to exit,
9 these hospitals to exit these businesses in favor of it
10 being taken up by free-standing, for-profit providers. Am I
11 understanding you correctly?

12 MR. BUTLER: A little bit of that, but I'm not
13 trying to protect underperformance in the hospital-based
14 services. I'm really not.

15 I just think that the other way of looking at it
16 is the profit margins that we are supporting are encouraging
17 the for-profits to enter and do more of it, maybe even more
18 than is necessary. So set aside any biases against the
19 hospital-based because actually in many of these areas we
20 aren't that great at doing it. It's not our primary focus.

21 MR. HACKBARTH: Generally speaking, the conclusion
22 that you draw from that is we need to be aggressive in

1 holding down the rates and squeezing out the very high
2 profit margins that are attracting.

3 MR. BUTLER: [Off microphone.] Yes.

4 DR. CHERNEW: I support the recommendation, and I
5 very much support what Peter said although I want to point
6 out one thing. The problem is if you think there's
7 heterogeneity, which we often think there is, you can't
8 squeeze out the profit margins of the for-profits without
9 destroying the profit margins of the ones that you might.
10 I'm not arguing this because of the quality measure issue,
11 but you can't get rid of the ones that you think are for-
12 profit and the ones that you have that implication for
13 without hurting the other ones even more because we don't
14 have that lever.

15 And the problem that I think we have is a review
16 of some personal bias. I am skeptical that we -- and we, I
17 mean that sort of very broadly -- are nimble enough to both
18 observe everything we would want to observe in terms of the
19 heterogeneity and then develop the regulations in a way to
20 get it done much more precisely. So in the end I support
21 Peter's view of having a much more holistic, bundled view.

22 We talked about like 10 different types of payment

1 mechanisms. Roughly, five or six of them are all long-term
2 care type, post-acute type services with some level of
3 substitutability.

4 We have very siloed discussions, very inconsistent
5 incentives in terms of co-pays, as Bob pointed out about
6 what happens, very different incentives about profit
7 margins, very different incentives about a whole series of
8 things, very little ability to have quality measures. We
9 often treat the quality measures completely different, so
10 the same person in a nursing home might have a different
11 quality set of metrics than that person in a long-term care
12 facility.

13 So my view is although I completely agree with
14 Mary that we need much more clinical research I don't view
15 that as fundamentally informing payment strategy as much as
16 actually clinical providers, to help them decide what to do.
17 And we need to make sure that we have the payment system
18 that enables the providers that want to do well and succeed,
19 with that information, to be able to succeed instead of one
20 that just pushes care down.

21 And we need to come up with quality measures that
22 are patient-centric across the whole type of patient as

1 opposed to site of care, place-centric. I guess site and
2 place are redundant, but anyway centric.

3 I think my general spirit of the recommendations
4 would be to move as quickly as we can. I like this
5 recommendation.

6 But separately, sort of our other June report type
7 thing, to try and get through these silos instead of
8 spending all of our time trying to look within the silos
9 about huge amounts of heterogeneity, and then we realize
10 yeah, but those people could be here, and then we have to do
11 another one, and then we have to do another one.

12 Then we want to put something in, but someone
13 points out there is some sort of cleavage in the payment
14 system. So you get this if you've been discharged from this
15 after three days, but not after four days.

16 So you see all these ones with green and red bars,
17 and you see people, like I think it was Evans. They split
18 out. They were all lumped in the middle. Now they're all
19 lumped to the sides.

20 And we have an exception for the 25 percent rule,
21 but if it's even, if it's a county that begins with a vowel,
22 we give them an exception. And you know all --

1 MR. HACKBARTH: Payment reform is important, I
2 take it.

3 [Laughter.]

4 DR. CHERNEW: Right. So I guess my point is I
5 think we should just go forward with this and devote a lot
6 of these other more detailed energies towards getting us to
7 where we want to go as opposed to the interim steps in this
8 bad system.

9 MR. HACKBARTH: Yeah. Cori.

10 MS. UCCELLO: I agree with the recommendation, and
11 I agree that we do need to think about this stuff more
12 holistically and substitution and make sure all that makes
13 sense, but that's not for today.

14 MR. GEORGE MILLER: I agree with the
15 recommendation. I agree with Peter except for I'd like to
16 substitute the word "bad actors" -- I think Nancy used that
17 term -- versus "for-profit," which is probably surprising
18 coming from me.

19 And I also agree with Michael that we should
20 probably try to find a way to find quality measures that go
21 across silos and sectors, so that we can evaluate
22 collectively should a patient be in an LTCH versus an acute

1 care hospital setting and be able to differentiate that.

2 Like it or not, there is still a cost issue. Is
3 the quality better, but do we pay \$1,000 more for it in a
4 different setting? So those are some of the issues we
5 should discuss.

6 And certainly quality has got to be the lever
7 first, I think, and certainly cost, but we do it inversely.
8 We talk about the quality, but we look at the revenue data,
9 and then we make the decision. So somehow we got to link
10 those two stronger together in my view.

11 DR. BERENSON: I support the recommendation and at
12 this moment have nothing to add to what has been a very good
13 conversation.

14 MR. KUHN: I'm generally supportive of the
15 recommendation although I would be a lot more enthusiastic
16 if we could add to the recommendation a restatement of I
17 guess the four-year ago proposal of some classification
18 criteria that's out there.

19 You know, by the time this report is published in
20 March of next year we'll be two years out from when a report
21 is due from CMS. The industry has already coalesced around
22 a set of criteria, and if you look at this industry, the

1 only -- as it was reported here, the only criteria for LTCHs
2 is that it's an acute care hospital with an average length
3 of stay of 25 days or more. You know.

4 I think they're entitled to a little bit more or
5 else they're going to be caught in this quagmire that we're
6 caught in here -- is that it's hard to make decisions when
7 you really don't have these things nailed down a little
8 tighter. And I think if we could rethink that and put
9 something, a little stronger statement there, I think that
10 would be very helpful.

11 MR. HACKBARTH: Well, what we could do is rerun
12 that recommendation in a text box and include a passage in
13 the text, reiterating how important we think this is and
14 urging to get on with it.

15 Nancy.

16 DR. KANE: Yeah, I support the recommendation. I
17 think we don't know enough to not accept that the profit
18 margins seem and the supplies seem -- they're there, and we
19 don't know if we want more or less of it at this point.

20 I just wanted to follow up on something Bob
21 mentioned about the cost-sharing difference between a SNF
22 and a LTCH. That's kind of worrisome to me, and I'm

1 wondering how many people actually go out to the SNF 20
2 days, whatever it is, and then switch to the LTCH to avoid.
3 I wonder how much of this is being driven by the cost-
4 sharing aspects of demand rather than the medical needs as
5 well, and it would be interesting to sort of get a sense.

6 I don't know if any of these people get admitted
7 from SNFs, but if they are it would be interesting to see
8 what that episode looks like and whether it's right at the
9 day they start cost-sharing that they get transferred into
10 the LTCH.

11 MS. KELLEY: It's something close to 20, 18 to 20
12 percent --

13 DR. KANE: That's a lot.

14 MS. KELLEY: -- that get admitted, well, not
15 necessarily directly from a SNF. They get admitted -- they
16 are not admitted directly from the acute care hospital.
17 Most of these patients were somewhere. I mean most of these
18 patients weren't at home.

19 DR. KANE: If you're on a ventilator, you weren't
20 at home. So it would be nice get a better sense.

21 And maybe one recommendation we could add to all
22 this is something about the co-pay differential and how that

1 incentive to go to an LTCH when the co-pay starts picking up
2 in a SNF might be waived if indeed that's what's happening.
3 I don't know.

4 MR. HACKBARTH: You know, I agree with the general
5 point about looking at the co-pay structure around issues of
6 substitution of services. That's really important.

7 But we also need to remember that the way this
8 system works now the vast majority of patients have
9 supplemental coverage. That means these issues are
10 irrelevant. They're not facing cost-sharing at the point of
11 service. So the issues are less sharp than they seem in the
12 abstract.

13 Bruce.

14 DR. STUART: I support the recommendation.

15 DR. BAICKER: I support the recommendation. I
16 support Mike's little rant. And I'm wildly --

17 [Laughter.]

18 DR. CHERNEW: [Off microphone.] [Inaudible].

19 DR. BAICKER: And I'm very enthusiastic about
20 increased data availability and better metrics that would
21 let us look across silos better.

22 DR. CASTELLANOS: I likewise support the

1 recommendation. I think the discussion has been very, very
2 positive, and I look forward to trying to solve this post-
3 acute care setting dilemma.

4 MS. HANSEN: I support the recommendation, and I
5 think I picked up also this whole issue of general cost-
6 sharing as a larger topic. I know definitely that right now
7 there's a great deal of coverage by supplemental policies,
8 but that is going to be changing as a result of PPACA.

9 So I just wonder if when we talk about benefit
10 design in the future and we were talking about cost-sharing,
11 especially with the home health benefit, whether or not
12 there's work underway or whether there is some work that we
13 could think about that speaks to the whole Medicare sets of
14 programs that we do and is existing cost structure of what
15 the co-pay would be, with the asterisk, knowing that right
16 now these supplemental programs do cover it. But if we're
17 starting to move to the principal of cost-sharing, could we
18 have something that's a little bit more unified, describing
19 this, and having it come described by virtue of the current
20 siloed programs?

21 But I think it was Mike who was starting to say,
22 you know, it's really regardless of let's just say that

1 there's an example of a septicemia or some of the diagnoses
2 that are listed here in these areas. What would normally,
3 possibly happen from a more client basis -- occur -- because
4 if you were in a rural place where you don't have this
5 versus a place that could use other services than a
6 facility-based service? How does that show up in the cost-
7 sharing and trajectory that they would go through?

8 So it's turning it around, but anticipating what
9 we need to think about the whole concept of appropriate
10 cost-sharing in the benefit design for the future.

11 MR. HACKBARTH: On Jennie's first point, PPACA, my
12 recollection -- somebody correct me if I've got this wrong -
13 - is that by 2015 the insurance commissioners are supposed
14 to submit recommendations on including cost-sharing in the 2
15 most popular models of supplemental coverage, which
16 currently have basically no cost-sharing at the point of
17 service. Is that right?

18 Scott.

19 MR. ARMSTRONG: I, too, support the direction that
20 the recommendations are taking us in.

21 I also just want to say I really appreciate how
22 Peter and Mike framed the broader set of issues that I look

1 forward to us talking about.

2 I was just looking and recognized if you put
3 skilled nursing, the inpatient rehab and long-term acute
4 care hospitals, what we spend on those, it's starting to get
5 to get to \$40 billion. At this inflation rate, it will
6 catch up with what we spend on provider payments pretty
7 soon. So it just seems to me that the way to get it under
8 control and to feel that we're getting a better return is to
9 look at how it all holds together in some different way from
10 the way in which this siloed approach requires us to look at
11 it.

12 DR. BORMAN: I support the recommendation. I
13 would just throw out the thought that as we identify some
14 areas about, that potentially could be enlightened by
15 comparative effectiveness reviews or sponsorship of work,
16 perhaps we should be having a running list that we might
17 share as PCORI takes shape and moves forward because some of
18 the things that were kind of in an abstract on the starter
19 set for them to look at may or may not be at the point of
20 the sword so much as some of the things that we might help
21 identify in our conversations.

22 MR. HACKBARTH: Okay, I just want to offer a

1 thought on this issue of for-profit, not-for-profit. You
2 know we've got 17 commissioners. I imagine we probably have
3 17 different points of view on that issue.

4 My own I think may be similar to Peter's. I don't
5 personally have an objection in principle to for-profit
6 institutions. I don't think for-profit are inherently worse
7 than not-for-profit.

8 I do believe though that they respond differently
9 to the payment systems, and we see that in a variety of
10 different ways. One way, which Nancy flagged, is if you
11 have really substantial overpayments that's going to attract
12 a lot of for-profit activity, aggressive entry into places
13 where there are high profit levels.

14 Another way we see evidence of in the hospital
15 payment system, if you remember the low pressure, medium
16 pressure, high pressure analysis that we discussed
17 yesterday. For-profits, even when they were under low
18 pressure, tended to have lower costs whereas not-for-
19 profits, if they have high revenues, are inclined to say:
20 Oh, I have a mission. You know. It's to delivery health
21 care to my community. I've got more money. I'm going to
22 invest more in that mission.

1 A for-profit is going to look at oh, I need to
2 make a return to my shareholders, and I'm not going to maybe
3 incur some additional costs that a not-for-profit might. So
4 they, for sure, respond differently to the incentives and
5 typically will respond aggressively.

6 I think the job of the Commission and what we need
7 to do on Medicare is make sure that our payment systems are
8 fair and don't allow undue opportunities for people to make
9 inappropriate profit, and we need to maintain pressure
10 across all of the payment systems.

11 Then I join Mike's --

12 DR. CHERNEW: [Off microphone.] Rant.

13 MR. HACKBARTH: -- rant.

14 [Laughter.]

15 MR. HACKBARTH: You know, about the urgency and
16 the importance of moving on and getting to new payment
17 models and getting out of the fee-for-service silos that
18 we're in. So that's my final word for this meeting.

19 Thank you, Dana.

20 We'll now have our public comment period.

21 MR. KALMAN: Good morning. I'm Ed Kalman. I'm
22 general counsel to the National Association of Long-Term

1 Care Hospitals. I'd like to help clarify the Medicaid
2 question that was raised.

3 As you see, the growth in long-term care hospitals
4 in the states of Texas and Louisiana, those states have a
5 limit on Medicaid days. They only allow 30 Medicaid days.
6 So these patients with very long stays have used these days
7 up. If you look at the data, a lot of these patients are
8 dually eligible. I come from Massachusetts. We have -- and
9 New York where New York Health and Hospitals in the long-
10 term care hospital business, we have lots of Medicaid
11 patients because they cross over. So that's helpful to that
12 question.

13 We are also the association that did the study on
14 cost-effectiveness, and we did it because we wanted to show
15 over a hospital episode of care whether there are patients
16 where the Medicare program saves money. And we wanted to
17 come up with a predictive model so that those patients could
18 be identified before they came to a long-term care hospital
19 with administrative data that's available to both the
20 hospitals and later to CMS so they can do a payment
21 adjustment.

22 So we are recommending a payment model that

1 rewards long-term hospitals for admitting cases that save
2 money, and it's quite substantial. We found -- we've got a
3 linked file; we followed the cases -- that long-term care
4 hospitals in 2010, using 2010 payment policies, saved the
5 government \$282 million. You take that and what CBO would
6 do with that over five and ten years, it's not short money.

7 Also, we've identified these are high CMI cases,
8 as you know, that are at very high risk of readmission if
9 they stay in acute hospitals because of the incentives of
10 IPPS which also generates more costs.

11 So I hope that's helpful.

12 MR. HACKBARTH: Okay. We are adjourned. Thank
13 you.

14 [Whereupon, at 11:53 a.m., the meeting was
15 adjourned.]

16

17

18

19

20

21

22