MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 10, 2009
9:19 a.m.

COMMISSIONERS PRESENT:
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AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: Okay, it is time for us to begin. Before we turn to the first session, let me make some opening comments for the audience and thank you all for coming, for your interest in our work. At this meeting, we will be focused on discussing draft recommendations on update factors for the various provider sectors, for fiscal year 2011. We're way out there in the future.

Just as a reminder to those of you in the audience, this is an annual responsibility of MedPAC's. We discuss draft recommendations in December. There will be no votes today. We will vote on final recommendations in January, and those recommendations will then be included in our March report to Congress.

The context for our update recommendations this year is unusual, with pending health reform legislation in Congress. Our job is to make recommendations for the Medicare program, as is. So, while what's happening in Congress obviously is getting a lot of attention and deservedly so, our focus the next couple days is different. We're not focused on health reform. We are focused on the Medicare program, as is, and what the appropriate rates for

providers should be in that context.

On the slide that's on the screen right now, these are sort of our guiding principles on payment which we have pursued in the past and will continue to do so again this year.

I emphasize the different in what we're doing from what Congress is doing because it can have a substantive impact on the recommendations. Congress, for example, is looking at Medicare payment policy potentially in the context of significant steps towards universal coverage, and that can influence how the Congress thinks about Medicare payment policy and how provider organizations think about Medicare payment policy. An example of that which has been very prominent is how hospitals feel about Medicare payment policy with universal coverage and without universal coverage. They look at the issue differently.

So, again, our task here is not to think about universal coverage, not to think about health reform, but rather consider Medicare payment policy with the Medicare program, as is. Periodically, over the next couple days, I will remind all of us that that is the task at hand.

As in years past, I will be offering draft

recommendations for the consideration of the Commission, and I hope we'll have a full and rich discussion of those draft recommendations. We will use that discussion to develop our final recommendations for January.

At the end of each session -- the morning session, the afternoon session -- we will have, as always, a brief public comment period. It will be brief, and I would emphasize to those of you in the audience who want to provide input to the Commission, that is an opportunity for you, but it is not the only opportunity or perhaps even the best opportunity. The staff go to extraordinary efforts to listen to people who have substantive information that could help guide our decisions, and I urge people to take advantage of that. In addition to that, we have an opportunity on our web site where people can post comments about our discussions and, in this case, our draft recommendations, and I hope people will take advantage of that.

Have I missed anything?

DR. MARK MILLER: You're okay.

MR. HACKBARTH: So those are our basic points. You will probably get tired of hearing me say some of them

over and over again, but bear with me.

Okay, so now we will move on to our first presentation on hospitals.

Mr. Stensland: Good morning, this session will address the adequacy of Medicare payments to hospitals and will set the stage for your deliberations on update recommendations for both the inpatient and outpatient rates. I'll discuss the work our team has done on indicators of payment adequacy and present the Chairman's draft update recommendation. Craig will then discuss payments to teaching hospitals, and Julian will discuss how changes in documentation and coding have affected hospital payments. We will then present the Chairman's draft recommendation on how to counterbalance the effects of improved coding.

Now there's a lot to cover today, so I'll be going fairly quickly, but there's detailed information in all your mailing materials.

We evaluate the adequacy of hospital payments as a whole, meaning we examine whether the amount of money in the system, including both inpatient and outpatient payments, is sufficient. In 2008, Medicare spent roughly $139 billion on traditional inpatient and outpatient fee for service

payments. This represents a 3.7 percent increase per beneficiary from 2007.

Each year the Commission deliberates, and it makes a judgment call as to the adequacy of hospital payments. Today, you will discuss whether fiscal year 2010 payments are adequate, taking into consideration the indicators of payment adequacy that you see on this slide here. They are access, quality, access to capital, and payments and cost which are used to compute margins. This same set of indicators, when available, is used in all the sectors we'll talk about today and tomorrow morning.

Now in addition, the MMA requires MedPAC consider the costs of efficient providers when making update recommendations, and we'll talk about a set of relatively efficient hospitals today and their performance on cost and quality.

Now, last month, we discussed how capacity was increasing and how access to capital is normalizing. Your mailing materials also discuss the growth in outpatient services and the stability in the volume of inpatient services per beneficiary. So I will not dwell on that now, and I'll turn to talking about quality.

The good news is the quality of care indicators are generally improving. We see improvements in in-hospital and 30-day mortality for the conditions we monitor, including AMI, congestive heart failure, stroke, hip fracture and pneumonia. There has also been steady improvement in the process of care measures that CMS reports on, such as the use of beta blockers.

However, two indicators have remained steady. We see mixed results with respect to patient safety indicators that are endorsed by NQF, and readmission rates have remained stagnant in recent years. Now, in the past, the Commission has recommended financial incentives to stir improvements in readmission rates.

So now I'm going to talk about Medicare margins based on the most recent data we have and our forecast for 2010. A margin is calculated as payments minus cost divided by payments, and it's based on Medicare allowable costs. The overall Medicare margin covers acute inpatient, outpatient, hospital-based home health, skilled nursing facility and inpatient psychiatric and rehabilitation services in hospitals that are covered by the inpatient prospective payment system.

The overall Medicare margins have trended downward since 1997, and they have been negative since 2002. From 2007 to 2008, the overall Medicare margin fell from minus 6 percent to minus 7.2 percent.

This slide shows how the overall Medicare margin differs across hospital groups. We see that rural hospital margins were minus 6.4 percent in 2008, which is better than the urban hospital margins, and this is due to policies designed to increase payments to rural hospitals including sole community hospitals, Medicare-dependent hospitals and critical access hospitals.

Roughly 1,300 small rural hospitals are critical access hospitals that receive payments equal to their costs plus a 1 percent profit margin. If you add these set of rural providers into the rural category, the aggregate total rural margin would be minus 4.5 percent, as we show in the footnote.

Major teaching hospitals also continue to have overall Medicare margins that are much better than the average PPS hospital. This is in large part due to the extra payments they receive through indirect medical education and disproportionate share payments. Craig will

talk about the IME and medical education payments in more detail later.

So one question you may have is why have margins been falling? The basic answer is that costs have been growing faster than the 3 percent average annual increase in payments that have occurred over the past 8 years. In 2008, payments rose by 4.5 percent per discharge due to updates of roughly 3 percent and documentation and coding improvements that also led to increased payments, as Julian will discuss later.

However, costs rose by 5.5 percent. As has been the case for several years, this is roughly 1 percent higher than the 4.3 percent increase in input prices. One possible reason the costs rose faster than input prices is that most hospitals did not face significant pressure to constrain costs back in 2007 when they set budgets for 2008. We will show later how costs vary significantly depending on the level of financial pressure hospitals face to constrain costs.

Now let's look forward to 2010, and we estimate that the overall Medicare margin in 2010 will be minus 5.9 percent, and this is over 1 percent better than 2008.

So the question is here why do we expect things to improve after 2008? The key reason that we expect margins to increase are as follows:

First, we expect documentation and coding to continue to improve, resulting in payments growing faster than the market basket in 2009, just like they did in 2008 when we had 4.5 percent payment growth.

Second, in contrast to 2008, we expect cost growth to be slower in 2009. Preliminary data suggest that costs are growing at roughly 1 to 3 percent in 2009. The big shift in cost growth could reflect a big shift in hospitals' financial pressure. Hospitals had strong overall profits in 2008, higher than in any recent year. Therefore, they appeared to be in good shape when they were setting budgets for 2008.

Cost growth was then strong in 2008. However, the outlook changed abruptly in the fall of 2008. Hospitals ended the year with weak profits due to a collapse in the value of their investments and a decline in the economy.

The financial difficulties in 2008 were followed by a greater focus on expense control by hospitals in 2009. The preliminary data show 2009 cost growth will be slower.

The census reports that through the first half of 2009 hospital cost growth dropped in half, and the for-profit chains, such as HCA and other large chains, report very low cost growth through the first 9 months of 2009, averaging around 1 percent.

So this difference in cost growth that we see from '08 to '09 reflects the relationship between financial pressure and cost that we've discussed before.

Now I'll show you a slide that's similar to what we showed you last year. This just shows that hospitals facing high pressure due to low non-Medicare profits have had pressure to keep their costs down for a long time.

We roughly define high-pressure hospitals as those with median margins less than 1 percent and stagnant or declining levels of net worth. These hospitals feel a strong pressure to constrain their costs, and, in years after they feel this pressure, these hospitals kept their costs down to a standardized amount of 91 percent of the average. You can see that in the first column of this slide.

The lower costs of these hospitals that are under high pressure contribute to them having higher Medicare

margins. Lower costs and the same Medicare rates results in better profit margins.

But a key question when looking at this slide is whether there's a set of hospitals that can perform relatively well on cost metrics and also perform relatively well on quality metrics.

So now we'll turn to hospital efficiency. And, for the audience, I want to be clear that when the Commission says efficiency it means producing good outcomes at a relatively low cost. In other words, efficiency is about more than just costs.

Our method for identifying hospitals that perform well on cost and quality continues to evolve. This year, to be deemed relatively efficient, a hospital must meet the following cost and quality criteria:

First, the relatively efficient hospital must excel on at least one measure, meaning either risk-adjusted mortality or risk-adjusted cost are in the best one-third every year from 2005, 2006 and 2007.

In addition, it cannot perform poorly on any measure. This means that risk-adjusted mortality, readmissions and cost must be in at least the middle third

in every year.

This is relatively strict criteria because any hospital with high cost or high mortality in one year is dropped from the efficient group. So far, these criteria are the same as last year. However, we've added two new screens to the data.

First, to address the concern that providers may have low cost because they are in a market where volumes per person are high, we remove the 10 percent of hospitals in counties with the highest service use from our sample. So you're not going to get into the efficient group if you're in a market where they have very high utilization.

Second, some commentators have suggested that it's easier to achieve low cost if a hospital primarily serves a select group of patients. The implicit assertion is that it's easier to achieve good outcomes at a low cost when poor folks are not part of your patient mix. While we do not weigh in on whether this is true, we remove the 10 percent of hospitals with the lowest Medicare shares from our sample, to be conservative.

And kind of in summary, the overall goal of this screening process is to identify hospitals that can provide

good outcomes at a reasonable cost while serving a broad spectrum of patients, including Medicaid patients.

The process of identifying these relatively efficient providers has yielded the following results: We ended up with a group of 218 hospitals that appear to be relatively efficient. This represents about 10 percent of the PPS hospitals in our sample. These hospitals come from across the nation. While they're more likely to be larger hospitals with integrated physician staffs, the efficient group includes a wide array of hospitals. Some are large teaching hospitals; others are small rural hospitals. Some employ their physicians; some do not. They differ in terms of geography, size and Medicaid patient loads.

In general, we find the top performers are able to outperform the comparison group on all the mortality measures in 2008. For example, the median performer in the top group had a 30-day mortality rate that was 5 percent below the national median on all CMS mortality measures: AMI, heart failure and pneumonia. Readmission rates, using the 3M methodology, were also 5 percent better than the national median. We also see that this set of relatively efficient hospitals is able to achieve better quality

metrics while keeping median standardized cost per discharge 9 percent below the national median. Lower costs allow these hospitals to break even on Medicare.

We also examined how hospitals that appeared to be relatively efficient on our metrics did with respect to patient satisfaction. We found that 64 percent of patients rated hospitals in the efficient set either a 9 or a 10 on a 10-point scale. This is similar to the ratings in the comparison group.

This slide shows the distribution of standardized costs per discharge, with low costs are on the left and high costs are on the right. For example, the hospitals on the far left have costs that are 72 percent of the national average. Hospitals on the far right have costs that are 128 percent of the national average. We see the median hospital is in that green bar where costs are 91 percent of the national average, about 9 percent less than the middle bar which is 100 percent.

And there are two key points that I want you to get from this slide. The first point is that there's a wide distribution of costs amongst hospitals, and the second point is that there are some hospitals, such as the median

hospital in the efficient group in that green bar, that can do relatively well on quality and still have costs lower than average.

To summarize, most payment adequacy indicators are positive, but Medicare margins were low in 2008 and expected to remain negative through 2010. However, there is a set of hospitals that have been able to maintain relatively low cost while maintaining relatively high quality care. In aggregate, these hospitals are breaking even on Medicare.

The data presented to you today lead to the Chairman's draft recommendation, which is the same as last year. It reads: The Congress should increase payment rates for acute inpatient and outpatient prospective payment systems in 2011 by the projected rate of increase in the hospital market basket, concurrent with implementation of a quality incentive payment program.

The current forecast hospital market basket is 2.5 percent. However, this forecast will be changed twice before payments are updated for 2011.

Now there are no spending implications for the recommendation as it's consistent with current law. We do not see any significant impacts with respect to

beneficiaries' access to care. However, there is a potential for improved quality of care being generated from the incentive payment program.

Recall that in addition to making recommendations on the level of Medicare payments, the Commission has also made recommendations on the distribution of payments. Last year, the Commission recommended the pay for performance program be partially funded with a reduction in indirect medical education payments.

Craig will now give you some background on IME payments and last year's recommendation.

MR. LISK: Good morning. I'm now going to briefly discuss the indirect medical education adjustment.

The IME adjustment is a percentage add-on to Medicare in patient and capital payment rates. About 30 percent of hospitals receive the IME adjustment.

The current adjustment formula increases operating payments by about 5.5 percent per 10 percent increment in the resident-to-bed ratio in teaching hospitals. There is also separate adjustment made to capital payment rates, but that adjustment is based on a different formula.

In preparing our margin analysis for this meeting,

we have updated our IME payment spending numbers and find that Medicare IME payments totaled $6.5 billion in 2008. These payments are distributed across PPS operating and capital payments for IPPS hospitals and include payments made to hospitals by Medicare for Medicare Advantage patients, and that's the separate IME payment for Medicare Advantage patients.

We've also updated our analysis of the empirical level of the IME adjustment. In our analysis, we measure teaching hospitals' patient care costs relative to other hospitals. We recalculated this relationship using 2008 cost report data. What is different from our prior analysis, which used 2004 data, is that we now have MS-DRGs in place, and that is one of the reasons why we redid the analysis.

Our analysis controls for cost-related payment system adjustments such as the wage index and case mix and outlier payments that hospitals receive. The result is that we allow the IME coefficient in our regression to pick up any remaining variation not captured by the payment system.

We find that costs increase about 2 percent for each 10 percent increment in teaching intensity. This is

essentially about the same level that we found in our prior analysis of 2004 data. The implication is that teaching hospitals receive a subsidy that is about 60 percent above what is empirically justified.

The Commission has extensively discussed over the past year what to do with the extra payments teaching hospitals receive from the IME adjustment. Last year, we made the following recommendation on the IME adjustment. In this year's report, the Chairman is proposing we restate the recommendation. It would be included as part of a text box in the report, and we would just be repeating what was the recommendation from last year, and it read: The Congress should reduce the indirect medical education adjustment in 2010 by 1 percentage point to 4.5 percent per 10 percent in the resident-to-bed ratio. The funds obtained by reducing the adjustment should be used to fund a quality incentive payment program.

Now Julian will be talking about documentation and coding improvement.

MR. PETTENGILL: Good morning. As Craig said, I'm going to talk about the impact on inpatient payments of documentation and coding improvements in response to the MS-

DRGs. Then I'll present the Chairman's draft recommendation which deals with this problem in a way that keeps all parties whole.

In response to a Commission recommendation, CMS adopted MS-DRGs in 2008 to improve severity measurement and payment accuracy. The MS-DRGs substantially changed the way cases are grouped for payment. Cases with very costly major complications or comorbidities, called MCCs, are grouped separately, and CMS also extensively changed the list of secondary diagnoses that qualify either as a complication or comorbidity, or a major complication or comorbidity. These changes created incentives for hospitals to improve documentation and coding of secondary diagnoses because they would receive higher payments if cases with a CC or an MCC were reported accurately.

The documentation and coding improvements, or what we call DCI, shifted some cases from lower severity and cost MS-DRGs to higher severity and cost groups within each base DRG.

Now there's nothing wrong with improving documentation and coding. We expect and encourage hospitals to do that. However, because there has been no real change

in patient complexity, Medicare's payments should not increase.

Did cases in 2008 shift from lower severity and cost MS-DRGs to higher cost and severity groups? The data show that they did. We examined how cases shifted among MS-DRGs within each base DRG between 2006 and 2008.

This slide shows the pattern for base DRGs that are split three ways. As you can see on the left, the share of cases assigned to the without CC or MCC groups fell by 6 percentage points, while in the right-hand bars you can see that the share assigned to the with MCC groups increased by the same amount. This pattern held consistently for nearly all base DRGs that are split in some fashion based on secondary diagnoses.

Shifts such as these can have a big effect on aggregate payments. To prevent changes in the DRGs from affecting aggregate payments, CMS has always been required by law to recalibrate the DRGs and the payment weights annually. Recalibration raises or lowers the payment rates to prevent changes in the classification and the weights, by themselves, from affecting aggregate IPPS payments.

Because of this shift of cases into higher paying

categories due to DCI, the standard prospective recalibration of the 2008 payment weights failed to prevent an unwarranted increase in payments. However, Congress gave CMS the authority to make a separate prospective adjustment to offset the expected increase in payments, in circumstances just like these.

Now the next slide shows the legislative background on this issue. Based on past experience, CMS actuaries estimated that DCI would be essentially complete by the end of 2009 and that it would increase inpatient payments by 4.8 percent. To offset the expected increase, CMS said that it would reduce inpatient base payment rates by 4.8 percent over 3 years.

The hospital industry argued that this estimate was too high. Congress responded, and current law now reflects the following agreement: CMS would prospectively lower the base payment rates by 1.5 percent over 2 years, 0.6 percent in 2008 and 0.9 percent in 2009.

If 1.5 percent turned out to be too little, based on actual data however, two things would happen. First, CMS would change the base payment rates in 2010, 2011 and/or 2012 to recover the difference in payments, with interest.

Second, CMS would also adjust the base rates to prevent further overpayments from occurring.

The next slide covers how large the offsetting adjustments might need to be under current law. This slide shows the bottom line under current law, 5.9 percent. Now I'm going to walk you through how you get there.

Analysis of 2008 Medicare inpatient claims by CMS and the Commission showed that DCI increased reported case mix and payments by 2.5 percent. This means that payments were 1.9 percent too high in 2008 because CMS had already a statutory adjustment of 0.6 percent.

We do not yet have 2009 claims data, but assuming that CMS actuaries are correct, we expect DCI to reach 4.8 percent in 2009. This means that payments would be 3.3 percent too high in 2009. That's 4.8 percent minus 1.5, which is the cumulative adjustment that CMS has already taken in 2008 and 2009.

Recall the current law limits recovery of overpayments to the period from 2010 to 2012. For 2010, CMS decided not to make any adjustment to either recover the known overpayments in 2008 or to prevent further overpayments from occurring. So, under the law, recovery of

overpayments can only be made in 2011 and 2012.

If we add the two overpayments together, we see that CMS would have to reduce the IPPS base payment rates by about 5.2 percent in 2011 or 2012, to recover the expected overpayments from 2008 and 2009.

To reduce the size of the hit, CMS could split the recovery evenly over both years. And, if they did that, they would reduce the base payment rates by 2.6 percent in 2011, they would leave the base payment rates at that level in 2012, and then at the end of 2012, when the recovery is complete, they would raise the rates again by 2.6 percent for 2013.

In addition, however, CMS would have to reduce the base payment rates in 2011 by 3.3 percent to prevent further overpayments from continuing.

So now you see how we get to 5.9. This means that the total adjustment in 2011 would be 5.9, which is 2.6 to recover overpayments and 3.3 to prevent further overpayments. Unless the update is unusually large, this would result in a substantial reduction in payment rates in 2011.

The adjustments required under current law are

rather large, and many hospitals have negative overall Medicare margins and may not be able to easily manage substantial payment reductions, even of short duration. So it may be desirable to develop an alternative schedule for preventing further overpayments and recovering accumulated overpayments.

The guiding principle here is to preserve budget neutrality but do it in a way that is manageable for hospitals. This is what the annual recalibration process is supposed to achieve but failed to do so because of DCI. One way to achieve budget neutrality would be to reduce the base payment rates by 1 percent each year until further overpayments are fully prevented and all overpayments are fully recovered. This policy would stretch out the needed adjustments over a longer period of time and thereby make the payment reductions more manageable for hospitals.

The downside is that overpayments would continue to accumulate for several years, and this would add to the amount that would need to be recovered to achieve budget neutrality. As a result, the 1 percent reductions in the base rates might have to be made for as long as 8 years.

The upside is that the payment rates would still

increase each year as long as the update was greater than 1 percent.

Of course, the schedule of adjustments for prevention and recovery might be restructured more aggressively. For example, the base payment rates might be reduced by 2 percent per year. This would shorten the duration of the adjustments to about four years because larger annual reductions would reduce the amount of continuing overpayments that accumulate and, therefore, the length of time needed to recover them.

With these thoughts in mind and in an effort to find a solution that keeps all parties whole, the Chairman offers the following draft recommendation for discussion. It reads as follows: The Congress should implement a 1 percentage point reduction per year to the inpatient base payment amount until further overpayments due to hospitals documentation and coding improvements are fully prevented and all overpayments are fully recovered.

In the accompanying text, we would describe how this policy might play out and how long it would take to achieve budget neutrality. As I mentioned, prevention and recovery together could take as much as 8 years, but we

won't know exactly how long until we have 2009 data.

Note also that we are assuming that the recoveries would include accumulated interest consistent with current law.

In terms of implications for spending, this recommendation would increase spending in the near term, and it would reduce spending slightly in the longer term. For beneficiaries and providers, while it has no major direct implications for beneficiaries, the recommendation would increase inpatient payments for all IPPS hospitals in the near term, and it would reduce payments slightly in the longer term.

In addition, the recommendation would make the burden of compensating for the effects of DCI predictable and manageable for hospitals because the reductions in payments would be stretched out over time.

This concludes our presentation. We'd be happy to take your questions and comments.

MR. HACKBARTH: Okay, nice job. Before we open the discussion, I just want to make a few other points about the context, and I waited until after the hospital presentation because this presentation illustrates some of

the points I want to make.

Broadly speaking, MedPAC makes several different types of recommendations. We make recommendations about update factors, which is what we're focused on the next couple days. We make recommendations about payment system improvements that don't increase or decrease the total number of dollars in the payment system, but reallocate, redistribute those dollars. For example, in the case of hospitals, we made the recommendation several years ago to move to severity-adjusted payment for hospitals because we thought that would be a more accurate and a fairer payment system. So we have update recommendations, redistributive recommendations.

Then the third broad category is that we make recommendations for payment reform which entail larger changes, and sometimes a major restructuring of how we pay providers in a particular sector. In the case of hospitals, an example would be the recommendation we made a couple years ago to test the idea of bundling payments for hospitals.

So we make a variety of different types of recommendations. Today and tomorrow, we are focused

principally on update recommendations, but I want to emphasize that all three types of recommendations are very important to a well functioning Medicare program, one that provides the necessary access for Medicare beneficiaries to high quality care provided by efficient providers.

So, although we're focused just on payment updates today, I want to remind people to think of this in a broader context. We have a lot of different types of recommendations.

Now, in point of fact, in our March report, I am suggesting that we rerun, repeat some of the distributive recommendations we've made in the past, recommendations for refining the payment systems. We wouldn't re-vote all of those recommendations. We will call your attention to them as we proceed through the various discussions. They would be highlighted in our March report, offset in a text box. We will do that because we think that redistributive recommendations are often very, very important to the fairness of the payment system in producing results we want for the Medicare program.

The last general point I wanted to make relates to the analysis that Jeff presented on trying to define

efficient providers. And I want to remind the audience that our charge from the Congress is to develop payment policy that's appropriate for efficient providers, pay rates that are appropriate for efficient providers of various Medicare services, and that's the significance of the analysis that Jeff presented.

So those are some more statements about the context.

As always, we will proceed through the commissioner questions and comments in rounds, with round one being clarifying questions, narrow clarifying questions. Start with Mitra and then come down the row here.

DR. BEHROOZI: I think this is very narrow. Jeff, have you overlaid the high financial pressure hospitals with the high efficiency hospital group? Do you know what the degree of overlap is?

MR. STENSLAND: It's not a complete overlap, but I don't have a detailed number on that. I can do that for you and get back to you.

DR. CHERNEW: In estimating the DCI numbers that they were looking at, did they assume that there was no change in true case mix? In other words, there were no

trends in case mix, or was all the change they observed related to DCI?

MR. PETTENGILL: The estimate is based on calculating the national aggregate CMI and using 2008 cases, using the new MS-DRGs and weights, and comparing that CMI with the aggregate national CMI for the same data, same cases, calculated using the 2007 DRGs and weights, the preceding DRGs and weights. And the difference is 2.8 percent, and we subtracted from that because there's always going to be some change whenever you're not using the recalibration data set.

We subtracted from that what we found for the same comparisons, using 2007 claims. That difference was 0.3 percent, and that's how we got to 2.5.

DR. CHERNEW: [off microphone] So you subtract out the prior trend.

MR. PETTENGILL: No.

DR. MARK MILLER: I don't think I would characterize it that way. I mean in fact the last comment, which is a small, very small part of this transaction. I think the most important comment is the estimate comes from looking at these same cases run through the two different

groupers.

So, I mean because there is some -- in the environment there sort of this, well, they made assumptions about the change in case mix. That's not what happened here. It's the same cases run through the two different groupers.

DR. CHERNEW: I was just going to let this go because this is round one. But, if you do that, how do you see what the coding change was, because you have the same fixed set of codes?

MR. PETTENGILL: I think the really important point here is that -- and not only did CMS adopt a different set of categories, but in addition to that they made major changes in the list of secondary diagnoses that qualify, that dictate where the cases go. Okay.

And it turns out that the changes that hospitals made in the way they coded the secondary diagnoses, frequently with more specific detail. So instead of saying congestive heart failure, not otherwise specified, which is their broad general code, they now tell you the specific kind of congestive heart failure, sort of the source.

Those changes didn't affect the preceding DRGs and

weights very much, and the reason they didn't is because you could get to be a CC with the broad general code. Now you can't get to be a CC or an MCC with a broad general code. You need the more specific detail. So hospitals responded to that change in the requirements, and they changed how they coded the cases, and that's what really accounts for the different, 2.8 percent.

MR. STENSLAND: Maybe I can try more of a general approach to what we did. You can take the software that tells you what the case mix is. You feed the claims into there. You can feed in those 2008 claims in the 2007 software, and you get out a case mix, and you'll see that that's a lower case mix than it was when you fed the 2007 claims through that 2007 software.

So, if you kept the software the same and didn't change any of the rules in terms of MS-DRGs, coding, grouping or anything, and just looked at what happened by just changing the claims from one year to the next, you would see an actual decline in case mix. Essentially, that is being netted out of this process.

DR. CHERNEW: [off microphone] That's the 0.3 percent.

MR. STENSLAND: It's not the 0.3 percent. The 0.3 percent is a different adjustment.

DR. MARK MILLER: That last thing is fairly technical.

MR. HACKBARTH: Yes. Maybe you can pursue this separately.

MR. KUHN: Julian, just a little bit more follow-up on the issue of the DCI and the methodology that we're employing here, is it mirroring what CMS is doing? Are you reflecting CMS's numbers, or is this a data run that MedPAC did?

MR. PETTENGILL: No, we did our run, but the methodology is essentially the same.

MR. KUHN: Okay. So we're in concurrence with CMS in terms of the methodology they've used fairly regularly.

MR. PETTENGILL: Our estimates and theirs are in complete agreement.

MR. KUHN: Okay. Thank you.

MR. GEORGE MILLER: Yes, just a technical question on Slide 5 considering the readmission of rates, you said they had been stagnant over time. Did we look at the detail behind the readmission rates? Are they grouped in any

stratified way by taking ed hospitals versus suburban hospitals, or is this an overall number? I'm a little concerned about readmission rates and what the makeup is.

MR. STENSLAND: The readmission rates across the different groupings, the rural/urban, on the major groupings are not that different. They're more similar than we would see in the mortality rates. But now, within individual providers in any one of those categories, you're going to see wide differences amongst rural.

MR. GEORGE MILLER: [off microphone] [inaudible]

MR. STENSLAND: Yes.

MR. HACKBARTH: So, on the second point about the variation at the individual levels, as we reported it several years ago, for some conditions, there are often three and four-fold variations in the readmission rates on a hospital basis.

DR. CROSSON: Yes, Jeff, sort of in the same part of the presentation on the quality part of the payment adequacy considerations, I notice that with respect to patient safety, two of the three most frequent occurrences actually declined or the number of incidents increased. The performance declined during the observation period of 2005-

2008.

During that same period of time, and at the current time, there's a lot of focus on these issues. The Institute for Health Care Improvement and other organizations have been engaged in initiatives to try to identify and correct these problems.

And I just wondered whether it's possible that observation bias, or the focus itself, might be leading to more identification and more coding of events that might not have been coded before, and I wondered if it's possible to correct for that or look at that.

MR. STENSLAND: I think that's very possible. I can't think of a way to correct for it. If anybody has any ideas, come and talk to us.

I think there is some concern, in my mind at least, when we look at the process measures being stable or somewhat getting worse. But then, if you look, the mortality is getting better, and the readmission isn't getting any worse. So it does look like on the face of it that that could be one of the reasons why these things are getting worse. It's better coding as opposed to worse care.

DR. BERENSON: Could you go to Slide 7 for a

moment. I have a question about the distributional impacts on margins. As part of health reform, there's the group that is getting unique attention, our rural hospitals, and yet this data suggest they're doing slightly better -- and, if you throw in critical access hospitals, actually a few percent better overall.

So I have two related questions. Is there some group that's not captured in this aggregate analysis? Are there rural hospitals perhaps that are doing uniquely bad on margins, that are getting some attention?

And the second question, I know that in FY 2009 regs, and subsequently, CMS is making some changes to calculations of wage index for rural floors and imputed floors. I don't fully understand it. Will that have any material impact on distribution to or from rural hospitals?

MR. STENSLAND: All right, I'll start with the reason. If you look historically, let's say you look back 10 years ago, rurals generally did worse on Medicare margins than urban.

There was a series of changes, some of them that MedPAC recommended, like equalizing the base rates, improving the disproportionate share of payments to rural

hospitals, that kind of equalized things. But there's also been some further adjustments that have gone on in recent legislation in terms of expanding payments for Medicare-dependent hospitals and that kind of thing. That has resulted in rurals getting a little bit better than urbans. So, kind of, the relative performance has shifted due to this series of legislation we've seen in the last 10 years.

Looking forward, I don't think that the imputed rural floors you're talking about are going to have much of a difference. That's in a very small geographic zone.

What will benefit rural hospitals going forward is there is a new rebasing of the sole community hospital rate which basically says they'll get paid whatever their historical costs were in 2006, meaning so a lot of the sole community hospitals will be moving up closer to a zero percent margin, so that rurals should be doing better.

But now saying that, on average, the rurals are doing better, but of course there is going to be individual cases where hospitals aren't doing so well. Probably those hospitals that are going to have the toughest time are going to be hospitals that are, say, too close to somebody else to qualify for sole community hospital status or critical

access hospital status. So they don't have any of these special features, but yet they still maybe don't have large economies of scale. Those might be the ones that aren't doing as well.

In terms of the isolated rural hospitals, those isolated small CAHs, or the sole community hospitals, they tend to do pretty well, given that I think there's a concern that these are important for access. So they have these special programs. So they do a little better.

MR. HACKBARTH: On the issue of the update of the base amount for the sole community hospitals, it's roughly half of rural hospitals. Well, what is the proportion of rural hospitals that qualify as sole community? My recollection was half.

MR. STENSLAND: It's a little less than half. It depends if you have the CAH pie in there or not. Most of the rural hospitals by number are CAH.

MR. HACKBARTH: Right.

MR. STENSLAND: But they're a smaller share of the total payments.

MR. HACKBARTH: So it would be half of the prospective payment hospitals would get?

MR. STENSLAND: I would have to check, but something in that area.

MR. HACKBARTH: Okay.

MR. STENSLAND: The majority of them are either sole community or Medicare-dependent.

MR. HACKBARTH: Then I'm trying to get a sense of how big an impact that might have on this differential between rurals and urbans. That takes effect in 2000 -- that's taking effect as we speak, right?

MR. STENSLAND: Yes, they're getting it, and it will affect their 2009 margins and 2010 margins.

MR. HACKBARTH: Any way that you can characterize the magnitude?

MR. STENSLAND: It's a material amount, and I have the number, but I don't want to misstate the number.

MR. HACKBARTH: Okay.

MR. STENSLAND: So I can give you it to you later. But it's a material improvement, especially for the sole community hospitals. They'll be one of the higher margin groups after it's done.

DR. KANE: On Page 9 of the presentation, you talked about the cost growth being lower in 2009. I guess

what's your assumption about 2010 to get to that margin? That's part one.

Then part two is: Is there a DCI adjustment in '10 or not? I kind of got confused because it said Congress says put them in '10, but then you're not. You're assuming until '11. Okay.

I'm sorry. So the question, I guess, then is what are the assumptions about cost growth in 2010? You talked about 2009, but you didn't say anything about 2010.

MR. STENSLAND: So 2009 is low cost growth. For 2010, we've actually, in our modeling, have projected a rebound in cost growth to something above the market basket, and that's basically because from the preliminary indicators we see it looks like hospital profitability generally has rebounded in '09.

There's a huge amount of uncertainty here as to what's happening in all these hospitals as they're doing their budgeting process for 2010. But the way we've modeled it is that the cost growth will be bouncing back up, maybe closer into the 4 percent range in 2010.

DR. KANE: You're making cost growth basically a function of how profitable they were from year to year.

MR. STENSLAND: Well, for 2010, that does factor into our projection. For 2009, it's based on partial year data.

DR. MARK MILLER: I guess I would respond to that. Generally, what we do is look at historical cost growth. The early indications of '09 are that it slowed down, and then the assumption is, well, what guess do you make about 2010.

So, rather than hold it down, which would give a more positive margin, and some of the indicators that we went through at our last meeting almost suggest something of a turnaround. So we went back to more of a historical growth rate, which in this instance exceeds the market basket by a bit.

DR. KANE: Well, I'm sorry, just a follow-up on that. So, in 2009, what will we estimate the profit margin to be and how close is our projection?

MR. STENSLAND: Last year, we made a project for 2009 of something, I believe it was minus 6.9 percent for 2009.

We kind of do this in advance. We didn't actually -- I don't have it at the tip of my fingers, what our margin

was for 2009 this time. It will probably be -- it's going to be in that range of the 2010, if we did it, maybe slightly better because of the cost growth in 2010 being bigger than the update.

The other thing you asked about was the DCI takeback, and there is no takeback in 2010. So part of the reason you're saying why are they doing better in 2010, well, they get the benefit of the DCI, but there's not takeback in 2010, and then the cost growth being lower in 2009.

DR. MARK MILLER: [off microphone] [inaudible]

DR. KANE: Yes, but it's only 2009 that's lower.

MR. BUTLER: Same slide and a similar question, Jeff. Something doesn't quite add up to me in this. I understand the MS-DRG impact. From what I hear you saying, the rebound in hospitals is based on kind of like the total margin, and you would assume that the Medicare margin is going to go the same direction. That's roughly the -

MR. STENSLAND: The total margins that rebound in 2009, we get that from the rating agencies' census and that kind of thing.

MR. BUTLER: Right.

MR. STENSLAND: When we're looking at Medicare margins, that's very different. And what we do there, to look at payments, is we run the payments through a model. So we basically take all the claims and say, well, what would happen if these hospitals had their 2008 claims, and they were all paid based on the 2010 policy, and we actually compute it. So we have very good projections on payments usually.

It's trickier to project the costs. The costs, we base them based on what we see in the data out there so far on costs for 2009.

MR. BUTLER: So then let me get to the cost side because there is something a little bit in conflict. You didn't report on it here so much, but in the chapter you highlighted a lot about employment growth. You said there's a 4.1 percent increase in FTEs, if you will, between November, 2007 and July of 2009, and you say that's an indicator of capacity and other things.

That would suggest that -- and yet there was another cost data point, 5.5 percent cost per discharge increase in 2008, and you say on this it's about half that for 2009.

So it's kind of interesting that you have employment growth at 4.1 percent and cost reduction per case down to 2.5, well, 2 point something percent from 5.5. It suggests it became a lot cheaper while we're still adding employees at the same time.

MR. STENSLAND: I think that 4 percent number you're seeing, that's over two years.

MR. BUTLER: Yes.

MR. STENSLAND: If you look at the number, you see employment growing through 2008, and then beginning in 2009 you'll see this flat space, which you haven't seen for I don't know how long. And then but in the last -

MR. BUTLER: It slows in 2009, but it still grows.

MR. STENSLAND: Yes.

MR. BUTLER: It's growing. It's picking back up.

MR. STENSLAND: Yes, it's flat in the middle of 2009, and then the last 3 months it started to grow again.

MR. BUTLER: Yes. Okay.

DR. MILSTEIN: This is a question referable to the DCI. I understand how we've tried to get at the impact of variations in coding, but the impact of changes in documentation, I'm not sure. On the face of it, it's not

clear how at the MedPAC level one could go about understanding reality in a given hospital or across the whole industry.

Is there any science here that could sort of shed light on where we are in I'll call it at this point the practically, infinitely open frontier of better documenting as a way of boosting DCI?

In other words, the difference between -- coding, I understand how you could go about capturing that and knowing where we stand relative to I'll call it a perfect coding standard. You can do independent audits. But, on the documentation, is there any science that could be brought to bear or that sheds any light on where we are on use of infinite perfected documentation to maximize payment under Medicare?

MR. PETTENGILL: That's a good question.

I guess a couple points. One, even for evaluating changes in coding, the traditional way that people used to do that was to use a gold standard sample. They'd take a sample of medical records, and they would run them gold standard coders, and then they would compare the way those cases played out in the case mix index with the way they

were coded by and submitted by the hospitals.

If you have documentation changes going on at the same time, you can't see it because the gold standard coders see the same medical record as the hospital coders. So there's no difference.

I mean the problem here is that you need to see the counterfactual. How would these cases have been documented and coded had the MS-DRGs never happened? And I don't know of any way to get around that problem.

MR. BERTKO: A follow-up that might be for Jeff, on Slide 9, and it may be a 2-part question. The first part is when you look at the 2008 margins, does that include the effects of investment returns and the collapse of the market and that part? Is it strictly operating margins?

MR. STENSLAND: That's strictly Medicare margins, and we don't include any investment income in the Medicare revenue, or losses in the Medicare costs.

MR. BERTKO: Okay, so no second part then.

MR. HACKBARTH: Let me just ask you to put up Slide 13. I just wanted to say a word about this slide and its significance to me. Sometimes in discussing payment policy and hospitals costs, it's easy to get the impression

that hospitals have some fixed level of cost, and it's immutable. If Medicare doesn't pay its share, then the cost must be shifted.

What this graph illustrates is that there's hardly immutable level of cost. In fact, there is a very broad distribution of cost, which links back to the charge to the Commission to identify and pay at levels that reward efficient providers of service. It's precisely because we have this broad distribution that's saying that our mission is to pay the cost. The average cost may not make sense, and what we want to do instead is try to create a dynamic where our hospitals continually look at the other, the low end of the distribution and try to figure out how do I get there.

So, to me, it's an important graphic display of the challenges that we face, and also the opportunities that exist.

Okay, let's now -- yes.

DR. CROSSON: Just one point, and that is to look at the bar that's highlighted in color. So I think it's important to emphasize that when Glenn is talking about our consideration of efficient providers, we're not talking

about the far end of the distribution curve. When we're talking about efficient providers, we're talking about hospitals, based on the data that have been presented, that are roughly in that green column. So, from a reasonableness point of view, it's important not to think that we're talking about efficiency as being way on the far left side of that diagram.

MR. HACKBARTH: Okay, I'd like to get to round two, and let me just make a couple requests for round two. First, I would like, if possible, for commissioners to give an indication of how they feel about the recommendations that I've proposed. It's perfectly to say I'm unsure, but if you have an inclination, it would be helpful for us to know it.

And then second, it would be really helpful to know any other information that you need to help guide your final vote in January, so that we can get that and get it to you as quickly as possible.

So, with those two broad guidelines, let me see hands for round two. Why don't we go the other way this time?

MR. BERTKO: Just a quick comment, Glenn, to follow

your request here, I'm inclined to go along with the Draft Recommendation 3, the market basket update and would remark in my observation of the Wall Street reports on private payers, that trends there are ticking upward slightly, perhaps an increase of about 50 basis points in overall trends, some of which has been identified as increased payment rates to hospital providers. So I think we need to continue our emphasis on accurate payment for efficient providers, and particularly in this, and I think this recommendation continues to send that message.

DR. CASTELLANOS: With respect to the IMA recommendation, I'm really uncertain on that, and I'd really like some more information. Especially, I don't know if it's possible to give some kind of an estimate, what effect that will have on some of the recommendations we've discussed under medical education, to include the effect of increasing HIT, increasing outpatient care and care coordination. What costs will that add to the hospital to provide that? So I'd really like more information on that before I can make a decision.

With respect to DCI, one of the big things in the physician community is that the doctors tend to undercode,

and then, when you have HIT, you get appropriate coding. I was wondering if that has been any studied at all on the DCI side, and I would like some information on that, but I think probably that would be I would agree with the DCI. I would go along with the update.

There are three points beside that, I'd like to make. One of them is a point that was brought up in the paper, both on Page 8 and on the Subtitle 3 concerning the hospital observation and the hospital admission, especially in the outpatient department. There needs to be some good clarification on that.

In the points that were brought up by the paper, you've mentioned that CMS has really loosened some of the definition, and, by doing, it's caused a lot of confusion, both on the hospital side, the beneficiary side and the physician side. I happen to live in Florida, and the RACs have really looked at this, and it's been a very contentious issue. A lot of time and a lot of money has been looked into that. I'd really like some, if we could give some clarification on that, up front, direct, rather than the direction we're getting from the RACs from behind.

This really impacts on the beneficiary. In the

observation, they had the 20 percent copayment, and on the admission, if they have not done their deductible, they have that. But more important, on the observation side, the costs of drugs are more expensive. Those days in observation, if this patient eventually goes into a SNF, those dates don't count for that three days.

So we really do need some clarification, and I was hoping maybe we -- I know we're here just for updates, but I think if we could get some information on that I would appreciate it.

The third thing is really something I'm interested in. I know we take surveys a lot. Peter, at the last meeting, mentioned a comment, if there's any survey not just on the patient who uses the hospital, but the physician who uses the hospital also -- in a respect that is the hospital providing HIT, is it providing the new equipment, is he providing an atmosphere to provide the best care for patient? And it would be nice if we could get MedPAC to do some surveys in that respect.

MR. HACKBARTH: A couple things that Ron said just trigger questions in my mind. Ron, in talking about IME, mentioned the expenses associated with adopting health

information technology. What I wanted to clarify was that, of course, Congress enacted in the Recovery Act significant funding for providers who adopt HIT. To what extent, if any, has that money been taken into account in your analysis?

MR. STENSLAND: The HIT money comes in, starts to come in 2011, and it's very uncertain right now as to what the requirements will be to get it and how much will come in 2011. And it doesn't hit our 2010 number at all.

This is a little different than we've done it in past years. We're just saying, what would the 2010 margin be, given 2010 policy? And we did that to kind of lead off what's going to happen in 2011, which is going to be some of the difficulty with respect to HIT and DCI.

MR. HACKBARTH: Yes. So there is significant money coming. Exactly who will be eligible, meet the meaningful use requirements is all to be determined.

The other thing that I wanted to just highlight was about coding change. I just want to be clear for people in the audience. I know you know this, Ron. There's no allegation that this is fraudulent activity, that this is somehow bad that coding is changing. It's just an

observation that in fact there is change, and the patients aren't changing.

So what's happening is the patients are more or less constant. Obviously, there are going to be fluctuations in the types of illnesses, but the patients are more or less the same. But more money is flowing into the system because of coding improvement, and that's what adjusting is about. There is not an allegation that there's fraudulent, inappropriate activity ongoing.

DR. CASTELLANOS: I guess my question is are we doing more accurate coding and getting paid more accurately because of these higher code rates? That's the question.

In the past, has there been any study showing maybe hospitals, like physicians, sometimes do undercoding?

MR. HACKBARTH: Do you want to make a comment on that, Julian?

MR. PETTENGILL: Well, yes. Sure, in the past, they have done undercoding in the sense that instead of reporting the detailed version of the diagnosis, they've reported the general not otherwise specified version, and that's a form of undercoding.

In the preceding DRGs, it didn't really make any

difference because they got credited as a CC anyway. In the new system, it does make a difference, and that's why they have started reporting the more detailed version.

As far as the coding itself goes, a lot of that is done with -- it's computer assisted, and the vendors for those products update them rapidly to reflect changes in CMS's requirements or in the system that CMS is using, DRGs versus MS-DRGs.

The documentation changes take a longer period of time because you have to convince physicians, hospitals have to convince physicians, to change the way they document the medical record, so that the coders can use the more detailed information.

MR. HACKBARTH: Okay, I apologize for talking too much, and I'm causing us to sort of fall behind here. So let me go back to the list. Arnie next.

If I don't hear you comment on Recommendation 1, silence I am going to interpret assent or no major reservation. So you can focus on the ones where you have concerns or questions.

DR. MILSTEIN: Maybe I'll comment on all three topics briefly.

With respect to Recommendation 1, I would like to better understand why there's not a productivity offset. That's, for me, kind of a standard, and it's missing. For me, that's a source of concern for all the reasons that we previously stated when we originally, when we adopted the general policy of expecting the same productivity growth in all industries.

With respect to letting the IME recommendation stand, yes, I probably voted for it at the time. But that being said, I will say it does concern me anytime we come up with a recommendation that does not align with empirical reality. We're saying 4.5. Empirically, it's 2 per 10.

I realize there are issues having to do with just the practicality of time and whether we can address, whether we can readdress this year, but I will say that I remain concerned that there appears to be an imbalance between our recommendation of 4.5 per 10 percent and what empirical reality suggests, which is 2 percent.

MR. HACKBARTH: You're saying a larger reduction?

DR. MILSTEIN: Yes, yes.

Then with respect to Recommendation 3, I think my comments are really asking that we consider, separate and

apart from the quantitative recommendation, a couple of accompanying comments.

The two that I think I would encourage us at least to consider is, first of all, this notion of never getting behind because then you end up with SGR redux which is what we are facing, I think, here. There was dialogue back and forth with the industry, but I think in some ways this is an object lesson, that if you give, then you just get in -- you risk much bigger trouble down the line where essentially the overhang is where it gets too big to really do anything about.

Then the second suggested text augmentation is I think my prior exchange illustrated that there is such a thing as the outer frontier. There is an anchor for reality with respect to coding. With respect to documentation, this is an area of kind of infinite flexibility that threatens to undermine I'll call it the cost management discipline and fairness that we're trying to embed in our recommendations.

I think the problem is about to get a lot worse with respect to documentation because we are now moving into electronic health records in hospitals and a much easier ability to sort of capture every conceivable event in a

hospitalization that might bear upon, that might improve documentation and thereby improve the severity that's coded. So I think it's very important that we enlist some scientific allies in thinking through how we really get a grip on what is reality and how that reality is shaped by documentation.

I sense from our answer that we've done the best we can, but my sense is it will remain an infinitely squishy frontier unless we begin to, unless CMS, not MedPAC, begins to really think it through systematically while we're waiting for the day where more bundled payment systems make all this go away.

MR. BUTLER: So, Glenn, I like the way you've framed the chapter, and I like the way the chapter is written.

I think the Recommendation 1, I can support the recommendation.

I like the fact that you separated out this coding issue, separate from Recommendation 1, and highlighted it. I think we should be saying it is what it is and validating it and putting it out there.

If you say what more information, Julian, you've

got your work, and you've got CMS saying the same thing. Is there anything else out there that would, where somebody would say, no, no, you've done methodology incorrectly? I'm not aware of any, but if there was, that could influence my support for Recommendation 2.

I'm not positive that the 1 percent a year is the right way to go, but I understand what your thinking is on that. So I'm not directionally thinking just take that off the table.

I think I also like the way you have put the IME issue into a text box, to acknowledge it but not vote on it again.

My one suggestion would be is all it does is say here's what we did last year, when we have discussed this a lot. There's one sentence at the end that says, we've discussed it a lot. I would change the wording in this more and start with not just this IME and extra payments. I would say, we have $9 billion in support for graduate medical education. We think all of those dollars should be more closely aligned with an accountable system.

Again, you've got dollars where you can leverage. This is one of those examples. It's not just about the

dollar amount. It's leveraging payments to help reform a system. So, if we can highlight that in the text box a little bit, to say there is a real opportunity here to do additional work, but by the way here's what we've recommended today, that's fine.

MR. HACKBARTH: And, of course, as you well know, we will be coming back to the GME issues in the spring.

DR. KANE: Yes. I sound a lot like Arnie today, it turns out. I support the IME vote that we did last year and just want to remind people that when you use IME to subsidize IT or any other purpose you're giving teaching hospitals a subsidy you're not giving everybody else, and it is a competitive environment out there. So I don't want IME to be used for other purposes, that hospitals get and others don't.

So I think the principle really should be, I agree with Arnie, that we should be paying the empirical amount, and we should try to develop a pathway to get there that doesn't cause undue disruption, but that does create more equity in terms of who gets those extra resources. So I support the re-vote on the old recommendation.

On the Recommendation 1, a couple things. I'm not

still very clear how we're projecting the costs for 2011. In fact, we still haven't got the 2010. It would be just helpful, I think, to see our historic projections of costs and profit margins by year and then what the actual is, just to get a sense of how far, how close we are historically, just to give us a sense of comfort of how close we are with our projections to what actually happens over the history.

I know it's really hard. This is not to play a game with who's better at this. It's just how comfortable should we be with our projections before we do this.

Then I agree with Arnie that we at least should have a discussion on why there's no productivity adjustment in here if we're going to approve this. I think the reason has to do with the fact that we've seen this steady set of losses. But is that the reason?

If the losses are because hospitals are not under financial pressure from the private sector, then shouldn't we still be imposing a productivity adjustment? So I think we really have to have a better discussion about that before we comfortably vote for just market basket without the productivity adjustment.

Then on Recommendation 2, I might not understand

yet quite this whole thing about the coding and how it distributes, but it would seem to me that there's a distributional impact. When you just do a 1 percent per year reduction to the inpatient base rate, aren't you penalizing everybody, but aren't there some hospitals that got better, got overpaid more than others because they disproportionately upcoded? They have more of these MCC categories.

So should it be across the board 1 percent or should it be that you take it out of the ones -- and I just may not understand how this works very well.

MR. PETTENGILL: Yes, the adjustment would apply to the base payment rate. So it would affect everybody. That's true.

As far as, well, it's like anything else. There is a variability in the extent to which hospitals either benefit or lose based on documentation and coding changes among individual hospitals.

At the hospital group level, for most of the groups that we look at, you know it's surprising how stable, how uniform the estimated documentation and coding improvement percentages are. There's not that much

variability. Some people would expect that small rural hospitals would have limited ability to benefit. It doesn't appear to be true.

DR. KANE: I would say maybe those groupings aren't the most meaningful and that perhaps it should be grouped on who has a lot of MCCs and who has fewer, regardless of their rural or urban setting.

MR. STENSLAND: No, it's actually -- remember that this is across all base DRGs. Now there are base DRGs that are very serious illnesses and others that are less complicated. You've got pneumonias, and you've got heart transplants. But, within those base DRGs, you've got cases with no CCs or MCCs and you've got cases with CCs and with MCCs, and those differences hold up. The differences in the weights hold up broadly, across all the different kinds of base DRGs.

So this is not something that is focused only on certain kinds of cases. It's very widespread.

MR. STENSLAND: I would just add that we do want some redistribution out of this. Remember this all came out of the specialty hospital study, and the specialty hospitals were taking the lower severity cases. So we say, okay,

well, if you take higher severity cases, we're going to give you more, and lower severity cases will pay you less. So, when this is all implemented, we do want some redistribution towards people taking the more severe cases.

And I think you should think of this as more of a budget neutrality adjustment, saying we don't want to have more money in the system just because we changed the weighting. So then we're going to take a budget neutrality adjustment down on everybody, but some people are still going to see more money because they happen to have the more severe cases.

DR. KANE: Yes. But who did we overpay in 2009, when we put these, whatever year it was? Who did we overpay?

MR. STENSLAND: I would say that they overpaid everybody because the whole base was too high.

MR. PETTENGILL: Yes.

DR. KANE: The base was too much for all types of classes.

MR. STENSLAND: Because CMS basically said we need a budget neutrality adjustment of 4.8 percent up-front, to make this thing equal. So there's no increase in payments,

no increase in the total amount of money in the system.

Some object and say, wait, wait, wait, wait. This coding isn't going to happen. You don't need that big budget neutrality adjustment.

But then the coding actually did happen. So now we say, we paid it. Now we've got to chase to get it back, and this is the chasing to get it back with a little bit of budget neutrality adjustment every year.

MR. HACKBARTH: I just want to pick up on the productivity issue that Arnie and Nancy have raised. This is the time for us to have our discussion on productivity, and so I appreciate the two of you raising it, and I invite other commissioners yet to speak to weigh in on the topic.

What I can do is explain the language, the draft language that I proposed. Those of you who have been on the Commission will recognize it is the same hospital recommendation that we've had for at least the last couple of years, maybe even three years.

It's an amalgam of different perspectives on this issue. On the one hand, we have had commissioners very concerned about the negative margins and the trend in margins, and on the other hand, commissioners believing that

we need to continue to apply pressure in order to encourage efficiency. And we came up with this amalgam of full market basket update coupled with P4P as sort of a combination of those two views.

The significance of the combined with P4P -- in fact, could you put up the actual language, just so we have that right in front of us?

Concurrent with implementation of a quality incentive improvement program -- that was language that I and Arnie, as I recall, and some other commissioners felt strongly about. We didn't want separate recommendations: full market basket, Recommendation 1, and a separate recommendation, P4P. We wanted to emphasize that we were supporting a full market basket only in the context of concurrently moving to P4P.

The significance of that at the time, and still the significance for me, is that what it means is that in essence the guaranteed update would be less than full market basket. So, if you talk 1 percent out to create the P4P pool, then the only update you would be guaranteed would be the market basket minus 1. Your ability to get full market basket or more would be contingent on your performance on

the pay for performance measures. So it would be an opportunity to earn more than the market basket minus one, but no guarantee of it.

So it's the combination of the two that ultimately became the common ground for those who wanted full market basket and those who wanted to apply pressure and those who wanted to advance the cause of pay for performance. That's how we got there.

To me, that still makes sense as a combination of reasons, but I invite comments on that.

DR. BERENSON: Yes, but I wasn't here, so I'm a little confused because we also have another recommendation that funds the P4P with the IME adjustment of 1 percent. How do the two reconcile?

MR. HACKBARTH: So, when we first began recommending pay for performance for hospitals and other providers, what we said is that pay for performance should be budget-neutral which means it should be funded by taking money out of the base rates to create a P4P pool, and we said that the size of that pool should be initially 1 to 2 percentage points, but grow over time as we become more confident in measures, develop broader measures. So, when

we talked about this combination of recommendations, what we were thinking was, well, 1 percent from the base rates combined with a percent from IME, to create a roughly 2 percent pool.

DR. BERENSON: Let me then make my comments and ask one question. I'm comfortable with the market basket as recommended without a productivity offset. I'll support last year's recommendation on the IME reduction, but I am in agreement with Arnie and Nancy that that shouldn't be the end of what we're doing. Ultimately, we want to get to the empirically-derived number.

I think there will be more experience with this conversion to the new DRGs, and we'll sort of get more experience, but I would hope next year at this time we're having a discussion about the next step. But, as a specific policy, as a way to fund a quality pool, it sounds like it's reasonable to do 1 percent to accomplish that goal, but to not take this off the table, so that we should come back.

I have my comment, and the question is around the DCI. The recommendation of 1 percent a year for 8 years, I guess I'm attracted to the alternative of 2 percent or perhaps 1.5 percent. I assume the pros and cons are you get

it done quicker via larger percent. But on the other hand, and to me, what we wouldn't want to do is actually have negative updates.

So I guess my question is what has been the range of market basket updates in the recent history? I'm sort of guessing they're in the 2.5 to 3.5 percent range almost consistently, year after year.

MR. STENSLAND: It's 2.1 to 3.4 over the last 10 or so years.

DR. BERENSON: So I probably would be interested in considering maybe moving the 1 percent to 1.5 percent or something like that, but I'm fully in accord with the principle of what we're trying to achieve there.

DR. CROSSON: Thanks. I'm in support of Recommendation 1. I think that although the presentation has had a lot of pieces to it, and it's somewhat complex, we're faced fundamentally with about the same situation that we were looking at last year.

We're also faced, as Glenn mentioned earlier, with a situation where events are swirling outside of the context of MedPAC's consideration that very well may, likely next year, change the context for how we make this determination.

Ron brought up one, which is the flow of ARRA dollars for information technology as just one example that's not part of health care reform. There are others that are part of health care reform.

But I think there is some value, given the fact that the elements we're looking at within our context haven't changed dramatically, for us being consistent with our approach in the last year or the last two years.

I'm also supportive of restating our recommendation with respect to IME, although I do support pretty strongly Peter's comments, and others, that in doing so we put it in a context of the fact that we are looking at this issue in much more depth than we were when we originally made this recommendation because I actually think that we have been discussing two potential issues around the excess payment beyond the empirical amount for IME payment. One is what's been mentioned here. It's the idea that to be fair, there needs to be some reduction in that payment down towards the empirical amount. However, we've also had discussions recently this year, in a slightly different direction, and that is that we ought to recapture some of the extra payment and redirect it within the stream of

payments for the training of physicians and other medical personnel.

Therefore, I think we're going to have to decide which we want to do more or more likely end up with some sort of a combination of the two. I think simply restating this without sort of explaining that we have a broader context might be confusing.

And lastly, I also support Recommendation 2. It seems to me to be rather fair. Anybody who has had experience running an organization values predictability perhaps even slightly more than largess, although some might argue that. Predictability is a little bit easier to deal with than wild swings in payments for folks, and I think this offers that.

So those are my thoughts.

DR. STUART: I support Recommendation 1.

In principle, I also support Arnie's idea or support -- this is going to sound like reverse negative -- the idea that it's dangerous to continue to overpay.

I hear what you're saying, Jay, in terms of predictability. But it strikes me that if we wanted to really provide theoretic support for getting this money

back, we separate the overpayment from the recoupment, and we stop the overpayment, whatever the implications of that are. Then, if you have to push back the recoupment, then you push back the recoupment, but at least to be on record as saying we know this change to this new system has led to overpayment, and we recommend that that overpayment stop in 2011. So that would be my recommendation.

My question comes back to Slide 7. We've spent a lot of time talking about margins, and margins are based on knowledge of cost and revenue, and all of that comes from the Medicare cost report. So my question is how much confidence do you have in the level of margins that you compute from the cost report?

This is really a two-part question. I mean it's been almost 30 years since hospitals have actually been paid on the basis of their cost, except for critical access hospitals. So the confidence level of the estimate is the first part.

The second part is we do have this increasing number of critical access hospitals that are paid upon their audited costs. So are the audit procedures for these critical access hospitals any different than for hospitals

that are not based upon their cost report? Are the reported costs different for hospitals that are, that move from a prospective payment to the critical access hospital? So it all gets back to kind of the accuracy of these data.

MR. STENSLAND: I think on an individual basis there certainly is always some question on the accuracy of cost reports, especially when you see some outlier data. But I think in aggregate, we don't. I think I have pretty good confidence that on aggregate it about balances out, and they're reasonable estimates in aggregate when we look at these big groups of hospitals.

Nancy Kane has done a lot of work on this. She might have her own different views.

In terms of the cost reports, it's the same basic cost report for the critical access hospitals and the other hospitals, but the auditors do focus on different things, focusing on things that affect payments.

The one thing that does flow through all of these cost reports is people are still getting outlier payments for high-cost cases. So they still do make a difference. The overall costs still do make a difference to their payments to some degree, if that provides you any sort of

comfort.

MR. GEORGE MILLER: On balance, I support Draft Recommendation 1. I would just like to highlight that, as Bruce was talking about, we have negative margins for hospitals across the board, and that certainly concerns me. Even in the rural areas, where there are negative margins, you have payment mechanisms that help them, like sole community hospital status and Medicare-dependent hospitals, and they still have negative margins. Then I'm concerned about the safety net hospitals.

So I can support that, but, like Nancy, I'm concerned about the cost issue, if we've done an accurate job of measuring the future costs based on these recommendations, because if they're off just a little bit then we're going to create more of a problem.

I also agree with Bruce. Well, I agree with Draft Recommendation 2. But I do agree in theory, we ought to stop the payment now. If we've got an overpayment, we need to stop it now. We don't want to create a hospital SGR going forward. But I would certainly like to have more discussion about how to recoup the overpayment, particularly in the rural areas and safety net hospitals.

Sometimes when we talk about hospitals, we think of hospitals as one homogenous, one hospital, but we've got a wide variation of hospitals. I'm wondering if the impact on larger Medicare-dependent hospitals will be different than a hospital that just has 20 percent or less Medicare patients.

Even in our definition of the efficient hospital, I'm wondering if we can get there if the majority of their patients, especially safety net hospitals, have a large percentage of Medicare and Medicaid patients, and if we could make them efficient if we had the ideal model.

In theory, I support the Draft Recommendation 1 -- not in theory, I support it, but the concern about costs.

Then Draft Recommendation 2, I would agree with that recommendation, but we have to figure out a way to stop the overpayment right now and then deal with the overpayment over some time.

MR. KUHN: In terms of the update, I'm generally supportive of that.

On the DCI, I'd really like to pick up a little bit where Nancy was and try to get a little bit more information to help me think through this. The reason I say

that is that one thing, as Glenn said at the outset, is we know that the Medicare program is all about transition and blends, but an 8-year transition is a rather long transition.

As a result, if I recall right, and correct me if I'm wrong, when CMS went about creating the MS-DRGs based on the recommendations of MedPAC, there were two parts of that. One was to go from the charge-based system to the cost-based DRGs. When that process occurred, it really did shift away from surgical to medical DRGs as that process went forward, and predominantly rural hospitals tended to have more activity in the space of medical DRGs than the surgical side.

So, when CMS, if I remember right, did those impacts, you did see a bit of that shift towards rural hospitals, away from more urban tertiary facilities. Then when the MS-DRGs kicked back in, you saw a reverse go back more towards, if I remember right, the surgical DRGs that benefitted again more on the urban side.

So, if we're looking at a longer transition, some more data for me that differentiates between the surgical and the medical DRGs, and maybe more impacts on the types of

hospitals there would be helpful for me to understand that a little bit more, if we could do that.

Then finally, on the IME, I'm generally fine with going ahead and putting the recommendation back in, from where we've been in the past, but I agree with what others have said. If we're going to come up with the major recommendations in the June report, I think we ought to at least be very clear in what we write in the report, that we might come back and revisit this issue in that other context of the June report as well, just so we're prepared to be able to deal with it there if we need to.

MS. HANSEN: Thank you. Relative to the 3 points, and 1 is Recommendation 1, I am curious relative to the productivity comment that was brought up. So I look forward to hearing that, but in that direction I still am supportive.

The IME, the same comments I think Herb and Jay made relative to if we're going to pay for this, and it's in the amount that Peter raised in terms of just the dollar amount, what is it that we still want to get value out of? As we do the reduction, still what kind of value are we able to still get from this added 60 percent that goes through?

The last aspect of the rate of reduction, I hear the need from an operational standpoint to have the predictability, but it's still niggling to just try to do it on that basis versus the rate of appropriate empirical reduction.

I have a separate, actually clarifying, question to do on Slide 12. Oh, let's see. Is this the comparing 2008 performers here? Yes. Excuse me. Sorry, I was mislooking.

It's actually something that's more of an outlier relative to the last bullet or the last comment about the rate of patients rating the hospitals, and it's like a 1 percent difference, which strikes me when the variance of actually other empirical performance. So the swing is so much bigger. So I'm just curious about any thoughts that you might have about the fact that the rating is so close, even though the performance of efficient hospitals is so different.

MR. STENSLAND: Well, I think it's going to depend on the different measures. First, one of the main measures we're looking at there is mortality. This is a survey, and you might not get good survey response for the people that

died. They do ask the relatives to respond to the survey, but that could be part of that.

There is some correlation between the readmission rates and satisfaction, but there's also a lot of evidence that says a lot of the things that the patients care about -- good communication, did they give me nice meals, some of these other amenities that might not directly fit into the outcome measures in terms of how.

MS. HANSEN: Yes, I think your last comment reflects some of my thinking, and it just raises the question about the validity of the tool or how the perspective is. So I guess I just want to put that on the table as to how to address that in the future when we assess it from the beneficiary perspective.

DR. DEAN: Yes, in general, I would say I'm supportive of the recommendations in general.

I had a couple comments I'll just make and try to do them quickly. First of all, one of the things that has bothered me over the last two years that I've been involved with the Commission is that I think too often we look at overall aggregate data. I think the importance of drilling down, and we find, say, this group of relatively efficient

providers, which is a terribly important accomplishment I would say, coming from an area which is frequently an outlier when you look at aggregate national data. I think it's really important that we do that more often and try to drill down on the data.

Secondly, with regard to the MS-DRGs, it clearly is an important thing to do. On the other hand, from a clinician's point of view, we have really been hit with a demand for more documentation in a system that already spends 25 to 30 percent on administration, and we're being asked even more so to increase that. I find it troubling. I don't know what the answer is.

But just as an example, just a few weeks ago, I was taking care of a lady that had an MRI in the middle of the night. Her blood pressure was 80. Her pulse rate was about 45. I had a lot of things to think about. Then our records people come back several weeks later. She had two IVs running, and they said, now was that second IV for rehydration or therapy? I said, you gotta be kidding me.

But that's the level because there's a different code apparently. I have no idea.

But we're getting to that level of demand that

somehow there's something else I should have put in the record to make, so they could make a distinction. They were going back and trying to track each individual IV, what went through each one. It was probably a couple hours of records people's time to try and figure out that one sort of what I considered a totally irrelevant question.

Now maybe it relates a little bit to Arnie's point, if I understood his comment, about EMRs. EMRs can do this, but also they can produce a lot of misleading data too.

Just this week, one of our employees brought me a record. Her husband has a serious illness. She brought me an elaborate three-page report from a consultant he had just seen, that had this beautiful review systems, this elaborate physical exam. And I probably shouldn't repeat in public what she said about that report. She said, I read that thing, and he didn't do it. He didn't do it.

You know, it wasn't that I necessarily think that -- and maybe this is not directly relevant, but it's one of the potentials we get into. I mean this was a beautiful report, and I'm not saying that the guy didn't get appropriate care, but the report didn't reflect what

actually happened.

So it is a concern. I guess it relates a little bit.

Maybe it ties into my last comment about the whole productivity issue. I have some skepticism about productivity, especially how we define it. Because if we define it as an increased number of units, I mean there's a lot of indication that we already do too much in many areas. It depends on how we define it.

I think a pay for performance approach based on what actually is the outcome of the process is a far more appropriate way to go rather than to try to measure, use some kind of parameters to come up with some kind of measure of productivity. Maybe I don't understand it, but it just seems to me that we can get trapped in that process. So I agree with the idea of Draft Recommendation 1 without a productivity adjuster.

DR. CHERNEW: So, quickly, I'm supportive of Recommendation 1 as it's written, particularly given your description of the history behind it, Glenn.

I will say, and I actually was going to say this prior, but now I can say I agree with Tom, that I'm wary in

general of the productivity adjustments -- not so much the spirit of what they're trying to do in putting pressure on providers, which I'm actually, generally speaking, very supportive of. But I think philosophically there's a view of what productivity means. We don't really have a pretty good sense of what it is.

Different industries, I think, legitimately would have different abilities to become productive or not productive, and so I think the spirit of keeping pressure on providers is correct, provided that we can pay them appropriately.

But I think the other pieces of evidence like entry into the industry, measures of quality and access, those types of things tell us whether we're too high or too low, and we can adjust. I'm wary of calling that adjustment productivity all the time, but I think as a matter of principle we should try and make sure that we meet the goals that you set on the original slide.

In terms of what I'd like to know before sort of my unequivocal support of Recommendation 1, with the other commissioners, I'm very supportive of all this efficiency analysis. I think it's actually tremendous for a whole

number of reasons.

Of course, the key issue is what comes up, I'm sure, is are hospitals identified as efficient really efficient? Is it something about them that they're doing as leaders? They're managing better. They're more efficient. Or is something about their environment or things they can't control that happen to be generating their low cost and their better outcomes?

The norm is, well, these other ones should just be able to do that. I'm not sure that's always true, although it's hard to identify what is missing. Why can't the inefficient ones just be the efficient ones? Do they need more consulting?

The one thing I guess I'd like to see, the one piece of data in the spirit of asking for data would be I'd like to sort of see the geographic distribution of these efficient providers. If I saw that they were all located in Massachusetts, which is a well-known bastion of efficiency, that would tell me some information as opposed to if I saw them located elsewhere.

So, in any case, I think the efficiency route is the right way to go, and I think the better we can defend

it, the stronger footing will be because I do think we have to worry a lot about the heterogeneity of these hospitals margins and not just what we're doing on average, but what we're doing for the really good ones that happen to not be in that efficient bucket. That's what you worry most about, what keeps you up at night.

In terms of IME, I want to throw my backing behind what was originally called the Milstein position, which is that I think in general sticking closer to empirical evidence as opposed to further from empirical evidence is probably a good principle, and there might be other reasons we would deviate from that. But if I were looking at Recommendation 2, my bias would be that I'd want to see a stronger note as to why we've deviated. Or maybe I should say instead, it's strikes me as a relatively generous recommendation, given the analysis that we've seen without going further.

In terms of the DCI things, I'm going to just -- I couldn't have done better because I don't understand enough about what went on, but I hope to understand more.

But, in spirit, I think there are two things going on there. One of them is a level, and the other one is the

speed of transition. So the speed of transition, I am honestly a little ambivalent about, and I think I'd be incredibly manipulatable to do what other people think is best. In terms of the level, I just need to understand more to figure out exactly what's really coding, what's not really coding, because that's a complicated thing to disentangle.

MR. HACKBARTH: Just a couple concluding comments and then a question, a couple questions for you.

First of all, on this issue of productivity, I just want to make a comment for the benefit of the audience on this, and I think the commissioners, certainly those who have served on the Commission for a while, understand it. We don't have a productivity adjustment in the hospital recommendation. As we go through the other sectors, it will show up in some other places.

When we use a productivity adjustment, we've not considered that an empirical estimate of how much productivity is improving in a particular provider group. Rather, the purpose of having the adjustment is to apply pressure on the rates as a means of encouraging ongoing efforts to improve efficiency. What we're trying to do is,

at least in a crude way, mimic the sort of pressure that is created in competitive markets where the market dynamic itself creates steady pressure for improvement.

Of course, in Medicare, we don't have competitively set prices. We've got administered prices. So, to create that ongoing pressure, we've got to do something like a productivity adjustment.

You can call it a fiscal sustainability adjustment. Over the years we've debated a lot what the right language is, and I'm not sure we'll ever find the exact right language. But the purpose when we have it is to apply ongoing pressure to improve efficiency, much as the taxpayers who fund the program feel in their day to day jobs and businesses. The general idea is there's no reason the health care sector ought to be exempt from that continuous, even relentless pressure to improve efficiency.

On the IME issue, I just want to highlight what's been alluded to several times. We will be coming back to IME in the spring, and look at Medicare's payment for IME and whether we like the way those dollars are currently used or whether we want to do something else with them that would further our goals for improving the training system. So

we'll definitely be back to that.

Now let me turn to my two questions. First is on the hospital update and whether there ought to be a productivity adjustment. I'd like just to sort of get a sense of where the group is overall. I'd like to get a show of hands on that. How many would like to see a productivity adjustment added?

And I'll ask in three parts, how many would like to see it added, how many really would like to see that, and then who's uncertain at this point? I really want to get a sense of the distribution.

So who would like to see a productivity adjustment added to the hospital update recommendation?

Who is opposed to that?

MR. HACKBARTH: Then who's uncertain?

Okay. All right. Then the other question I want to ask is about the pace of taking back the coding dollars. We heard some people say too slow, shouldn't let this linger so long. How many would like to see a faster schedule for taking that money back?

MR. HACKBARTH: I don't think it's productive or necessary right now to try to pinpoint a number, but clearly

that's something we've got to explore in our conversations between now and the January meeting.

MR. GEORGE MILLER: It's fair to ask that question, but shouldn't we know what the update is going to look like before we determine because if you say let's take 2 percent a year, if the updates come under 2 percent, we're creating a negative margin. So shouldn't we know that first?

MR. HACKBARTH: The two are interactive.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: We don't have the time right now to try to go through the various combinations. So we'll work on that. As always, I'll be in touch with commissioners between now and the January meeting, and sort of talking through options.

DR. SCANLON: On this idea of including or not including the productivity adjustment, it seemed to me in our discussions in prior years we, in some sense, came to what we thought was the net update that was appropriate.

In some ways, we could argue that what we're doing for the hospitals is we're including the productivity adjustment, but we're taking it from something, the market

basket plus, because of what we think the margins are. In other provider types, we go to zero which is not market basket minus productivity, but it's our judgment that given the overall circumstances zero is the appropriate number.

So it's not so much that we had it in or didn't have it out. It was I think in our thinking, but it ends up being that we're comfortable with the market basket level here as the appropriate amount of pressure, given other circumstances.

MR. HACKBARTH: Okay. Well, as I said, I will be calling each of you between now and the January meeting, and we'll have some options for you to react to.

Thank you, Jeff and Craig and Julian, for your work on this. It's complicated stuff. You did an excellent job of explaining it.

So next we move on to physician services.

Okay, when you are ready.

MS. BOCCUTI: Our presentation today has two main sections. First we are going to present our payment adequacy analysis, and this is the one that follows the framework with the access, quality, volume, et cetera; and then a draft update recommendation for your review. And

then Kevin is going to introduce a study about the accuracy and equity of payment for physician services. We have limited time, so we are going to move fairly quickly, but feel free to ask questions during the question period.

So for our payment adequacy analysis, we look at access, of course, and we use several indicators for this assessment. Of course, we do not have the cost reports as we do in other sectors, so we tend to focus a little more heavily on the access indicators. And as you recall, MedPAC sponsors an annual telephone survey to obtain the most current data possible on beneficiary access to physician services. We completed this year's survey just several weeks ago, so the data are quite current, and Hannah is going to be presenting those results in a minute.

Also for our access analysis, we look at other national surveys, both of patients and of physicians, and this year we conducted focus groups with both beneficiaries and physicians, and we will discuss some of those themes.

So now on to the telephone survey.

MS. NEPRASH: We will first look at the ability for people to schedule physician appointments. We continue to find that most Medicare beneficiaries and privately

insured people do not regularly experience delays getting an appointment. Among survey respondents seeking an appointment for routine care, 77 percent of Medicare beneficiaries and 71 percent of private insured individuals reported that they never experienced delays getting an American people. As expected for illness or injury, timely appointments were more common in both insurance groups. Among survey respondents seeking an appointment due to illness or injury, 85 percent of Medicare beneficiaries and 79 percent of privately insured individuals reported that they never experienced delays getting an appointment.

These differences between the Medicare and privately insured populations are statistically significant, suggesting that Medicare beneficiaries on average are less likely than privately insured individuals to report unwanted delays in getting appointments.

We also asked respondents about their ability to find new physicians when needed. It is crucial to realize that a small number of survey respondents sought a new primary care physician, only 6 percent of Medicare beneficiaries and 8 percent of privately insured people, which indicates that most are satisfied with their current

PCP. Among this small share looking for a new PCP, 78 percent of Medicare beneficiaries and 71 percent of privately insured individuals said they experienced no problems finding one. Twelve percent of Medicare respondents looking for a new PCP reported a big problem finding one. This is significantly lower than the 21 percent of privately insured individuals who reported a big problem. Keep in mind that given the low share of people looking for a new PCP, this proportion of Medicare beneficiaries reporting a big problem comes to less than 1 percent of the 4,000 survey respondents with Medicare.

So now to specialists. As in previous years, we found that access to new specialists was generally better than access to new PCPs. Eighty-eight percent of Medicare beneficiaries seeking a new specialist reported no problem compared to 84 percent of privately insured individuals. Overall, Medicare beneficiaries are less likely than privately insured individuals to report problems finding a new physician.

As Cristina mentioned, we also analyzed the survey results by race. Difficulties getting timely appointments are more likely for minorities than whites, with both

Medicare and private insurance. Minorities in both insurance categories were significantly less likely than whites to report never experiencing delays scheduling routine care appointments and significantly more likely to report always experiencing delays.

Among the small percentage of respondents looking for a new specialist, minorities were more likely than whites to encounter problems finding one. However, no such difference was observed for those seeking a new PCP. Further breakdowns by race and ethnicity showed a few differences between white and African American Medicare beneficiaries or white and African American privately insured individuals. But as you can see in your mailing materials, Hispanics and other races were more likely than whites to report access problems.

Although minorities experienced more access problems, those with Medicare experienced fewer problems compared with their privately insured counterparts. MedPAC will continue to track these questions closely in future surveys, but for now, I will turn it over to Cristina, who will talk about how our results compare with other national surveys.

MS. BOCCUTI: So other organizations have conducted similar surveys, asking systemic risk questions, namely, CMS through the CAHPS Fee For Service Survey, the Commonwealth Fund, the Center for Studying Health Systems Change, and AARP. And in the interest of time, I am not going to go through all these results, but it is important to know that they do show similar findings to what we have been finding. But we certainly describe some of the results in more detail in your mailing materials and then in a forthcoming chapter.

On the next slide, we summarize here results from national surveys of physicians as opposed to the discussion we have been having regarding beneficiary experiences.

So here I will highlight those from the Center for Studying Health Systems Change, which recently released a report for 2008, and its results are generally consistent with findings from other physician surveys, namely, the National Ambulatory Medical Care Survey and MedPAC's 2006 Physician Survey. And they show that most physicians accept at least some new Medicare patients.

The AMA bullet on the bottom is a survey of a slightly different kind. It focuses really more on claims-

processing issues, and it found that Medicare performs similar or better than private insurers on claims-processing measures such as accuracy and transparency. Although Medicare had higher rates of denied claims, it is important to note that Medicare does not require preauthorization for services, as do many private insurers.

So this year we included questions in our focus groups on beneficiary and physician access issues. These are the same focus groups that Joan Sokolovsky talked about in our September meeting, and they took place in Baltimore, Chicago, and Seattle. The participants in these focus groups totaled 99 Medicare beneficiaries and 64 physicians, and overall we found that access to physician services does not appear to be a major problem in any of these three areas. But reports of some difficulties were voiced, more in some areas than others.

So first I am going to review what we found in the beneficiary focus groups. For the most part, beneficiaries stated that they had longstanding relationships with a doctor, usually a primary care physician. Several reported that they heard about primary care doctors not accepting patients, but they did not experience those problems

themselves.

One finding is that it was more frequent that we heard about access problems for specialists, but that really relates to the situation where it is much more common to be looking for a specialist since, as I said, they have these longstanding relationships. So it did not surprise us that they would mention specialists that they might have had to make several phone calls, et cetera, but that I think relates a lot more to the new health problems and needing to find a specialist is a much higher frequency.

Most beneficiaries reported that they did not have to wait an unreasonable amount of time to get an appointment with their doctor, especially with their primary care physician. We did note that lower-income beneficiaries were more likely to encounter access problems than higher-income individuals. And a few beneficiaries reported that compared with their previous experience with private insurance, they preferred having Medicare because they experience fewer hassles.

And then on now to the physician focus groups, we asked physicians about their willingness to accept new Medicare patients and their ability to find referrals for

them. Although most physicians were accepting new Medicare patients, a few were not. Some specialists did emphasize to us the importance of maintaining their Medicare revenue and accepting Medicare referrals into their practice. Psychiatry was the most frequently cited specialty where there were problems getting referrals for their Medicare patients. All of the physicians accepted some private insurance, but that, of course, varied by plan and by market area.

Some physicians in our focus group indicated that they did not accept Medicare Advantage plans -- one said, say, for example, because of hassle reasons -- but did accept Medicare patients, traditional Medicare. But other physicians, even in the same area, had the reverse policy, so it really did depend on the physician's office in several cases. Medicaid was by far the least accepted insurance among the physicians.

There was considerable agreement on likes and dislikes in our physician focus groups. All the physicians complained that their Medicare payments were low relative to private insurance rates. Almost all physicians reported that they did like the predictability and reliability of

Medicare, and many also commented that they appreciated Medicare's lack of pre-approval, which made it easier to get surgical procedures done more quickly.

A third item that many physicians appreciated was the reliable coverage that Medicare provided for their patients so they did not have to worry about. And others stated that they enjoyed treating the elderly patient population and found that working with them was intellectually rewarding.

So the next slide here is a shift now away from the focus groups. Carlos Zarabozo managed our work assessing Medicare fees for physician services relative to those for too large insurers. So here on the slide looking at the far right bar, for 2008 Medicare rates were nearly 80 percent of private rates averaged across all services in geographic areas. This rate remained generally stable over the last several years.

And then the next slide, now, of course, in addition to payment rates, physician revenues are affected by volume, and we continue to see annual increases in the volume of services physicians provide per fee-for-service beneficiary. So looking cumulatively, growth has grown

slower for evaluation & management and major procedures relative to the three other categories.

Kevin is going to discuss more details about the implications of this later in his presentation.

Moving on to our assessment of ambulatory quality, John Richardson managed this work, so I want to thank him. Using here our claims-based measures, we found that most of our quality indicators -- that is, 33 out of 38 -- were stable or improved slightly from 2006 to 2008. Among the five indicators that declined, differences were small but statistically significant, and we describe those instances in more detail in the mailing materials and in the upcoming chapter.

So now for the second part of the adequacy framework, changes in costs for 2011.

CMS' preliminary forecast for input price inflation is 2.1 percent. Within this total, CMS sorts the inputs into two major categories: physician work, that is, physician compensation, wages, benefits for physicians -- that is expected to increase by 2.2 percent; and physician practice expense, which is expected to increase by 2 percent.

CMS' forecast for the Medicare Economic Index, which includes a productivity adjustment and is commonly known as the MEI, is 0.9 percent. Note that this is for 2011, fourth quarter. These forecasts do change every time there is a new quarterly report, and it depends on which one you are looking at. So you may see slight variations in this 0.9 number, but that is because of different forecasts, iterations.

Going on to the draft recommendation, the Chairman's Draft Recommendation for Physician Services, here we have the Congress should update payments for physician services in 2011 by 1 percent. A bit of background for this.

For the year 2009, the update was about 1 percent. That was enacted through MIPPA legislation. For 2010, the SGR currently calls for a 21 percent cut. The Commission has stated -- well, let me also say that for 2011, the year for which we are making this recommendation, the SGR calls for a further 5 percent cut and then again for several subsequent years.

The Commission has stated that it is not supportive of these continued annual cuts, but the

difficulty we have here today, of course, is that we do not know what Congress might do about the updates in the near future. So given the array of the factors we have reviewed here in this assessment, for instance, the generally good access, quality, volume keeps increasing, and the need to be fiscally disciplined while maintaining access to physician services, here we have the proposed update of 1 percent.

So regarding the implications, the spending effects are, of course, very large because any increase would be scored relative to the cuts that are in current law. Additionally, this update would increase beneficiary cost sharing but would maintain current supply of and access to physicians.

Here to emphasize the importance of access to good primary care in a well-functioning delivery system, we will be reprinting our recommendation from previous years in the chapter. And as you may recall from your discussion last year, your were requesting that we discussed this recommendation, that we had another vote on it, and we increased the chapter last year to accommodate that. And we will certainly refer to this extra section that we wrote about in the 2009 report, and in the forthcoming report we

will cross-reference that.

In addition, we will be reprinting this recommendation, as I mentioned, and that is calling for a budget-neutral increase in payments for primary care services provided by practitioners who focus on primary care.

Now Kevin is going to go on with the last section of the presentation.

DR. HAYES: At the October meeting, there was extensive discussion of several issues concerning the accuracy of prices in the physician fee schedule. With the March report, we want to set up those issues and continue to work on them from there.

One issue is the fee schedule's estimates of the time that it takes physicians to furnish services. On the slide, we can see that time is an important factor in determining the fee schedule's relative value units. Depending on the type of service, time explains from 72 percent to 90 percent of the variation in the fee schedule's RVUs for physician work. The strength of the relationship makes it important to get the time estimates right.

In addition to time, intensity, or work per unit

of time, is the other factor influencing the fee schedule's work RVUs. Intensity is represented on the slide here as compensation per hour. Comparing physician specialties, we do see some variation in compensation per hour. Note that this is compensation per hour calculated with the fee schedule's estimates of physician time.

We get a very different picture, however, when we calculate compensation per hour not with the fee schedule's estimates of time, but instead with the hours physicians actually work. For numbers on compensation per hour worked, we contracted with The Urban Institute in partnership with the Medical Group Management Association. On the chart, we see wide disparities, both among physician specialties and between the two calculations of compensation per hour.

About the only way that the two sets of calculations could differ as much as they do is if the fee schedule's estimates of time are too high. That's what we are going to examine further.

In the work we have done so far, we have found also -- and all of this is laid out in the draft chapter that we sent you -- that some physicians furnish a high volume of services, that there is a concentration of short-

duration services in some physician practices, and that during a patient encounter, multiple services are often furnished together. Each of these factors -- time, duration of services, and services furnished together -- has implications for how the time estimates are -- how time is estimated and how services in the fee schedule are valued.

So you see where we are with this work and the questions that have arisen so far. From here we will learn more about the time estimates and the process for how they are developed. The work could lead to recommendations for collecting, say, better data on time and for otherwise ways to improve the process.

That concludes our presentation of the draft chapter. We welcome your questions and look forward to your discussion.

MR. HACKBARTH: Okay. Let me see hands for round one clarifying questions.

DR. DEAN: On the access information, is there any geographic breakdown by that? Because, again, the same comment I made a little while ago. I think we are looking at aggregate data, and my suspicion is that there is a lot of variation within that data in terms of from one place to

another. Is there any way to break that down geographically?

MS. BOCCUTI: Well, nationally, even other surveys haven't really been able to do that so much. They are on a national scale because the markets get so small when it becomes an issue.

Do you want to mentioned something about the survey?

MS. NEPRASH: We did look at the results by urban and rural beneficiary respondent, and I am happy to get you a more detailed table on that. At least within Medicare, there were not very many significant differences in access by urban and rural beneficiary.

DR. DEAN: But the problem I have with that is that the definition of "rural" is huge, and it includes a wide diversity of different types of locations. So I am not sure it is all that helpful.

MR. HACKBARTH: Tom, just a reminder. We need to be careful to separate two issues. I think you are probably right that access issues vary geographically. In fact, I am almost sure that you are right. A separate question is to what extent is that due to Medicare payment policy as

opposed to issues in health care delivery in the particular markets. So those are just analytically separate questions.

DR. DEAN: I guess my concern is that this data may give an unrealistically optimistic or positive view of the overall situation. But, anyway, the reason for it, I agree, is more complicated.

MR. HACKBARTH: So let's just stipulate that there is a difference, and then the question would become for this discussion: Is the Medicare update an effective tool for dealing with issues that might be attributable to problems that go way beyond Medicare?

MS. HANSEN: Yes, my comment is really in the same vein of discussion, that I think it is great because all the different sources that we, you know, corroborated the access point, and that in reality maybe other factors, I think, you know, Glenn, you mentioned like communities that are growing quickly, and so there is one thing about the demographics of change of a community, and then maybe the delivery system itself.

I just wonder, you know, because in the body of the report there are still about 550,000 people who reported some difficulty of access, whether or not there is some way

to at least frame this discussion, because certainly at AARP, even though one of our reports reported as it did, we certainly get enough volume to indicate there are hot spots. And as I recall, maybe CMS four or five years ago did a hot spot report, and whether or not that also is another way to kind of get underneath a little in terms of greater texture, because I think, frankly, our policymakers get that same question and overture by their constituents.

So if we could somehow just at least put a perimeter around the discussion of the access issue and the fact of how it may be different from Medicare payment policy, but just something in the text to address this issue, because it still comes up in a colloquial discussion to raise the whole question of access, despite all the kind of the disciplined studies that, you know, we are quoting.

MS. BOCCUTI: I think what happens, too, is that even for the -- as you just mentioned and as Hannah was mentioning, relatively it is 1 percent, 2 percent of the Medicare population having these numbers, and it is the half a million that you described.

When they are having a problem, it is disturbing for them, and it does cause them to reach out and talk about

this. So I think that when it is a problem, it is not minimal to them. And so I think we have mentioned this in the chapter, and Glenn raised this, that because of what it is, it deserves attention, but it is not on a national scale as large as it might seem because of the attention that it is getting.

MR. GEORGE MILLER: Just quickly, and I apologize because I do not remember reading it in the chapter, but can you give me the demographic information on the physicians you surveyed? I think I remember reading about the beneficiaries, but I don't remember reading about the physicians.

MS. BOCCUTI: The physicians that we discussed, I think, that we were talking about here were from a focus group situation, so I think there were 64, I think I said. And you question is what about them, the --

MR. GEORGE MILLER: Yes, demographics, small, rural, urban --

MS. BOCCUTI: Well, it was varied. There were in much more -- they were in MSAs because we were in Chicago, Seattle, and Baltimore. So they would tend towards that, although I would say some came from suburbs, and we had

primary care groups and we had specialty groups. So they represented a variety of different specialties, and in that regard we kind of oversampled within our focus group the primary care physicians, although they make up such a large percentage of doctors in the U.S.

MR. GEORGE MILLER: How about racial -- [off microphone]?

MS. BOCCUTI: I wouldn't be able to give you statistics on how they are represented, but we had people from all -- not all different, but it was not all of one race, and it was ethnicity and even other heritage backgrounds, from Eastern European physicians and some that have emigrate.

MR. GEORGE MILLER: My follow-up question is: Do you know their patient population? More importantly, who do they serve?

MS. BOCCUTI: Yes, they talked about that because they did say that sometimes they -- several did have Medicaid patients, but some said that they did not accept Medicaid patients. And so we discussed -- and those that were self-pay or uninsured. So we brought those issues up, and I would say that we asked about that specifically, and

so we got answers that told us that some serve low-income populations and some did not.

DR. BERENSON: This may be in the weeds, but on number 13, if you would go to that, I understand there were inputs to practice expenses -- rent, cost of labor, et cetera. What are the inputs to physician work? I do not understand what gets --

MS. BOCCUTI: Those are the physician income and the benefits, so for physician health insurance.

DR. BERENSON: Oh, okay.

MS. BOCCUTI: The practice expense of the staff's wages and benefits.

MR. HACKBARTH: Though that estimate, is that physician specific or is that for sort of comparable professionals?

MS. BOCCUTI: It is for physicians, I think. Right?

DR. HAYES: No, it is comparable -

MS. BOCCUTI: Oh, so it is office, yes, non-factory -

MR. HACKBARTH: Right, right.

DR. KANE: In Massachusetts, where everybody

thinks we do not have access to primary care because of our universal coverage -- which is not quite true -- people have done studies of access, but they do not ask people how they feel. They actually measure how many days it takes to get an American people. And I am wondering, have we got that kind of quantitative -- so these are all subjective. These are kind of rubber yardsticks of what different people think is an unwanted delay. And have we ever tried to do it the other way, which is to say how many days does it take a routine appointment, you know, an urgent appointment, by primary and specialty, as just a way to kind of create a standard yardstick.

MS. NEPRASH: Our survey really asks their opinion of whether they had to wait -- whether they were satisfied with how long they had to wait. It does not ask them to quantify the days. And in part, I think -- Cristina, correct me if I am wrong, but this is a sample size thing. You know, in order to draw meaningful distinctions with the results and the end that we have, this is how we are phrasing the question.

MS. BOCCUTI: Well, I don't know that it was for sample size reasons. I guess you are saying getting

different categories of variables. But I think that that is the real question about their opinion about access. And maybe we want to discuss it, but it is whether they feel that they had unwanted -- they had to wait too long.

DR. KANE: The only issue can become that you get used to it. I mean, I am used to thinking it takes 6 months to get in -- you know, so was it an unwanted delay or -- you know, I guess how do you -- I agree, you know, ideally, satisfaction is -- I think going back to what Jennie was actually trying to say, too, a little bit. And different markets, too, I mean, in Boston people are just used to waiting a long time, and so, yes, it is not an unwanted -- you know, you don't say much about it, but you know it's a long time.

MS. BOCCUTI: In the focus groups, I think it came up whether it was an appropriate amount of time, so it is something to discuss.

DR. STUART: I believe that the Medicare Current Beneficiary Survey: Access to Care actually has questions about the amount of time that it took to get an appointment, how long you had to wait once you were in the office. So there is some quantitative data available there.

DR. KANE: Could we look at that? That might be a useful -- and just see what the changes have been over --

MS. BOCCUTI: We certainly can. MCBS data come out several years late-dated, and so we try to get the survey usable and done and as quick as possible. But we will think about that a little bit more.

MR. HACKBARTH: In their own way, each is a legitimate measure, but they are measuring different things. Back at Harvard Vanguard, before we went to same-day scheduling -- and we used to track this a lot -- we actually did both. We would survey satisfaction because ultimately that is a very important thing for a group to know if the patient is satisfied. But we would also look at number of days to the next available appointment and saw different information in the two pieces.

DR. MARK MILLER: I also think in the days of the recall issues, right?

MS. BOCCUTI: Yes, I think that's a good survey issue, and also they have had several appointments, and so, you know, they are making this sort of -- we are asking them speak generally about your experience with routine appointments and with specialty appointments.

DR. KANE: Yes, if I could add, I think the way it is done -- I know the ones I have seen have been done by people actually calling and asking and recording it -- in other words, not asking beneficiaries about their experience but just call --

MR. HACKBARTH: Call a physician's office and try to schedule an appointment.

DR. KANE: Yes.

MR. HACKBARTH: That is what we do, yes.

MR. BUTLER: Yes, we've had discussions here in the past couple meetings about pricing power and how negative Medicare margins for hospitals are not necessarily a problem if you make it up on the pricing side. You report here that it has been pretty consistent, 80 percent of Medicare -- I mean, of the private payer rates has roughly been stable, as if there has not been kind of a cost shifting on the physician side over time. Could you talk a little bit more about that? I know you said, well, they make it up on volume or it is a smaller percentage of their business compared to hospitals. Are there any other insights to why that has -- the relationship between the private and Medicare payment has been pretty stable?

MS. BOCCUTI: Two things I'll mention. First, it didn't used to be this stable. I mean, we are looking at a lot of years here, and before this time there was more -- gaps were bigger. But I don't think that I'm revealing anything proprietary to say that many private insurers' rates track similarly to Medicare's, and so I think that that is in some way reflective of why these are getting very stable.

MR. BUTLER: But wouldn't you think that instead of getting 120 percent of RBRVS, a group or physicians would say, "I want 130"? You know, so it is still tied to Medicare, but at just a higher percentage.

MS. BOCCUTI: Right. And -- well, I think maybe other people want -- other commissioners, yes.

DR. BERENSON: I mean, is this ratio basically the comparison of Medicare fee schedule to private payer fee schedules?

MS. BOCCUTI: Yes.

DR. BERENSON: All right. So we are missing the out-of-network activities, the fact that some people in the private sector may be paying more out-of-pocket off the fee schedule, essentially, and so it is not actually -- I am not

sure the ratio was stable between what people are paying -- or what physicians are receiving from their private patients versus what they are receiving from Medicare. I think that might be changing.

MS. BOCCUTI: Carlos, that is right. It is not the allowed charge. It is the fee schedule payment, right?

MR. ZARABOZO: [Off microphone.]

MS. BOCCUTI: I will repeat for him. I think Carlos was saying that he wants to double-check that what we said is correct, that whether it is sort of the allowed amount or the actual fee paid out from the plan.

DR. BERENSON: But, again, even that, with balance billing it is not exactly clear that the amount paid out by the plan is representing what the physician is receiving. I mean, it may not be a huge factor, but it is one.

DR. MILSTEIN: The other point is the point that I think emerged in Martin Gaynor's testimony, which is hospital markets tend to be a lot less competitive than physician markets. So hospitals have a lot more ability to cost-shift what they consider to be underpayment by other payers onto commercial payers; whereas, that is less true of physicians, except in markets in which the physician groups

are very organized, which is a minority of the U.S. markets.

MR. HACKBARTH: Okay, other clarifying questions?

DR. CASTELLANOS: I have two clarifying questions. One is, again, the access issue. I agree that is a concerning issue. I think we need to drill down a little bit. You know, is it because of physicians aren't available? Or -- and maybe I am going to be touching some toes -- do the Medicare beneficiaries have unrealistic expectations that, "Because I have a headache, I need to be seen yesterday"? And I think we need to look at that because, as a practicing physician, we open our office to anybody with an emergency, and their definition of an emergency is somewhat different than what I consider an emergency. And I think sometimes the patients have a little bit unrealistic expectations.

I think there may be some issues here on the economic viewpoint, even though Massachusetts has 97 percent insured, just because you have insurance does not mean you have access, especially with Medicaid. And as George put out, maybe there is some racial problems.

The second question I have -- and it is a real concern I have -- is that I noticed in the reprint that 13

percent of the Medicare fees now go to physicians. And if I remember, that number several years ago was around 16 or 17 percent. And over that same period -- and I am just curious if you have any reason for that.

And the third question, again, is on access. We do not have the chart here, but on page 8 of what you turned out, I agree, I think, Medicare is doing a great job. But private pay is not, and Medicare pays 80 percent of private care. There has got to be something going on there. I am just curious if you have any ideas on that.

MS. BOCCUTI: Well, the 13 percent number, it is not that Medicare payments for physician services have gone down, so that would indicate that the other payments are going up if the share of Medicare payments for physician services -- if the share is going down, it means other spending is going up, too, because physician spending has not gone down. So it would be on other components.

DR. CASTELLANOS: But the share of the revenue has gone down.

MS. BOCCUTI: Their share, but not their total. But not the total revenues.

DR. HAYES: You are talking about total spending?

MS. BOCCUTI: Medicare spending. That is the 13 percent I think you are referring to. When you said fees, you mean total Medicare outlays.

DR. CASTELLANOS: Yes.

DR. HAYES: Or it's MA.

MS. BOCCUTI: Right, all of the other things which include Medicare Advantage.

DR. MARK MILLER: [Off microphone.]

MS. BOCCUTI: Right. I just do not want to leave the impression that Medicare spending on physician services has decreased.

I think the first part of what you were talking about with the access -- and that is sort of the opinion issue that I think Nancy raised, whether, you know, is one day unreasonable or not, so we can think about that further.

And then the third point was?

DR. CASTELLANOS: Just that --

MS. NEPRASH: Private.

MS. BOCCUTI: Oh, private, right. I understand what you are saying.

MR. HACKBARTH: Okay, round two, same ground rules as last time: for or against, what questions do you need

answered in order to reach a judgment.

DR. SCANLON: I'm very supportive of the recommendation. Actually, my comment would be about the issue of looking at the relative values, and I am struggling some to understand sort of what we might be finding.

I am very much in favor of trying to improve the data we have there and the amount of review that we have, but I think we also -- you know, the underlying sort of principle is that we are establishing relative values for the typical patient. And so the question is whether some of the variation that we are seeing comes about because practices are dealing with an atypical distribution of patients. And, you know, should we then adjust the relative values? Which means we are changing our principle, which might be the appropriate thing to do, but it is different than saying we are correcting for a data problem that we have had, because, you know, the short-duration services, that could be an issue that they overestimated when we went through this process, and we could think about, you know, if correcting for that overestimation is the right thing to do. But sort of other kinds of phenomena that we may observe may be more due to that some practices and some specialties end

up -- and remember one of the things in the relative value, we moved from a world where fees were set on a specialty level, a specialty specific level, to a uniform fee schedule, and whether we have missed something sort of in that process.

And so I am just not sure what we are going to find here. I think it is very important that we do pursue this, but it is going to be a question of kind of what the lessons are we take away, and particularly if we start to question fundamental principles, we have to think about sort of what is it we are going to substitute for those fundamental principles.

MR. BERTKO: Okay, I am going to suggest that the recommendation would be okay, but with something along the lines of what Bill was saying. We have, I think for everything, come out for accurate pricing, more accurate pricing, and particularly the disparity graph on Slide 19 shows that we don't have accurate pricing. Our previous work on activities of the RUC and the process there would at least give implications that might be inaccurate.

So if you were to go to the fee schedule recommendation, which would be -- I would suggest amending

it to plus 1 percent, like the hospital one, with a concurrent recommendation to work on more accurate pricing across specialties in particular. And then separate from that, I would want to reemphasize our -- at least my interest in having the primary care fee schedule again recognize the need for a budget-neutral increase relative to everything else.

DR. CASTELLANOS: Thank you. I think we all appreciate that none of us likes the current payment update and how it is being done. And I suspect that there are some significant problems, and I think there is a significant problem in the physician community that we are not recognizing, and we are seeing a break in the wall now, and that is with psychiatry. This population is the lowest percentage of doctors participating in Medicare. It is the highest percentage of doctors leaving Medicare. They have their worst reimbursement on Medicare payments, and they don't qualify for the primary care exemption. And in my community, that is the hospital's biggest cost because the psychiatrists don't come to the hospital. And we had a thing called the Baker Act, and we have about 50 patients a day in that hospital. And we can't get any psychiatry

service, and to get these people out of that hospital into an appropriate facility when we don't have psychiatry access, it costs the hospital a tremendous amount of money, and that is not reimbursed by the State. So we are seeing a break in physician payment causing access.

Now, I recognize this is a very small field, but I suspect if this continues, it is going to increase significantly.

Now, we need to get away from the fee-for-service. We all agree to that. We need to pay for quality, and we need to pay for outcomes. But we also need to pay appropriately for costs. And if you look at my payment increase from 2001 until now, it is 1.6 percent. But my costs, depending on CMS or NGA, are going up 20 to 30 percent.

So my suggestion is that we look at appropriate reimbursement for cost for sure, and recognize there is a crack in the wall with psychiatry, and I suspect if this continues, we are going to have other specialties who can rely not on Medicare payments but on regular payments for servicing that population base.

MR. BUTLER: Well, I support the recommendation.

I am troubled, though, by the fact that, you know, if we think that you can live with 1 percent given what physicians are incurring in terms of their costs of running their practices, it is not realistic. Yet there are other volume increases and other participating physicians have in other parts of the economic pie that are help making them whole.

I do think one issue in particular, IT, is something in the next year we ought to look at a little bit more carefully, particularly in terms of where the costs are incurred as well as where the benefits are going to occur. Our experience is when you put with the stimulus dollars coming out, and a number of physicians, you know, saying now is my time, this is going to reduce their productivity in the short run, and maybe even in the long run. But there are many benefits of IT that sometimes will accrue to outside the physician's office, so it is still a good idea. I just think it is something we need to understand a little bit more going forward as one of the inputs to looking at the unit pricing for physician services in future years. But I do support the recommendation.

DR. KANE: I support the recommendation just because, you know, we don't know what else to do, and

certainly minus 20 percent is not a good recommendation. I don't think 1 percent is adequate for some. I think it may be excessive for others. I think the RBRVS system is just kind of losing its ability to maintain access for beneficiaries in a variety of specialties, and we really -- it is getting to be fairly urgent. I think psychiatry is just one of the places where it is getting to be quite urgent.

We did talk last time, when we talked about education, I think it was, or something about physician education, that perhaps the RBRVS, in thinking about the different aspects of physician time, that maybe something about what society values should be part of it, for instance, lifestyle or, you know, what gets people into a profession or what their value-added is to the health care system. Not that I know how to quantify that. But I think we talked about this earlier, that we should try to start rethinking -- right now it is time, intensity, and -- I don't know -- mental effort or something. I am not quite sure why we don't have other attributes in the -- if we are going to think the relative value system at all, which I am not so sure is a good exercise -- then maybe we ought to

start trying to put in other variables that we also think need to be put into consideration, because certainly we think, for instance, people are not going into primary practice because of issues not really the time, mental effort, and intensity, but the lifestyle and other -- you know, inability to create productive use of your time and to generate $240 an hour instead of $99 an hour. So maybe that needs to be built into the system.

Meanwhile, we are just playing with a very broken system, and, you know, 1 percent plus, minus 5 percent, you know, it is very hard to make this be equitable anymore. It is just totally broken.

DR. BERENSON: Well, I am going to disagree with you on the last line. I think the RBRVS system is not where we want to be in five or ten years. We want to have new payment forms. But I think what Kevin has done is identified something that is actually solvable, which is actually getting real-time estimates -- I mean, better-time estimates. We will never -- there is a better way to do this than we are now doing it by simply relying on 30 doctors from each specialty society to have self-interested estimates of how long it takes them to do something.

Even in the NAMSI data, there is overestimation, and there it is not even for self-interest. Physicians overestimate their times in just reporting in that context. And I think it would be doable -- I know Herb agreed with that I think two meetings ago -- that CMS could, in fact, with some resources, actually do a much better job of estimating the time, and that would go a long way, I think, to correcting some of the mispricing.

To the extent that we would consider the correct price to be a relationship to sort of the cost of production, you are raising another issue of introducing other concepts of value, and we had a brief conversation about that a couple of months ago. Again, I think that is possibly a place we want to go, but I think we should just fix what we can fix right now, which I think is getting the times much more accurate.

I just have one or two other comments. I support the recommendation of the 1 percent. It hasn't come up in the conversation, but I think there's a sort of complementarity to a targeted increase for primary care in the -- is it in the 5- to 10 percent range -- or in that range, with the changes that CMS has now done in the

regulation. Using the new AMA survey, there is also an increase to primary care. I was concerned that 5 percent wasn't going to do very much, but with the two together, going forward, I actually think we would be making a significant -- we would be doing some redistribution. And if then you combine that with what would come out of more accurate pricing, which might also produce some redistribution, I think we could be making a significant set of improvements in how RBRVS functioned as the interim payment model.

And I will just repeat the other thing. I don't think we can get to a new payment model around accountable care organizations or new organizational models as long as we have the kinds of disparities of income in the existing fee-for-service. The most recent, possibly apocryphal, story I heard was that a radiologist out of training going into a rural area in the Midwest was getting $800,000 and 16 weeks vacation. Now, that is not all on Medicare, but the work that Urban and MGMA have done pretty much shows that the sort of ratios that exist in private payers, because they use the Medicare fee schedule, exist in Medicare as well. And so I think we could address that.

I don't think we move to these new forms as long as it is so lucrative to stay in the existing distorted fee-for-service system. So I think we have to work on this while we are trying to evolve into new payment models and new organizational models.

MR. HACKBARTH: Kevin, a question for you, and this is picking up on one of Bob's points. If you add up the effect of the last five-year review on the work values, the recent practice expense changes, plus a 5- or 10 percent bonus, what is the cumulative impact of those things together on payment for primary care services?

DR. HAYES: That's a good question. I would have to put together some numbers, and I will get back to you on that. But that would be something that is doable now that the final rule has come out that has got the RVUs for next year. We don't know what the conversion factor is going to be yet, but we can make some estimates, and I will get that for you.

DR. CROSSON: Well, I have to admit Bob's story there made me pause for a minute and wonder exactly how old could you be to apply for a radiology residency program.

[Laughter.]

DR. CROSSON: I guess there is always time.

I support the recommendation. It is consistent, again, with what we have done in the past. I actually have to admit that I was pretty surprised, almost shocked actually, to see the degree to which the time component contributes to the disparity of income. I would not have guessed that intuitively, for some reason. And I think I agree with Bob in the sense that this is one of the most concrete things that we have had in these years that we have discussed this payment conundrum to get a hold of and actually try to do something about it.

When you look at the distribution there on Slide 19, however, I also agree with Bill, and I think that the kind of changes implied by making this correction are perhaps as dramatic as anything we have done in the time I have been on this Commission to move in this direction.

And so I think we are going to have to go about this very thoroughly, very carefully. It is going to take some time. And I also wonder, you know, in the end whether or not -- you know, to avoid some sort of dislocation for the Medicare program and Medicare beneficiaries, this sort of change might actually need to be approached on an all-

payer basis in some way, and that eventually that might be what is necessary. And perhaps although it can take us outside of our mandate, we ought to at least think about that as we address this issue.

MR. HACKBARTH: Although the usage of Medicare's relative values is pretty widespread.

DR. STUART: I support both the recommendations as well, and I share Ron's concern with respect to psychiatry. It reminds me, when we were talking about primary care, we are making a distinction between primary care physicians and primary care, and I can't remember exactly where we can down on this. But, clearly, there are individuals who are severely mentally ill where the psychiatrist is or should be the first source of care. And so if we put this in the report, referring back to the recommendation that there be a budget-neutral reallocation to primary care, I think we should be clear what we mean by primary care so that that is not confusing in terms of some suppositions that readers might have that may be a little different from what our more nuanced view of that.

MR. HACKBARTH: My recollection is the statute defines certain services as primary care services, and

psychiatry is not on that list -- or is on that list?

DR. STUART: [Off microphone.]

MR. HACKBARTH: Yeah.

MR. GEORGE MILLER: But that would not preclude us from making that recommendation, right? Right, just for clarity.

MR. HACKBARTH: And for a point of information.

MR. GEORGE MILLER: Well, I support the recommendation as well, and as Bruce and Ron said, I also would support making psychiatry as part of that. From the hospital perspective, we get those patients down in the ER, and then we have to babysit them. And if we can't find someone to refer them to, it is a major problem.

I want to go back to Bob's comments. I found t very, very refreshing, and I really appreciate his comments concerning the payment for physicians. I support the recommendation, but as Nancy talked about, I think we may need to look at -- and maybe even now make a recommendation -- look at a different way to calculate not only the cost for them -- and Slide 19, as Bob indicated -- no, as Jay indicated, was very, very revealing the disparities between those payments. But I would like to see, my opinion is, not

only cost but some community value. We are still dealing -- in the calculation, we are still dealing with tax dollars for the benefit of beneficiaries of the Medicare program. And with that mandated, then I think that we could talk about some community value of where those physicians -- to encourage primary care physicians and psychiatry, then you can talk about some type of modifier that deals with increasing the community value using tax dollars and deal with my favorite subject of disparities as well by adding another component on it.

How you do that, I don't know, but from a policy standpoint, that may be a way to address the inequities with specialty care or folks going to a rural area and getting $800,000 to get payments. Yes, there is something wrong with that system. It is support by the Medicare program, quite frankly, and that physician salary, if he is employed or she is employed by the hospital, would go on the cost report.

DR. STUART: See, Bob didn't think that was enough money.

MR. GEORGE MILLER: Yeah, I understand that.

[Laughter.]

DR. MARK MILLER: Could I just ask a couple things? Kevin -- and I hate to ask a question like this with 150 people in the room, but the second definition --

MR. HACKBARTH: Kevin hates it even more.

DR. MARK MILLER: Yeah, I know. Actually, you can see it on his face, right?

In our second definition of primary care that is based on proportions of services, couldn't a psychiatrist qualify under that?

DR. HAYES: They could, but they would have to have a practice, they would have to have a claims pattern that would include a focus, that would show a focus on office visits, visits to patients in long-term care facilities, and home visits.

My understanding is that psychiatrists typically bill with codes other than those that we have defined as primary care services.

DR. MARK MILLER: I see. Okay. That was the question. On the $800,000 thing, I was wondering, Jay, with my current training, I would do it for $200,000.

[Laughter.]

DR. CROSSON: Yeah, we could actually set up a

special medical school for this purpose.

MS. HANSEN: This is probably first a clarifying question. Cristina, relative to the primary care category, does this include advanced practice nurses who can bill for this?

MS. BOCCUTI: You're talking about the recommendation --

MS. HANSEN: For primary care.

MS. BOCCUTI: Yes, we talked about it as being a practitioner that bills Medicare Part B, so it wasn't just for MDs and DOs.

MS. HANSEN: Good.

MS. BOCCUTI: So it would for the advanced practice nurses. Then, of course, if they were being billed -- they were being supervised, it would be at the physician's rate, and if the nurse is being the biller, they would still have the increase, but it would be at the nursing rate.

MS. HANSEN: Okay. So my general theme is I am supportive of the recommendations, but I would like perhaps a little bit more background on maybe the future trend. I just happened to visit Pennsylvania recently and noticed

that some of the access to primary care is much broader than, say, some other states may have, and I just wonder if the access to primary care is better in some states by virtue of these factors of enlarging the definition of primary care access points. So just maybe a little bit more description of how different that is in some states that seem to incorporate that, like Pennsylvania.

MS. BOCCUTI: Yes, it's not just states; it is other areas, too. You know, we were in focus groups last year near Albany, and there was very good access to primary care. And I think part of it is because they had a lot of medical home structures there. And so I think it gets to markets where there have been models for primary care that have been more helpful.

DR. DEAN: First of all, I basically support the recommendation -- or both recommendations, actually. As I read this, my first reaction was we are putting way too much emphasis on the time issue and somewhat -- a follow-up on Nancy's comments, although I have to admit that if Bob is correct -- and he probably is -- this is the only way -- we have got to do this first before we can get to a more defensible payment structure. Maybe it needs to be, but

there is so much variability in terms of how physicians do any different any given procedure. it is a moving target. Things change. Technology changes. To try to lock it down, I think we are always going to be behind.

I guess the thing that troubles me is that really the input costs, whether it is time or equipment or whatever, is really not the relevant issue. The issue is what is the value of the procedure. And somehow we have got to move toward that.

Now, it ain't easy. I understand that. And so -- but I don't think we should lose sight of that and get caught up in putting too much of our effort into trying to fix the system that I think in the final result is not going to give us the answer that we want.

Finally, just a comment about what constitutes primary care, I think we have got to be careful. It certainly is true that there are patients who their major need is, for instance, psychiatric care. But if that psychiatrist is going to be their primary care physician, that person also needs to be sure they get the preventive services; they also need to be sure their diabetes gets taken care of and their hypertension. And most of the

specialists that I deal with don't want anything to do with that other stuff. Even though if it is the endocrinologist dealing with the difficult diabetic or whoever, yes, they will be the most common or the physician that they need to see the most. But just because they see him the most doesn't mean they are doing primary care.

So we don't want to lose sight of that prospect or that issue, I guess. Thanks.

DR. CHERNEW: I am supportive of the recommendation, but I wanted to say a few things about the interesting discussion. One is the recommendation is about overall updates, but so much of the discussion and so much of the chapter and the analysis is about differences across specialty, which we have stunningly little purview except to say we need to do a better job and the process is broken, all of which I agree with, and I think the more strongly we can say that to revisit that is important.

I think there are few things. We don't want sort of a fixed-dollar-per-time kind of notion because someone gets six years of medical training and spends an hour doing something, you get some sense that that is different in one way or another, although, again, measuring by value, like I

really cared about this part of my body and not that part, or whatever, that's how you get to school teachers or professors who are underpaid, because what we do is so valuable it is just a lot of people don't do it.

So it is very hard to come up with what the right measure of value is because we shouldn't be paying on value. But we also shouldn't be paying just on time. And there is some complicated thing. The thing about that that I would use as an indicator, which, interestingly, we don't see at all in here, is we talk about willingness to accept Medicare patients, which I think is a very good indicator, but we don't talk about other basic indicators. We don't have an analogy to margin, for example, which is income. So you don't see a lot of discussion about what basic incomes are. In fact, we often equate revenue with income, but we don't do a very good job of measuring incomes one way or another, in essence, except when we hear comments. And we don't do a very good job of measuring sort of entry. We talk about acceptance of assignment for Medicare, but we don't talk about how many people want to be physicians, how many people want to be physicians in a particular type of graduate specialty. We did in our graduate medical education

discussion. And I think all of those things, if taken together, would illustrate that the primary care specialist distinction that we often make is a little bit too crude, because even within the specialties there is dramatic variation, and the issue about psychiatry illustrates that to some extent in what the returns are to those education -- what the demand is for them, and somehow the process, which has not typically been what we have dealt with, at least not in our January or December discussions, have been able to deal with that. And I think addressing that more at some point is probably worthwhile. But for now, I think I am fine with the recommendation.

MS. BEHROOZI: Yes, I'm also supportive of the recommendation. Actually, the issue about psychiatrists jumped out at me also, Ron, mostly because the paper notes that psychiatrists are not accepting any new patients, not just not Medicare patients. And also really because psychiatrists are not -- their importance, I think, both to Medicare patients and to the health care system in general, is not because they are anything like primary care physicians, but because they and other who specialist in behavioral health are becoming -- it is becoming

increasingly obvious that depression and other kinds of behavioral health issues are the kinds of comorbidities or, you know, covalent conditions or whatever that exacerbate every other kind of health care condition because people, you know, don't get to their other care providers, they don't take their medications, they shut themselves off from other people, and don't, you know, have community support, whatever. It is things other than the primary care type of function that psychiatrists should be adding in terms of value.

So I don't think that the overall update process is necessarily the place to address psychiatry, while maybe it is a little bit more amenable to dealing with the whole primary versus specialist distinction.

The other point that I wanted to make is also, I guess, not really -- it doesn't fit so well in the update process, but just to note it, on the issue of access. And I think, you know, what Jennie had said earlier, if there are ways to kind of drill down into the places where there are reports of difficulty with access, as we were doing with, you know, non-white beneficiaries, whether it is geographic or, you know, other characteristics, would be useful. But

one thing that you have identified is particularly people with lower incomes and minorities are more likely to report they didn't see a physician when they thought they should have. But that is not necessarily because physicians aren't accessible.

And so, you know, we have to keep in mind that as we are increasing what the payments are to physicians, then we are also increasing what the beneficiaries have to pay out-of-pocket. Now, that doesn't mean I think we shouldn't pay doctors more because their costs of living or whatever are going up but, rather, I think we really need to keep that in mind. We need to tie this together with the benefit design work that we are doing, that I think Rachel is principally doing and, you know, recognize that more in the context where we can deal with it.

MS. BOCCUTI: Really quick, we will come back next time and talk about psychiatry. I think there are going to be some other payment issues that are going on, not just in the cost sharing but I believe that they are slated for some payment increases. So I want to get that clear and bring that back to you. I think that that might address some of the issues you are talking about and may be more up to date,

and I will bring that to you next time.

MR. HACKBARTH: Okay, thank you. I appreciate your work.

We are well behind schedule. We have one more session before lunch on payment adequacy for ambulatory surgery centers. This last discussion on physicians was a good discussion. Important issues were raised. I think if we went back and looked at the transcript, probably 75 percent of the discussion was about distributive issues, which are critically important, in some ways as or more important than the update itself. But the business at hand is the update factors, and if we allow ourselves to get sidetracked into the distributive issues in every other discussion as we go through, we are going to be here to well into the evening. So I am going to --

MS. BEHROOZI: You have someplace better to go?

[Laughter.]

MR. HACKBARTH: We'll treat that as a rhetorical question. So as we proceed through this discussion in the afternoon, I am going to urge people to not forego any mention of the distributive issues, but let's just sort of raise a flag and say we need to come back to this as opposed

to explore them in as much detail as we have to this point.

With that preface, Ariel?

MR. WINTER: Thank you. Today's presentation on ASCs has two parts. I will first discuss whether CMS should use a different market basket than it currently uses for ASCs. During last year's ASC update discussion, the Commission asked us to explore whether the Consumer Price Index for Urban Consumers, or the CPI-U, should continue to be used as the market basket for ASCs, and I am going to report on our research in this area.

Next, Dan will discuss the adequacy of payments for ASCs and the Chairman's proposed recommendation for 2011.

We want to first thank Hannah Miller for her excellent work on the market basket analysis.

The projected change to providers' input prices for the coming year is an important part of the Commission's update process. CMS currently uses the total CPI-U to determine the annual update for ASC payments. The CPI-U includes a broad mix of goods and services, such as food, housing, energy, and transportation. Medical care counts for only 6 percent of the total CPI-U. Thus, the CPI may

not be a good proxy for ASCs' input costs.

At the Commission's request, we examined whether an alternative Medicare price index would be a better proxy for ASC input costs. We looked at a hospital market basket for inpatient operating costs, which is used to update payments for inpatient and the outpatient, respective, payment systems. We also examined the practice expense portion of the Medicare Economic Index, which measures changes in physicians' practice costs. The MEI is one of the factors that CMS uses to calculate the physician update under the SGR.

ASCs probably have many of the same types of costs as hospitals and physician offices, such as medical equipment, medical supplies, clinical staff, and building-related expenses.

We first compared the growth of the hospital market basket practice expense portion of the MEI and the CPI-U for medical care to growth in the total CPI-U. The trend line for the MEI does not include CMS's productivity adjustments. In other words, it only reflects the changes in physicians' practice costs. As you can see in this graph, these other price indexes have been growing much

faster than the total CPI-U. This historical experience suggests that using a price index based on health care costs could lead to higher ASC updates in the future, which would increase Medicare spending.

We also examined the annual stability of these price indexes, and the detailed chart is in your paper. We found that between 2001 and 2010, the total CPI-U is more volatile than the alternative indexes we looked at. On the one hand, having stable annual updates helps providers with their long-term planning. However, the accuracy of a price index may be a higher priority than its annual stability. In other words, we may be willing to tolerate volatility if the index reflects changes in providers' underlying input costs.

We also compared the distribution of ASC costs to hospital and physician practice costs. Because CMS does not have recent data on ASC costs, we used de-identified ASC cost data from 2004 obtained by GAO through a survey of ASCs. This file lists expenses for several hundred cost categories, so we grouped related items into four standardized cost categories, which are shown on the slide: Medical supplies and drugs; employee compensation; other

professional services, which includes things like legal, accounting, and office management services; and finally, a residual category of all other costs, which includes rent, capital costs, utilities, medical equipment, malpractice insurance, and certain other expenses. The file lacked disaggregated data on the costs included in this residual category, which made it difficult to do a thorough analysis.

What we are trying to do in this table is to first identify similar categories of costs across settings, and then, second, to look at whether the mix of ASC costs is comparable to hospital or physician practice costs. Our analysis suggests that ASCs have a different cost structure than hospitals and physician offices.

We found that ASCs have a much higher share of costs related to medical supplies and drugs than the other two settings. This difference could be related to ASC's high volume of cataract procedures, which use intraocular lenses. These lenses are included in the medical supply category and are relatively expensive. Another factor could be that physician offices and outpatient departments provide many evaluation and management services, which probably have lower supply costs than surgical procedures.

The share of ASC costs related to employee compensation is similar to physician offices but much smaller than the hospital share. The share of ASC costs in the residual category of all other costs is almost the same as the hospital share, but smaller than the physician office proportion.

This residual category at the bottom is divided into multiple categories in the hospital market basket and the MEI, but for the purposes of this comparison, we have consolidated them into a single category.

It is important to point out that our analysis is not conclusive because we did not have disaggregated data for several types of ASC costs. In addition, the data are from five years ago and the mix of ASC services has been changing, as now we will discuss in a few minutes.

The bottom line is that we don't think we have adequate data to make a decision on replacing the ASC market basket. This highlights the need for CMS to collect new ASC cost data to further examine whether an alternative price index would be an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed. A unique ASC market basket could include the same types of cost

categories as a hospital market basket or the MEI, but with different cost weights to reflect the distribution of ASC costs.

And now we will move on to Dan's portion of the presentation.

DR. ZABINSKI: Okay. Now we are going to discuss payment adequacy for ASCs, and as we begin that discussion, important factors to remember about ASCs include that total Medicare payments to ASCs in 2008 were $3.1 billion. The number of fee-for-service beneficiaries served in ASCs in 2008 was 3.3 million. That ASCs are a source of revenue for many physicians, as 90 percent of ASCs have some degree of physician ownership. Also, Medicare payments are a fairly small share of total ASC revenue, about 20 percent. Then, finally, under current law, ASCs will receive a payment update of the full CPI-U of 1.2 percent in 2010.

Over the coming slides, we will discuss some of our standard measures of payment adequacy for ASCs. First, we will start with access to care and the supply of ASCs, then ACSs' access to capital, and then finally, Medicare payments to ASCs. However, we were not able to evaluate ASCs' quality or cost data because ASCs do not submit those

data to CMS.

An important issue we are cognitive of in our analysis is that CMS is phasing in a substantially revised ASC payment system over 2008 through 2011. This revision resulted in a 32 percent increase in the number of covered surgical services, payment rates that are based on the relative weights from the outpatient PPS, and separate payment for ancillary services, such as drugs and radiology, that used to be packaged into the payment rate of the associated surgical service. And this is the first year that claims data are available for assessing the effects of these revisions.

Our analysis of those data suggest that ASCs are adapting reasonably well to the revised system. For example, the volume of ASC services for a fee-for-service beneficiary increased by 10.5 percent in 2008 over 2007. Services that were newly covered under the revised system accounted for 4.9 percentage points of this 10.5 percent increase. Also, Medicare spending per fee-for-service beneficiary increased by 9.7 percent in 2008, and newly covered services accounted for 2.9 percentage points of that increase. The increase in 2008 is slightly higher than the

already robust rate of increase of 8 percent over 2003 to 2007.

Then looking more broadly at payment adequacy in recent years, we also found evidence that indicates that beneficiaries' access to ASC services has been increasing. Looking at the first column of numbers, from 2003 through 2007, the number of fee-for-service beneficiaries served increased by 6.4 percent per year, on average. Note that this is fee-for-service beneficiaries, so this increase occurred despite rising Medicare Advantage enrollment that resulted in lower overall fee-for-service enrollment.

Also, you can see that the service volume per fee-for-service beneficiary increased by an average of 10.2 percent per year and that the number of ASCs increased by an average of 286 per year. On a percentage basis, this translates to an average annual increase of 6.7 percent.

And turning to the second column of numbers, the number of fee-for-service beneficiaries served increased by 2.8 percent from 2007 to 2008, despite a decline of 2 percent in total fee-for-service enrollment. Also, as we mentioned on the previous slide, the volume per beneficiary continued its strong growth into 2008.

However, we found that the growth in number of ASCs slowed in 2008, rising by only 3.7 percent. And this slowing in the growth of ASCs may be due to the downturn in the capital markets and the economy. Also, it is plausible that some investors are waiting to see how the revised payment system affects existing ASCs before entering the market.

Another measure of payment adequacy is access to capital. For ASCs, the best measure of access to capital is the change in the number of ASCs, that is, the number of new ASCs minus the number of ASCs that closed. As we saw on the previous slide, growth was strong over 2003 through 2007, but slowed in 2008, which was caused at least in part by the downturn in capital markets in the economy. But the downturn is unrelated to Medicare payments, so changes in access to capital in 2008 may not be a good indicator of payment adequacy.

As a part of our analysis, we also found that the number of surgical services per beneficiary and the number of beneficiaries served has grown much more quickly in ASCs than hospital outpatient departments, or HOPDs, which is the sector with the greatest overlap of surgical services with

ASCs. This difference may suggest a migration of surgical services from HOPDs to ASCs in recent years, which may present some advantages.

In particular, ASCs may offer efficiencies for patients and physicians relative to HOPDs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling. For physicians, ASCs can offer customized surgical environments and staffing. In addition, cost per service and cost sharing per service are lower in ASCs than HOPDs. Therefore, a shift of services from HOPDs to ASCs has the potential to lower aggregate program spending and cost sharing.

However, although the ASC growth does have the potential to decrease aggregate spending and cost sharing, we are concerned that the ASC growth also has the potential to increase aggregate spending and cost sharing. For example, most ASCs have some degree of physician ownership, and this raises the possibility that physicians have an incentive to perform more procedures than they would if they had to perform all outpatient surgical services in HOPDs. This would increase overall outpatient surgical volume. And although ASCs are different than specialty hospitals, this

is similar to the Commission's analysis of physician-owned specialty hospitals in 2006, which found that entrance of cardiac hospitals into a market is associated with a greater increase in volume than would otherwise be expected. And if this increase in surgical volume is great enough in ASCs, Medicare spending could actually increase.

In addition, a study of medical facilities in Pennsylvania suggests that the growth in ASCs has hurt HOPD profitability. And in response, it is plausible that HOPDs may try to enhance their Medicare revenue by providing more services, which would increase program spending and beneficiary cost sharing overall.

So to summarize the last two slides, the growth in the number of ASCs does have the potential to reduce aggregate program spending and beneficiary cost sharing. But these reductions will not occur if the growth in ASCs increases aggregate surgical volume by a sufficient amount or if the payment rates are sufficiently lower in alternative settings, such as physician offices.

Now, an important issue regarding ASCs is that in contrast to other health care facilities, ASCs do not submit cost or quality data to CMS. However, these data are

important for three reasons. They allow us to fully evaluate the adequacy of Medicare payments to ASCs. They allow payments to be based on quality. And they allow for effective evaluation of the ASC market basket, as Ariel mentioned.

Now, to summarize our analysis of payment adequacy, our measures of payment adequacy indicate that access to ASC services has been increasing and that ASCs' access to capital has been at least adequate. In addition, we lack cost and quality data to do a fully effective evaluation of payment adequacy.

As the Commission considers an update on ASC payment rates, several goals should be balanced. On the one hand, you want to maintain beneficiaries' access to ASC services by paying providers adequately so that they are willing and able to furnish services, but at the same time, we want to hold down the burden to taxpayers, maintain Medicare sustainability, and keep providers under financial pressure to hold down costs.

And for this year, we have the following Chairman's draft recommendation, that the Congress should increase payments for ambulatory surgical center services in

calendar year 2011 by 0.6 percent. In addition, the Congress should require ASCs to submit to the Secretary cost data and quality data that will allow for an effective evaluation of the adequacy of ASC payment rates.

In regard to the first part of this recommendation, given our findings of payment adequacy and our stated goals, we believe a moderate update is warranted. Also, the patterns of access measures haven't changed much since last year. Therefore, we are proposing last year's 0.6 percent update.

In regard to the second part of the recommendation, in our March 2004 and March 2009 reports to the Congress, the Commission recommended that ASCs submit cost data to the Secretary, and the purpose of these cost data would be to help determine payment adequacy and for setting payment rates. In addition, the Secretary has authority to collect quality data from ASCs and quality measures are available, but CMS has decided to delay collection of quality data to allow ASCs time to get adjusted to the revisions in the payment system that occurred in 2008.

Implications on spending are that ASCs are poised

to receive an update in 2011 equal to the projected CPI-U of 1.8 percent. Therefore, this recommendation would produce small budget savings over one year and over five years.

For beneficiaries and providers, we found strong growth in the number of ASCs and the number of beneficiaries treated in ASCs, as well as providers being willing and able to furnish services under the revised payment system. Therefore, we anticipate this recommendation having no impact on beneficiaries' access to ASC services or providers' willingness and ability to furnish those services.

And now we turn it to the Commission for discussion.

MR. HACKBARTH: Thank you, Dan and Ariel.

So let us begin with round one clarifying questions, and I would urge people to keep them very focused and brief. Ron?

DR. CASTELLANOS: For clarification. You said this year, you recommend for 2011 0.6, and you said that was the same as last year?

DR. ZABINSKI: That is what we recommended last year.

DR. CASTELLANOS: That is not what the material here says. It says there was a 1.2 increase.

DR. ZABINSKI: That is what we recommended, but they received a 1.2 percent.

DR. CASTELLANOS: Okay. Thank you.

MR. HACKBARTH: Clarifying questions? George?

MR. GEORGE MILLER: In your research, could you determine or can you do research to determine the demographic make-up of the beneficiaries ASCs served, to include the percentage of Medicare patients, Medicaid patients, self-pay, and charity care, and how that compares to the community they serve, the total community, not just the market share? And then if in that community there is a hospital and if they are similar to the market share of -- especially a community hospital.

I was very much troubled by the information in Pennsylvania, the impact that ASC had on hospitals and the profitability of hospital departments in Pennsylvania. And then where those ASCs are located. I want to make sure they are serving the same market share and providing the same level of service to charity care patients, Medicaid patients, self-pay patients, and the demographic of those

they serve. If you have got a minority community, they get the same level of care.

DR. ZABINSKI: In terms of the payer mix, the only data I am aware of that looks at payer mix would be data collected by MBMA, which is based on a very small number of ASCs -- it is less than 100 -- and I can look and see what they show. For Medicare, we know it is about 20 percent from their data. I don't recall what it was from Medicaid and other payers or for uninsured. I do recall that the uninsured rate is very low. I don't recall the exact percentage.

In terms of the demographic composition of the beneficiaries they serve, we have not done that analysis. I am not sure we are going to have time to do that before the January meeting, but what I can certainly -- it would not be a problem to look at the literature and see if there have been any studies of this demographic make-up, and we can add this to our list for future work.

MR. GEORGE MILLER: Okay. And then I have a potential future, if you do a focus group survey on ASCs, and this is probably a loaded question, quite frankly, but if an ASC had two patients, one had insurance and one did

not, where the surgeries or procedures would be done with those two patients.

MR. HACKBARTH: Further clarifying questions?

DR. CHERNEW: [Off microphone.]

MR. HACKBARTH: Okay. I will be on the lookout for that.

Okay. Hearing none, let us do round two. Again, I would like to know, Mike, how you feel about the recommendation and what information you need to reach a decision.

DR. CHERNEW: So I am going to answer the question, what information I need to make a decision, and the question I had that was sort of clarifying but is more so, there are parts of the text that talk about the connection between the ASC payment rates and comparable payment rates if things were done elsewhere. So, for example, it being tied to the non-facility component, the practice component.

But if our update here differs from our update in those other sectors, is that connection broken? Do you understand what is confusing? In other words, I would like there to be a comparability in these payment rates to things

based on where -- not so much where they are delivered, but how much they are paid, and I can't figure out if the updates are different, how that connection can be maintained.

DR. ZABINSKI: No, I mean, the connection will be maintained -- let me see how to say it. What they do is -- most services are paid on -- they get the relative weight of the outpatient PPS, okay, and then -- but it is not the same payment rate. It is just the relative weights are the same.

DR. CHERNEW: Right, so the -

MR. HACKBARTH: For the conversion factor. The conversion factor -

DR. ZABINSKI: The conversion factor is different, exactly.

DR. CHERNEW: But if the updates are different, then the actual amount of money will be different. You get $9 if you do it here and -

MR. HACKBARTH: If the updates are different, the gap between the conversion factors won't stay constant. It will change.

DR. CHERNEW: And so what was confusing me was in the text, it says that for many services, they use the non-

facility practice expense portion to set the rate, but that can't -- understanding that is the information I need to know to understand whether to support this.

MR. WINTER: On that question, what they do is they compare the practice expense payment amounts, which includes the RVU times the conversion factor, to what the ASC would get under the normal system, which is based on the outpatient PPS relative weights and the ASC-specific conversion factor. So there, if you increase the physician conversion factor by different rates, then you increase the ASC conversion factor -

DR. CHERNEW: Which we are -

MR. WINTER: -- that will affect that comparison.

DR. CHERNEW: Right -

MR. WINTER: Which is what was proposed here.

DR. CHERNEW: Right. Okay.

MR. HACKBARTH: This area of how much we pay for the same service and different types of providers, whether it is physician office, ASC, hospital outpatient department, is a really important area and also one that we have wrestled with in the past with not complete success. So you are raising a very legitimate concern.

Others? Mitra, did you have your hand up? Any comment on the draft recommendation? And silence will be assumed to be assent. Boy, I really scared people. I can never -

DR. BERENSON: I like the -- I support the recommendation on the update. I want to ask a question about the recommendation to, I guess, to collect cost data. I am happy about the quality side. I mean, we are talking about 5,000 entities, an obligation on CMS not just to collect it, but then to make sure it is accurate, et cetera. I am wondering if this is a good place -- and also, the spending for ASCs is $3 billion. Physicians are about $60 billion. Whether this is a good place to sort of seriously do sampling of efficient entities.

And one of the prime purposes for the cost report is to figure out what the market basket is. I don't think you need to collect cost data from everyplace to get a sufficient sample to figure out what that market basket should be. I noted in the table you provided in our reading materials that 15 conditions were actually three conditions. They were all variations on endoscopy, cataract removals, and -- what was the other -- it was spinal injections. And

my hunch is that sort of the -- and that represented, by my quick count, about 70 percent of the volume was just in three conditions, that we could probably develop a topology, or CMS could, of the different variations of ASCs and figure out how to sample them and get good cost information.

So I guess my question would be whether we really get value added by having a firmer ability to relate our payment to costs. That would only be true if those costs were accurate. I am wondering whether it is worth all that effort. I think we have a lot of other parameters on which to base the updates.

So I guess that would be my suggestion. If we are going to go, as we talked about in the last hour, to sort of getting times accurate for physicians and ideally practice expenses accurate, we are not going to ask for cost reports or time sheets from every doctor. We are going to figure out a sampling strategy. And I think this would be a great place to start that kind of activity.

MR. HACKBARTH: I think this is a good and important point, and the text alludes to the fact that we wouldn't necessarily have to get cost data the old fashioned way like we have for hospitals and you could use sampling

and other approaches. Maybe what we could do is look at recasting, rewording the recommendation to sort of tilt more strongly in this direction. Do people support that? So we will try to figure out how to reflect that better in the actual language of the recommendations.

DR. KANE: So this is just to link it a little bit to the prior discussion about physicians. It seems that the productivity here is on the physician component of this, but, in fact, the three primary specialists here, orthopedics, gastroenterology, and ophthalmology, are among those whose time measures were grossly off. And one wonders if the ASC is a contributor to that and whether there should be a discount on the physician time, probably not the facility, but that if you are in an ASC and you are doing a procedure, that the physician's time should be assumed to be X percent more efficient, and that is why the ASC exists and we are making all these claims. But yet you are paying the physician time as though they are anywhere, and yet they are set up nicely to do ten of them in a row all conveniently.

I know I am not talking about the facility, and I support the recommendation and particularly with Bob's adjustment to the cost data, but shouldn't we also be

linking the physician piece -- when it is done in an ASC, we want to assume there is a productivity improvement here -- and build that into the physician fee on the ASC? I know I am between you and lunch, but I just wanted to bring that up as a thought for later.

MR. HACKBARTH: Well, again, I think it is an important point, an important insight. It would be difficult for us to do for the update recommendation, but it is something to consider as we delve further into the physician issues.

MR. BUTLER: Okay, hopefully complementary to Bob and Mike. Almost 30 percent of the, if you add them up, are eye cases, and, like, 20 percent are -- and here we had a case where Medicare is almost the exclusive purchaser. So if there is ever a case where we ought to be able to move the market where it should go and put it in the right setting, this would be one we ought to really drill into.

My own feeling is that there are far too many of these that are still done in the hospital operating rooms that are not the best, cheapest place. We do it, and some of it is the reluctance of the ophthalmologist to take them to their own surgery center, where the payment rates are

probably -- they are lower. You could get a win-win.

I think it is an area that is almost 30 percent of this business that if we really kind of focused on, we could make some recommendations that, I think, could save money and put people in good settings.

DR. CASTELLANOS: A couple of comments for more indigestion before lunch. George, I am a little bit concerned about your comment -- could you turn to Slide 16 -- - about being concerned about the profitability of the Pennsylvania hospitals. I don't think we want to go there. If you are going to be concerned about the physician, and you are assuming 90 percent of us compete against the hospital, then we are going to be concerned about hospitals employing doctors. I mean, we don't want to get into that fight.

Where we want to stay is where is it most appropriate? Where do you get the best quality? And where do you get the best outcome? So I think we really want to stay away from profitability, in my regard.

The second issue is the text that you sent really talked a little bit about CPI and market baskets and there has been no discussion on that, and I would hope we would

get away from CPI and get into the market basket. I think that would be the direction we need to go.

MR. GEORGE MILLER: And if I could just respond, I am concerned about profitability only on distribution, fair and equitable, that if an ASC takes Medicaid, self-pay, and anyone through the door equal to the population, I have no problem. If they compete against the hospital, I have no problem.

But if, and I use the example, they have two patients, if they do that procedure in the ASC if they have insurance and if they don't have insurance they do it in the hospital, then that is why the hospital is losing money and that is a problem. And I am not going to support a recommendation if I find out that there is disparity in where the beneficiaries are treated. If you start a program, an ASC, only to take insurance and Medicare patients and everybody else has got to go to the hospital or somewhere else because of financial support, because of financial reasons, I am not going to support the recommendation.

DR. CASTELLANOS: George, I couldn't agree with you more, but you have asked for that data. Let us look at

the data and go from there.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: This is part of this complex set of issues around how do you create an appropriate, I don't want to say level playing field, but an appropriate playing field between providers who provide the same or very similar services in different settings and we are not going to be able to do that justice right now. We can come back to it. It is an important topic, but it is one of these tar baby topics. You put one mitt on and then the other and you wrestle with it for a while, you get real dirty, and often still don't have the right answer.

So I would be happy to see the text refer to that issue as something that is worthy of further exploration. I don't think we ought to be taking sides in the debate based on just a partial discussion of the topic.

Okay. I think we are done. You didn't have your hand up, did you, John or Bill? Okay. We are done with the morning session.

We will now have a brief public comment period, and I see people coming to the microphone, so let me give my speech first, and you have heard it before. Please keep

your comments to no more than two minutes. When the red light comes back on, that means your two minutes is up. And I would remind people to go to the MedPAC website. There is an opportunity there, as well, to make your comments on our discussion.

MS. LOWE: Thank you. I will keep it brief. I appreciate the opportunity to make a couple of comments about the ASC industry. My name is Mary Anne Lowe [phonetic]. I represent the ASC Advocacy Committee.

Just a couple of thoughts on the volume changes from 2007 to 2008. I think it is important to understand that a lot of the volume growth we see in terms of the number of procedures is related to procedures for which there is either very low payment or no payment at all that were added to the list and for which ASCs can now submit claims. Importantly, I think the rate of growth for procedures that were on the list in 2007 and continue to be offered in ASCs in 2008 was only 2.7 percent. So that is a very reasonable rate of growth from our perspective.

And also, when you talk about -- MedPAC uses services per fee-for-service beneficiary and not services per patient, so when ASCs are increasing the number of

beneficiaries served, the spend per fee-for-service beneficiary goes up. To the extent that we are seeing more patients in the ASC that were previously seen in the hospital, it makes MedPAC's number of ASCs spend per beneficiary go up even though the overall spend is going down because they are seen in a lower-cost setting.

We think those are very important points to keep in mind as you think about this information.

On the quality data, we agree wholeheartedly. We would like to submit that information. On the cost data, I think the important piece as far as the hospital market basket and the CPI are is that we would like to see ASC spending move at the same rate as the hospital outpatient department so that we don't get into the question of are the incentives about the volatility and the difference between the two payment systems driving site of service selection. If they are moving on a similar track, I think that takes a lot of that element off the table.

Thank you.

MR. ROMANSKY: Thank you. My name is Michael Romansky. I am Washington counsel to the Outpatient Ophthalmic Surgery Society.

We would support the ultimate development of an ASC-specific inflation update index, but we believe that pending the development of such an index, which could take some amount of time, we think that the Commission ought to recommend the adoption of the best available index pending that.

It is significant -- you know, it is inarguable that the CPI-U does not involve inputs that are appropriate for the ASC. I think we can all agree to that. We know that the ASC rates, when they are updated by the CPI-U or when they are updated by any index that is less than what the hospital rates are updated by, such as 0.6 percent, creates a divergence in payment rates between ASCs and hospitals that is totally unrelated to the costs of performing these services.

And we would hope that the decision to establish fair and reasonable payment rates will not be deferred for another year.

Thank you very much.

MR. MAY: Hi. Don May with the American Hospital Association. Just a couple of comments.

The first thing, I want to start with

recommendation two on the coding issue. On the timing of adjustments, we are generally supportive of spreading these kinds of things over a series of years. I think in this case, we also have to look at the level of the market basket, and just setting a certain amount without knowing what the market basket inflation is is somewhat difficult.

On the level of what that adjustment is, we also have concerns with CMS's analysis and their methodology that they use, and therefore what the projection of the coding and documentation adjustments should be. CMS has historically seen about a one percent growth in case mix over time, and yet if you follow the analysis that they do, their analysis actually shows a substantial reduction in case mix index, which really doesn't seem to make sense. They really haven't done an analysis of real change in patient severity. And, I am sorry, when I say saying case mix, I meant patient severity. And so we really want them to look at patient severity.

There also are other things that would encourage, or would drive patient severity to become more complex and really goes in the face of CMS's analysis that patient severity has decreased, things like the expansion in ASCs

and outpatient, leaving all the complex surgeries for the inpatient side and not on the outpatient side.

There are also other factors that affect documentation and coding that are totally separate and apart from MS-DRGs and that really need to be taken out of what that coding and documentation adjustment for the MS-DRGs would be. And if you look at the Recovery Audit Contractor Program that is out there, that has just been broadened to all States, that program over the last three years drove significant change in coding and documentation. That documentation change happened not because of MS-DRGs, but because many cases were being considered not medically necessary because the documentation wasn't there. So those types of things also need to be considered and taken out of that coding adjustment for the MS-DRGs.

The second point, on the update, we definitely believe that the payment adequacy of hospitals for Medicare is not where it should be and that hospitals should get a full update recommendation. Even in your analysis of those most efficient hospitals, the 218 that are barely breaking even, that means that they are having a hard time making it under Medicare. And if that is the average, many of them

are actually losing money, many of those efficient hospitals. And if this coding and documentation really did create overpayments, then they are really losing money and very few of them are making money serving Medicare patients if those overpayments are taken out of the system.

Last, on IME, I really do think with IME that is a better discussion to have in the broader context of medical education that you are having for the June report.

In terms of dropping all the way down to the empirical level, we definitely want to discourage that, because remember, just because those are a couple percentage points, that is really a much more significant reduction in payment. That one percent drop from 5.5 percent to 4.5 percent is really a 20 percent reduction in IME payments. So doing that kind of significant change would be very, very problematic for America's teaching hospitals.

Thank you.

MS. McILRATH: Sharon McIlrath with the AMA. I am going to be brief because not having seen the MGMA data in any detail, but I do know that the MGMA hours are different than the hours in the PPIS survey that CMS has just accepted and changed with the PE values. So before you drew any

conclusions about what that tells you in regard to the accuracy of the time estimates, I think you might want to look at sort of underneath that data and compare it to some other data.

MR. HACKBARTH: Okay. Thank you.

We will reconvene at two o'clock.

[Whereupon, at 1:10 p.m., the meeting was recessed, to reconvene at 2:00 p.m., this same day.]

AFTERNOON SESSION [2:02 p.m.]

MR. HACKBARTH: Okay. Put your seat backs in an upright position and buckle up. Next on our list is outpatient dialysis services. Nancy, whenever you are ready.

Oh, thank you, thank you. That is a reminder to me to repeat some of the things I said this morning at the beginning of the session. This is really directed to the people in the audience, which maybe means that I should wait a minute while people file in.

Okay. So I see some faces who were here this morning, so bear with me hearing this twice. But I wanted to remind people that as MedPAC considers its update recommendations this afternoon and tomorrow, the context for what we are doing is a little bit different from what the Congress is in the process of doing in health reform.

MedPAC's task is to take the Medicare program as is and make recommendations, in this case for update factors for the various provider groups, in pursuit of these principles of Medicare payment that are on the screen.

The debate on health reform is a little bit different context in that Congress is looking not just at

Medicare payment policy, of course, but also at universal coverage and other dimensions of the health care system. And that difference in context could lead some people to different policy conclusions, and this morning I cited the example of how hospitals, as represented by the AHA and the Federation of American Hospitals, have looked at the Medicare update differently when it is accompanied by steps to move towards universal coverage, and it sees a link between those two public policies.

Well, that is not what we are doing here. We are looking Medicare in isolation, and although health reform may pass, it hasn't passed so we're looking at Medicare as it is today as we speak. So a little bit different.

As in years past, I am offering to the Commission draft recommendations at this, our December meeting. Final votes will occur in January and take into account the discussion that happens this month.

I think those are the important points. Thank you, Nancy.

MS. RAY: Good afternoon. Outpatient dialysis services are used to treat most patients with end-stage renal disease. My presentation this afternoon is composed

of two parts. First, I am going to briefly describe the new payment method for dialysis services that is set to begin in 2011. Then we will proceed with our adequacy analysis. The information that I will be providing you will help support your assessment of the adequacy of Medicare's payments. At the end of today's presentation, I will present the Chairman's draft recommendation for you to consider about updating the composite rate for calendar year 2001.

So, currently, Medicare pays for a limited bundle -- it is called the composite rate -- of dialysis services. It includes nursing and other clinical labor, dialysis equipment and dialysis supplies. Notably, Medicare pays facilities separately for certain dialysis drugs, including erythropoietin stimulating agents -- that includes EPO and Aranesp - that is used to manage patients' anemia, a common comorbidity among dialysis patients. And dialysis drugs currently account for roughly 30 percent of the total spending to the sector, which is roughly $8.6 billion in 2008.

As some of you know, MIPPA mandated that CMS modernize the outpatient dialysis method. The statute implements a longstanding MedPAC recommendation to broaden

the dialysis bundle and include commonly furnished and needed services, including dialysis drugs and laboratory tests that are now paid for separately. The new PPS is set to begin in 2011. MIPPA also required that CMS implement a low-volume adjustment and an outlier policy as part of the new payment method.

The pay-for-performance program, it is a 2 percent reduction, at most a 2 percent reduction on facilities payments -- and I believe it is the first for Medicare -- will begin in 2012. There is a detailed description of CMS' proposal to implement the new PPS, and that is included in your paper. I am happy to take questions on it.

Now, facilities can either opt in or be completely paid under the new PPS in 2011 or can choose to have the new method phased in over a three-year period. Either way, the payment update recommendation for 2011 that you are considering will affect the composite rate component of the broader bundle.

So then moving to our payment adequacy analysis, here are the four payment adequacy factors that we will be considering: beneficiaries' access to care, changes in quality, providers' access to capital, and payments and

costs for 2010.

There has been a net increase in the number of facilities from year to year. In 2009, we see about 5,200 facilities. Most are free-standing, about 89 percent, and for-profit, about 81 percent. In addition, two large dialysis chains dominate the sector; 60 percent of all facilities are associated with these two national for-profit, publicly traded chains.

You see here that the number of facilities is continuing to grow in both rural and urban areas between 2003 and 2008. The other point to take away from this slide is that the proportion of the two large chain sin urban and rural areas is roughly equivalent.

So access for most beneficiaries appears to be good. One measure we look at is the capacity of facilities by assessing whether the growth in the number of machines where people are dialyzed -- that's called hemodialysis stations -- tracks dialysis beneficiary growth. Between 2003 and 2007, stations have increased by about 3 percent per year, while Medicare dialysis beneficiaries have increased by about 2 percent per year.

Over the past several years, we have specifically

tracked access for minorities and beneficiaries eligible for both Medicare and Medicaid. Consistent with previous years, we see that facilities have not changed the mix of patients they treat in terms of beneficiaries' characteristics and eligibility to also receive Medicaid.

As I just mentioned, there is a net increase in the number of facilities from year to year. When facilities do close, it does not appear to be disproportionately affecting African American beneficiaries or beneficiaries dually eligible for Medicare and Medicaid. Closures appear to be more linked to the size of the facility in terms of number of dialysis stations and their profitability.

So we also look at the growth in the volume of services as a marker for beneficiary access to care. Here we track growth in the number of dialysis treatments and beneficiaries. This is from 1996 to 2008, and here you see that the two measures have closely tracked one another.

We also look at change in the volume of drugs furnished. In recent years, the volume of drugs has not increased as much as in the past. Since 2005, for example, the volume of erythropoietin-stimulating agents has grown much slower than in the past. Since 2005, the increase was

small per year, about 0.6 percent per year. By contrast, between 1996 and 2004, the volume of ESAs grew at about 13 percent per year. And I'm focusing in on ESAs because they account for about 70 percent of dialysis drug payments.

So what causes change in volume? Well, the first reason is the MMA. Beginning in 2005, the MMA decreased the payment rate for most separately billed Part B drugs, including dialysis drugs. Now, in 2008 and 2009, Medicare currently pays ASP+6 for dialysis drugs. Before the MMA, drugs were paid at a much higher rate. The MMA increased the composite rate through the add-on payment, which took back some of the profits that were associated with the dialysis drugs.

Now, the last three bullet points on this slide refer specifically to changes in ESA volume. CMS changed its payment policy for ESAs called the ESA Monitoring Policy. Since April 2006, the agency reduced its facilities payments if patient's hemoglobin levels exceed a certain level. New evidence has been published recently that has shown that high doses of ESAs have negative side effects on patients, and the FDA issued a black-box warning in 2007 based on this evidence. This also may have led to practice

changes.

So here you see per capita spending. This is from 1996 to 2008. This is for dialysis drugs to free-standing facilities, and you see that different pattern here before and after 2005, which was the implementation of the MMA. And you see the drop in spending for ESAs and other drugs between 2004 and 2005.

Since 2005, drug spending -- well, spending for other drugs, not-ESAs, has increased. You will see the decline in ESAs. Not on the graph are payments for composite rate services, the actual dialysis treatments. And note that that has also been increasing since 2005.

We looked at a variety of measures to assess changes in dialysis quality. For some measures, dialysis outcomes remain high or continue to improve. Quality is moving in the right direction for hemodialysis adequacy, which measures how well the dialysis procedure cleans the patient's blood. A proportion of patients are receiving adequate dialysis, which is good.

Anemia management, the proportion of patients with their anemia under control, has also remained high and slightly increased during this time period. The use of AV

fistulas, the recommended type of vascular access, the site on the patient's body where blood is removed and returned during hemodialysis, has been improving over the past several years. Quality is moving in the right direction.

And so although quality is high for these measures, for the first time this year we looked at the variation with adequacy and anemia management and found some variability with anemia management, particularly the proportion of beneficiaries maintained at high hemoglobin levels, that is, greater than 12 grams per deciliter, or whatever. In 2007, the percentage of beneficiaries with high hemoglobin levels ranged from 17 percent for facilities in the 10th percentile to 72 percent for facilities in the 90th percentile. Remember, recall recent clinical trials have shown that chronic kidney disease patients with hemoglobin levels that are too high are at greater risk for adverse events, including death and serious cardiovascular events.

So improvements are still needed in other aspects of care, and this is outlined in your paper. Patients' nutritional status has showed little improvement over time, and this is of concern because in dialysis patients

researchers have linked this measure to higher rates of hospitalization and mortality. Rates of hospitalization overall have remained steady at about two admissions per year. By race, the adjusted hospitalization rate is slightly greater for African American dialysis patients than white patients.

In addition to looking at overall hospitalization rates, this year we looked at 30-day hospital readmission rates for dialysis beneficiaries. Inpatient readmissions are sometimes indicators of poor care or missed opportunities to better coordinate care.

A significant number of hospitalizations for dialysis beneficiaries resulted in readmissions. Using 2007 hospital claims for dialysis beneficiaries, we found that about 32 percent of all hospitalized dialysis beneficiaries were readmitted to a hospital within 30 days in 2007. And this 30-day readmission rate has remained relatively constant. We found roughly the same proportion in 2005.

Overall first-year adjusted mortality rates have decreased over the past five years, but it still remains high. And the proportion of all dialysis patients registered on a kidney transplant waiting list remains low.

Regarding access to private capital, indicators suggest it is adequate. As mentioned earlier, an increasing number of facilities are for-profit and free-standing, and there is a net increase in the number of facilities from year to year. Analysts remain positive about the two largest publicly traded provider chains. Remember I told you that these two chains account for roughly 60 percent of all dialysis facilities.

Providers, even small providers, appear to have access to private capital to fund acquisitions in 2009, and investor analysts appear not to be worried about the effect of the new PPS in 2001 and beyond.

So here is the Medicare margin for both composite rate services and dialysis drugs. It was 4.8 percent in 2007 and 3.1 percent in 2008. We project it will be 2.4 percent in 2010. Some of the reasons for the margin to fall between 2007 and 2008 is that while drugs remain profitable, the volume of ESAs fell, and the payment per treatment for ESAs fell more than the cost per treatment fell.

Average cost per treatment for composite rate services increased by about 2.2 percent between 2007 and 2008. However, there was no update to the composite rate in

2008. CMS did increase the add-on to the composite rate, and together this represented a 0.5 percent increase for the composite -- combining the composite rate and the add-on payment. The 2010 projection does reflect the increase to the composite rate by 1 percent in 2009 and 2010.

For the sector, we have not yet looked at the margin for the efficient provider, but this year we looked at the distribution of the cost per treatment in 2008 adjusted for each facility's wage index and average case mix. This analysis suggests that some facilities are able to furnish care at lower cost than others. While the average adjusted cost per treatment was $161 per treatment, it ranged from $140 per treatment for facilities in the 25th percentile to $178 per treatment for facilities in the 75th percentile.

So the second part of our update process is to consider cost changes in the payment year we are making a recommendation for -- 2011. CMS' ESRD market basket projects providers' costs will increase by 2.2 percent in 2011. As is the case with other provider groups, we consider the Commission's policy goal to create incentives for efficiency.

The Chairman's draft recommendation reads as follows: The Congress should update the composite rate by the projected rate of increase in the ESRD market basket less the adjustment for productivity growth for calendar year 2011. In terms of spending, this decreases Medicare spending relative to current law. Current law right now has the composite rate equal to the market basket minus one percentage point in 2011.

Also, again I want to reiterate this update recommendation would apply to the portion of the broader payment bundle associated with the composite rate services. And to be clear, based on the current market basket of 2.2 percent and the Commission's expectation for productivity growth of 1.3 percent, this recommendation would be an update of 0.9 percent.

That concludes my presentation, and I look forward to your discussion.

MR. HACKBARTH: Thank you, Nancy.

So let me see hands for round one clarifying questions.

MR. BUTLER: So on page 8, slide 8, two questions related to this. This has basically doubled in 12 years, I

think, whether you do treatments or number of beneficiaries, the amount of services have basically around doubled, right? You have gone 15,000, 17,000 up to 34,000, and 150,000 to 300,000 or so. So it suggests either there is overtreatment, or there is the incidence of disease requiring the treatments -- that is kind of my question. The patients -- do we have an incidence of diseases requiring dialysis that have gone up at that same pace, which explains the increase in utilization? Or are there other things that would explain these trends?

MS. RAY: Okay. To be clear, the axis on the left-hand side, dialysis treatments, so that's total number of treatments per year.

MR. BUTLER: Right.

MS. RAY: Across all dialysis patients.

MR. BUTLER: Right.

MS. RAY: And I'm sorry. That should be 15 million to 35 million. And so dialysis patients, Medicare pays up to three treatments per -- three dialysis treatments per week. So the volume growth in terms of dialysis treatments --

MR. BUTLER: Correlated with the number of

beneficiaries receiving treatment.

MS. RAY: Well, it's correlated with the number of beneficiaries. So if you have -- if you increase patients' compliance to show up and receive dialysis to get the three treatments per week, that will increase volume. Reductions in the number of hospital days will increase outpatient dialysis treatments as well.

So in terms of number of treat -- in terms of spending for composite rate services, which is the payment for the dialysis treatment, that has gone up similar rates -- it's about 8 percent per year during this time period. Does that help explain?

DR. MARK MILLER: Yes, Nancy, to his question, let me just try t his.

MR. BUTLER: Utilization versus rates.

DR. MARK MILLER: Yes. I mean, I think what Peter's pointing out -- and I don't have the precision to answer it precisely. But what is a good driver behind this trend is that more people are having symptoms that require being dialyzed, and it is being driven by more the clinical incidence of the disease. That is, I think, the question.

MR. BUTLER: That's what it looks like.

MS. RAY: Yes. Yes.

MR. BUTLER: And I was trying to confirm that, although maybe there's some fine line whether somebody should be dialyzed or not, and I don't understand that. But I'm trying to separate those factors. And then you could also even ask above and beyond that: Is the composite rate -- is this even another chance for bundling, too, on not just a maximum of three per week, but should there be a bundle for a period of time in terms of number of treatments? I am trying to get at the utilization side versus the pricing side.

DR. SCANLON: The question I wanted to add to this was whether we know if there's any effect in terms of survival, because this is a stock, and so as people are joining dialysis, are they staying in it longer, and that adds to the number of people over time.

MR. HACKBARTH: Presumably, there has been some increase in the new entrants as a result of increasing rates of diabetes and other illnesses. So it is a multi-factorial issue.

Other clarifying questions --

DR. MARK MILLER: I'm really sorry. Just before

we go on, because the other part of your question just now was, well, what about other opportunities for bundling. So the way the process -- and, Nancy, you know, obviously I am in your territory so be careful here. You know, obviously the process has moved to the point where we are talking about a bundle of the composite rate dialysis, that type of stuff, plus the drugs.

In some of our conversations with the industry, without any specifics, you know, they also talk about opportunities where they want to think about, you know, taking the people and managing, you know, through dialysis as being the dominant diagnosis and determining factor for this patient and saying that they want to start to think about it that way as well, almost -- go ahead.

MS. RAY: Well, they have used the term "accountable care organizations" as what they see as the next step for possible payment in this sector.

MR. HACKBARTH: So I just want to make sure that I am clear and other Commissioners are. So there are a number of different paths you could go down. The most basic is to bundle on a per dialysis session basis the facility -- what used to be called the facility cost plus the drugs and

commonly used lab services and the like. And that is what is being worked on right now.

The next step would be to say we are not going to just do it by dialysis session, we are going to bundle over time dialysis services.

And then the third possibility would be even broader still. It is all medical services for a population that has ESRD.

But what Congress mandated CMS to do was the first. Am I right?

MS. RAY: It is broadening the bundle to include the composite rate, dialysis, drugs, and labs, and the --

MR. HACKBARTH: On a per session basis?

MS. RAY: Well, CMS chose to implement it on a per session basis.

MR. HACKBARTH: I see.

MS. RAY: Excuse me. CMS proposed to implement it on a per session basis. Congress gave them discretion, flexibility, if they wanted to, and CMS proposed to maintain it on a per session.

MR. HACKBARTH: Okay. Thank you.

MR. BERTKO: And just to add to that, it is about

the only place in the physician fee schedule where physicians are paid a monthly payment for the renal physician in dialysis, although that is now modified by the number of visits that they make. But I was going to ask a little more about the quality incentive payment program. CMS has that now proposed to be implemented. Is that a pure penalty? And so that is question one. You are saying yes. And did MedPAC ever offer an opinion about how this pay for performance should function? Did this come out of MedPAC proposals, or was this something CMS sort of did on their own?

DR. MARK MILLER: Do you want to take it or do you want me to?

MedPAC made a set of recommendations on pay for performance several years ago which Nancy did all the work on as it related to dialysis. I don't know why she isn't answering this question. But basically at that time we said budget neutral within, you know, just like we have been talking about in our other sectors.

DR. BERENSON: But in this case, it is not a bonus. It is a penalty. So is that something we said, or is that something -- I mean, it makes some sense to me, but

I'm just trying to figure --

DR. MARK MILLER: And I'm telling you we did not say penalty. It was budget -- I mean, you could think of it this way: We said budget neutral, the block of dollars for dialysis. Any individual, you know, dialysis facility could get less and would view that as a penalty, and any other dialysis facility could get a reward and view that as a bonus. But, on net, it was a budget-neutral proposition. I am correct, right, Nancy?

MS. RAY: Yes, that's correct. I just want to say, in CMS' proposed rule they have laid out the outline of the quality incentive program, the P4P program. They are still missing a lot of detail, so the one item that they did include were the measures to be used beginning in 2012. But as far as the other specific implementation issues, I think it remains to be seen. But MIPPA required -- well, MIPPA gave the flexibility to the Secretary to withhold up to 2 percent payments and link that to quality.

MR. HACKBARTH: Other clarifying questions? [Off microphone.]

MR. GEORGE MILLER: Thank you. Last year, in the material there was a report about the percentage of African

Americans who got dialysis, and with these new numbers on the slide on page 8, I was wondering if that percentage had changed over time. Or do you know?

MS. RAY: I can get back to you on that.

MR. GEORGE MILLER: Okay.

MS. RAY: It could be in my text.

MR. HACKBARTH: George, the percentage of dialysis patients that are African American, or the proportion of African Americans that have end-stage renal disease?

MR. GEORGE MILLER: No, who have end-stage renal disease and then get a kidney transplant.

MS. RAY: Oh.

MR. GEORGE MILLER: I'm sorry. I left that out, the important part. A transplant, because there was a disparity last year, if I remember correctly.

MR. HACKBARTH: Yes.

MS. RAY: Right, and that material, we can add that material to the text. I don't have those numbers off the top of my head, but it's available and I can --

MR. GEORGE MILLER: And so the question, because of the growth on Slide 8, has it improved from the time you reported last year as well? The percentage of African

Americans who get a kidney transplant, has that improved?

MS. RAY: I will have to get back to you on that. I don't know the answer to that.

MR. GEORGE MILLER: Okay. Thank you.

DR. MARK MILLER: My guess would be that it is probably not a lot of improvement since last year.

MR. GEORGE MILLER: And because of the growth has it gotten worse? That is my question.

DR. MARK MILLER: We can check that.

MS. RAY: Yeah. I do know the proportion on the kidney transplant waiting list has remained about the same.

MR. KUHN: Nancy, I was wondering if you could share a little information on what we have in terms of the change in terms of facility versus home dialysis and the site of service of the treatment. And then also any speculation that you could provide in terms of the new proposed rule for the PPS system from CMS, will that be more of a site-neutral payment system, do we think? Or will that bias one study over another? I am just curious your thoughts on that.

MS. RAY: Okay. I don't have my exact numbers in front of me, but over time, the proportion of patients

receiving dialysis in their home has decreased, particularly over the past 10 years, 10, 15 years or so. That includes -- and peritoneal dialysis is still the dominant home modality, and the number of PD patients -- the proportion of patients that are PD has declined.

There is actually a small increase, like in the past year or two, but overall it has dropped it.

Use of home hemodialysis, there is a lot of interest in that among some in the renal community, and although the number of home hemodialysis patients is small, it has slowly increased as well.

In terms of the proposed rule, CMS for adult patients has proposed the same base payment rate for in-center hemodialysis and home dialysis. So to the extent that costs for home dialysis remain under in-center hemodialysis, then that should provide some incentive for the use of home dialysis.

MS. HANSEN: Yes. Thanks, Nancy. If we can go to the Quality slide on page 12, a couple of questions there, and one that eventually related to diverse minority populations and the cost to the beneficiary. But the two on quality have to do with the rate of readmission within 30

day. I think I understand that. The 2007 claims say that there was a 32 percent readmission rate as compared to, say, typical Medicare beneficiaries, generally 18 percent readmission rate in 30 days. And so any way to focus in on how to look at that as a quality improvement area for the bonus? Because, I mean, that is a significant difference between 18 percent for average Medicare beneficiaries, and 32 percent for this population. Is that a major -- you know, because just the number seems quite significant for the readmits.

DR. BERENSON: Well, you might want to take it, but I was going to just jump in and say these are very -- I mean, these people have four, five, six --

MS. HANSEN: Comorbidities, yes.

DR. BERENSON: You know,, they've got heart failure and they've got diabetes and they've got a whole bunch of things. I'm not saying that rate is good, but you can't make that simple comparison.

MS. HANSEN: Right.

DR. DEAN: A very different population

MS. HANSEN: Right, okay. So it's just the ability to think of anybody who has multiple comorbidities

and great difficulty.

The second one is the proportion of people on transplant lists, if that is an indicator of quality. Do we know why that percentage has been unchanged, relatively speaking, over these years? Because it is about 17 percent, right?

MS. RAY: Yes, I think there are a lot of factors that go into that, including patient education and knowing the different options for treatment of their end-stage renal disease. There are some instances when patients are better informed about their options, they are more likely to, you know, well, consider home dialysis for one thing, as well as transplantation. And in that regard, MIPPA also implemented pre-ESRD education of beneficiaries. So it remains to be seen, the effect of that.

Now, other factors as well affect the -- you know, first being worked up to be considered for a kidney transplant and being put on the waiting list. And we went and we discussed those factors at greater length in last year's report.

MS. HANSEN: So do you think because it is in MIPPA that there is possibly some time before we yield some

higher numbers of people who might be then interested or, you know, informed about the possibility, coupled with whether or not there is a supply?

MS. RAY: Well, I think we will have to watch -- we will have to monitor the volume -- the use of this new educational benefit, I think, to slowly -- I mean, I don't know if we could specifically pinpoint the effect of that new provision.

I think that more awareness in general from both patients and providers about the need to educate and consider patients for kidney transplants is important.

MS. HANSEN: Okay. Now I know it is stated as a quality goal. I just wonder how realistic this was, and so that was just more -- because that's a very big decision to go from, you know, dialysis to a transplant.

Then the other had to do with George's question about minority populations. I think at one time there was some discussion of some greater consideration of risk adjusters for minority populations because there is some disproportionate increase, I think, for African Americans, and CMS was going to be looking into that. As we think about bundling, is this something that has been worked out

so that when bundling potentially occurs, that risk adjuster is factored in?

MS. RAY: Okay. So CMS in their proposed rule for adult dialysis patients, for the broader bundle, they have proposed many beneficiary-level case mix adjusters, including age, sex; there will be a case mix adjustment if you are in the first four months of dialysis; and then for 11 comorbidities; and for body mass.

CMS has proposed at this point not to adjust payment for race, even though the agency did note that their regression analysis did show that the coefficient for race was significant.

MS. HANSEN: So that was just an administrative decision at this point?

MS. RAY: Right, and, again, this is CMS' proposal. It has not been finalized yet.

MS. HANSEN: Okay. And the last one has to do with the recommendation. The recommendation indicates that there may be higher beneficiary costs with this bundling. And so normally I certainly have my own proclivity toward bundling, but getting underneath this as to why it might be more expensive to beneficiaries, I understand when we start

bundling some of the medications, it goes into this bundling of the 20 percent of beneficiary share of costs. But when you keep the medications separate, some people actually benefit from being under the Part D program, in which case they actually save more money on that side.

So does bundling then cause some people who might have paid less end up paying more as a share of cost?

MS. RAY: Okay. So, again, this is with the broader payment bundle that we are talking about.

MS. HANSEN: Right.

MS. RAY: And, yes, CMS has proposed to include selected ESRD-related Part D drugs into the broader bundle, and there could be differences, higher or lower -- I am not sure which, but, you know, it could vary from patient to patient -- in moving these drugs from Part D to Part B.

Also, the other effect on the co-payment is for laboratory services. With them in the bundled rate, then, of course, the 20 percent total co-payment would apply to that as well.

MS. HANSEN: Could that be amplified in the course of the next write-up about this as to what the impact might be toward beneficiaries?

MS. RAY: Sure,

DR. MARK MILLER: I know Glenn also has a comment on your comments. This is something of a dilemma to work through because in putting together the bundle, you want to construct a bundle and a payment that says you are responsible for this patient and here are the things that you are responsible for. And if you leave the kind of door open for D and other places, then there's opportunities to say, okay, I'm not going to give you this, you just go. And so that's kind of the trade-off. The downside is the downside that you have brought up. Once you pull it all in, the beneficiary does have the 20 percent. And depending on how they would have been treated in Part D, that can go either way.

But I think also Glenn has something to say.

MR. HACKBARTH: As it happens, Nancy has been working on the comment letter on the proposed rule on bundling for ESRD, and one of the issues that we raise in the letter, the comment letter, is about race and ethnicity as an adjuster, and basically we urge them to look carefully at doing that.

What CMS said in the proposed rule was that they

were concerned about the accuracy and reliability of existing data, whether it was sufficiently accurate and reliable to use for payment adjustment purposes.

It occurs to me that another issue that I don't think we touch on in the draft, Nancy, is the issue of should we be focused on bundling per session or, you know, multiple sessions. And as my earlier comment indicated, I was thinking that Congress had told CMS that they had to do it on a per session basis and that it wasn't a matter of discretion. And so that's something I'd like to kick around with you and Mark and whether we ought to be adding that to the draft comment letter as well.

Other clarifying comments? We are still in round one. Since Mitra is a one and a half, she is going to go ahead.

MS. BEHROOZI: I want to say this delicately and sensitively. I notice in the paper that with respect to -- the reason it might be a clarifying question is because it's really about what does one-year mortality show us. You know, of course, we don't want people to die. We certainly don't want them to die in the first year. But what does it really show us as a measure? And it kind of goes a little

bit to Peter's question, I think.

In the paper it says that, by race, one-year mortality is lower among African Americans than among whites, 218 versus 251 per 1,000 patient years, which is, you know, pretty significant, 20 percent or something like that different, right? And I can't imagine that in this one corner of health care suddenly African Americans are getting so much better health care. But, you know, it raises a concern -- I don't want more African American people to die in dialysis. I want there to be less people overall dying in dialysis in the first year, for the record. But is this an indicator of the treatment that came before. Maybe does this raise a concern about people being pushed too soon into dialysis, which is a terrible burdensome and, you know, life-altering kind of treatment? Obviously, in many, many, many cases, it is entirely necessary, but it just seems sort of an anomalous number, and we are putting it in as a quality measure, but maybe it's telling us a little bit about something else, too.

MS. RAY: And I think you've raised a good point. I think what -- I'm not sure the point is that dialysis patients have been pushed in too soon. I think some might

argue that the care that they have gotten in the pre-ESRD period has not been as good as it should have been.

And you're right, and if -- and we have seen that for patients who, for example, don't see a physician specializing in renal disease until at the point when they require dialysis, they tend to be hospitalized more in the beginning, in their first year, than those who have been under the supervision of a physician specializing in renal care.

I think some researchers have looked at that one-year mortality rate, again, because it is high, to try to look at it to come up with ways to try to reduce it. So I think that is what they would argue about why they would use it. But I think you raise a good point. There are other factors. Their pre-ESRD care certainly does feed into that number.

MR. HACKBARTH: Okay. Round two, and remember, if possible, I'd like to hear how you feel about the draft recommendation and any information you'd need to make a decision.

DR. CHERNEW: So, first, I support the recommendation.

Second, my information from my friends that study dialysis and ESRD is that this increase that we saw is generally a real case mix. Just with obesity and hypertension and a series of things like that, there are actually more people that need dialysis. And my question is: I know of no evidence that people are being overdialyzed. I don't think it is something that people seek out. It is hard to convince someone to go have done. I might be wrong and maybe there is overdialysis, but I'm not aware of any evidence of overdialysis.

And so I think that this actually strikes me as an area where we have been remarkably successful in many ways. The quality seems clearly better. We have better information than in other places.

DR. MARK MILLER: I'll be very brief, and I am completely off script with both Nancy and Glenn, so this may not go well.

In terms of success, it is also says to me this is almost a public health problem. You know, we're dealing with kind of the payment at this stage, and there is success there in improving that. But why so many more? Because I get the same sense as you. People don't opt for dialysis

except in the extreme.

MR. HACKBARTH: In fact, it seems like there may be some indication that more frequent dialysis would improve quality, at least I think that is -- if I understand the paper correctly. And so that plays into decisions about bundling. You know, that would be an argument in favor of keeping it on a per session basis and paying more if there are lots of sessions as opposed to on a per month basis where there might be an incentive to reduce the number of sessions.

Okay. Continuing with round two.

DR. DEAN: I just wanted to follow up on Jennie's comment about the readmission rate. I think it's very clear that this group of patients will have a higher readmission rate than the general population. On the other hand, as Bob said, they have multiple problems. And I think it is a great opportunity to look carefully at it and to look at the coordination of care, because if there is any place where good coordinated care should have a payoff, it would be in this group.

So I think monitoring that number and looking for how much variation and distribution there is across the

whole population would be an important thing to do.

MR. HACKBARTH: Other comments on the draft recommendation?

DR. DEAN: I support the recommendation.

MR. HACKBARTH: Thanks, Tom.

MR. GEORGE MILLER: Yes, one, I think I support the draft recommendation, but I do want to see that other information first. And Mitra covered my other comment, so I appreciate her bringing it up, and then Tom also about the coordination of care. But still on the point about readmission -- and this is just a technical question. If there is higher readmission, doesn't that go against the hospital and then the hospital is going to be penalized when we get to the quality issue on readmission?

MR. HACKBARTH: If there is not some appropriate risk adjustment for the patient.

MR. GEORGE MILLER: And that is not in my notes. Unless it's risk adjusted out. So we'll identify that so that it doesn't adversely affect readmission with the risk adjustment?

MR. HACKBARTH: Well, you know, what we've said on the topic of readmissions is that you need appropriate risk

adjustment, at least to the best of my recollection. I don't think we specifically said adjustment for, you know, ESRD.

MR. GEORGE MILLER: But this would be when we'd have a cross-walk, too. All right.

DR. BERENSON: I just wanted to jump in on the issue that Mitra raised about African American patients having a lower mortality. I mean, one potential explanation is that more non-African Americans are being offered this in extreme circumstances that they are in so, therefore, have a higher mortality rate. So I don't know that -- I mean, there is some potential other explanations here which are more consistent with African Americans getting less than whites.

DR. CROSSON: Just on that point, the other potential contribution is the underlying disease process that led to renal failure in the first place, and there could be differences in populations.

DR. KANE: I support the recommendation. I guess I'm wondering when we talk about which direction to bundle, I'm wondering if it doesn't make sense -- I know this is hard to imagine, but to bundle across payer types for this

particular condition, because it is the condition upon which -- what's affecting Medicare costs is the condition the person arrives in, to a certain extent, I mean, certainly the mortality but also the comorbidity, and whether there can't be some -- at least recommend some experiments in, you know, kidney disease before they go to failure and whether there can't be some partnerships with Medicare and some large private payers to try to pick up these people before -- or even Medicaid. I don't know how many people might have been Medicaid, but picking up these people before they come in and have to be -- and some of them are dialyzed, I guess the first three or four months they are still under their other payer. And the whole thing with the AV fistula it seems to me had to do with their pre-Medicare situation.

And I'm wondering how much Medicare might actually save if it could collaborate or share risk or create some kind of innovative episode case management with these people before they became in total failure or three months post total failure, I guess, in some of these cases, because there is a three-month eligibility wait.

So, anyway, it just seems like this is the kind of thing where you'd really want to see bundling go into the

pre-Medicare phase to try to reduce Medicare's overall cost and improve the quality of the care.

MR. KUHN: I think CMS is currently running some demonstrations for folks with chronic kidney disease and trying to see what they can do to either forestall or eliminate it altogether for people with CKD going into full renal failure. So there is some work already going on in that area that we might want to look at in the future.

MR. BUTLER: I think the important lesson here is that we're going beyond this composite rate to think about managing the health of a population, and mostly federal dollars are behind this, and if there is an area where we get, again, kind of control over almost a pilot way to look at, another way to look at the Medicare program and the treatment of chronic diseases, I think we're saying let's push this one a little farther as another kind of tool that we can learn from that could potentially be applied to other diseases as well.

DR. SCANLON: I support the recommendation, and a comment and I guess a question that comes from some of the earlier discussion.

In reaction in part to what Mike was saying about

in some ways we've been successful here, I think I'd like to be a little more cautious, and actually it kind of relates to whether we could feel comfortable about making the composites bigger. All of this work is somewhat dated at this point. When we looked at sort of oversight of ESRD at GAO, we found that while it's kind of an ideal candidate in terms of you've got a population of people that are relatively homogeneous compared to some of the other populations we're dealing with, and you've got sort of a controlled set of providers, there wasn't -- and, again, it often came down to resources. There wasn't the kind of oversight that you would want to have happen. There wasn't the sharing of data. There wasn't the frequency of inspections. There wasn't really the kind of scrutiny that you want to happen. And so if you create incentives that could lead to under-service, you have to be, you know, cautious about that.

The question -- and, actually, it comes from Jennie's comments and the discussion about sort of why the composite rate is increasing beneficiary co-pay. How does our recommendation increase beneficiary cost sharing as opposed to the composite rate? I don't think we should have

to take responsibility for increasing the beneficiary co-pay by reducing the amount of the composite rate. We should actually get credit for reducing beneficiary cost sharing, shouldn't we?

MR. HACKBARTH: I'm not sure I'm following, Bill.

DR. SCANLON: Well, it says in the draft recommendation on 15, increase beneficiary cost sharing, our recommendation.

MR. HACKBARTH: I assume that's just because any rate increase --

DR. SCANLON: No. We're talking about decreasing the rate. We're talking about decreasing the rate relative to current law.

MR. HACKBARTH: Oh, I see what you're saying now.

DR. SCANLON: It says that were going to decrease Medicare spending. Why aren't we decreasing beneficiary spending, too?

MR. HACKBARTH: Well "current law" is the --

MS. RAY: Yes, overall it will increase the co-payment, but you're right, relative to current law --

DR. SCANLON: The composite rate increases the co-payment. We're decreasing the composite rate.

MS. RAY: Yes. Yes.

DR. SCANLON: To give ourselves credit.

MS. RAY: Yes.

DR. MARK MILLER: [off microphone] We'll clarify that. Good catch, Bill.

MR. HACKBARTH: Okay. Thank you, Nancy. Good job.

So we were a little bit more disciplined that time. We picked up five minutes. We can still do better, though. I know we can do better.

So next up is home health services. While Evan is getting ready, let me just say for people in the audience who weren't here this morning, as we go through and I ask Commissioners for their at least preliminary views on draft recommendation, the rule here is silence means assent, so if you see people skipped over and they are not electing to say something, that is because they agree with the draft recommendation.

Okay, Evan, whenever you are ready.

MR. CHRISTMAN: Thank you. Good afternoon. Similar to the other providers you have already gone through today, I am going to review the Commission's framework as it

relates to home health, and we begin with supply and access.

As in previous years, the supply of providers and the access to home health continues to increase. Ninety-nine percent of beneficiaries live in an area served by one home health agency. Ninety-seven percent live in an area served by two or more. The number of agencies was over 10,400 by November of 2009, about a 4 percent increase over 2008. Since 2002, the number of agencies has increased by about 50 percent, which equals an additional 480 agencies a year, or a little more than 1.5 agencies per day.

Similar to previous -- oops, next slide. Similar to previous years, almost all of the new agencies are for-profit and located in a few States, really in a few regions within these States. The concentration of agencies in certain areas, especially those with a history of fraud and abuse concerns, prompted CMS to conduct on-site reviews of home health agencies in L.A. and Houston.

There was also a problem with many providers gaming or abusing the home health outlier system that was concentrated in Miami-Dade County. Over half of outlier payments in 2008 were made to agencies in Miami-Dade, an implausible amount that attracted concern from CMS and the

industry. CMS is working to recover payments in that county and has implemented some safeguards to reduce the vulnerability of outlier payments to fraud and abuse. We talked about this at last month's meeting, and I can say more if you have questions.

Next, we looked at volume, and the use of the home health benefit has increased significantly in the last six years. The number of users has increased to 3.2 million in 2008, or over 9 percent of fee-for-service beneficiaries. The number of episodes has risen about 50 percent since 2002 to 6.1 million in 2008. The episodes per user has risen by 20 percent, implying that beneficiaries are staying on the service for longer periods.

The mix of episodes is also shifting toward higher-paying services, particularly the amount of episodes with therapy has increased, and the next slide sort of takes us through how this has happened.

Now, before I go through this slide, let me briefly recap how Medicare paid for therapy prior to 2008. This is important because CMS revised therapy payments in 2008 and providers changed the mix of services they provided in response to the changes.

In 2001 through 2007, there was a single payment adjustment for therapy that increased payment for episodes with ten or more therapy visits. It roughly doubled payments. Now, if you turn to the graph, particularly the middle three bars, you can see that the share of episodes just at or above this threshold, those with ten to 13 therapy visits, increased from 11 to 15 percent between 2002 and 2007. The groups of bars on the left and right of the graph show the share of episodes in 2002 and 2007 for episodes below and above the ten-visit threshold. If you look at the share of episodes in the six-to-nine and 14-plus therapy visit groups, they were unchanged in 2002 and 2007. This should not be surprising, because under a ten-visit threshold, there was no incentive to provide more of these episodes.

In 2008, CMS's revisions to the payment system changed that. The ten-visit threshold was replaced with a series of multiple thresholds that increased payment more gradually. In effect, the revisions raised payments for episodes in the six-to-nine and 14-or-more therapy visit categories and lowered payment for those in the ten-to-13 therapy visit category. And you can see the results of that

change on the graph. Starting again with the middle group of bars, if you look at the bar for 2008, you can see that the share of these episodes, which were paid less under the new system, dropped back to 11 percent. On the other hand, remember that the 2008 revisions increased payment for those in the six-to-nine and 14-or-more therapy visit group. Not surprisingly, the share of these episodes increased. The share of episodes in the low group increased by about one-third, and the share of episodes in the 14-or-more group increased by about 25 percent.

One-year changes of the magnitude observed in 2008 did not occur in any previous years, and the changes illustrate how payment incentives can rapidly reshape home health utilization. Prior to 2008, episodes that just qualified for the extra therapy visits grew steadily, while those just above and below the ten-visit threshold were unchanged. When the incentives were revised in 2008, providers reacted swiftly and provided fewer episodes with reduced reimbursement and more of those for which payment increased.

The next table shows risk-adjusted quality measures for home health, and with a few notable exceptions,

the table shows they have gradually improved. For the first five measures, all measures of a beneficiary's functioning, such as the ability to get out of bed or bathe, the steadily rising line indicates that there has been a consistent increase in the number of beneficiaries who improved on that measure at the end of their home health stay. The bottom line is the rate of hospitalization, and as you can see, it is pretty much unchanged from previous years.

Next, we look at capital. Overall, home health agencies appear to have adequate access to capital, but it is worth noting that the home health agencies, even publicly traded ones, are less capital-intensive than other health care providers. Most home health agencies are too small to be studied by capital market analysts, but analysts have concluded that the major firms that are publicly traded have access to the capital they need on reasonable terms. For the non-publicly-traded agencies, the continuing entry of new agencies reflects that smaller entities are able to get the capital they need to expand. As I mentioned earlier, the number of agencies has increased by about 50 percent since 2002, with an annual average increase of about 480 additional agencies a year.

Next, we turn our attention to margins for 2008. You can see that overall margins are 17.4 percent. However, as you can see by the lines below, there is some variation in the margin. For example, the agency at the 25th percentile in the margin distribution had a margin of 2 percent, while the agency at the 75th percentile had a margin of 26 percent. This distribution is similar to previous years.

The pattern for margins by geography and type of control were also similar to what we have seen in previous years. Margins for providers that serve mostly urban patients were 17.8 percent, while it was 15.7 percent for agencies that serve mostly rural patients. For-profit providers had margins of 18.5 percent and nonprofit margins were 14.3 percent.

I would note that we only project margins for freestanding providers. Hospital-based providers, whose margins were included in those reported during the review of hospital payments, averaged a margin of negative 4.6 percent in 2008.

Now, these margin results are consistent with what we found last year and in prior years, and an important

question is why home health agency margins have been so high for so long. Since 2001, home health margins have averaged 17.4 percent. These margins have remained high despite numerous adjustments to the market basket. For example, in 2002 through 2005, the market basket update was reduced, and in 2006, it was eliminated entirely.

These high margins are the result of at least two factors. The first factor is that home health agency cost growth has been lower than the payment update in most years. The average growth in cost per episode has been about 1.9 percent a year, while the rate of inflation assumed in our payment updates have averaged about 2.9 percent a year. Because actual inflation has been lower than market basket inflation, payment increases have exceeded the growth in providers' costs in many years.

In addition to the low cost growth, another reason for the high payments are that Medicare's base rates are based on obsolete assumptions about the home health product. When setting the initial rates for the PPS, CMS relied upon data about the number of visits that occurred in 1998, when the interim payment system was in effect, which equaled 31.6 visits. However, the average number of visits dropped

between 1998 and the implementation of PPS to about 21.8 visits in 2001, about equal to the average of 21.6 visits in 2008.

Now, the BBA anticipated that there would be a drop in visits, and there were some adjustments to the base rate. But the adjustments did not anticipate the degree to which home health would change and the base rate was clearly overstated. As you may recall from the previous slide, the margins in the first year of PPS were 23 percent, implying that the rates we paid were well in excess of costs.

The significant drop in visits may raise concern about stinting on care, but the changes had little or no detrimental impact on quality. MedPAC and others found that the quality provided under PPS was equal to the care provided during the IPS period before 2001.

Another area of concern has been that there is significant variation in the margin of home health agencies. Though this is true, the range of variation for home health agencies is about equal to that of other Medicare providers. For example, the range of variation between the 75th and 25th provider under the inpatient PPS was about 27 percentage points, about the same as the variation in the

home health PPS I showed you two slides ago.

The issue is not the existence of this variation, but whether some of it is caused by inaccuracies or flaws in the way Medicare pays for care. To gain a better understanding of whether this was the case, we examined variations in home health financial performance in 2007. As we presented last month, the major factor that explained the variation was differences in cost among providers. We found that costs per episode were 40 percent lower for high-margin agencies and payments were only 7 percent higher. There was no difference in the chronic conditions, functional limitations, or agency quality.

We will continue this analysis, but so far, the conclusion it suggests is that the difference in margins are primarily caused by differences in cost.

Overall, we estimate margins of 13.7 percent in 2010. These estimates include several adjustments for plan payment policy. First, it includes the impact of the market basket increases planned for 2009 and 2010. These increases are partially or completely offset by reductions for improvement in coding that occurred in the early years of the prospective payment. We also included the effects of a

reduction for coding improvement that is planned for 2011. And finally, we assumed some growth in case mix consistent with the trend of previous years.

For costs, we assumed they would go up by the market basket increase. This reflects the trend we saw in 2008, but we note that generally inflation has been less than the market basket, so this is a little high relative to historical experience.

Here is a summary of our indicators. Beneficiaries have widespread access to care. The number of agencies continues to increase, reaching about 10,400 so far. The number of episodes and rate of use continue to rise. Quality shows improvement on most measures. Access to capital is adequate. The margins are 13.7 percent for 2010.

Here is the Chairman's draft recommendation for 2011. It is similar to what we included in the last March report. The recommendation reads, the Congress should eliminate the market basket update for 2011 and direct the Secretary to rebase rates for home health care services to reflect the average cost of providing care.

Now, we expect that a change of this magnitude may

result in some agencies leaving the program. However, we expect beneficiary to be adequate, even with a reduced agency supply. As you saw from a few slides ago, we have been able to have a high level of access for many years with significantly fewer agencies than we have today.

We also plan to reprint the third recommendation from last year that sets up a framework for patient safeguards. The recommendation reads, the Congress should direct the Secretary to assess payment measures that protect the quality of care and ensure incentives for the efficient delivery of home health care. This study should include alternative payment strategies, such as blended payments and risk corridors and outcomes-based quality incentives. We expect that this would have no spending or beneficiary provider impacts.

This completes my presentation. Please let me know if you have any questions.

MR. HACKBARTH: Okay. Round one clarifying questions.

MR. BERTKO: Evan, just a question about the reported excess in some of the counties, Miami-Dade, that you cited. If you were to take those out, does it change

the margins or anything very much?

MR. CHRISTMAN: When we have looked at it without South Florida, it has not changed it significantly, and generally, I have also found, frankly, that agencies in problem areas tend to drop out in some of the cleaning that we do anyway of the data, so I am not surprised by that.

DR. MILSTEIN: Looking at the great speed with which the volume of services adapts to payment changes, which are breathtaking, it does suggest that there may be a problem with certifying the appropriateness of these services. Could you just remind us what safeguards CMS has in place to try to make sure that patients who are in this program, as well as the duration of the number of visits, bears some reasonable semblance to some independent determination of perceived need.

MR. CHRISTMAN: Sure. Under the law, home health is a benefit that is delivered by the agency, obviously, but technically, it is delivered under the sort of supervision of a physician. And for every home health episode, whether it is a new episode for that beneficiary or a continuing episode in a spell, every 60 days, the physician is basically required to sign an order that attests to the

beneficiary needing the service and meeting the standards for eligibility for the service, that they are homebound, they have a skilled need. And that is sort of the linchpin of ensuring that what the agency is doing has some, you know, clinical requirement behind it.

DR. MILSTEIN: Clarify what the rules are in terms of the relationship between the physicians who are doing the certifying and the agency.

MR. CHRISTMAN: Yes. I mean, I think the short answer to that is as long as they are not doing anything that trips over a False Claims Act or anything like that, it is not really any different than a relationship between a doctor and anybody else who delivers Medicare benefits.

So, for example, the physician could be a medical director working for the agency. And as I recall, the magic words are they can't -- any remuneration that the agency pays the doctor cannot be based on the volume or value of referrals to stay out of trouble with Stark.

DR. KANE: What did Congress decide the update was for last year after we recommended -- we recommended zero. What did they decide to update it last year?

MR. CHRISTMAN: Well, they haven't passed any

legislation --

DR. KANE: I mean, for 2010.

MR. CHRISTMAN: They didn't -- they haven't passed any legislation for 2010 payment policies yet since we last made any recommendations, so I don't think they have taken any action.

DR. KANE: What was the --

MR. HACKBARTH: I think what Nancy is asking, what, in fact, happened to the rates at the beginning of fiscal 2010? Was there an update because there was a baseline market basket increase?

MR. CHRISTMAN: Yes. I am sorry. Yes. Okay. So they did -- yes, they did the market basket, but that market basket was offset by an adjustment for past coding practices. Because the market basket for 2010 is low -- it is, like, 2 percent -- and the coding adjustment was a negative 2.75, so actually their rates -- before some other adjustments that were made, their rates went -- that pulled their rates down. There was also a change to the outlier policy that reduced their outlier payments, and to compensate for that, they had to pull the base rate up.

DR. KANE: But the impact was their profit margins

stayed up around -- so they basically experienced a zero update and their profit margins --

MR. HACKBARTH: Well, we don't have the actual cost information real-time, so we won't --

DR. KANE: But you have estimated.

MR. CHRISTMAN: Right. But I think the other piece that is pretty critical in here is, yes, those two things create some downward pressure on their margins, but the thing that, to some degree, compensates for that is that the average case mix has grown by one to two points a year, and we have factored that in.

So even though their payment updates in some ways have been somewhat thin, the fact that they can keep costs low and that their payments are going to go up because of rises in the case mix, that helps to keep their margins pretty resilient. I mean, really, the best graph to get a sense of that, in my opinion, is the bar chart --

DR. KANE: Yes, but --

MR. CHRISTMAN: -- that we show the margins across all the years, because if you look at that bar chart, in every year on that graph, the payment or the update was either eliminated or reduced except for 2007. In the

history of this payment system, we have only gotten the full market basket to these guys in one year. And as you can see, even with all those reductions, through a combination of measures, they have found a way to offset them and earn pretty healthy margins.

DR. KANE: So for 2010, you are projecting a 13.7 percent margin. So it sounds like even when their actual rates were actually reduced slightly, they still, because of the case mix and the manipulation of the changes in the therapy mix, they were able to -- so what is it that people don't know in Congress about the home health industry that they don't go along with actually a reduction of more significance?

DR. MARK MILLER: Without a lawyer present, you won't answer that question.

[Laughter.]

DR. KANE: Yes. I mean, what is the question that they are getting that we are not? I mean --

MR. HACKBARTH: Well, suffice to say they are looking at recommendations like the ones that MedPAC made as part of health reform.

DR. KANE: But is there something we are not

looking at that we are not getting that says they should maintain these levels of profit margin?

MR. HACKBARTH: No. Again, we made recommendations for taking back the coding creep and zero update and rebasing and Congress is, as we speak, deliberating on legislation that would include very similar, if not identical, provisions.

DR. KANE: So the message is not that these margins are okay with Congress. I mean, I am just trying to get insight into why they continue to have these kinds of margins --

MR. HACKBARTH: Well, Congress is, you know, a lot of different people --

DR. KANE: I know.

MR. HACKBARTH: -- 535 people, so I think it is not productive to try to characterize Congress's state of mind. It is factually true that to this point, they have not adopted our recommendations for cutting the rates, the rebasing, et cetera. It is also factually true that the pending health reform legislation in both Houses -

DR. KANE: Goes after it.

MR. HACKBARTH: -- includes provisions, if not

identical to what we have recommended, in the same general direction.

DR. KANE: So we are not missing the argument. They are just taking these same facts and just taking them to a different recommendation, or a different conclusion?

MR. HACKBARTH: Well, again, they may end up at a place that is very similar to what we recommended a year ago.

DR. KANE: Okay.

MR. HACKBARTH: Time will tell on that.

DR. BERENSON: Yes. I want to pursue what I found the most striking part of the presentation, was the rapidity of new agencies, 480 a year with 60 percent in three States. It is reminiscent of pre-BBA days. What do we know about the content of the accreditation, and in particular, these independent certification agencies? Do we know, for example, how many applicants are turned down? Have you looked at sort of the content of the application to see if in any way it weeds out folks who shouldn't be in the business?

MR. CHRISTMAN: We haven't, is sort of the short answer, and what Bob is referencing is the fact that up

until the change in policy in 2007, State survey agencies were doing the bulk of certification for new agencies, and because of a policy change, now, most agencies pay to have a private accreditation done that can count in lieu of that State certification.

I think, you know, CMS's policy point obviously is they have accepted their accreditation as being equitable to what a State survey agency would do. And you are right, we don't know things like sort of denial rates. There is -- sometimes people have mentioned anecdotally that the length of time it is taking some agencies to get in is longer because it is taking them longer. I guess they are referred to as deferrals of accreditation. But I don't think that -- I don't know that we have any evidence that they are any better or any worse of a hurdle than the process that people were using before.

DR. STUART: Evan, could you go back to Slide 7, please. Now, these rates are case mix-adjusted, is that right?

MR. CHRISTMAN: Yes.

DR. STUART: Okay. Because if you didn't know that, you would say, well, it could be that quality is

improving, or it could be that you have got a less debilitated population. And if you think about the growth in the volume of use of these services, you would think that the most debilitated would be the ones that would get it first, and then if you were in an area where there is real growth in numbers, that they would almost by definition have to be taking a less debilitated case mix. And I am just wondering whether there is something wrong with the case mix adjustment. Is this something that you feel comfortable with? In other words, do you feel comfortable that, in fact, the quality of care is actually increasing?

MR. CHRISTMAN: Well, I think that that is a good question, Bruce. I think that -- the question I have had, again, is the consistency of the pattern, really everybody going up by about one point a year and the adverse event rates basically being unchanged from year to year. I think that we don't have a good explanation for why it looks the way it does.

In terms of the quality of the case mix, there have been some questions about whether it works well among agencies, at sort of the agency level. But I think that that is something that I am still, frankly, trying to get a

handle on. I don't know that -- I would expect a little bit less variation in the population at the national level from year to year than I see when I am trying to adjust between agencies. So that has been something that has given us pause. But I think we still -- these are the outcomes measures. They have been through the NQF process, things like that. But I think it is a fair question of whether we understand the trends well enough and the risk adjustment that is underneath it.

DR. STUART: If that is the case, then I would suggest that maybe we should be a little more -- you should put some qualifiers on the conclusion that the quality is increasing. I mean, if you don't really know, then I don't think we should be definitive about it.

MR. HACKBARTH: Other clarifying questions?

Let me ask a question, Evan. A week or so ago, there was an article on the front page of the New York Times about home health and the payment changes that the Congress is considering, and a point made in the article was that some people fear that a reduction in home health payments is penny wise and pound foolish in that home health helps reduce hospitalization rates, keep people out of the

hospital, and so a rate reduction could have negative consequences.

There are a number of reasons I don't think that logic follows. I won't go into those. But it did raise a question in my mind whether we have ever looked at the association between home health use and hospitalization rates. My recollection is that there is substantial geographic variation, and so you could do some cross-sectional analysis. And we have had -- we could do time series analysis. We have had these periods where usage dropped way off of home health and then accelerated rapidly and we could compare those to hospitalization rates. Have we ever done that?

DR. KANE: Also skilled nursing, use of skilled nursing.

MR. HACKBARTH: Or both, yes. But I picked the hospitalization because that was the focal point of the New York Times article. Have we ever looked at that association between home health and other services?

MR. CHRISTMAN: We haven't looked at it that way. I think we have sort of got some work cooking that is going to pick up that. One is we want to look at what is going on

with length of stays. I commented that it is going up, and our sort of question is, it now looks like more people are coming from the community than the hospital into home health, less of a post-acute care benefit, and trying to understand that. For example, are we avoiding hospitalizations when we admit people from the community? I don't know that that has been proven definitively either way.

In terms of the relationship between the amount of home health services and whether it avoids hospitalizations, there is an inherent logic in that and we want to look at it. But I guess the thing that I would notice is the thing that is -- in the time that I have been doing this, the thing that is most striking to me is that the use of home health services seems to correlate most with supply. You know, the more agencies we have, the more home health we wind up with. So seeing if we can lead that back to hospitalizations is definitely a separate question. I guess it is hard to walk away from the conclusion that that is what is driving a portion of the growth we have seen.

MR. HACKBARTH: We need to move on to round two now. Comments on the draft recommendation and any

information requests? We will begin with Bill.

DR. SCANLON: I am supportive of the recommendations, and I guess I wanted to underscore things probably said before, and I think that this year, we have been amassing more data that relate to this. I mean, I think we both have a structural problem in payment, but we also have bigger problems with respect to home health, and the growth in the number of agencies is an indicator of kind of both.

This idea of -- and the issue has been raised about the accreditation process. We really need to know how good that is. We also need to know how good the survey process is. When CMS admits agencies, and we have known in the past that that hasn't been the most rigorous bar in terms of people joining the program and, in fact, when we have heard about some of the problems with fraud and abuse, it has been -- sort of been indicated that it is so easy to become an agency, I can do it, I can operate for a while, and then I can leave and come in under another name and operate again. And we need to think about how do we get control over that, because this payment policy is not going to solve all of our problems. Oversight is also a key sort

of part of the problem. So I think in our chapter, hopefully, we will say, let's not rely only on payment policy.

The second thing, I think, in terms of the margin distributions, yes, it's true that there are big cost differences, but I think that's maybe just too simple to talk about them as cost differences, because within those cost differences that we're observing, there's potential differences in services and potential differences in the efficiency of delivering services, and we haven't yet been able to sort out those differences and I think we want to do that. How much is administrative cost? How much is actual direct care cost?

I noted in the difference between the top quintile and the bottom quintile that the agencies with the highest margins have higher case mix scores and provide lower visits, both on the order of about 10 percent. And so you think about that just alone, what that adds to your margin. I mean, it is a quite considerable thing to think about.

The last thing I would underscore was Bruce's points about the quality sort of scores. We've expressed concerns about, as you indicated, at the agency level, sort

of the quality of the case mix adjustor, and I had exactly the same sort of hypothesis that Bruce had, which is if we're bringing more people in and these are basically categorical case mix adjustors, aren't we potentially bringing in some of the people at the lower end of each category or each cohort as opposed to sort of whom we've had sort of before.

The other thing I would add to this, and this kind of relates to the fact that we've had this huge explosion of agencies, you know, the quality of the data coming in, it's not being scrutinized. We don't know whether people are reporting accurately sort of these kinds of measures. And so there's a question of whether this drift, which is really what it is -- it's not much more than a drift -- is accurate about what's really happening with quality or it's a combination of a lot of things that can contribute to a situation where the reality is there's no change, or maybe there's even some deterioration. It's not clear at this point.

DR. CASTELLANOS: Two questions. These are really one-and-a-half questions. We're not talking about accreditations, but we're talking about the vast number of

new agencies coming on board. Does this come under CON in any State, and if it does, has there been any effect by CON?

MR. CHRISTMAN: Well, the States that have shown the most -- a lot of the growth, California and Texas, don't have CON for -- excuse me, Florida and Texas don't have CON for home health, and so that's been something folks have talked about. Florida has become so concerned about Miami-Dade they have implemented a CON, or a moratorium, effectively, in Miami-Dade. But it definitely is striking that some of the most problematic areas don't have CON. But that doesn't mean that improper behavior isn't occurring in markets that do have it.

DR. CASTELLANOS: And the second question, the last one, is the supervision by the physician. I know we brought that up previously. If the physician, he or she, is she obligated to see the patient? Does he or she get paid to supervise this patient? And is it possible that, considering what we did with hospice, that we could put some criteria as what a supervising physician's responsibility is?

MR. CHRISTMAN: Okay. They aren't required to see the patient. They do get paid for what's called care plan

oversight, which is they get paid effectively if they meet the requirements for it, to do the paperwork associated with a home health certification. And then in terms of the hospice model, that's definitely something we have in mind. I think what we want to do is get a sense of -- a little bit better sense of what the longer-stay patients look like in home health and what would be the appropriate way to go about creating that kind of requirement if it seems necessary.

DR. CASTELLANOS: Thank you.

MR. HACKBARTH: Ron, any comment on the draft recommendation?

DR. CASTELLANOS: [Off microphone.] Well, I support it wholeheartedly.

MR. HACKBARTH: Arnie?

DR. MILSTEIN: I think -- I support the recommendations, as well, but we also have an area of payment where things are not, I think, what any of us would consider to be fair, particularly in relation to other provider categories, or a reasonable use of public funds. And so my suggestion would be, should we consider kind of, I'll call it a tripwire augmentation of the first

recommendation about rebasing to say that in the event that this rebasing does not occur within X-period of time, then we recommend a more substantial downward adjustment, so that these kinds of margins are not perpetuated in the event that Congress elects not to rebase. That would be idea number one.

MR. HACKBARTH: The reason for my wrinkled brow is that in order to do rebasing or anything like rebasing in terms of the economic effect, I think would require legislation from Congress. It's not within CMS's regulatory authority.

DR. MILSTEIN: I'm referring -- in the event that Congress elects not to pass legislation that would lead to a rebasing --

MR. HACKBARTH: Yes, then we --

DR. MILSTEIN: -- then there would be some kind of a downward adjustment, a negative adjustment in the update. In other words, it's -

MR. HACKBARTH: So the Congress would have to do that, also, is what I'm getting at.

DR. MILSTEIN: Right. Right. Exactly. In other words, right now, if the recommendation on page 15 occurs, I

think we'd all feel more and more comfortable with the situation.

MR. HACKBARTH: Mm-hmm.

DR. MILSTEIN: But what about -- what I'm suggesting is a supplementary recommendation that would essentially be worded, in the event that such legislation is not passed, then we would, by a certain date, then we would recommend a downward adjustment in the payment rate. That's the --

MR. HACKBARTH: [Off microphone.]

DR. MILSTEIN: Yes. Yes. One or -- A or B, not perpetuation of the current equilibrium. That's idea number one.

A second idea is Slide 6, if you had to say, okay, what would prima facie evidence of service volume being massively driven by payment rules rather than medical appropriateness, this would be it. I mean, you just don't get anything cleaner than this. And so I think we should also come up with a recommendation having to do with an approach to certifying need for these services that is drastically different than what's currently in place.

And whether we -- I can't remember exactly what we

recommended for hospice, but something -- this just cries out for strong medicine, and so something along the lines of a physician other than the physician financially affiliated with the home health agency making the determination, and maybe even taking it a step further, given this -- I can just imagine what it's like to be an attending physician getting lobbied and you're busy -- and to also think about is there some way of coming up with something as equally -- what is the word -- gripping for a physician as the physician attestation rule that was implemented concurrent with hospital prospective payment, which, frankly, really caused physicians to be very meticulous about making sure that the diagnoses, in this case, that the hospital was -- and codes that the hospital was proposing that would essentially determine the hospital's DRG payment rate were really made -- were clinically true, or clinically valid. But this is the equivalent of appropriateness on fire.

MR. HACKBARTH: So there have been some recurrent themes in this conversation. One is the potential for conflicts of interest in the certification decision as a potentially problematic area.

A second is to give more substance to the

certification of need and ongoing oversight of that by the referring physician.

A third is maybe we need to be tighter at the process of certifying new agencies or ongoing monitoring of existing agencies.

And then fourth is focused effort on areas where there is pretty self-evidently fraud, as in Dade, where we have got extraordinary outlier payments being requested.

Let us put our heads together and think about how we might incorporate those themes, whether in the text or potentially in terms of additional recommendations.

Peter, any comment? Nancy?

DR. KANE: Well, the other piece, I guess, is that it sounded like the market basket exceeded the rate of growth in costs most years and maybe we should rethink the market basket. I mean, is there something about the way the market basket is constructed that is not picking up the right mix of costs --

MR. HACKBARTH: Well, they are different things.

DR. KANE: -- or the rates or the indices for the costs?

MR. HACKBARTH: They are different things. The

market baskets, by design, are unit price measures where costs per case include not just the unit price changes, but the volume of services, in this case, per home health episode change. So you wouldn't necessarily expect them to be identical. In fact, what we would like to see over time is providers becoming more efficient in coming up with ways to hold down the costs.

DR. KANE: So the market basket is just the weighted costs weighted by categories times a proxy for the expected inflation for that. But do we think that's correct?

MR. CHRISTMAN: I mean, I think that the way I kind of keep this straight is it's an input price index. It simply measures the costs of inputs. And so if firms are able to reduce their costs by changing what their outcome is and still deliver an adequate benefit that --

MR. HACKBARTH: Changing the mix of inputs --

MR. CHRISTMAN: Or changing the mix, yes. They're able to beat it. But I think that that's something we could think about, whether or not the market basket needs to be rethought. The frustration is that it's always the starting point for where payments are going to be pegged, so that if

it's off, it does contribute to -- it could contribute to a mismatch in the long run.

DR. KANE: The reason it might be off is if it was off by the same reason that you need to rebase, which is it used the costs back when they set up these original episodes, assuming, I think, 1998 skill mix or whatever year it was. Was that when they set up the market basket weights?

MR. CHRISTMAN: They've updated the market basket since then, and really, because the categories of items that home health agencies buy really doesn't change that much, what really changes is the weights among different categories. And it has been reweighted. It was reweighted in the middle part of -- I think with data in the middle or latter part of this decade. But I think that -- I would be suspicious of the low cost growth we see except I have the margins that I do, and those high margins and the low payment updates that have occurred in many years make the low cost per case numbers I get credible to me. But beyond that, I think understanding why that is and whether it has implications for the market basket is definitely something worth thinking about.

DR. KANE: [Off microphone.] And I support the recommendation.

DR. BERENSON: Yes. I support the recommendation. I wanted to make a different point. In Executive Session, we had a brief conversation that Jennie initiated about sort of quality reporting and pay-for-performance and wanting to get back to sort of thinking strategically about it. To me, this is a great example, having dialysis and then home health, where in dialysis we have excellent measures. They are absolutely appropriate to what dialysis is supposed to be achieving. They're not easily gameable. And here, we've based on Bruce and Bill's suggestions, and I agree completely, we don't know what we have in the way of quality outcomes, but we have a recommendation from last year that we would emphasize outcome-based quality incentives.

But you've ticked off at least five things that a value-based purchaser would want to do, in my view, before worrying about outcome measure rewards or penalties or something like that. To me, this is a great example of where value-based purchasing does not equal pay for performance. You would adopt a whole bunch of different kinds of strategies, and only when you really had some

confidence that your quality measures were reliable would you really want to build that in. We want to get the right agencies into this program. So that was the point I wanted to make.

MR. HACKBARTH: And it is a good one. Let me just say a word about the genesis of that language that is in the recommendation.

One of the concerns that we've had in previous discussions is, let's assume the rates are significantly reduced as a combination of the coding -- the offsets for coding and rebasing and they go down 15 percent. Given the rather amorphous nature of the product, there is a concern that, okay, rates are 15 percent lower. We'll just change the product that we're producing and still have double-digit margins. And so what we were trying to express there is we've got to figure out what it is we want to buy in terms of what the beneficiaries, the patients, are getting so that we have a system where we're certain we're protecting that and it's not being sacrificed.

Now, we are some distance, I think, from having those measures in hand, but that was the intent. And maybe we can look at that language and see if it can be worded in

a way that better conveys the point.

DR. CROSSON: I guess I was going to make the same point or a similar point. I support the recommendation, but I have some private reservations about whether it's actually going to work, that is, the rebasing process, for the reasons you said. I mean, if you look at Slide No. 10, and Evan has referred to this several times, in the face of all sorts of different reductions or freezes, the profit margin has remained the same.

You know, I am a proponent of prospective payment, but I suspect that, so far, at least, this is a circumstance in which it doesn't work very well, and it doesn't work very well presumably because the benefit itself is obscure. It seems to be fungible in terms of the frequency with which it's delivered, the nature of the services that are delivered, the skill level of the individuals delivering the services and their reimbursement level, and then also the absence of quality measures.

So if I were someone in CMS and I suddenly got a memo across my desk that said, please rebase the payment system for home health visits, the first question for me would be, well, based on what? What is it that I would be

rebasing, and it suggests -- and maybe this is the point you made, Glenn -- that there's going to have to be some tacking down of what it is actually that's going to be paid for. And if that is, in fact, the case, then I'm an enthusiastic supporter.

MR. HACKBARTH: Evan, would you put up Slide 16 for a second? So just to get our minds in gear here, this would be one of the recommendations that we would not re-vote. This would be rerun in a text box. At least, that was the plan. That was my proposal.

Now, if you look at the actual text of the language, we say two quite different things. The first sentence says, well, the Secretary should assess payment measures that protect quality of care, and this is the one that caught Bob's eye. The second talks about alternative payment strategies, including use of blended rates.

Evan, correct me if I'm wrong or if you feel differently about it. My guess is that the second of those things is easier to do than the first. Getting the quality measures that are robust enough that we really feel confident that we're defining this product is a worthy goal, but not necessarily an easy thing to do.

Bill, my recollection -- the second sentence about alternative strategies was a conclusion that Bill led us to over, actually, several years, I think, and Bill's point was precisely because we have got a poorly defined product, it is not suitable for strict, fully prospective payment and so we ought to give serious consideration to moving towards a system that, for example, blends prospective payment with cost.

And so based on this conversation, what I'm coming to is, well, maybe what we need to do is re-vote, have a new recommendation on which we vote that emphasizes the second part of this. We have got to change the payment system and time is of the essence in doing it, as well as doing the conflicts and the attestation requirements and all the other things we discussed.

DR. CROSSON: I would agree with that.

DR. SCANLON: And I was so happy last year to have risk corridors in there that I was supportive of this whole recommendation, but I have expressed the same concerns that Bob has had over the years, which was, one, about the quality measures that we have for home health, and two, about the data that we have to implement them. In both

cases, they really undermine what we might want to accomplish. While it may be an ideal, we are not there. And so the risk corridor, in some respects, is protective of the program, and actually, I mean, it is going to encourage service as opposed to the current system, which really discourages service. If I can get away with providing less, I make more on my margin.

DR. MARK MILLER: Well, we will obviously do this, and we will take this back and try and crank through the language. There's at least a couple of things I would kind of point you to.

Actually, in the last sentence, it also says outcome-based quality, and some of the thinking was is that you have that oasis-based kind of status of the patient quality measures, but there was some discussion of, well, what if it is emergency room? What if it is hospital readmissions, where there is something -- I am not actually measuring the home health product. I am actually trying to figure out whether somebody is hitting other areas of the system when they shouldn't have. So that thought process was involved here.

The only thing I will say about part cost and part

bundled payment is, I mean, when this was on a cost basis, this wasn't functioning very well, either. I mean, we had the same patterns of home health agencies coming in --

DR. SCANLON: Right, and that was a pure cost basis and that was probably the problem. And the only control we had then was on the price of a visit. We had no controls on the number of visits. The idea of the risk corridors would be to put something that combines the bundled concept with incentives to both sort of be efficient and penalties for not being.

MR. HACKBARTH: And as somebody said -- I think it was in this discussion -- the challenges here aren't going to be solved solely by payment system revision. We've got to do these other things about how people are referred to home health, et cetera, and improve those, as well.

DR. BERENSON: [Off microphone.] May I make just one more point?

MR. HACKBARTH: Yes --

DR. BERENSON: Very fast, just that I generally like outcomes more than process, but you need case mix adjustment to do outcomes, and that is the problem.

MR. HACKBARTH: Okay. We've managed to lose that

five minutes that we made up last time, so if everybody will please be brief and to the point. Bruce?

DR. STUART: I will be brief. I voted for Bill's piece here that shows up as recommendation three, but I think we've gone past this now. I really do. I think that whether it is cost or whether it's prospective prices, it really is the product and we should have language that reflects that, because this implies that we know what the product is, sort of, despite the language around this that suggested the lack of definitive definitions. But I think we really have to nail this thing down this time and I would really like to see some other language that was focused on that as the primary recommendation for this benefit. Otherwise, we are going to be here next year and we are going to be talking the same thing.

MR. HACKBARTH: Yes. I'm with you in terms of objective, Bruce. But what I'm focused on is doability and how quickly you can do it. I agree that the ultimate solution to this problem is a clear, robust definition of the product. I've been doing Medicare for 25 or 30 years. People have been saying that the whole time. I am not optimistic that that's going to be resolved real fast.

I do think -- and notwithstanding Mark's entirely appropriate cautions -- I do think that you could move away from fully prospective payment much more quickly, attenuate some of the problems -- not solve them, let's be clear about that, but attenuate some of the problems, and then bring in some of these other administrative steps to have a relatively short-term, more robust package that's likely to improve the situation. It won't solve it. It won't make everything in home health perfect. But it will improve the situation.

If we say, oh, what we're going to do is go after the robust definition of the product that we're trying to buy and how to measure it, that's an ever-elusive goal, I fear.

DR. STUART: I agree, and I do support the basic recommendation.

MR. GEORGE MILLER: Very briefly, in listening to this discussion, I guess I'd raise the question, do we have the right product for what we were trying to do? I don't know if we should raise that question, but because we've been doing this for about -- home care has been a problem for 20 years that I recall, maybe we don't have the right

products, so we can't devise an appropriate payment stream to solve the problem. I don't know if we can take that on our plate, but under the mandate, make sure we are using tax dollars appropriately and providing value to Medicare beneficiaries, I would raise the question.

MR. HACKBARTH: That is what I was just trying to say.

MR. GEORGE MILLER: Yes.

MR. HACKBARTH: I agree in principle --

MR. GEORGE MILLER: But you don't know what to do about it.

MR. HACKBARTH: -- but trying to define the product is a very difficult thing to do, and I'd like to see us recommend some things that can improve the situation sooner than that.

MR. GEORGE MILLER: For one year or two.

MR. HACKBARTH: Herb?

MR. KUHN: Yes. I support the recommendation we have before us now, but I also look forward to the enhanced recommendation that we will see. Having said that, two parts that would be helpful for me as we go forward.

One, I agree with Bob. The definition of value-

based purchasing can be whatever you want, but the bottom line for me, it's measured performance and some of the things that you articulated in terms of common themes, I would put in that category of measured performance. So we need to address those.

The other thing that would be helpful for me as we think about that enhanced recommendation here is going back to what Arnie was alluding to earlier where we were looking at the therapy services. When CMS made that change from that hard cut-off at ten and then we saw everybody kind of bundled around 11, 12, 13, the idea at the time was to create almost an outlier-type incentive, so that if more services were delivered, they were at a lower rate, and hope that would be a good controller there.

So as we think about that particular aspect, if we could go back and look and see what CMS's projections were and their impacts of what they thought that policy would be, whether it is from the policy shop or from the Office of the Actuary, but I would like to see how far was missed in that first year as a result of that new payment change, because as we all know, productivity works both ways and health care productivity works in terms of generating more services or

getting more efficient. It looks like productivity went upward on this one and I'd just like to see how much they missed it by, if we could look at that, as well.

MS. HANSEN: Just that I would support, and I would really support the latter conversations that we recently have, and then emphasize one way to just be objective about it is Chart 11 really speaks to Jay's comment about fungibility, you know, and still producing the same result. So there are enough charts in here, Evan, that you have produced that just tie some dots together that emphasize the discussion we most recently had.

DR. DEAN: I appreciate the discussion. I'd like to come at it, actually, a different perspective in a way, and I think it's an example of how aggregate data can be misleading, because the situation in my area is absolutely totally different than the image that we've seen. I happen to live in an area where these services are not available. The number of home health agencies in South Dakota is declining. We've lost three in the last year, which doesn't sound like many, but that's almost 10 percent of our agencies. Most of our agencies are facility-based. I think about three-quarters of them are not-for-profit and about

two-thirds of them are hospital-based. There's a whole quadrant of the State where there are no agencies.

So I understand that the recommendation makes good sense for the problem, which is obviously a real problem, and I have no doubt -- there's probably, to some of the previous comments, I mean, this is a distribution issue. I'm sure that the aggregate amount of money going into home health is probably adequate or way more than adequate. But the current distribution structure clearly misses at least one whole State that I happen to know something about.

So I think that the recommendation certainly addresses a problem appropriately, but we really need to expand it, and I'm not exactly sure how, but --

MR. HACKBARTH: I think your characterization was a good one, Tom, that what you're referring to is an issue about distribution of payments as opposed to the size of the payment pool --

DR. DEAN: [Off microphone.] I'm sure the size of the payment --

MR. HACKBARTH: Well, we've got ample evidence that the size of the pool is way more than ample. And as I've said to you when we've talked about your situation in

particular, I'm open to the idea that there may be some areas of the country that are sufficiently unique because of distances traveled, whatever, that they could require some special adjustments. And I'm open to you or anybody else to try to figure out whether we can define such a category in a way that's appropriate and rigorous.

To say that we ought to pay all home health agencies at this rate in order to deal with Wessington Springs, I think is crazy.

DR. DEAN: [Off microphone.]

MR. HACKBARTH: Yes. Mike?

DR. CHERNEW: I agree with what Tom said, and let me just quickly say, first, that in response to a very early comment by Nancy, the evidence evaluating the interim payment change that happened in the 1990s suggests that there were big cuts, losses in utilization, that they were having a very hard time finding quality decrements associated with that. So I think there's some evidence that there was room there.

But that being said, I do believe, and I think Tom said it well, that this is really a valuable benefit for a lot of people, and figuring out how to preserve it while

getting out the part that's waste is really our challenge, and that's hard to do when you're only dealing with averages. We don't know what are good or bad agencies. We don't know what's appropriate care at the margin.

So one thing I think we should do, for starters, is try and figure out, if we look at the low-margin agencies, for example, figure out, where are they geographically, so we know what the low-margin agencies are. It would be nice to know, where are they, just Dartmouth-Mathy kind of way. We know that they're rural and urban, but we might be able to see they're all in the Dakotas or something, and that would be useful to know. And it would be nice to know if we had good quality measures one way or another for them, because that's really the group that we're worried about harming when we do the recommendation, which incidentally, I support.

The last thing I'm going to say, and I'm going to sound like an economist, and I try not to do that too much in public --

[Laughter.]

DR. CHERNEW: -- is there seems to be no discussion of what beneficiaries pay or any type of market

test for the value of these services. The entire approach that we've had around the table is what we pay, how we certify, how we inspect, and where all the horrible data observation of what goes on. And if I understand correctly, and I might be wrong, the beneficiaries aren't paying anything at all for any of this. And so, as I said, my grandmother, who loved her home care, incidentally -- because they were nicer than my mother --

[Laughter.]

DR. CHERNEW: -- which is true --

DR. DEAN: Do you want that on the record?

DR. CHERNEW: Yes, actually, I do.

[Laughter.]

DR. CHERNEW: But in any case, I'm not sure that she needed all that she had, and having her have to pay some would have been a pretty good market test of whether she thought it was worth -- because the people love their home care, and I think a lot of the stuff it does is good, even if we can't measure it in our quality. And the idea to say it's free, but we can't measure the benefit so we're going to cut the payments, is really a challenge.

So I would be amenable to thinking about ways of

making it, at least under some conditions, maybe means tested or something else, at least having some market test for these types of services. That might be off point.

MR. HACKBARTH: No, I think that's a good point, and going back a number of years, I can't remember exactly how many, in fact, we had at least considered if not made recommendations to introduce a copay to home health. The time I'm remembering is in the context of discussing restructuring of the benefit package, and so that may well be something worth coming back to, Mike.

Mitra?

MS. BEHROOZI: Had you started round two at this end of the table, I would have been fighting to get that restated recommendation out there as one that we re-vote on, but I don't have to do that now because everybody else has much more eloquently made the case for that.

I would just suggest that in the text, we do more of the discussion that we had done before. I think that's, when in the Executive Session I was sort of going on around it, I think the text doesn't kind of line up with the restatement of that, or re-voting on that recommendation.

I would include, I think -- I would hope that

going to a more refined kind of payment system would be at least partially for the purpose of addressing the variability that Tom is talking about, whether it's regional or whatever. I mean, that's kind of the point. It's not just to take -- so, yes, I support the first recommendation, but I don't think it's kind of as important as the second recommendation, because saying there's too much money in home care and then flat across the board, whether it's a no update, or as Congress is considering in health care reform, a 13 percent reduction across the board, doesn't address any of these much more sophisticated nuanced question that we've raised. So I'd really like to emphasize that about the second recommendation.

MR. HACKBARTH: Thanks, Mitra.

Just one other thought related to Tom's comment. If Medicare were to go to a system with risk corridors or blended perspective and cost-based payment, the effect of that would be to attenuate the effects at the two ends of the continuum. So you would reduce the number of very high-profit agencies and you would reduce the number of losing agencies, and so there might be a secondary benefit, at least for some of the agencies that you're concerned about,

Tom.

Okay. Thank you, Evan. Lots of food for discussion and thought.

Okay, next up is hospice, and let's see. We are 45 minutes roughly behind schedule, for those keeping score.

We've got hospice and skilled nursing facilities left to go, and both are important, and I know commissioners have a lot of interest in each of those. So I don't want to gift short shrift to either, but I, again, would like to be as efficient as we can be.

Kim?

MS. NEUMAN: Good afternoon. We're now going to focus on hospice. I'll present the most recent data for your consideration as you assess Medicare payment adequacy for hospice services, but first a quite note about the November meeting.

A couple of commissioners asked specific questions at that meeting about our analysis of hospice visit data. I've researched these questions, but in the interest of time I will not cover them now. I'd be happy to answer any of them during the question round, or otherwise we'll follow up with you afterwards.

Before we look at the latest hospice data, a couple key background points. The Medicare hospice benefit provides beneficiaries with an alternative to intensive end of life care. The benefit includes a broad set of palliative and supportive services for terminally ill beneficiaries who choose to enroll. By enrolling, the beneficiary agrees to forego curative care for their terminal condition. More than one million Medicare beneficiaries received hospice services in 2008 with Medicare spending exceeding $11 billion.

The hospice benefit was implemented in 1983 on the presumption that it would be less costly to Medicare than conventional end of life care. Two major constraints were placed on the benefit:

To be eligible, a beneficiary must have a life expectancy of six months or less if the disease runs its normal course. Two physicians must initially certify that this is the case, and then, at specified intervals, a hospice physician must recertify that this remains the case.

Congress also placed a cap on the average payment per beneficiary a hospice can receive. This cap is applied in the aggregate on average across all patients admitted to

a hospice in a year. Hospices that exceed the cap must repay the excess to Medicare.

The Commission has spent a fair amount of time on hospice in the last few years. To recap where we've been, our prior analyses showed rapid increases in the number of hospice providers, mostly among for-profits, a substantial increase in the number of hospice users and a substantial increase in average length of stay, driven in part by incentives in the payment system that make long stays more profitable than short stays.

We also identified weaknesses in accountability within the hospice benefit, including reports of some physicians certifying patients for hospice who may not meet the eligibility criteria, and questionable relationships between some nursing homes and hospices that may raise conflict of interest issues. To address this, in March, 2009, the Commission made recommendations to reform the payment system, increase accountability, and collect more and better data.

So now we'll take a look at the most recently available hospice data, using our standard update framework. The number of hospices has increased substantially in the

last decade, growing from about 2,300 providers in 2001 to about 3,400 in 2008. The increase in the number of hospices has been driven largely by growth in for-profit freestanding providers. Not shown in the chart, the number of hospices has grown in both urban and rural areas, about 8 percent per year in urban areas and 4 percent per year in rural areas, from 2001 to 2008.

Hospice use among Medicare decedents has grown substantially in recent years. The percent of decedents using hospice grew from 23 percent in 2000 to 40 percent in 2008. Over this time period, hospice use increased across all demographic characteristics we examined: gender, age, race and ethnicity. Despite this growth, there remains a lower prevalence of hospice use among racial and ethnic minorities.

Between 2000 and 2008, Medicare hospice spending almost quadrupled as the number of hospice users and average length of stay increased.

Between 2000 and 2008, the number of hospice users doubled from just over 500,000 to just over a million. Average length of stay also increased among decedents from 53 days in 2000 to 83 days in 2008. The increase in length

of stay reflects largely an increase in very long hospice stays. There has been substantial growth in hospice length of stays at the 90th percentile, with an increase from 141 days in 2000 to 235 days in 2008. In contrast, the median length of stay has held steady at 17 days since 2000.

The increase in long hospice stays appears to be partly the result of enrollment of more beneficiaries with non-cancer diagnoses, for whom it may be harder to predict life expectancy. However, a change in diagnosis profile does not fully explain the growth in very long stays. Some providers, particular providers that exceed the hospice cap, appear to have a higher prevalence of long stay patients across all diagnoses.

We estimate that the share of hospices exceeding the cap in 2007 was 10 percent. Above cap hospices are mostly for-profit providers. They have long lengths of stay even after controlling for diagnosis. For example, in 2007, about 47 percent of patients with COPD had stays exceeding 180 days in above-cap hospices compared to 24 percent in below-cap hospices.

Hospices exceeding the cap also have a much higher rate of patients discharged alive than below-cap hospices.

In 2007, nearly half, 46 percent, of the discharges from above-cap hospices were live discharges compared with 16 percent in below-cap hospices. These high discharge alive rates, along with long lengths of stay, may suggest that above-cap hospices are enrolling beneficiaries before they are ready for the Medicare hospice benefit.

Some critics of the hospice cap have asserted that the cap impedes access to care. Our analysis shows no evidence that this is the case.

In the following slide, we have the top 10 states with the highest use of hospice among Medicare decedents. These states all have above average hospice use rates. As you can see from the chart, many of the high-performing states in the faint yellow there have a low rate of hospices exceeding the cap. This demonstrates it's not necessary to exceed the cap to achieve high hospice use rates.

If I were to put up the same chart with the top 10 states with the highest use of hospice by minority populations, you'd see the same pattern -- no relationship between hospice use rates by racial and ethnic minorities in the share of hospices exceeding the cap.

Now moving on to hospice quality, currently, there

are no publically available data on hospice quality that cover all hospices. Some hospice industry associations have surveys of family members and patients. These data, however, are not public and do not cover all hospices.

CMS is currently testing 12 hospice quality measures and 7 hospices in New York. These are measures that would generally be obtained through medical records. Some examples are the percentage of patients with certain symptoms such as pain, nausea or anxiety, who receive treatment or experience symptom relief within a specified time period. The project is scheduled to be completed by October, 2010, and is being conducted in accord with NQF standards.

Now taking a look at access to capital, with regard to hospice, it's important to note that hospice is less intensive than some other provider types in terms of capital. Access to capital among freestanding hospices has a couple of facets:

Publically-traded hospices are reporting strong financial performance and are likely to have solid access to capital.

Robust market entry of for-profit freestanding

providers also suggests availability of capital.

Access to capital for nonprofit freestanding providers is more difficult to discern.

Hospital-based and home health-based hospices have access to capital through their parent provider.

Next, moving on to costs, this slide shows that costs per day vary by type of providers. Freestanding hospices have lower costs per day than provider-based hospices. For-profits have lower costs than nonprofits. Above-cap hospices have lower costs than below-cap hospices. And rural hospices have lower costs than urban hospices.

The differences in costs we see across freestanding, hospital-based and home health-based providers are partly accounted for by differences in length of stay and indirect costs. Across all types of hospices, those with longer lengths of stay have lower costs per day. Freestanding hospices have longer lengths of stay than provider-based hospices and, consequently, lower costs per day.

But after taking into account differences in length of stay, freestanding hospices still have lower costs than provider-based hospices. This is partly because

freestanding hospices have lower indirect costs than provider-based hospices, which may suggest that the costs for provider-based hospices may be inflated by the allocation of overhead from the parent provider.

So the next slide shows our estimates of aggregate Medicare margins for hospices over time. From 2001 to 2007, the aggregate hospice Medicare margin has oscillated roughly between 4.5 and 6.5 percent. In 2007, the aggregate margin was 5.9 percent, down slightly from 6.4 percent in 2006.

A couple points about how we estimate margins, on the revenue side, we exclude Medicare overpayments to above-cap hospices. On the cost side, consistent with our methodology in other Medicare sectors, we exclude Medicare nonreimbursable costs. This includes bereavement costs and some small nonreimbursable administrative costs.

The exclusion of bereavement costs raises an issue. The statute requires that hospices offer bereavement services for the family members of their deceased Medicare patients, but the statute also specifies that bereavement services are not reimbursable by Medicare. The costs associated with bereavement services are not insignificant. So the Chairman, in developing his draft recommendation for

the hospice update, has contemplated this issue.

The next slide shows hospice margins by type of provider. In 2007, freestanding hospices had a margin of 8.8 percent compared with 2.3 percent for home health-based hospices and minus 10 percent for hospital-based hospices. Part of the reason for these margins' differences is the higher indirect costs among provider-based hospices. If home health-based hospices and hospital-based hospices had indirect cost structures similar to freestanding hospice, we estimate it would increase their margins by 6 to 10 percentage points, and it would increase the overall industry-wide Medicare margin by roughly 2 percentage points.

In terms of margins by type of ownership, for-profit hospices had margins of 10.5 percent compared to 1.8 percent for nonprofit hospices. Among freestanding nonprofits, however, margins were higher, 5.6 percent. Urban hospices had more favorable margins, 6.5 percent, than rural hospices who were at 1.2 percent.

Then finally, below-cap hospices had margins of 6.2 percent in 2007, slightly higher than the industry-wide Medicare margin of 5.9 percent. Above-cap hospices had

margins of about 20 percent for the return of cap overpayments and 2 percent after the return of overpayments.

So now we estimate the margin for 2010 to be 4.6 percent. In making this projection, we started with our 2007 margin estimate and made several assumptions, including full market basket updates to the payment rates for 2008 to 2010. We also assume costs grow in line with market basket. We take into account changes to the wage index values in 2010 that result in a small decrease in payments, and we factor in the reduction in the hospice wage index budget neutrality adjustment in 2010 and 2011, which reduces payments to hospices.

So, in summary, the supply of providers has grown, driven by growth in for-profit hospices. The number of hospice users, length of stay and total spending has increased. The 2010 projected margin is 4.6 percent.

With that, I'll read the Chairman's draft recommendation: The Congress should update the payment rates for hospice for 2011 by the projected rate of increase in the hospital market basket index, less the Commission's adjustment for productivity growth.

The implications of this would be a decrease in

spending relative to current law, no adverse impact on beneficiaries is expected, but there may be increased financial pressure on some providers. Overall, though, we would expect a minimal effect on providers' willingness and ability to care for Medicare beneficiaries.

Sorry, technical difficulties. There we are. That's the draft recommendation. Those were the implications.

One final point, as you know any update recommendation would affect aggregate payment levels but not the distribution of payments across providers. However, the Commission's March, 2009 recommendation to reform the hospice payment system would affect the distribution of hospice payments. In particular, the payment system reform model recommended would have the effect of increasing payments for hospices who tend to have fewer very long stay patients, which would increase payments to nonprofit hospices, provider-based hospices and rural hospices.

In our 2010 report to Congress, we anticipate reprinting the Commission's March, 2009 recommendations, and they are this first one for payment system reform, the next two on accountability and the third one on more data

collection.

So, with that, I will conclude the presentation and look forward to your discussion.

MR. HACKBARTH: Nice job, Kim.

For the benefit of the audience, let me just make an introductory comment on this. Much of our recent discussion about hospice has focused on very long lengths of stay. I want to emphasize that the issue around long lengths of stay is the timing of the admission to hospice, and it's not about wanting people to die more quickly or anything like that. It's really about the timing of the admission to hospice, and when the admission is early, obviously, that tends to increase the average length of the stay.

Okay, let me see hands for round one clarifying questions, starting with John and then Peter and Nancy.

MR. BERTKO: Kim, Slide 11, please. I'm struck here by the two states here with these very high percentage of hospices exceeding the cap. A two-part question, the first was are there diagnoses or explanations for why these particular ones?

Then the second part is: Is CMS doing anything to

investigate why so much excess, so many of them are exceeding the cap?

MS. NEUMAN: I can't speak to your question about a specific state. I can tell you looking at the cap, hospices in general across all states.

When we look at the profile by diagnoses, what we see is that these hospices have longer lengths of stay across all diagnoses. So it's not just that there's a different mix of patients that they're taking. It's that these patients are staying longer, regardless of the diagnosis.

As far as additional CMS efforts beyond sort of the cap regulations of taking back overpayments, I'm not aware of any additional sort of scrutiny in that area, but I can check.

MR. BERTKO: Yes. I mean part of this I'd just be interested in. It's what Glenn said a moment ago. It's almost the recruitment of people into hospice at maybe too early of a time, inappropriate time. So I don't know if anything has been looked at on that.

MR. HACKBARTH: Go ahead and finish making your note, Kim.

In fact, let me just follow up on this same issue. In your presentation, you briefly mentioned, Kim, on Page 10, that for above-cap hospices substantially more patients are discharged alive. Could you just elaborate a little bit more on that and what data we have on that, because it goes to this timing of the admission and people being admitted?

MS. NEUMAN: Sure. So we have data on the discharge status of each beneficiary who is in hospice. So we looked at all of the discharges, both those that were alive and deceased, and we looked at what proportion of them were alive versus diseased. We saw that among the above-cap hospices, 46 percent of the discharges were live discharges compared to among the below-cap hospices where it was 16 percent.

We also looked at it by diagnosis, to see if perhaps diagnosis was somehow skewing these numbers. But across every diagnosis, we see substantially higher discharge alive rates among above-cap hospices than below-cap hospices.

MR. HACKBARTH: Okay.

DR. CASTELLANOS: Maybe level two, but that's a very interesting point.

Now I'd like you just to clarify if these patients are discharged from hospice alive, then readmitted at a later date, everything starts over again. So you can discharge a patient and then appropriately or inappropriately discharge the patient, but at a later date reinvolve him into the process with no penalty. Is that correct?

MS. NEUMAN: Well, a patient, as long as they are certified as meeting the eligibility criteria at any point in their life, of having a life expectancy of six months or less, can be enrolled in hospice.

Now one aspect of the hospice cap is that the patient is counted in the cap collection in the first year that they enroll in hospice, except for a couple technicalities which I won't get into. But, as a result, what happens is if a patient were to be in hospice for a long time and then be discharged alive and then reenter hospice later in their life again, that hospice that took this patient a second time in the cap collection would wind up having the dollars for this patient count without them counting in the denominator as a beneficiary -- so the extra dollars without extra people. To the extent that this

happens, it makes it more likely that someone will exceed the cap.

DR. CASTELLANOS: Are you saying then it's probably advantageous for some people to do that, that are close to the cap?

MS. NEUMAN: I'm saying that it would be disadvantageous to readmit someone who had already been in service in terms of the cap, potentially.

MR. BUTLER: The context of my question is I want to apply our principles consistently. So, this morning, we looked at -- I think it was this morning -- the market basket for the hospitals which were losing 7.2 percent, and we said full market basket index, which we have a draft because even if you're an efficient provider. We felt at least at this time, that's the draft. At the other end of the spectrum, either huge margins, it's either zero or in fact let's rebase to cost, even on top of that.

This is a little one of those in-betweens, and I'm trying to understand. On Page 19, coming in between is it's not wildly profitable and it's not a wild loser, so I'm trying to think about this increase appropriately.

You have an estimated margin of 4.6 in 2010, and

then when you take into account the recommendation, this says full market basket, assume from 2008 to 2010, with these other adjustments.

Then the recommendation that Glenn has put on the table suggests the full market basket minus the productivity. What would happen? First question, what does the recommendation do to the estimated 2010 margin?

MS. NEUMAN: The recommendation affects 2011.

MR. BUTLER: I'm sorry, 2011.

MS. NEUMAN: So the recommendation would be market basket, which is estimated right now to be 2.5 percent minus productivity, 1.3 percent. So it would be a 1.2 percent update in 2011.

MR. BUTLER: And I could assume that it's supplied then to a performance one year earlier of 4.6 percent.

MS. NEUMAN: Right, under 2011 policy. Yes.

MR. BUTLER: Okay. So I'm a little less clear in my mind now. What should we be shooting for as a margin, if any, or should it be zero in general, in principle, that we're kind of shooting for as a principle? It's a hard one, but it's not unimportant in my mind.

MR. HACKBARTH: It is an important issue and one

that I've wrestled with, Peter.

If you look at the draft recommendations and our past actual recommendations in previous years, the range of the recommendations is smaller than the range in the margins for the different sectors. So there's more difference in the margins than in the updates.

So is that a good thing or a bad thing? Well, I would say number one is that keep in mind that we have not reduced the update process to hitting a target margin. We look at financial performance and adequate access and access to capital, new entrants. We look at a variety of different factors, I think appropriately so.

And I don't think we want to get into a position of saying, oh, there's a target margin and what we're trying to do is hit that with the update number.

So, looking at hospice relative to some of the other providers, set aside hospital for a second, roughly similar in projected margins to dialysis and not too different from what we'll hear tomorrow on inpatient rehab and long-term care hospitals in terms of projected margins. We're sort of getting ahead of ourselves because we haven't looked at those recommendations yet, but I am recommending

different updates for those sectors that have similar projected margins. The reason I'm doing that is because in that case I'm taking into account the history of financial performance.

I'm mentioning this just to highlight. I don't think we ought to get into a formulaic, oh, the margin is this, therefore the update is that. I think that would be a mistake. I think we need to look at factors more broadly.

MR. BUTLER: I start thinking. Because of our discussions, I've tended to think market basket minus the productivity is kind of one way to look at it. To me, if it falls within a range of maybe a zero to 3 percent, zero to 4 percent profit, I'd argue you need a little profit to get cash to keep the business going.

So I would look at it kind of if it fell in that kind of range, then I'd say, well, then maybe the principle of market basket minus productivity is about right. I'm just sharing how I would think about it, but there are many other factors.

DR. KANE: Just a quick question and comment on the access to capital for nonprofits, you say it's difficult to discern. How many of the nonprofits are freestanding,

not hospital-based or nursing home-based?

MS. NEUMAN: There are more for-profit freestandings than not for-profits, but it's not an insignificant number. I can tell you. Let me just see.

DR. KANE: Is it like 100 or 300?

MS. NEUMAN: It's more in the three or more hundred range. Let's just look here really quick.

I'll have to follow up with you on that. It's not an insignificant number. There's a good chunk of freestanding nonprofits.

DR. KANE: So they may file IRS Form 990s if they're nonprofit.

MS. NEUMAN: Yes, they would.

DR. KANE: Therefore, you could see their balance sheets if you needed to, and they often list the debts, any kind of debt. So you could actually do it. I mean not that you want to do it one by one.

MS. NEUMAN: Right.

DR. KANE: But you may do a sampling, and you could actually test their access.

MS. NEUMAN: Okay, I'll take a look at that.

DR. BERENSON: Not in your presentation but in the

paper you sent around, there's this interesting finding that Medicare Advantage decedents are in hospice more than fee for service, although it's somewhat narrowing. Could you remind me how the payment flows? Who pays the hospice in that situation?

MS. NEUMAN: In that situation, Medicare pays the hospice for the fee for service beneficiary, just like they would pay them for the managed care beneficiary.

If the person needed services that were not related to the terminal condition, and I'm hoping my managed care colleagues will confirm this for me, I believe that the managed care plan can then provide those services, and Medicare will reimburse the managed care plan on a fee for service basis. Is that right, guys?

MR. ZARABOZO: Any provider can provide.

MS. NEUMAN: Any provider can provide them. Thank you, Carlos.

DR. BERENSON: Does the monthly capitation payment for the MA plan cease? That's what happens?

MS. NEUMAN: Yes.

DR. BERENSON: It's an offset. I mean it's a reduction?

MR. ZARABOZO: The person stays enrolled in the plan. The plan is paid the rebate dollars, essentially. That is, in other words, the extra benefits, the non-Medicare coverage benefits are still that portion of the payment. The MA payment is made to the plan, so that the person continues to be eligible. For example, like eyeglasses or whatever is still available through the plan.

Also cost-sharing, forgiveness of cost-sharing, a reduced cost-sharing through the plan is another benefit for which the rebate dollars are paying. If the person needs services unrelated to the terminal condition, they get that benefit.

MR. HACKBARTH: Clarifying questions?

Then on to round two comments on the recommendations and any request for additional information.

MR. BERTKO: I mean I support the recommendation. But just to make it stronger about the need to fix the short term versus long stay ones, do we want to again try thinking about a joint recommendation, a two-part recommendation that says do this update, less productivity, if you do the other part? That's a rhetorical question.

MR. HACKBARTH: So the implication would be if you

don't improve the payment system, no update.

Ron and other commissioners, as we go around, feel free to comment on John's proposal.

DR. CASTELLANOS: Slide 17, I guess one of the things that concerned me on this slide is we're excluding bereavement costs. I guess what I'm saying is since we're excluding it should we be a little bit more prescriptive as to what we expect or what we would like hospice to provide, to include bereavement costs, chaplain service, stuff like that? I don't see that involved.

MR. HACKBARTH: I'll ask for Kim's help here in a second. My understanding, Kim, is that the bereavement services are required services, but for reasons that aren't entirely clear to me they are excluded from allowable costs. So, when Kim reports the margins, the costs are understated by the amount of the excluded bereavement costs.

We're doing some more research to try to understand fully the reason for that, but that was a factor in my mind in making the update recommendation. To the extent that the costs are understated, the margins are overstated, and that was a reason why I thought market basket minus productivity as opposed to a zero update was

the thing to do here. Obviously, there's no right answer to this question, but that was part of my reasoning.

Other comments on the draft, requests for information?

DR. CROSSON: Yes, I support the recommendation. I'm not sure that I agree with the idea about making it contingent on the establishment of the U-shaped payment curve. I think there's been a fair amount of sensitivity in the last year or so, to end of life care, to hospice benefits and the like, and I think the changes that are justified and that we've recommended could end up being hung up for all sorts of different political reasons, and I'd hate to hold the update hostage to that.

MR. HACKBARTH: Others?

MS. HANSEN: Just a clarification about the bereavement costs because that can be significant. So is there a collection of information from the hospice programs, all the hospice programs, about the nature and the extent of their bereavement costs incurred?

MS. NEUMAN: Well, we have them on the cost report, so we know that they're about 1.5 percent of costs.

And hospices have to document they're providing

these services and so forth. So there is some of that information, although that's not the kind of thing that we have access to.

MS. HANSEN: So, given that, this average of 1.5 percent, is that rather even across all hospice providers or does it look different from sector to sector?

MS. NEUMAN: It is generally even across most of our hospice provider types. There is a little bit more bereavement in -- let me just confirm this before I say it. I believe that the nonprofits have a bit more bereavement costs than the for-profits.

MS. HANSEN: The reason I just ask was whether or not that 1.5 percent makes some significant difference in their rates to consider.

MR. HACKBARTH: At the bottom line, I consider 1.5 percent a significant difference, and hence, as I said, that was a factor in my thinking that as opposed to no update we ought to do market basket minus productivity.

DR. CHERNEW: I only have a question, which is probably for another time to think about this, but it is do you have any sense of how well the benefit design works for people that are in nursing homes versus in communities that

are in hospice and how?

One of the themes that I have throughout is how the benefit discussions we have work for a person. So, if someone is, for example, in a nursing home, they could also be in a hospice. So then they're getting the nursing home payment, and they're getting the hospice payment.

I'm not sure if they're more profitable, less profitable, longer stays, shorter stays.

MS. NEUMAN: Well, that's definitely something we're interested in looking at because I think that's been a recurrent theme, about whether the hospice payment system is sort of appropriately targeted or appropriately structured for the nursing home population who might have different needs from patients who reside in the home.

Last month, in our visit analysis, we found that nursing home patients actually were getting slightly more visits than patients in the home, and controlling for length of stay. So that raised some questions sort of about what's driving that. We'll have more data on visits, so we can get a better sense of sort of what's going on there.

And then there's also the question of whether there may be cost savings associated with patients in

nursing homes in terms of less travel time, ability to have a staff member at the facility rather than going from house to house.

So those are questions that to the extent that we can, we'd like to continue to look at that, but I don't think we have all the answers that you would like at this point on that issue.

MR. HACKBARTH: As you'll recall, Mike, another aspect of that that we looked at was potential conflicts of interest and referrals from nursing homes to hospices.

Okay, thank you very much, Kim. Well done.

And the last one for today is skilled nursing facilities. We made up a little time. We're about 25 minutes behind schedule. No pressure, Carol.

MS. CARTER: Okay, are we ready?

MR. HACKBARTH: Go ahead.

MS. CARTER: Okay, we'll be using our standard analytic framework for addressing the adequacy of SNF payments this afternoon. You all remember this is a per day payment system, and we've gone over the details of it before. So I'm not going to dwell on that here. It's in the paper.

In fiscal 2009, spending for SNF services was up over $25 billion. That's the line in yellow. The growth in spending has slowed a little bit, but it was still up 6 percent from 2008.

Fee for service enrollee spending is shown in green, and that increased slightly faster.

We gauge beneficiary access using a couple of different measures. First, the number of SNFs has grown slightly, about 2 percent, since 2001, with hospital base share having stabilized at about 7 percent of the industry. There's been a steady growth in the number of bed days available for SNF patients.

Turning to volume, volume measures both increased between 2007 and 2008. Covered days increased 3.4 percent, and admissions increased 2.3 percent. The share of beneficiaries who use SNF services has been steady at just under 5 percent.

Because providers view Medicare as a good payer, most beneficiaries appear to have little difficulty accessing SNF services, especially if they need rehabilitation care.

While access is good, we are concerned about two

subgroups:

The first are patients with medically complex care needs, such as patients who are dehydrated or have pneumonia. We have found that the number of SNFs treating these patients has decreased between 2005 and 2007, even though the number of SNFs increased slightly during this period.

The second group of concern are racial minorities. We found that minority beneficiaries had lower admission rates but longer stays.

In this slide, you can see the admission rates and covered days for whites and other races. Admissions for other races were 15 percent lower than for white beneficiaries, and the differences have increased over time. The stays for other races were longer, but this may reflect differences in their comorbidities.

We have not studied what accounts for these differences. It is possible, for example, that minorities use other post-acute services instead of SNF care, or that minorities are less likely to be hospitalized which would then qualify them for a Medicare-covered SNF stay.

The trends in service use are consistent with

those we've discussed in previous years. On this slide, I look at the three trends and your past recommendations to address them:

First, as I just mentioned, fewer SNFs admit special care and clinically complex patients. This trend reflects the inequities of the payment system that underpay for medically complex cases and overpays for therapy care. You recommended adding a separate component to pay for non-therapy ancillary services and replacing the current therapy component with one that bases therapy payments on patient characteristics, not service use. CMS is examining the issue of a separate NTA payment and plans to change the case mix classification system beginning in 2011.

The second trend, rehabilitation days make up a growing share of days, and the intensity of therapy services continue to increase. This trend reflects the incentives inherent in the PPS to furnish therapy services and the payment system's distortions, so that as therapy costs rise, payments rise even faster. The changes you recommended would more closely match therapy payments to therapy costs. Although CMS plans to change how patients are categorized into the rehabilitation case mix groups, it has not moved

away from basing payments on service provision.

Third, days are increasingly qualified for the highest payment case mix groups based on services that can be furnished during the preceding hospital stay. You recommended that CMS base its payments on the services furnished by the SNF, which CMS will implement beginning in 2011.

Turning to quality, we use two measures to assess the quality of care: risk-adjusted rates of community discharge and potentially avoidable rehospitalizations for five conditions. Looking at the seven-year trend, we see slow improvement. The rates of community discharge increase between 2005 and 2007 -- that's the group of bars on the left -- while the 2007 rate of rehospitalization was about the same as it was in 2006.

We continue to see differences by facility type and ownership. Hospital-based facilities look better on both quality measures compared to freestanding facilities, after controlling for case mix, ownership and location differences. Differences by ownership were mixed but small, with for-profits having higher community discharge rates and higher rehospitalization rates compared to nonprofits.

Unmeasured case mix differences and other factors that were not accounted for could explain some of these differences in quality.

We looked at differences in quality measures by race and found that the observed differences were not statistically significant once other factors, such as patient's conditions, were considered.

Turning to SNF access to capital, because most SNFs are parts of larger nursing homes, we assessed the access to capital for nursing homes. Lending to nursing homes has improved since last year, but it is still slow. The slowdown is not a reflection of the adequacy of Medicare's payment. Even though Medicare is a small share of most home's revenues, it is seen as a generous payer that homes rely on financially.

Analysts report that capital is available particularly for projects that spread risk, such as those that involve multiple sites or across multiple states, but that borrowers should expect more careful scrutiny of both their finances and operations. They told us that lenders are uncertain about the level of Medicare payments, given the condition of many state budgets, and lenders lack

certainty about how to price loans given the low lending volume, making comparables harder to find.

But again, access to capital is related to general lending trends and not the adequacy of Medicare payments. Medicare continues to be a preferred payer.

Comparing payments and costs, the aggregate Medicare margin for freestanding SNFs in 2008 was 16.5 percent. This was the 8th year in a row that the margin was above 10 percent. There continues to be variation in the financial performance across facilities, ranging from 7 percent for nonprofit SNFs to 19 percent for for-profit facilities. Rural facilities continue to have higher margins than urban facilities.

Looking at the distribution of margins, we found that half of freestanding SNFs had margins at or above 17.9 percent, one-quarter of SNFs had margins at or below 7.4 percent, while one-quarter had margins at over 26 percent. About 16 percent of SNFs had negative margins.

Looking at the distribution of standardized costs per day, one-quarter of SNFs had costs per day that were at least 10 percent higher than the national average, while one-quarter had costs that were 14 percent below the

national average.

I should mention that we adjust for differences in case mix using the nursing component relative weights which may not accurately reflect case complexity for all patients.

Not shown on this table, hospital-based facilities continue to have very negative margins, negative 74 percent. We have often discussed the reason for the large differences in per day costs between hospital-based and freestanding facilities, including their higher staffing levels and staffing mix, unmeasured differences in case mix, their higher overhead given their small size, and the fact that physicians may treat SNF patients as extensions of their inpatient stays.

I wanted to note that our recommendations to revise the PPS would redirect payments to hospital-based facilities based on the mix of patients they treat. We estimated that payments to them would increase by 20 percent.

To provide some context for margins, we compared freestanding SNFs in the top and bottom quartiles of Medicare margins. We found that high-margin SNFs had case mix adjusted costs per day that were 42 percent lower than

low-margins SNFs, achieved in part by having higher average daily census and longer stays over which to spread their fixed costs. Unmeasured differences in case mix could explain some of the cost differences between high and low margin agencies.

On the revenue side, high-margin SNFs had payments that were 7 percent higher than low-margin SNFs, reflecting a smaller share of less profitable, medically complex stays and a higher share of more profitable therapy days.

In our first attempt to look at efficient providers, we identified SNFs that had relatively low cost and furnished relatively good quality. I should point out in an environment in which the average margin is over 16 percent, it is not clear if we have identified efficient providers. It is possible that after multiple years of margins above 10 percent, there is not sufficient pressure on providers to be efficient.

That said, to be in the relatively efficient groups, SNFs had to be in the bottom quartile of costs per day, be in the best third for one quality measure, and not in the bottom third for the other quality measures for three years in a row. The quality measures we examined were our

risk-adjusted community discharge and rehospitalization rates, and 6 percent of SNFs met these criteria.

Comparing these SNFs to other SNFs, we found that they had community discharge rates that were 40 percent higher, rehospitalization rates that were 21 percent lower, and standardized costs per day that were 15 percent lower, and they had much higher margins, 25 percent. It is clear that it is possible to furnish relatively low cost, high quality care and do very well under this payment system.

We project the SNF margin to be 10.3 percent in 2010. The margin goes down for two reasons:

First, CMS lowered payments to more accurately account for the impact of the new case mix groups implemented in 2006. Whenever CMS implements a new case mix system, it adjusts payment, so that the classification system by itself does not raise or lower payments. We talked about that this morning during the hospital meeting. While CMS based its estimate on the best information it had at the time, more recent data indicate that the adjustment resulted in considerable overpayments, and so CMS lowered payments for 2010.

The second reason for lower margins is that SNF

costs have been increasing faster than the market basket. We assume that costs will increase at the five-year actual average cost growth and not the market basket in this modeled margin. This may be a conservative assumption because cost growth may slow due to broad economic conditions.

Before we discuss the update recommendation, I wanted to point out that the update is not the only tool, and we've talked about that in other sessions.

Past recommendations that you have made are listed here. First, you've recommended revising the PPS, so that payments are more equitable. You also recommended linking program payments to beneficiary outcomes by establishing a quality incentive payment policy. You also recommended expanding and improving the publically-reported quality measures, and gathering better information about service use, patient diagnoses and nursing costs. We plan to remind Congress of these recommendations by placing them in a text box.

So, to recap, we see that the supply of providers has increased slightly. Volume has increased. Quality has slowly improved. Capital is available, but lending is slow

due to factors not related to Medicare payments. The 2008 margin was 16.5 percent, and the project margin for 2010 is 10.3.

And with that, I'll put up the Chairman's draft recommendation: The Congress should eliminate the update to payment rates for skilled nursing facilities for fiscal year 2011.

Given that margins were higher in 2008 than they were in 2007 and projected to be more than adequate to accommodate expected cost growth, this continues to be a reasonable recommendation. The distributional impact of this recommendation would be dampened with the adoption of the recommended changes to the PPS that you have made before. This recommendation would lower program spending relative to current law by between 250 and 750 million dollars for fiscal 2011 and by 1 to 5 billion over five years. It is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

With that, I'll take your questions and comments.

MR. HACKBARTH: Thank you, Carol. Could you put up the slide that has our past recommendations?

So, you said that CMS is planning to do the non-therapy ancillary adjustment or a separate component for that in the future. Is that right?

MS. CARTER: I said they're looking into it.

MR. HACKBARTH: What about the others on therapy and outlier?

MS. CARTER: Well, they don't have authority to do an outlier policy.

MR. HACKBARTH: Okay.

MS. CARTER: And they are not currently looking at basing therapy payments on patient care needs.

MR. HACKBARTH: Okay. One other clarifying question about the outcomes, when we look at readmission rates and discharge to the community, are those rates somehow risk-adjusted?

MS. CARTER: Yes, they are, and this year we actually updated our risk adjustment methodology.

MR. HACKBARTH: Okay. So it isn't just based on the case mix used for payment.

MS. CARTER: No, it's no.

MR. HACKBARTH: Okay. Okay, clarifying questions.

MS. BEHROOZI: Thank you, Carol. In the paper,

and I guess you make some reference. Yes, you do make reference to it in the presentation, that nonwhite beneficiaries utilize SNF services at a lower rate than white beneficiaries do, and their length of stay is longer.

Either this is really obvious, or I'm leaping to a conclusion. Do you know whether nonwhite beneficiaries tend to cluster more in the complex case category as opposed to the location.

MS. CARTER: I haven't looked at that. I don't know.

MS. BEHROOZI: It might be useful to know whether that's the reason or whether there is some other factor at play.

MS. CARTER: Yes, it's possible I can get that information by January. I'll have to talk to our programmers about that.

MR. HACKBARTH: Other clarifying questions?

MS. HANSEN: Well, thank you, Carol. This is really nicely put together. I really appreciate also the recommendations that just give a context.

So it does go back to the access question on Slide 6, with fewer SNFs treating medically complex patients and

still as a category, regardless of race, but just this is a population in general that I've always wondered. We talked about the ESRD readmission rate and just because people have so many comorbidities.

So do the recommendations that likely might be considered by CMS help us address this potential cluster of individuals who oftentimes are not as easy to admit?

Because I think the report internally, the text that we had that complex cases seem to represent about 6 percent of SNF patients in the facilities that accept these cases and only about one-half of 1 percent of total patient days. So it seems to be a relatively small number.

Because of that, the distribution amongst a lot of SNFs and having the competency and skill to deal with it, I just see that as in some ways an awkward setup for expecting an occasional, a few very complex cases to be easily or effectively staffed and cared for by SNFs. So it makes me think, one, about the access and, number two, who might be best equipped to deal with this. So the loss of the hospital-based SNFs does concern me.

So is there anything here that seems to allow us to, again, assure quality access for these medically complex

patients based on past recommendations we made coupled with our current recommendation?

MS. CARTER: Well, let me say two things. When we modeled the impact of the proposed and recommended changes, we did look at facilities that had high shares of those patients, and we found that their payments would go up by 7 percent. So it is targeting dollars towards those patients.

And for facilities that have high ancillary costs, and that would include some of these patients, their payments would increase by 21 percent. So our recommendation changes are definitely trying to target money towards medically complex patients with high drug and ventilator care needs.

I should add that the case mix system that CMS plans to adopt in 2011 will increase payments for some of these patients, and I'm remembering ventilator patients. The payments go way up for that group of patients. So even some of the case mix changes that they're proposing will address some of this.

DR. MARK MILLER: And to make sure all of this right, I think two other things. One, we did that model, and the payments for the hospital-based SNFs went up very

significantly.

MS. CARTER: Right, 20 percent.

DR. MARK MILLER: Something like 20 percent, and then also up thereabouts is what I'm hearing.

Then very much what I would call sort of an Arnie or Mike comment, based on some other things that they said -- not this, this is mine. But also, if you are also at the same time sort of saying we're overpaying on the therapy side, you're also giving them an incentive to take a harder look at these patients again, if you're moving the money in that direction as opposed to right now where everybody is just going and grabbing therapy patients.

I'm hoping I didn't speak out of turn for you too.

MR. HACKBARTH: Other clarifying questions?

MR. GEORGE MILLER: You started to talk about an efficient provider. I guess my question is: Is there a correlation between a SNF efficient provider and an acute care efficient provider? Do you see an efficient provider as a hospital that has a SNF? I don't know if you tied those two together.

Then further, what efficient hospitals have a SNF, home care, hospice, ASC or any of other combinations where

they could shift some of their costs? I'm really not asking a SNF question. It's about the earlier discussion, but I'm just wondering if there's a correlation.

MS. CARTER: In the efficient SNF provider analysis, we did that on freestanding SNFs. So I can't answer your question directly.

MR. GEORGE MILLER: Okay.

MS. CARTER: A couple of years ago, Craig actually looked at whether hospitals that had SNFs, sort of how it affected their bottom line because it does facilitate, right. A hospital can move patients into their SNF. So, even though the SNF may be losing money, it's a strategic decision about having a place to put patients into a lower care level.

MR. GEORGE MILLER: I'll come back and ask that later.

DR. STUART: In the hospital chapter, we make a big deal about looking at the Medicare margin and comparing it to the facility margin. What do the facility margins look like for the nursing homes that contain the SNFs?

MS. CARTER: They were 1.9 percent.

DR. STUART: I'm sorry?

MS. CARTER: 1.9.

DR. STUART: So we do find. It's an important point because we do find the opposite relationship here that we find in hospitals, and we know that's true. You said that Medicare is a relatively generous payer for nursing home services as opposed to hospital services.

DR. CROSSON: Carol, maybe I should know this, but I was looking at the difference between Page 11 and 12 in terms of the average margin. My question is this just 16.5 and 17.9, is that just the difference between mean and median? Or is the average, when we talk about average margin, 16.5, is that weighted for volume?

MS. CARTER: Yes, that is an aggregate margin, so it would be weighted by volume, the 16.5.

DR. CROSSON: The 16.5.

MS. CARTER: Right. And the other margins here, these are -- well, those would be the margins at that percentile, right.

DR. CROSSON: That should be the median. Am I wrong?

DR. MARK MILLER: [off microphone] That's the median.

MS. CARTER: At the 50th percentile, that's the median, right. And then for others, here when I'm comparing, say, margins for the efficient groups, that's the median for that group.

MR. BUTLER: Yes, it's not our role to prop up the shortfall on the Medicare payments, but nevertheless I'm sensitive to it in the sense that the next year is going to be incredible in some states in terms of what they're going to do to Medicare. So it could come back to be an access issue, nevertheless, for us.

So I have a question, though, on what's included typically in a nursing home when you look at the range of services because one view of it is, well, it's mostly all skilled nursing beds, whether it's Medicare or Medicare. Another view is that at the other end of the spectrum is the skilled nursing facility sits in a very large retirement community that has independent living, the whole works.

Now, I know you don't have all the statistics, but is the bulk of the institutions that call themselves nursing home primarily skilled nursing beds, or is a fair amount of the typical nursing home business also go well beyond the skilled nursing beds?

MS. CARTER: The typical nursing home has maybe 12 percent Medicare. So Medicare is the minority player, if you will. But that's not true for hospital-based facilities where the majority, I think, of hospital-based facilities are Medicare.

MR. BUTLER: My question is not Medicare as a percentage of the payer, but skilled nursing beds as a percentage of the services that a typical nursing home offers. They could have daycare for adults with memory problems. They could have a range of things. So I'm just trying to get a mental model of the typical nursing home.

MS. CARTER: Well, most of them. I'm still trying to get a handle on this. Most homes are duly certified, and so the bed could be used today for a skilled patient, but tomorrow for a nursing home level patient. So it's not quite as clean as it might be in maybe some other industries.

That said, nursing homes typically treat skilled patients. Many of them, and a growing share of them, have hospice services, and some of them also have outpatient rehab. So they are not necessarily just nursing home business, and they're certainly not skilled nursing facility

businesses because that would be the minority of what they're doing.

Does that help?

DR. SCANLON: I would say that it's the minority of what they're being paid for by Medicare, but the certification requirements for nursing facilities are the same as the certification requirements for skilled nursing facilities. So we basically have the 1.7 million beds that could be SNF beds, but we just don't have that volume of Medicare patients at any point in time.

I mean, Peter, I think you're thinking of a retirement community or other campuses where, as Carol said, they may provide other services, but relative to the 16,000 or so nursing homes, that's a relative minority

MR. HACKBARTH: I just want to pick up on your first comment, Peter, about we don't -- I can't remember your exact words, but we don't do Medicaid or that's not our responsibility, something to that effect. I know you know this, but I want to do it for the broader audience. It's not just that we don't do Medicaid. It's that if we were to use Medicare to cross-subsidize Medicaid, it would have bad effects in at least two, actually more than two, but two are

particularly prominent for me.

First of all, using Medicare as the vehicle would poorly target the additional dollars. The nursing homes that have the highest proportion of Medicare would get the most money, but it's the ones that have more Medicaid that need the most help. So it's a very inefficient way to provide support.

And, to me, that's always been problematic, but it's really problematic given our overall fiscal situation. We don't have the luxury of sloppy efforts at subsidization.

The second piece is that if the federal government were to stand up and say, oh, we'll take responsibility for the bottom line for offsetting the Medicaid shortfalls, what do you do if you're a state legislature and governor?

You say, well, that's terrific. That's a reason for me to be even more aggressive in reducing the amount that I pay. The Feds are going to pick up the balance. It's their bottom line.

So it would just lead us further into a problematic area.

If there is a concern about shortfalls and Medicaid payments, the solutions are in higher Medicaid

payment, more federal government support for Medicaid, a lot of different ways it could be done. It isn't through using higher Medicare payments to SNFs. It just doesn't get us to where we want to go. So it's not just that we don't do Medicaid.

MR. BUTLER: And that is captured well on your point, sir, well captured in the draft chapter. So I do agree with that.

MR. HACKBARTH: Others?

DR. SCANLON: On the point about, the question of lower use by minorities, I don't know if you're explored it, with the geographic pattern there. This relates to the fact that this industry that we're trying to use is not a Medicare-dominated industry, that it's really Medicaid and state policies.

There are very large differences in terms of the amount of nursing home beds in a state relative to the elderly population. I don't know how that relates to any kind of geographic pattern in terms of minorities. Basically, states in the south will probably have 1/3 the number of beds than in some of the upper midwest states, for example. So, to the extent that there is any geographic

difference in terms of the distribution of minorities, that may relate to sort of some of the things that we're seeing here in terms of admissions.

MR. HACKBARTH: Okay, round two.

MS. BEHROOZI: In this iteration, I get to try to make the case first, but I'm sure others will make it better.

As to the two recommendations -- whoops, I'm looking at the wrong paper -- or the recommendation that we would just be restating or reflecting in the paper, I would suggest that the situation is somewhat similar to the home health situation, and maybe we really ought to re-vote on it because I'm just comparing the two presentations, the two slide presentations. You have almost exactly the same variation. You have the same median margin. You have the same 40 percent lower cost per episode and 7 percent higher case mix. I'm reading that from the home health paper because it's the same here.

Again, the importance of the more nuanced recommendation seems to argue in favor of actually re-voting on it than just doing the no update thing by itself.

MR. HACKBARTH: Here's the difference that I see,

and I welcome your reaction to it. In the case of SNF, as Carol reported, at least parts of our previous recommendations seem to be, if not at the point of adoption by CMS, they're actively considering the non-therapy ancillary and the therapy piece. The outlier portion does require congressional action.

Part of the issue that I was concerned about on home health was that our recommendations about changing the payment method and the like, nobody is actively working on or even considering for that matter. So I see a little different sense there.

In addition, I'm quite comfortable with where our SNF recommendations are. I think they're good recommendations. I hope both CMS and the Congress move ahead with dispatch to do them.

On the home health side, actually we talked about restructuring our recommendation to change the emphasis, which made me think re-vote.

So they seem a little different to me. Does that make sense to you?

MS. BEHROOZI: I understand what you're saying, but I'm not sure that that's enough to persuade me that we

shouldn't vote on the recommendation again because I just sort of feel like that's a direction that we have been moving in over the last couple of years is to kind of use the updates as a vehicle to really make the point. So they've picked up, or are starting to pick up, on some of it, but it really does seem like this is so well thought out, so careful, would address so much of the issue, unless you think it's too pushy. You know. Simply say, we mean it.

MR. HACKBARTH: Let me think some more about it, and we can talk some more about it. A concern that I have is if we choose this one to re-vote as opposed to just rerun in a text box, and not the one on primary care or some of the hospital ones, what is the basis for distinguishing among them?

As I said a minute ago, I think there is a difference between the home health situation and this one, and so that's what I'll be worried about. What is the implicit message when we're re-voting?

MS. BEHROOZI: To that, I would say it's about the wide variation really. It seems like there's a lot of extra money going into this. Making an update recommendation

that's an across the board, just take the money out of it kind of recommendation just doesn't seem to have much to do with what we've identified as the problem at all. That's the similarity that drives me to say it.

MR. HACKBARTH: Other round two?

DR. DEAN: I generally support the recommendation, although as I look at these Medicare margins, there's a difference between the top and the bottom, and I just wonder if we're really comparing apples to apples. I mean I think you alluded to some of the differences between the negative margin facilities, and the high margin, but I wonder if we need to try to look more specifically at those two groups and see if we're really comparing the same kinds of things. Are they different?

I guess the reason for that is are we going to hurt facilities that truly are providing vital services, the ones that are. If those, that group that's in the 10th percentile is there because of sloppy management, no problem. I mean they shouldn't get an update.

But if those high costs are related to other factors, and I think that's a possibility. I don't know that it is, but I guess I would just like to know more about

that group and see if we're being appropriate.

DR. SCANLON: If I could just comment on this, I mean I think if you go into a state, it would not be a surprise to find 100 percent difference in the costs per day of nursing homes across the state. In some ways, you need to think of nursing homes the way you think of single family homes and how much variation there can be in single family homes in a community or within a state, and that's what it is because these are residences for a very significant population. So they vary considerably in terms of the services they're providing.

The cost reports don't distinguish any of that. They capture all the costs of whatever is being provided by that organization, and Medicare is sort of operating in that context. So one of the things from either a quality measurement perspective when you try to look at the whole home, or from a cost perspective and you're trying to focus on Medicare, it's almost impossible because you're in this sea of variations that's being driven by other forces.

MR. HACKBARTH: Other round two comments, questions?

MR. BUTLER: Okay. So, about a year ago, I was

quite vocal in supporting readmission rates as being something appropriately to move ahead on, and hospitals taking some accountability, and we've done that. I kind of feel like we're at the same point on the nursing home side of the readmission issue because they too have often incentives to hospitalize. It refreshes their Medicare days and dumps a problem.

I don't know whether now is the time to make -- I don't know that it's precise enough to make a recommendation around it, but I'd like to think how we can bring this one, so we align the hospitals and the nursing homes, working on the issue together.

MR. HACKBARTH: An excellent point. Refresh my recollection, Carol, it seems to me that we have recommended pay for performance for nursing homes, and in fact, we actually engaged the folks in Colorado in trying to develop a better measures of performance, one of which was readmission rates.

MS. CARTER: Right. Yes. So, when I said that we both used the risk adjustment model originally and had them update and sort of refresh that risk adjustment model this summer, and that is one of our quality measures, and it was

specifically one of the measures we mentioned in our pay for performance recommendation.

MR. HACKBARTH: So maybe we ought to rerun that, and then, in a text box, explain that we're rerunning it because we want to bring in sync the SNF incentives and the hospital incentives. How's that go?

DR. MARK MILLER: This is a little ugly, but if it's going to be completely in sync, then it should be a penalty. The way we had proposed it was budget-neutral among SNFs.

MR. HACKBARTH: Yes. Let us think through that. The basic point about syncing up is a good one.

MR. BUTLER: Short of accountable care organizations, we're going to cobble together efforts to reduce utilization.

MR. HACKBARTH: Right, right.

MR. BERENSON: Can I just jump in and ask? Just to follow-up on that, Carol, the readmission rates, are those for particular targeted diagnoses?

MS. CARTER: Yes, it's for five potentially avoidable rehospitalization rates.

MR. HACKBARTH: Other round two?

Great work, Carol.

So we are at 5:22, 7 minutes behind schedule, not bad.

Okay, we'll now have our public comment period. While people are thinking about whether they want to go to the microphone, let me remind folks that the public comment period is not your only opportunity to comment on our work, nor even perhaps the best. We urge you to communicate with the staff. We urge you to use our web site, where you can also post comments on our meeting discussions.

So, welcome to the microphone. Ground rules are no more than two minutes. When the light goes back on, your two minutes are up. And please begin by identifying yourself and your organization.

MR. RIGG: Understood, Mr. Chairman. I appreciate that, and I also appreciate that I'm standing between you and the door. So I will keep it very brief.

My name is John Rigg. I'm from the California Hospital Association. The California Hospital Association, we're somewhat unique in that we represent a great proportion certainly than average and, if I'm not mistaken, the greatest number of hospital-based distinct part skilled

nursing facilities in the country.

That number, I'm sorry to report, has been dwindling at a rate of about one every six months in the State of California. We once represented almost 200 of them. We're now down to close to 100 of them. I believe that the latest numbers out of Sacramento is that has dwindled to under 100 of them.

You all know the cause behind that. It is profoundly low Medicare margins, profoundly Medicaid margins, although our members do not tend to treat as many Medicaid patients because those patients are placed outside the distinct part SNF afterwards.

I was only coming up to highlight a policy problem that you all are already extremely aware of, and that is the profoundly low margins and the profoundly low reimbursements for distinct part SNFs are driving our members out of the business and are driving beneficiaries' access down to zero as far as high quality distinct part skilled nursing facility care is concerned.

Our members tend to provide a higher intensity and higher quality of care to patients in the State of California than do our freestanding counterparts, and we

have empiric data, as you do, that that is indeed the case. And our members have felt as though, for a long time, they've been inadequately compensated for what amounts to higher quality care.

So I would suggest as you're considering going forward with skilled nursing facility recommendations, that you consider every time a no update recommendation, as has been the case for the last at least two or three MedPAC cycles, goes through, absent non-therapy ancillary, absent outlier policies, it's another nail in the coffin of the distinct part skilled nursing facility in our state, and I believe throughout the nation.

Perhaps that's something that this Commission is okay with. Perhaps it's something that you aren't. But I believe that every time this recommendation is once again passed unanimously, or close to unanimously, by this Commission it's implicitly moving the policy in that direction.

So, thank you for that time. It's just something to think about that I would suggest you discuss in the ensuing month.

And I wish you all a happy holiday, and I look

forward to seeing you again in January to discuss this further. Thank you.

MR. HACKBARTH: Any others?

Okay, we are adjourned until 9:00 a.m. tomorrow morning.

[Whereupon, at 5:27 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Friday, December 11, 2009.]

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 11, 2009
9:00 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, J.D., Chair
FRANCIS J. CROSSON, M.D., Vice Chair
MITRA BEHROOZI, J.D.
ROBERT A. BERENSON, M.D.
JOHN M. BERTKO, F.S.A., M.A.A.A.
PETER W. BUTLER, M.H.S.A.
RONALD D. CASTELLANOS, M.D.
MICHAEL CHERNEW, Ph.D.
THOMAS M. DEAN, M.D.
JENNIE CHIN HANSEN, R.N., M.S.N., F.A.A.N
NANCY M. KANE, D.B.A.
HERB B. KUHN
GEORGE N. MILLER, JR., M.H.S.A.
ARNOLD MILSTEIN, M.D., M.P.H.
WILLIAM J. SCANLON, Ph.D.
BRUCE STUART, Ph.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: It got silent right at 9 o'clock. That is impressive. Good morning. Let me, for the benefit of people in the audience who weren't here yesterday, just say a couple words about the context for what we're doing.

The December meeting, of course, is when we consider our update recommendations for various health care providers, and we'll be doing that this morning for inpatient rehab facilities and long-term care hospitals. Today we will discuss draft recommendations with votes in January. Of course, the other major activity in Medicare policy at this point is the congressional deliberations on health reform, which include important decisions about Medicare payment policy.

What we're doing in considering these recommendations is basically setting aside the activity on the Hill. Our job is to focus on Medicare as is, without regard to health reform. And so any effort to try to compare what we're doing with what Congress is doing can be a little bit complicated.

This morning we are going to begin, however, with Medicare Advantage, and, Carlos, Scott, who is leading the

way here?

Oh, right. Everybody needs to remind me at the beginning of each session. When we consider our payment update recommendations, the guiding principles for what we're trying to accomplish in Medicare payment policy are these items that are on the screen, and I think we're ready now, Carlos.

DR. HARRISON: Good morning. Carlos and I will present new information on the Medicare Advantage program today. We will present findings that will go into our March report chapter. More specifically, I will present the latest data on plan enrollment, the availability of plans for 2010, and our analysis of bids and payments for 2010. Carlos will present data on benefit enhancement and plan quality.

Enrollment in MA plans continued to grow substantially in 2009. From November 2008 to November 2009, enrollment in MA plans grew by 10 percent, or by 1 million enrollees. There are now about 11 million enrollees in MA plans comprising 24 percent of all Medicare beneficiaries.

Enrollment patterns still differ between urban and rural areas. Plan enrollment grew about 14 percent in rural

areas and about 9 percent in urban areas. However, despite the strong growth in rural areas, about 15 percent of rural beneficiaries are in MA plans while in urban counties about 26 percent of Medicare beneficiaries are enrolled in plans.

If we look across types of plans, we see growth in all plan types. HMOs added about one-half million enrollees, the greatest number of any plan type, while PPOs, both regional and local, grew 42 percent, the most rapidly of any type.

The rate of growth for private fee-for-service has been slowing considerably. The 7-percent growth figure this year was 35 percent last year and much higher in the last few years. We might even expect to see a decline in 2010.

Now let's look at plan availability. Access to MA plans remains high in 2010, and Medicare beneficiaries will have a large number of plans from which to choose. MA plans are available to almost all beneficiaries, as has been the case since 2006.

Looking at the top line, more local coordinated care plans, or CCPs, will be available in 2010 than in previous years; 91 percent of Medicare beneficiaries will have a local HMO or PPO operating in their county, up from

88 percent in 2009 and 67 percent back in 2005.

I don't have all of the historical data to produce separate rows for HMOs and local PPOs, but for 2010, 84 percent of beneficiaries will have an HMO available, and 73 percent will have a local PPO available.

Access to regional PPOs decreases to 86 percent in 2010, down from 91 percent previously. This is the result of the only insurer in two regions decided to discontinue its regional product. Enrollment in those two regional plans had totaled about 2,000. Private fee-for-service plans continue to be available to 100 percent of beneficiaries for 2010.

On average, 21 plans are offered in each county in 2010, down from 34 plans in 2009. There are two principal reasons for this decrease.

First, CMS made an effort to reduce the number of low-enrollment plans and duplicative plans. A duplicative plan is one that did not provide meaningful differences from other choices. Most often this refers to a family of plans from the same insurer with small differences among the benefit packages. Through the call letter that CMS publishes instructing plans how to submit bids, CMS made it

clear it wanted to reduce the number of duplicative offerings.

The second reason for the decrease is that we are beginning to see the effects of provisions in MIPPA. MIPPA requires that by 2011 private fee-for-service plans must develop provider networks in areas where there are two or more coordinated care plans. Some private fee-for-service withdrawals may be occurring in anticipation of this deadline. Indeed, while there is still an average of 13 private fee-for-service plans available for 2010, that is about half as many as in 2009.

As a very quick reminder to help us get through the next slide, let me briefly describe how CMS determines payments to plans.

A bidding process is combined with administratively set bidding targets called benchmarks to determine the capitated rates paid to plans. Plans submit a bid for the basic Medicare benefit, and it is compared with the benchmark. If the bid is higher than the benchmark, the plan is paid the benchmark, and enrollees would pay the difference with a premium. However, if the bid is below the benchmark, the plan is paid its bid plus 75 percent of the

difference between the bid and the benchmark, and the remaining 25 percent of the difference is retained by the Medicare program. The plan must then use its share of the difference to enhance its benefits, and Carlos will go into more detail on the enhancements in a couple of minutes.

The benchmarks are always at least equal to fee-for-service spending in a county and are usually above fee-for-service levels. The benchmarks are above fee-for-service levels because of some technical factors, but primarily because Congress wanted to encourage plans to go to low-payment areas that were not served by plans. Thus, legislation guaranteed that no county would have payment rates below so-called floor rates. In many areas, the floor rate was well above the county's fee-for-service Medicare cost.

I think you can tell these are preliminary data from this slide. Our preliminary analysis of plan benchmarks and MA payment levels shows that both continue to be well above fee-for-service spending. We find that in 2010 MA benchmarks will be on average 117 percent of spending in Medicare's traditional fee-for-service program. Bids will be 104 percent of fee-for-service spending, and

payments will be 113 percent of fee-for-service spending. Bids are up a couple points from last year, but both benchmarks and payments are down a point from this past year.

Now let's focus on a couple of plan types. We estimate that HMOs bid an average of 100 percent of fee-for-service spending, which suggests that HMOs can provide Parts A and B services at or under the cost of fee-for-service Medicare. However, because of the high benchmarks, we are still paying them 112 percent of fee-for-service.

Other plan types bid more. For example, private fee-for-service plans bid on average 116 percent of fee-for-service. In addition, private fee-for-service plans tend to attract enrollees from floor counties, so their benchmarks average 118 percent of fee-for-service and, as a result, Medicare payments to private fee-for-service plans will average 117 percent of fee-for-service.

I mentioned on the last slide that benchmarks are a lower percentage of fee-for-service spending for 2010 than in 2009. In fact, on an absolute dollar basis, the 2010 MA benchmarks are about a half a percent lower than the 2009 benchmarks. This change in benchmarks is the result of

several payment factors.

Two factors are rate reductions legislated in MIPPA and prior legislation. The phase-out of so-called hold harmless payments and the phase-out from benchmarks of indirect medical education, or IME, payments to teaching hospitals combine to lower benchmarks by an average of 1.3 percent. I can give you more detail on these phase-outs on questions if you'd like.

The other factor is the national growth percentage by which benchmarks are updated each year. It is based on the overall expected growth in fee-for-service spending with corrections for past years' mis-estimates on the level of fee-for-service spending. For 2010, the national growth percentage is 0.8 percent.

Now let's look at that surprisingly low growth percentage for 2010. Services subject to the Medicare sustainable growth rate, or SGR, which includes physician services, are assumed to be cut by 21 percent for CMS' purpose of calculating the 2010 benchmarks and the fee-for-service equivalents that we use as a comparison.

If Congress eliminates the 21-percent cut and instead keeps physician rates for 2010 equal to those paid

in 2009, then the CMS actuaries suggest that their estimates of fee-for-service spending would rise by about 4 percent. In other words, if the Congress eliminated the cut to the physician fee schedule rates and did not adjust benchmarks for 2010, the MA to fee-for-service comparisons on the last slide should all be lowered by four percentage points.

For example, the estimated MA payments would average 109 percent of fee-for-service spending in 2010 rather than the 113 percent we report on the previous slide.

However, even if an SGR change took effect for 2010, the four-point change in our estimates would be an anomaly that would only apply for 2010. Presumably, CMS would estimate 2011 fee-for-service levels and the national growth percentage with knowledge of the changes for 2010 and subsequent years. And remember I just said that the national growth percentage corrects for past mis-estimates. CBO and CMS are aware of this situation, and when CBO scores SGR changes, the score includes an interactive effect with Medicare Advantage.

Now Carlos will discuss enhanced benefits and plan quality.

MR. ZARABOZO: As Scott mentioned, when a Medicare

Advantage plan bid is below the benchmark, 75 percent of the difference is to be used to enhance the benefit package for plan enrollees. Listed on this chart are the five options that plans have for benefit enhancement. A plan can choose one or more of these options.

The majority of dollars that go towards benefit enhancement are used to reduce cost sharing for covered services under Medicare Part A and Part B. This comprises 54 percent of the dollars, the proportion shown in red on the pie chart. Providing benefits not covered by Medicare, the second item, comprises 21 percent of the dollars, and the three other options -- reducing the Part B premium, reducing the Part D premium, or enhancing the Part D benefit -- comprise the remaining shares of the distribution of enhanced benefits.

These proportions are slightly different from last year when reducing cost sharing represented 60 percent of the dollars. This year there is a slight shift towards enhancing the drug benefit.

In this slide, we present a different way of looking at the enhanced benefits in relation to Medicare program expenditures. What we show here is the dollar value

of the enhanced benefits compared to the cost to the taxpayers and Medicare beneficiaries who finance the cost of the Medicare program. In the table, the middle column of numbers shows the rebate dollars, including the cost to the plans of providing enhanced benefits. The last column removes the so-called load. The load is the cost to the plan of providing the benefit, which is a combination of plan administrative costs for the benefit plus the plan profit or loss.

Looking at the first row of numbers, the numbers for all MA plans, what this table shows is that, on average, each beneficiary that chooses to enroll in MA costs the Medicare program $97 a month -- more than if the person had remained in fee-for-service Medicare. The last column shows that about two-thirds of the dollars the plans are paid above fee-for-service are translated into net benefits for enrollees, or $63 per person per month.

The difference between the subsidy amount to the plans -- that is, the amount they are paid above fee-for-service -- and the amount going towards enhance benefits varies by plan type. HMOs receive payments that average $93 above fee-for-service levels. Much of that amount is

translated into enhanced benefits for enrollees. On net, HMO enrollees receive $82 worth of enhanced benefits.

This level of enhanced benefits contrasts sharply with the situation in other plan types. With the extreme case being private fee-for-service plans where Medicare pays on average $105 per month, more than fee-for-service. Most of the $105 amount is retained by private fee-for-service plans to cover their costs of providing Medicare Part A and Part B benefits, resulting in enhanced benefits valued at an average of only $18 per enrollee per month in private fee-for-service.

As you can see from the teeny, tiny yellow letters here, as Scott noted, with regard to these figures on the ratios in relation to fee-for-service, these numbers are subject to change. The SGR effect is relevant here. What would change in this table is the first column of numbers, which uses the current estimate of fee-for-service expenditures for 2010. If there is legislation that will maintain physician fees at 2009 levels in 2010, then the first column of numbers should be reduced by about one-fourth to 30 percent, depending on the plan type.

Across all MA plans, the dollar level of payments

above fee-for-service, the first number in the all MA plans row, would be closer to the rebate dollar amounts shown in the table. The rebate and benefit amounts would remain unchanged.

Although the numbers in the first column would be lower, there would still be significant differences by plan type in the share of the subsidy amount that went towards enhanced benefits, with private fee-for-service still the extreme case of a very small share of the subsidy being used for enhanced benefits.

Moving now to the information about quality of care in MA plans, we find results that are very similar to last year's results. The Healthcare Effectiveness Data and information Set, or HEDIS, tracks process and intermediate outcome measures. The most recent HEDIS data show year-over-year results that are similar to last year's results. The National Committee for Quality Assurance that oversees the HEDIS system, stated that this is the third year in a row that performance in Medicare plans is flat compared to the previous year. This year commercial and Medicaid plans that NCQA tracks were in the same situation; that is, they showed little improvement over last year.

In the HEDIS measures, we continue to see wide variation in results across Medicare plans for individual measures; that is, some plans have very low scores on measures for which other plans have very high scores. As was true last year, newer plans tend to have lower HEDIS scores.

In other measures of quality and patient experience in MA plans, results are positive but little changed from last year. The Consumer Assessment of Healthcare Providers and Systems, or CAHPS, is a survey of patient experience and enrollee ratings of their plans and the providers in those plans. The most recent CAHPS results show that Medicare enrollees are satisfied with their plans, more so on many dimensions than commercial plan enrollees surveyed through CAHPS. However, Medicare Advantage CAHPS results for this year were almost exactly the same as last year's in terms of the average levels of satisfaction.

The Health Outcomes Survey for the most recent two-year period to which the survey applies shows that all health plans had physical health outcomes within expected ranges. But out of 187 plans in the data set, ten showed worse than expected mental health outcomes and two showed

better than expected mental health outcomes. MA plans across all plan types perform well on the measures of flu and pneumonia vaccination rates for their enrollees.

This is the second year in which CMS is assigning star ratings to health plans. Here we look at the star ratings for overall plan quality, which is a composite of HEDIS, CAHPS, and HOS results, in addition to information about appeals, complaints, and information on CMS-required corrective action plans. In addition, CMS includes information on the plan's call center performance and plan disenrollment rates.

This table shows that almost half of HMO plan enrollees in MA are in plans with high star ratings, at or above 3.5 stars. This is also true of local PPO plans. Among plans that have a star rating, about 46 percent of enrollees in local PPOs are in plans of 3.5 stars or higher.

This year three plans, all of which are HMOs with very small enrollment, have a 5-star rating, the maximum rating. Last year there were no 5-star plans. As we discussed in the mailing material, the elements that go into the star ratings are different this year, and, therefore, you cannot directly compare this year's star ratings to last

year's.

Compared to other plan types, the performance of HMOs and local PPOs is far better than that of regional PPOs and private fee-for-service plans. Here we show that the majority of enrollees in regional PPOs and private fee-for-service plans are in lower-rated plans. We also note that 45 percent of private fee-for-service enrollees are in plans that have no star rating, either because they are too new or there is insufficient information to rate the plans. For other plan types, very few enrollees are in this situation.

We conclude our presentation by displaying past Commission recommendations on MA that will be reprinted in the March report. There are three such recommendations: having the MA benchmark set at 100 percent of fee-for-service; introducing a pay-for-performance system to reward quality in MA; and having the Secretary compute clinical measures to compare quality in MA to quality in the traditional fee-for-service program.

Thank you, and we look forward to your questions and comments.

MR. HACKBARTH: Thank you, Scott and Carlos. Could you put up Slide 6? I just wanted to go through,

Scott, what you said about these numbers just to make sure that I've got it correct.

So the 113 percent you say would fall to 109 if you adjust the calculation to reflect the likelihood that physician fees will not be cut by 21 percent. So if they were held constant, it would go from 113 to 109. Is that correct?

DR. HARRISON: Correct.

MR. HACKBARTH: Then you went on to say that that is really sort of a one-time effect and would not endure.

DR. HARRISON: Right.

MR. HACKBARTH: That is a little complicated. It may be worthwhile for you just to go over that more slowly.

DR. HARRISON: Well, what happens is CMS projects -- when they project the growth percentage, say, for 2011, they will take what they consider to be the best estimate of fee-for-service -- the USPCC, best estimate of fee-for-service spending in 2011 and update it from the last level that they published. So the last level that they published is here. If the fee-for-service spending went up 4 percent because of the SGR change, then that would be included in the national growth percentage for 2011.

MR. HACKBARTH: Now you went on to say that when CBO does its estimates, I think the way you put it was when CBO scores SGR changes, it scores the interactive effect with Medicare Advantage. And I just want to make sure that what that means is that the Medicare Advantage savings that are being discussed on the Hill and the CBO scores for those include this effect.

DR. HARRISON: Yes. If it is in the bill, it would include for that effect, yes.

MR. HACKBARTH: Okay.

DR. HARRISON: Now, they may not list it -- you know, they do these big scoring tables. There is a line usually that says interaction with MA, and so the interaction actually may be down there, not in the top-line MA line.

MR. HACKBARTH: Okay.

DR. MARK MILLER: But the fundamental point, I think, is that this process, this is sort of -- the MA rates get locked; fee-for-service, we don't know what's going on; and if the Congress comes along and say, Oh, by the way, I'm restoring the SGR, then by definition that ratio gets smaller because fee-for-service comes up. Then as you move

forward -- this is kind of, you know, the junior varsity version. So then in the subsequent year, basically the benchmark catch up to the fact that fee-for-service got raised, and so in theory, all things being equal, you should return to whatever the relationship was.

I want to be really clear about all things being equal. There is a bunch of legislation about to happen, or potentially happen, which could change the background. And, also, depending on what Congress does with SGR, we could find ourselves at this time next year in the same circumstance. And so exactly what that percentage is going to look like a year from now has got a lot of moving parts to it. But all things being equal, it should go back to the relationship that we have been estimating. That is kind of the junior varsity --

DR. HARRISON: Correct. Now, you know, on the other hand, if legislation were to cut hospital rates, we would see a decrease in --

DR. MARK MILLER: Right, you have got a lot of moving parts here. And then the other thing I was going to say about the CBO scoring, the other way to think about the CBO scoring is they are estimating the dynamics over a ten-

year period, and to the extent that this is kind of moving up and down, they are making those assumptions through the period, and so they will be catching up. And that is why the savings estimates aren't affected by the fact that this, you know, estimate could bounce up -- this ratio could bounce up or down.

DR. HARRISON: Right.

MR. BERTKO: I agree with everything that has been said and would make only one other point here. In the bid part, most plans that I know of bid actually what's likely to happen, not what's current law. And the Office of the Actuary, in reviewing the bids, allows historical things to be built in, and that means you assume the SGR is going to be fixed because it is a prospective bid. And so in that sense here, that 104 represents apples and the payments, the benchmarks as here, are oranges, just as Scott has described.

DR. MARK MILLER: I think that means what Scott said is that if this adjustment occurs, that bid will come down four points, too.

MR. BERTKO: No, no -

DR. MARK MILLER: Well, but the ratio will shift.

MR. BERTKO: The ratio will change, yes.

DR. MARK MILLER: The bids stay constant.

MR. BERTKO: The dollar amounts are fixed.

DR. MARK MILLER: And in a sense the fee-for-service spending catches up to the bid.

MR. BERTKO: Right.

DR. CHERNEW: On this point, at least for private fee-for-service -- I don't know if this happens in the other plans -- the prices that are being paid by the private are related to the prices that Medicare is using. So this is -- are we in round one, or is this round zero?

[Laughter.]

DR. CHERNEW: In any case, whatever round we are in --

MR. HACKBARTH: This is one. We are clarifying.

DR. CHERNEW: But this is relating to your question. If the SGR changes, that means the prices that are being paid by the private fee-for-service changes by definition. So when they make their bid, are you telling me in this discussion that their bid is predicated on their anticipation of what they think the Congress will do, and if the Congress doesn't do that, their bid is just off?

MR. BERTKO: The answer is yes to both, and Congress has been very faithful in eight of the last nine years of making that change, even after the fact.

MR. HACKBARTH: Okay. We'll continue with round one.

MS. BEHROOZI: Just to continue with this, is it possible for you on Slide 9 then to, just for one of the lines, give us an idea of -- maybe just that top line, you know, if that went down to whatever, $72 or $70 in the first column, what happens --

MR. ZARABOZO: [Off microphone.]

MS. BEHROOZI: Right, in the first column.

MR. ZARABOZO: Yes, the first column would be a reduction of 25 to 30 percent.

MS. BEHROOZI: Right. So if that is $70 --

MR. ZARABOZO: Right. So that, for example, looking at the $97, let's say it is around $73 or whatever, that is what I mentioned. The rebates would be much closer to the distance between fee --

MS. BEHROOZI: So the rebate stays seven --

MR. ZARABOZO: The rebate dollars stay the same. The benefits only stay the same. Those are part of the bid

and, therefore, unchangeable.

MS. BEHROOZI: Okay.

MR. ZARABOZO: What is changing is the ratio, and the fee-for-service estimate changes and, therefore, our difference between fee-for-service estimate and the bid changes.

MS. BEHROOZI: I see.

DR. CHERNEW: I have a question on Slide 4. It's just a definitional question, and I have just become confused now. Zero premium plans, as you note, are no premium beyond Medicare Part B, but so a zero premium plan could still have a Part D premium? Because --

DR. HARRISON: No.

DR. CHERNEW: With drugs.

DR. HARRISON: With drugs. Total zero here.

DR. CHERNEW: So you have no Part D premium either?

DR. HARRISON: Correct. For this measure. I mean, plans can do what they want but --

DR. CHERNEW: Right. I understand. So it's the number of plans available for which they're getting drug coverage and their other -- whatever other benefits they are

getting for free.

DR. HARRISON: Correct.

MR. HACKBARTH: It's the percentage of Medicare beneficiaries that have the option of such a plan.

DR. CHERNEW: I understand, but what they mean by that is have the option to get both their enhanced medical and --

DR. HARRISON: Just by paying their Part B premium.

DR. CHERNEW: -- their enhanced drug by just their Part B premium and no Part D premium either.

DR. HARRISON: Correct.

MR. HACKBARTH: Clarifying questions, round one.

MR. KUHN: Two quick questions. One, can you refresh or remind me where CMS is in terms of documentation and coding on the MA side and where that discussion is?

And then the second question, if we can go back to Slide 3, and the new enrollees, the million new enrollees that came in this past year, there is the discussion that a larger number of poor and minority individuals elect MA relative to the same proportion in fee-for-service. And does that hold true for this new tranche of a million

enrollees that came into the program? Or do have that data and do we know?

DR. HARRISON: We don't have that, the answer to the second question. The first question, this year CMS did implement -- I am going to call it a cut in the risk scores to account for coding creep. The adjustment this year is 3.41, which is supposed to cover two prior years and creep through 2010?

MR. KUHN: Do we think that was robust enough in terms of the adjustment based on our analysis? Or do you think the agency ought to go back and continue to look pretty aggressively at coding?

DR. HARRISON: I think there's a difference of opinion within the agency, and they'll run the numbers again to see.

MR. KUHN: Okay.

DR. HARRISON: But right now that's all that's contemplated officially.

MR. GEORGE MILLER: On Slide 10, could you just elaborate on the variation we're finding in the results on quality across plans? What does that mean by variation? Can you describe what that is?

MR. ZARABOZO: Well, one of the things is the newer plans tend to have lower scores than older plans.

MR. GEORGE MILLER: So it's by plan --

MR. ZARABOZO: But also within an individual HEDIS measures, you can see wide, wide variation between the lowest score and the highest score, is the other point.

MR. GEORGE MILLER: Okay. Thank you.

DR. BERENSON: Following up on Herb's question, I didn't see in your write-up, do we have with the coding adjustment where the plans are in aggregate in terms of an overall risk score in relationship to fee-for-service? Do you know what that is?

DR. HARRISON: I am trying to remember. I do look at that from the bids. I take it out of the bid side, and I think they were getting pretty close to one. But I don't think they were there yet.

DR. BERENSON: Okay. And the related question, I know there have been some commentaries on the need for even further refinement in risk adjustment. I know Jerry Anderson has talked about underestimates of patients with chronic conditions. I think MedPAC in the past has talked about the issue if you have more exposure to physicians,

say, in Miami, to pick a place at random, you might have a tendency either then to have a higher risk score because you have more exposure -- I mean, is CMS actively refining their risk adjuster, do you know?

DR. HARRISON: I believe they are going to roll out a new one for 2011, but I am not sure.

DR. BERENSON: Okay. Thank you

DR. HARRISON: We will look into that.

MR. BUTLER: So this obviously is the one exception of not an update issue, so I assume we're doing this just because it is a continuing interest of ourselves and Congress in general.

MR. HACKBARTH: Yes, and we will have a chapter in the March report, and that is part of our statutory mandatory. Each March we are to report on Medicare Advantage.

MR. BUTLER: Okay, so --

DR. MARK MILLER: And we will be rerunning the --

MR. HACKBARTH: Yes, and we will have the text box, as Carlos mentioned, that includes past recommendations.

DR. HARRISON: Now these are the past

recommendations that Congress has not acted on yet. We have had several over the years that they have acted on.

DR. MARK MILLER: And, I'm sorry, just to say this a little bit differently, this is a payment rate issue like in PPS, or any of the prospective payment systems, and that is why we're doing it here and why it's part of the legislative mandate we do it in March.

MR. BUTLER: Right.

DR. MARK MILLER: If that's what your question is.

MR. BUTLER: Okay. So you keep doing a better and better job of explaining, you know, the so-called subsidy, and I like what you have presented here. What I am a little less clear on is whether this is a different message in terms of the amount of opportunity here, if they follow the kinds of recommendations we've made in the past. So when you take the SGR and you go from 113 to 109, does that result in a different number that Congress would be looking at in terms of the potential savings, so to speak, out of our Medicare Advantage recommendation that we've made in the past?

DR. HARRISON: Right. We would just expect that this would be a one-year anomaly.

MR. BUTLER: Right.

DR. HARRISON: And things would reset to the neighborhood of 113 in the future. Now, you know, there are reasons why it could go up or could go down a little bit, but it's likely to still remain above 109.

MR. BUTLER: So stated more specifically, and maybe not accurately, I think there was a 150 billion number over ten years or something that originally was the number, right?

DR. HARRISON: right

MR. BUTLER: And so what would happen to that number in the aggregate with this one-time --

DR. HARRISON: Nothing.

MR. BUTLER: Okay. That's what I'm clarifying.

DR. KANE: The last recommendation, didn't we end up writing a whole chapter on those differences? And do we have, therefore, any recommendations on what those measures should be? Or are we just not going to connect those two?

MR. HACKBARTH: Well, that's the mandated report that we voted on in -- was it November or October?

DR. KANE: Right. But do we want to then put into this recommendation those findings or not?

MR. HACKBARTH: In fact, that's going to be run as a chapter in the March report.

MR. ZARABOZO: That's right. The MIPPA quality section is a chapter within the March report, and, therefore, this will be cross-referenced in those recommendations.

DR. KANE: Okay.

MR. HACKBARTH: Yes. So the MIPPA report that we voted on in November had a March due date, so as opposed to publishing a separate document, we're just including it as a chapter in our March report. So there will be an extensive discussion of those issues.

MR. ZARABOZO: And you're correct, it does pertain to that very last recommendation, because we do say specific things about how to do that.

DR. MILSTEIN: In your prior discussion of the -- this is referable to Slide 11. In your prior discussion of the Health Outcomes Survey, which, you know, measures change in mental and physical functioning for a group of enrollees in a given MA plan, you had previously, you know, attacked the problem of CMS setting overly strict limits for determining when mental functioning or physical functioning

had deteriorated. And when you did that, it showed that -- it did not favorably portray the impact of Medicare Advantage plans on beneficiaries' mental or physical functioning.

Since that time there is now another year's worth of Health Outcomes Survey data. Do we have any reason to believe that Medicare Advantage plans are doing any better than the last time you checked when you evaluate the impact of the MA plans on beneficiary mental and physical functioning with this, you know -- but in a fashion that does not restrict us to these very tight thresholds for determining difference that CMS has arbitrarily imposed over the last several years?

MR. ZARABOZO: Well, as I mentioned in the mailing material, at the Medicare.gov website they use a different standard for reporting on the HOS results. So there you see that there are -- and using the same data set, which is the current cohort, 2008, where on the one side the HOS online, the statistical reporting of the results shows no difference across plans, that all plans are within expected ranges. At the Medicare.gov website it does show a little bit more difference among plans. There were four plans with a lower

star rating. Most of the plans got a four-star rating, and four plans got a three-star rating on the physical health; whereas, this says no difference among plans.

DR. MILSTEIN: I'm asking a different question. I'm saying previously in a report to us you dug down into these scores and actually showed that MA plans, at least using your drill-down, appeared to be unfavorably impacting mental and physical functioning. I think the original frame of reference was the old Medicare fee-for-service, you know, comparison --

MR. ZARABOZO: Right. That was --

DR. MILSTEIN: As you look at the distributions of score changes, if you had a chance to do that, what I'm asking is: Is there any evidence that what appears to be adverse impact is at all attenuating, improving?

MR. ZARABOZO: And I don't know. I have not looked at the numbers for the current cohort, the 2006 to 2008, to compare it to the prior years. But I can get that data set to do that.

MR. HACKBARTH: Other clarifying questions?

[No response.]

MR. HACKBARTH: Okay. Since we don't have a draft

recommendation for this conversation, we'll have round two, more -- no holds barred. Mitra, do you want to lead the way?

MS. BEHROOZI: Sure, why not? So I just really feel like when there is public discussion about Medicare Advantage, there is a lot of public discussion about the additional benefits, and then we talk -- I guess I just was a little disappointed that you didn't put in the public presentation the subsidy column of the chart on, I guess it is, Slide 9 to really put a point on it what the cost is for every additional dollar of benefit. And I think that's really -- that's kind of the key to understanding why we say it should just be brought into line with fee-for-service. And, you know, as a result of the SGR fix, I realize that that is the column that's most subject to change, but I think that just makes the point most dramatically. If you get an extra dollar of benefits, that's great. But if you realize that it costs $1.50 on average to get you that dollar, where is that other 50 cents going?

DR. MARK MILLER: I'll take the responsibility for that and the gigantic yellow letters on that. I actually asked for them to blink, but they wouldn't do it. I'm

hoping that for January we have it. I just thought that if it is going to switch that quick, the number would be out and then a lot of upset when the number changed the other direction. So I asked for caution here and asked for the yellow letters, and I'm hoping in January we can actually do what you're saying.

DR. CHERNEW: I think this is actually in the other March MA report we discussed, but I think it's important to say here, which is the MA plan shouldn't be discussed as if it's totally separate from the traditional Medicare fee-for-service sector. They're using the same doctors, and the things that they do spill over. So when we think about comparisons between MA and fee-for-service, we have to recognize that. The effects of MA might be broader than just the effects that you see when you compare it to some fee-for-service in terms of utilization patterns, and particularly in terms of some of the quality measures. And that's not to diminish the importance of any other type of comparisons, but I think it is important contextually and in terms of interpretation of what we're seeing in judging the value of MA plans.

MR. HACKBARTH: And, you know, that also is true

on the payment side. So in markets where there is a high Medicare Advantage enrollment, a high percentage of the Medicare population enrolled in MA plans, and to the extent that it's true that private insurers are paying more than Medicare, that means a big hunk of the Medicare population is bringing higher unit prices with them than under traditional Medicare, and so, you know, looking at the hospital margin for Medicare without the MA dollars flowing into it is a misleading measure. So there are both types of spillover effects.

MS. HANSEN: I think my two questions are part of the "no holds barred" level. One of them has to do with employers. I think I've asked in previous questions just the role of subsidy, you know, that kind of goes on with employers who are encouraged to keep their plans reasonably whole, but they also got a subsidy. And the question I asked last time was whether or not that was a time-limited one, and I think I got the response that it was not.

But I guess the question I have is: What impact does the employer subsidy have on the amount of money that gets bid relative to -- you know, the bid rates that we have there, but that the employers are a separate group. How

significant of a dollar amount does that have as an impact to that?

DR. HARRISON: In the chapter we have the table that includes the employers and the SNPs.

MS. HANSEN: Right. And it seems like --

DR. HARRISON: There we go. And the employers bid quite a bit more. They're bidding 112 percent of fee-for-service.

MS. HANSEN: So they're bidding close to always --

DR. HARRISON: Much closer to their benchmarks.

MS. HANSEN: Benchmark here. So, proportionally, what implications does that have just in terms of the whole dollar impact to the program and all?

DR. HARRISON: Well, we're paying 115 percent for enrollees in employer-sponsored plans.

MR. BERTKO: Can I just add to Scott's thing? It's a complicated question along the lines of, I think, the one Mike was saying, the intertwined part of it. You have some parts of the country, namely, California, where Kaiser, for example -- and Jay could comment on this -- have a lot of employer-related groups. People age out of Kaiser under 65 into Kaiser retirees.

On a second level, the growth in employer-related groups has primarily been in the private fee-for-service. And so on that side of it, you are picking the subsidies that come out of the high benchmarks where private fee-for-service is.

The third part of that is that even on employer quotes, it operates on a different level than it does on these. You have a standard 800 series plan that's bid, and then most typically, you know, the state of XYZ's public employees want to do this, and you actually look at what their population is in terms of the usage. Many times these usages are well above the standard for Medicare there because they tend to have had rich benefits, and they're replacing them.

So even though the bids are higher, part of the reason they're higher is because they're actually providing care and benefits to a higher-use group compared to 1.0 average Medicare across the board. So you've got all these various interactions here.

DR. CHERNEW: I didn't understand that. I thought they were bidding a standard benefit package in a risk-adjusted kind of way. So --

MR. BERTKO: Well, there are two levels on that, too, Mike. I didn't drop into that detail. So there is an 800-level plan that is the base play, and then, you know, the state of XYZ has -- I will exaggerate here -- a $5 co-pay for all physician visits and $100 deductible for Part A. Well, all of that then gets combined into how much of a supplemental premium is added on, plus how much is paid in terms of the benchmarks -- what is it? -- 117 or 119 percent for private fee-for-service, if it's the private fee-for-service plans, and then that's all mushed together so that the overall bid, A, works for the employer and they actually decide to buy it; and, B, is profitable for the insurer who is offering that particular kind of benefit. So those two parts have to mesh together.

DR. HARRISON: The other thing is they're bidding for this base benefit package, but what they may be providing each employer may be different and more generous.

MR. BERTKO: Yes. But it comes --

DR. CHERNEW: It's not in the bid [off microphone].

DR. HARRISON: It's not in the bid, like a plan might say all of my calendar year bids for all insurers, I'm

going to give you one number, I'm going to give CMS one number, and then I'm going to negotiate separately with each employer.

MS. HANSEN: You know, this is obviously a multi-matrix set of complexities. In the chapter I think certainly there are aspects of it. But there seems to be just a lot of texture to this that also includes a lot more money than readily apparent. So I just think that in terms of our understanding all the different kinds of buckets that we're dealing with, just to be able to have a readily understandable impact when we have encouraged employers to keep their premiums -- I mean keep the benefits and participate in all of this, just outline that out of just -- you know, basically some disclosure to this.

MR. HACKBARTH: My recollection is that some year, in the last few, we actually had a fairly in-depth discussion of the employer-based piece of MA and went through some of these complexities and differences.

MS. HANSEN: So that you feel that we covered it in a previous chapter?

MR. HACKBARTH: Well, we can bring forward some of that into this chapter.

DR. HARRISON: Now, we also expect a change because 2010 is the last year that employers can offer private fee-for-service.

MS. HANSEN: Okay.

DR. HARRISON: Well, in 2011 they all have to be network products.

MS. HANSEN: So then perhaps some of the impact of this might go away.

DR. HARRISON: Some of this may change. We don't know what employers will do or what the insurers will do to -- what they'll offer.

MS. HANSEN: The only reason I bring it up is just there's a whole level of added benefits and things like that that are beyond really what the original plan was for the incentives, of course, of keeping the employers in play. So it just is one of those factors --

DR. HARRISON: Are you referring to the drug retiree subsidy?

MS. HANSEN: I think it's the combination, and, John, you probably know this in greater depth.

MR. BERTKO: I guess I would modestly differ with the precise interpretation in the statement you made, which

is most of the employers who do this, combining the drug subsidy with the A/B subsidy, tend to offer the same level of benefits, but the way they're paid for now differs because instead of having just a base Medicare and a retiree drug subsidy, they may be putting those two together and picking up some of the benchmark subsidies, which in many cases serves to reduce the employer's out-of-pocket costs.

MS. HANSEN: Okay. That's actually probably as cleanly stated as ever. That's fine. I just, it was in reading the materials, that was the case.

Then one quick other one, the CAHPS survey, and I just -- this isn't -- I'm not sure that this fully belongs here in terms of my question, but I was intrigued, as you noticed, yesterday that when we looked at the high value, lower cost of plans in terms of efficient providers yesterday, the ones that rated the highest in terms of the percentage of plans -- I think there were about 200 -- relative to the other plans. And when given the CAHPS survey, the difference of satisfaction or rating was like all of 1 percent. And so here we have on page 11 the CAHPS survey shows MA employees satisfied with their health plans and the care they received at the same levels as last year.

So putting the two comments together, it just raises for me a question about how does a member really evaluate satisfaction and quality. And so it's a broader question. It's not for us. It's a metric issue. But when we report these things, you kind of wonder what the material value is. That's all.

MR. HACKBARTH: Round two questions.

DR. STUART: I have a question about special needs --

MR. HACKBARTH: George, did you have one -- okay.

DR. STUART: I have a question about special needs plans, and you provide a little bit of detail in the chapter about them. The last time that the Commission addressed this issue, there were a number of outstanding questions about impending changes in CMS regulations and how that might affect the distribution of plans in terms of those that focus on institution only, dual eligibles, or chronic diseases. And I'm wondering if you could just tell us where you are in terms of that investigation.

DR. HARRISON: I don't think that was going to be one of the major thrusts for this year. We hadn't kept track. We know that they implemented some things, and we'll

have to see how they shake out.

DR. STUART: I would like to see something in the chapter on that because that's one of the cases -- I mean, that's one of the areas where we thought there was real promise in MA, and one of those areas where, if they go down to 100 percent of fee-for-service, it might well be that some of the benefits that are lost are benefits that would be important for coordinating chronic care. I'm not trying to say that that's true or not, but that was an area of promise. And so it would be interesting at least to see when you know more about when the bids come in, the proportion of bids that fall into these different categories, so at least we will have that information available along with the more general information about the number of plans that are in coordinated care.

DR. MARK MILLER: I guess just a little more color to that. Last year we had kind of longer extensive discussions of employer and SNP and what was going on. We have that information. There's always a question of how much to rerun year after. But, you know, I'm hearing, no, I want to see that again. So there is sort of the monitoring and what's going on aspect of things, and we can either

bring that back into the chapter at some level to make sure that we stay on it if this is something that you guys want to see.

I continue to think along the lines in SNPs on what you were saying, and there is work that we're thinking about, and it's not just for managed care, but also thinking about more broadly in fee-for-service how the special needs plan model can be used, because when you think of some of the discussions that we've had about organizing Medicare benefits along the lines of conditions rather than the silos, which you guys are very clear on, that's one of the ways you could make it work.

I think the shaking out and seeing where it's -- what Scott was saying, there has been some activity, legislative and regulatorily, in this area. We need to line our ducks up on the basis of that and what's happening or potentially going to happen, and then take another run at it after, I think, some things have shaken out a bit.

DR. STUART: I agree. This may well be more appropriate for the June report, but I want to make sure that there's something in here that kind of tracks the Commission's interest in this segment of the MA people.

DR. MARK MILLER: [Off microphone.]

MR. GEORGE MILLER: To follow up on Jennie's question about quality, on the part of the recommendation concerning the pay for performance should apply to MA plans to reward plans for providing higher quality, how are we going to tie that together? We have got a benchmark that all the plans could hit. But could you describe for me how pay for performance would work in this case? I think I understand it. I'd like to have it explained so I could understand it. I'll put it that way.

MR. ZARABOZO: Well, the last recommendation regarding how to finance the pay for performance was to take the 25 -- in the rebate computation where 75 percent is retained by the plan, so take the 25 percent that the government would otherwise retain, and that would fund the pay-for-performance pool. But your question might be how do you determine which plan is better than another.

MR. GEORGE MILLER: Correct.

MR. ZARABOZO: Well, that was the purpose of the other chapter, which is there is a lot of information here, and a lot of work needs to be done to determine how to appropriately compare plans one to another and determine who

has the better-quality plan.

DR. BERENSON: First, I just wanted to comment on your earlier comment about the extent to which -- if I understood it correctly, the extent to which there is more MA enrollment, there is a higher compensation to providers than in fee-for-service. I don't think we really know systematically. I mean, anecdotally some plans clearly track their commercial rates in those contracts, and others are actually able to use Medicare rates. Private fee-for-service virtually by definition uses Medicare rates.

It came up at a previous meeting. It would be useful to actually know what those rates are for MA plan contracts.

MR. HACKBARTH: And I agree with that, Bob, and in my comment to Mike I said "to the extent that," and, in fact, we don't know, and often I assume the information is regarded as proprietary and not disclosed by the plan or the provider by contract provision.

PARTICIPANT: [Off microphone] -- be lower, right?

DR. BERENSON: I doubt that it would be lower. I agree with that. In any case, I just want to -- yeah, you did say "to the extent." I just think it would be useful --

it could -- well, I don't know, we get from -- if there's some way of preserving confidentiality and getting aggregate kinds of data, just like we did, you know, in those previous surveys as to how much plans are paying doctors and hospitals. I don't think we named anybody. We just got some aggregate information. And I will -- well, actually, okay.

The second point, could you go to the last slide, which is the recommendations from 2005? There they are. I just wanted to clarify since I am new. The first bullet there is, I think, worded very nicely -- I want to just clarify -- to permit either the payment neutrality at the local level or to permit some kind of a blended payment in which the quality is aggregate at a national level but there are variations. I assume that was done intentionally and that the Commission at this point doesn't go beyond that. Is that right?

MR. HACKBARTH: That's correct. It was intentional. This was 2005, is when we voted on these recommendations, first made them. There at the time was considerable discussion about whether to do it at the county level or, you know, some other way, and we did not include

specifics on at what unit to do the 100 percent.

DR. CROSSON: I may be remembering this wrong. John could correct me. But I thought at the time there was an amendment that added the two words "on average." I think that was John's amendment.

MR. BERTKO: [off microphone] Yes.

DR. CROSSON: And I think we added that to the recommendation. I could be wrong.

DR. MARK MILLER: Is this not the actual language in the report?

DR. HARRISON: We may have removed it at the county level or something like that.

MR. HACKBARTH: Yeah, and so I agree it's on average, and we left unspecified whether that's on average at the national level or that we try to do it at some other level. Then we also -- there was a Crosson amendment saying that we need to be careful about the transition from higher rates to lower rates. So, in answer to your question, it is not explicit.

DR. KANE: I think I really liked the analysis of how much more we're paying for the enhanced benefits than they cost, but I think the real point is how much more Part

B premiums are because we're paying more. I just think we might want to keep adding one more metric in here, which is how much more the Part B premium is for the non-MA participant because we are doing it this way, because I think otherwise the -- it's not that they cost us more; it's that they're getting them at all subsidized by all the other beneficiaries that I think is the thing we want to keep our eye on. Certainly, yes, it's not a very efficient way to buy enhanced benefits, and on top of that, all the other beneficiaries are paying for them. And what is that impact on their Part B premium? How much -- I just think that would be a metric that would be useful to keep in the report so we can pay attention to that issue.

MR. HACKBARTH: My recollection is that's not in the chapter, and I assume it's still in the $2 to $3 range.

DR. HARRISON: The last time I think we had it at $3, and I don't believe we've done it yet for this year. But it would also really -- again, this number would also change a lot depending on what happens with SGR.

MR. HACKBARTH: Yes. And then the other metric that, as I recall, is in the chapter that was not in the slide presentation is the ratio of bids to benchmarks,

which, again, is subject to this adjustment.

DR. HARRISON: Right.

MR. HACKBARTH: And so that's a metric that we've used as a rough indicator of who's providing additional benefits out of efficiency versus out of just additional federal dollars.

MR. BUTLER: You asked for any areas of additional analysis. First, I worry about the transition, too, but I think the philosophy of this group has been to transition things. And have no fear, politicians turn cliffs into slopes anyway. But there are 24 percent now enrolled, and 100 percent have access to a plan and 85 percent have access to a plan with Part D. That's what I think you've reported.

What I've lost track of is the concentration of is there anything really disproportionate about enrollment geographically so that when you look at transition and look at people's flipping plans and out of plans, remind me, you know, what areas of the country, what regions, what markets might be impacted the most that we're going to hear the most noise from.

DR. HARRISON: I guess it would depend on how the benchmarks are changed. There are different --

MR. HACKBARTH: The House bill and the Senate bill take significantly different approaches to this. Even though the total aggregate savings are sort of in the same ballpark, as I recall, the distributive impact is presumably pretty different.

The House bill takes more the local area approach, keep the rates paid to private plans in sync with Medicare at local areas with a transition to get there. And, you know, correct me if I'm wrong, Scott. The Senate bill has the competitive bidding approach, and the distributive implications of those two I would think would be pretty significantly different, although I'm not sure anybody has a real sound grip on just how different. You can take over from there.

DR. HARRISON: Well, areas that are high fee-for-service where plans have been able to bid well under fee-for-service, such as South Florida, are likely to suffer more under the competitive bidding and --

MR. BUTLER: [Off microphone.]

MR. HACKBARTH: But now that I think of it, even the competitive bidding approach was amended. There was a Nelson amendment to sort of attenuate some of those impacts.

DR. HARRISON: Making it a shallower slope.

DR. MARK MILLER: Just to Peter's question, though, I've heard you guys say this before, and I can even do part of it. So there are areas of the country where you're more likely to be enrolled in managed care, and those are places like Miami, South Florida --

DR. HARRISON: Southern California.

DR. MARK MILLER: Michigan, yes.

MR. ZARABOZO: Oregon, New Mexico, apparently --

DR. MARK MILLER: Oregon, New Mexico.

MR. ZARABOZO: Hawaii.

DR. MARK MILLER: Puerto Rico.

PARTICIPANT: Canada.

DR. MARK MILLER: Puerto Rico, right.

[Laughter.]

MR. ZARABOZO: I'm sorry.

DR. MARK MILLER: That's the other thing to take away from this, though, in the broad increase in enrollment, it has also gotten much more generalized, but there are some specific markets that have been kind of the leaders and where there's been high penetration for many years. And that was a quick rattling off, and we can give you detailed

information if you care.

DR. MILSTEIN: A couple comments. I actually was -- I'm sure I voted for it, but I was surprised that in 2005 we recommended that if we're going to fund P4P for Medicare Advantage, it come out of what otherwise would be savings to the government, that the government's 25 percent.

If that's so, is that something we might want to consider reexamining since we have a different national fiscal picture now than we had in 2005? Right now the idea is we should sacrifice Medicare Advantage as a potential engine for government savings in order to fund quality improvement. You know, private sector purchasers would never accept that kind of a proposition.

MR. HACKBARTH: Carlos' description was accurate. It seems to me that there's little point in going back over this because of the major pending legislative changes that affect the payment structure. If at that point, once the new payment structure becomes clear, we want to go back and look at funding of P4P, then I think that would be the appropriate time.

DR. HARRISON: Now, both bills do have quality bonuses in there.

MR. ZARABOZO: Right. But the other point, though, about -- this recommendation, of course, is in the context of the many recommendations from MedPAC, one of which is 100 percent of fee-for-service.

DR. MARK MILLER: At that time, the line of reasoning across the board on pay for performance was it's budget neutral and a redistributive function, and this, assuming 100 percent of fee-for-service, was the same thing, is what led us to that point.

DR. MILSTEIN: Thank you. My second comment is, you know, there is an echo here of our discussion yesterday of ESRD provider bundling and whether or not ESRD providers might want to take longitudinal accountability for total spending per person per year and for quality.

It occurred to me that, you know, this is part of a broader set of, I will call it, alternative visions for how to achieve more health with fewer dollars in the Medicare program for people at higher risk of bad health and generating a lot of -- incurring a lot of Medicare spending. And I wonder if it might be possible to -- I know it is not easy to sort of spring loose prematurely information on the Medicare demos, but we do, for example, you know, have some

demos already in the field -- in many cases the results are in, but CMS has not yet released them -- that might allow us to take an early look, you know, for a given disease category like chronic kidney disease or ESRD patients, you know, how these two different engines for accountability are working, referring specifically to Medicare Advantage SNP plans as one engine, and accountable care organizations focused on a particularly high-risk segment of beneficiaries as exemplified, for example, by some of the demos in chronic kidney disease that are already up and running.

And so the question is: If staff could spring loose some information that might allow comparisons, I think it might be useful to get some early evidence on which of these two vehicles might be a more cost-effective vehicle for the Medicare program.

MR. HACKBARTH: We'll look into that and see what information we can get.

MR. BERTKO: I'm going to offer an observation and an opinion and look to Carlos and Scott to see whether they might agree with it. I will not hold them to it. If you could put up Slide 3 again, this is just to opine mainly on the likely effect in 2011 on private fee-for-service, which

now has 2.4 million members and a total of about 1.4 million in local and regional PPOs.

As Scott, I think, has correctly said, there is a network requirement where there are other CCPs in 2011, and that essentially says private fee-for-service needs to be in a network.

Once you get to that point, it is inane to have a private fee-for-service network when you can have a PPO, whether regional or local. And so one of the comments I would make is we're probably very likely to see a shift, which has already started, I think, in a little bit of this, out of private fee-for-service and into the PPO side.

My hope -- and I use that noun carefully -- is that once they become PPOs they will take advantage of the greater care management possibilities that are in PPOs. I think the documentation that you showed in the PPO benchmarks today showed not much going on, but it also is a bit of chicken and egg. When you have relatively few people, it's tougher to do. And given that this may be my last statement on it, I will just say pay attention, guys, for next year.

I don't know if you guys would agree with that

direction, but it seems to me it might go in this way.

DR. HARRISON: We're definitely keeping our eye on it, and we're not sure which way it's going to go.

MR. HACKBARTH: Could I just ask about something that was in the draft text -- that is, the work that GAO has done comparing after the fact the costs incurred to the bids? Could you say a little bit about that?

MR. ZARABOZO: The numbers that we show are based on the bids, that is, the projected, and in the text we have a projected level of administrative costs and so on. They went back and looked at the actuals and compared them and found a big difference between the actuals and what actually occurred in a given year compared to what was bid for that year in advance. Now --

MR. HACKBARTH: And they've just done it for two years?

MR. ZARABOZO: I don't think they've updated the results from that.

MR. HACKBARTH: Yes, and so I think the text as they did it for 2005, 2006 --

MR. ZARABOZO: Right, right. And as far as I know, they have not updated that. But part of the bid

review process is to look at past actuals and compare them, too. So one of the issues in that time period was you had a lot of new plans, so you had no sort of history to compare it to.

MR. HACKBARTH: So the significance of this is that the bid includes within the loading factor a certain amount of profit, and at least in these two years, GAO is saying the actual profit was higher than that because the actual costs incurred were lower.

MR. ZARABOZO: Right. That's correct.

MR. HACKBARTH: It will be interesting to see if that persists. You know, market theory would suggest that over time there is an incentive to bid accurately and there would be pressure on this. Whether that will be true in fact, I don't know.

MR. ZARABOZO: And I think what I was trying to say was that CMS has more information to evaluate a prospective bid in relation to past history.

MR. HACKBARTH: That could also -- okay. Thank you very much. We need to move on to payment adequacy for inpatient rehab facilities.

Go ahead, Kim.

MS. NEUMAN: Good morning. We're now going to focus on Inpatient Rehabilitation Facilities, or IRFs. We're going to examine the most recent available data for your consideration as your assess Medicare payment adequacy for these providers. I'll discuss access to care, the supply of facilities, occupancy rates, volume of services, and quality, and then Craig is going to discuss access to capital and payment and costs. Then Craig, Jay, and I will all be available to answer your questions.

Before looking at the data, a couple of background points on IRFs. IRFs provide intensive rehabilitation therapy in the areas of physical, occupational, and speech therapy. Medicare fee-for-service spending was about $5.8 billion in 2008, with fee-for-service beneficiaries accounting for about 60 percent of IRF patients.

In 2002, a prospective payment system for IRFs was implemented. Prior to that, IRFs were paid under TEFRA on a modified cost basis.

Because IRFs are regarded as a setting that provides more intensive, costly care, Medicare has criteria to determine whether a facility qualifies to be paid as an IRF and whether IRF services are covered for an individual

beneficiary.

In terms of the coverage rules, beneficiaries must generally require three hours of therapy at least five days per week for IRF services to be covered. There are additional coverage rules which CMS is in the process of updating.

IRF facilities must also meet certain criteria to be paid as an IRF. The criterion that has received the most focus in recent years is the compliance threshold. So you've heard about the compliance threshold in past years. It used to be the 75 percent rule. It is now the 60 percent rule. Originally, the rule required that 75 percent of an IRF's patients fall into one of ten, now 13, diagnosis categories for the facility to be paid as an IRF. Enforcement of the rule originally was lax. It was suspended for a time and then reinstated in 2004. At that time, CMS had planned to phase in the compliance percentage to 75 percent by 2008, but Congress in 2007 permanently capped the threshold at 60 percent.

So now we'll look at the most recent data on IRFs in the various areas of the update framework. First, supply of facilities. This slide shows the trend in the number of

IRFs from 2002 to 2008. Looking at the top line in the table, we see the number of IRFs increased modestly in the early years of the PPS, peaking in 2005. The number of IRFs then decreased modestly from 2005 to 2007. In 2008, the number of IRFs was stable, unchanged from the 2007 level.

The next slide shows another aspect of supply, occupancy rates. Occupancy rates have been on a downward trend for most of the last decade, with the decline accelerating in 2004 with the renewed enforcement of the compliance threshold. In 2008, IRF occupancy rates rebounded slightly, but still remain well below levels earlier in the decade, suggesting that facility capacity is adequate to meet demand.

The next chart shows Medicare fee-for-service spending and volume trends. Aggregate fee-for-service spending on IRFs increased from 2002 to 2004 with implementation of the PPS. Total fee-for-service spending declined from 2004 to 2007, reflecting a decline in the rate of IRF admissions among fee-for-service beneficiaries due to renewed enforcement of the compliance threshold and a reduction in Medicare fee-for-service beneficiaries due to increased Medicare Advantage enrollment. Both the decline

in spending and the decline in IRF use among fee-for-service beneficiaries tapered off in 2008.

While the volume of fee-for-service patients has declined, payments per case have increased substantially. In recent years, the increase in payments per case generally reflects the impact of the renewed enforcement of the compliance threshold. In response, IRFs changed their admission patterns, for example, to admit fewer patients with hip and knee replacements who do not count for the compliance threshold and have a lower case mix and payment rate.

The next chart shows the percent of IRF patients with various diagnoses in 2004 versus 2009. The mix of IRF cases has changed over this period. The most common IRF diagnosis in 2004 was major joint replacements of the lower extremity, accounting for almost a quarter of IRF cases. By 2009, IRF joint replacement cases decreased substantially, accounting for 11 percent of total cases. This movement away from joint replacement cases was expected with the renewed enforcement of the compliance threshold because it significantly limited the types of joint replacement patients that counted toward the threshold. Stroke is now

the most common IRF diagnosis, followed by fracture of the lower extremity. We have also seen an increase in IRF admissions for brain injuries, neurological conditions, and debility in recent years.

The drop in the number of IRF cases has raised the question of whether the compliance threshold is creating an access problem, so as we have done in the past, we've looked at the ten acute care hospital discharges that resulted in the highest admissions to IRFs and tracked these cases to see how the patterns of discharge from hospitals to post-acute care changed over time.

In the slide, we have the example of knee and hip replacement patients, the area where we have seen the largest shift in IRF patient caseload. The chart shows that the share of hip and knee replacement patients discharged from the hospital to IRFs has decreased, while the share discharged to home health and SNFs has increased. This suggests that patients who might have previously received care in IRFs are receiving it in other post-acute care settings.

Now, moving on to quality, to assess quality, we have historically used a measure commonly tracked by the IRF

industry, the Functional Independence Measure, or FIM. The FIM score measures physical and cognitive functioning. A higher score means more functional independence. To assess quality, we look at the average increase in the FIM score between admission and discharge, what is called FIM gain. We look at this for all beneficiaries in IRFs and beneficiaries discharged from IRFs to home. We will focus on the all beneficiary data, which is at the top of the chart. Trends are similar for both groups.

In the third line in the table, we see that FIM gain between admission and discharge increased from 2004 to 2009. This suggests that quality may be increasing, but we need to be cautious in drawing conclusions because the mix of patients admitted to IRFs has changed over this time period. We have contracted with RTI to explore the development of risk-adjusted quality measures for IRFs, such as FIM gain and other potential measures, like discharge to the community and hospital readmission rates. We will update you on the findings from this work when they become available.

Now, I will turn it over to Craig to discuss access to capital and payments and costs.

MR. LISK: Good morning. I am going to start and discuss IRFs' access to capital. As noted in some of our sessions yesterday, following the economy-wide crisis last year, access to capital in the health care sector is normalizing.

The majority of IRFs are hospital-based units that have access to capital through their parent institution. As discussed in the hospital session last month, hospitals' access to capital is operating in a more normal manner, as demonstrated by lower hospital bond rates, a level of bond offering similar to that in 2007, and a steady amount of hospital construction. Publicly-traded freestanding IRFs have reported strong financial performance and have access to capital. Access to capital for smaller for-profit and nonprofit freestanding IRFs is more difficult to discern.

Next, I am going to talk about payments and cost trends for IRFs. In this graph, we show the cumulative growth in per case payments on the top line in yellow and costs for IRF patients, the blue line. Prior to implementation of the PPS for IRFs, IRFs' payments and costs tracked each other closely. With the implementation of the PPS in 2002, payments grew rapidly in the first two years of

the IRF PPS, while costs grew less than input price inflation.

In 2005 and 2006, costs per case grew rapidly, about ten percent per year, reflecting, in part, changes in admission patterns due to enforcement of the case mix compliance thresholds. This resulted in a more complex mix of patients as measured by CRGs and a sizeable reduction in total patient volume, which likely resulted in some diseconomies of scales in these institutions, as you recall, the drop in occupancy rates that Kim just talked about.

In 2007 and 2008, costs continued to rise faster than payments, but the growth was cut in half, to around five percent. This slow-down in cost growth suggests that the effect of providers' adjustments to the final 60 percent compliance threshold may have leveled off.

This next slide shows the trends in IRF margins over time, and as you can see, it reflects the pattern of payment and cost growth we showed in the prior slide. With implementation of the IRF PPS, margins rose substantially in 2002 and 2003, and then started a modest decline but still remain healthy in 2008. The aggregate margin in 2008 was 9.5 percent, 2.5 percentage points lower than in 2007.

This next slide shows a breakdown in IRF margins by different categories of providers, and there is substantial variation, as we have seen across other sectors across providers in margins. The 25th percentile of providers, margins minus 10.6. But the 75th percentile, it's 16.2 percent.

Freestanding and for-profit IRFs have the highest margins, 18 percent and 16.8 percent, respectively, in 2008. Hospital-based IRFs and nonprofit IRFs have comparatively lower margins. Hospital-based IRFs show a margin of 4.2 percent, and nonprofits show a margin of 5.3.

Urban IRFs have somewhat higher margins than rural IRFs, 9.7 versus 7.4 percent. Rural IRFs, I want to point out, do receive a 20 percent payment adjustment under the IRF PPS.

Margins also vary by the size of the IRFs, with smaller IRFs having the lowest margins and larger IRFs having the highest. For instance, IRFs with one to ten beds had a margin of minus-five percent. Eleven to 21, it was 0.6. Twenty-two to 59 beds, 8.6. And 60-plus more beds had a margin of 17 percent. This relationship with size of the institution is seen across the different hospital groups

that we see here. So size is a big factor in determining the margins of these institutions.

We have modeled IRF margins for 2010 and 2011 policy, except for the update in 2011. In projecting the 2010 margin, we estimate it to be five percent in 2010. In projecting this margin, we take the most recent available data, which is from 2008, and then consider the policy changes that have taken place between 2008 and 2010. In this analysis, we took account of that rates in 2009 were held to 2007 levels and a technical outlier adjustment was also made in 2009 that reduced payments by about 0.7 percent in aggregate. We also account for a market basket increase that took place in 2010 in their payment rates. We assume in our estimates that cost would rise at market basket for this group of hospitals.

Taking all this into account, we project a margin of five percent in 2010. The projected decrease in the margin is driven almost entirely by hospital rates being set at 2007 payment levels in 2009, with just the market basket update for 2010. So essentially, over a three-year period, they had just one market basket increase in their payment rates.

With that, I will return to Kim to wrap things up.

MS. NEUMAN: So to summarize, facility supply stabilized in 2008. Recent volume in spending declines also tapered off. Access to care appears to be adequate, but is complicated to assess. With regard to quality, we have seen an increase in functional gain over time, but case mix changes prevent definitive conclusions. And the projected 2010 margin is five percent.

So with that, I'll read the Chairman's draft recommendation. It reads, the update to the payment rates for Inpatient Rehabilitation Facilities should be eliminated for fiscal year 2011. The implications would be a decrease in spending relative to current law, no adverse impact on beneficiaries is expected, there may be increased financial pressure on some providers, but overall, we expect a minimal effect on providers' willingness and ability to care for Medicare beneficiaries.

That concludes our presentation. We would be happy to answer any questions and look forward to your discussion.

MR. HACKBARTH: Thank you. Good job.

Let me just ask a clarifying question about the

payment system. So 60 percent of the patients need to fall within one of the 13 conditions. How are the others paid for?

MS. NEUMAN: They are all paid the same way. The 60 percent rule is criteria that a facility has to meet in the aggregate -

MR. HACKBARTH: Right.

MS. NEUMAN: -- to be able to be considered an IRF. But then wherever -- whatever diagnosis you have, you are paid according to your case mix group and the payment rate is determined in that way. I would note that the case mix levels for patients that are outside of the 60 percent rule are, on average, lower than those that are within it, so the payment rates are slightly lower, on average, but that varies by situation.

MR. HACKBARTH: So for a Medicare patient not within the 13 conditions, goes into an IRF, they're still being paid at the IRF rate, which is higher than the acute hospital rate. That increment, the difference between the IRF rate and the acute hospital rate, does that vary by -

MS. NEUMAN: It does vary -

MR. HACKBARTH: -- case, by diagnosis?

MS. NEUMAN: It would vary by diagnosis. I mean, on average, the IRF payment per case is about $16,000 and average length of stay is about 13 days. So I'm not sure what the comparable figures are -

MR. HACKBARTH: Comparable number, Craig, for acute -

MR. LISK: On a per day basis, it's lower than what it is on an acute-care hospital, if you look at what the average is, on a per day basis.

MR. HACKBARTH: Because of longer average length of stay?

MR. LISK: Because it's a longer average length of stay across these cases. But the total cost is generally higher than what it is on the inpatient acute-care hospital.

DR. MARK MILLER: In terms of clarification on that 60 percent, that's across all patients?

MS. NEUMAN: All patients.

DR. MARK MILLER: Not just Medicare.

MR. HACKBARTH: Round one clarifying questions. John, and then Ron.

MR. BERTKO: If I could ask you to go to, I think it's Slide 10. This is an interesting slide. It seems to

show that people are getting treated. My question is, because I don't know enough about IRF payments, is does this represent a savings or a cost when people like this with these kinds of conditions are treated in other facilities?

MS. NEUMAN: Well, that's not an easy question to answer. If you look at just the payment amount in the setting, IRF versus SNF, for example, we pay more in IRF for these folks than we do in SNF. But then you have to factor in, too, the count whether these folks are rehospitalized, and we don't have an estimate at this time of sort of the overall across a 60-day or 90-day period what their costs are. That's something that we have some projects trying to look at post-acute care, sort of costs in the longer term. But I don't have a sort of a big picture answer for you at this point.

MR. HACKBARTH: It's also the issue of making an apples-to-apples comparison of the patients, because we don't have common assessment instruments. It makes the cross-provider comparisons more complicated to do.

MR. BERTKO: Right. Right. I was just wondering. You said you had a project. I mean, I take it that's an episode kind of look at this. Is that likely to emerge

before January?

MR. LISK: No.

MR. BERTKO: All right.

MR. LISK: The one thing I could say is that, for instance, the SNF patients who are, let's say, hip and knee tend to stay longer in the SNF, so there's more days of care there and also that's a factor here, too. So it's kind of hard. As I said, we don't have the patient assessment instrument to compare across these things -- settings.

MR. BERTKO: Okay.

DR. CASTELLANOS: Kim, this is really a continuation of the same subject. I guess John's question is, what are we getting for the money we're spending, and he's talking about costs. I'd like to look, and I know you're going to focus in and drill down to, is what do we know across all post-hospital facilities, looking at readmission rates, quality, outcomes, both short-term and long-term. What benefits are we getting? I know these all have to be, as you mentioned, risk adjusted, but as a clinician, we do have some input as to direction where we're sending these patients and that information is terribly important to us.

MS. NEUMAN: Well, I think that's a big issue that there's a lot of interest in right now. As Glenn mentioned, the absence of a common assessment tool across the settings makes it very difficult to draw definitive conclusions, even once you have the data of the sort of cost in the various settings, or even if you have mortality rates or readmission rates.

So I would say that there's work going on in this area. For example, CMS is doing a demonstration where they are fielding a common post-acute care assessment tool across the settings, and when that materializes, which a report to Congress is due in 2011, that will give us a better sense of our sort of potential to answer some of these fundamental questions. I think everyone wants to know the answers to the questions that you're asking, and there's literature trying to look at this. But until we have a better post-acute care sort of assessment tool, it's difficult to say for certain.

MR. HACKBARTH: Is the demo up and running?

MS. NEUMAN: Yes, it is up and running, yes, and they have selected data -

MR. HACKBARTH: And the report date is in 2011?

MS. NEUMAN: Yes.

DR. MARK MILLER: And here at the Commission, what we have tried to do, for better or for worse, is also tried to go at this within a given silo, and some of the uniformity we are reaching for are things like, well, readmission rates, use of emergency room, discharge to the community. Even though the individual patients may be very different in any given setting, within that setting, if you can ask those questions, does that help? Now, it doesn't apply to all these settings. I know immediately people are seizing up. But, for example, in the SNF setting, we have developed risk-adjusted measures peculiar to SNFs and made a recommendation that this is how CMS should be looking at SNFs with this notion that the broader place we all want to be is much more on a unified assessment instrument over the long haul, hopefully where this demonstration is going to take us. And so we're sort of doing it blow by blow and trying to keep our eye on the bigger picture.

MR. HACKBARTH: [Off microphone.] Arnie?

DR. MILSTEIN: [Off microphone.] He answered my question.

MR. BUTLER: Slide 15, just a very technical how

you do the averages here, because you've got a 9.5 percent margin overall, and if you look at hospital-based and freestanding, quite a difference, with 82 percent of the facilities being hospital-based but only 61 percent of the cases. So how do you weight -

MR. LISK: These are aggregate margins, so it's total revenues -- it's total revenues minus total costs over total revenues, and that's an aggregate for the group of hospitals. So -

MR. BUTLER: But you don't take averages of each of the institutions -

MR. LISK: No. No.

MR. BUTLER: -- averages, because you -

MR. LISK: No.

MR. BUTLER: -- couldn't get to 9.5 with that -

MR. LISK: No, we do not take the averages of the individual institutions -

MR. BUTLER: So you weight it by the number of discharges -

MR. LISK: So essentially, it is case weighted, if you think about it in that way, but we -- our margins are always presented in aggregate fashion in terms of when we

present margins to you folks, so -

MR. HACKBARTH: Weighted by volume -

MR. BUTLER: I think I got my answer.

DR. BERENSON: Yes, a basic payment question related to the transfer policy for reducing payment to an acute-care hospital for some conditions when there's a transfer to another facility. Are the 13 conditions that are here, are those in those conditions, or some of them -

MR. LISK: Yes. I think a fair number of them are. I'd have to go back and check specifically, but I know a lot of them are.

DR. BERENSON: So to the extent that these are hospital-owned IRFs, to the extent that they're transferring internally, they're getting a reduction on their DRG payment -

MR. LISK: If they stayed more than one day less than a geometric mean length of stay. So -

DR. BERENSON: Okay. Right.

MR. LISK: -- it's generally a small -

DR. BERENSON: No, understood.

MR. LISK: -- fraction of cases, and cases that go -- on average, cases that tend to go to any of these

facilities, on average, sometimes have longer lengths of stay than the cases that don't use them.

DR. BERENSON: Okay.

DR. STUART: I have a couple of questions that I'd like to follow up on on round two, but this will be very quick. Slide 10, you noted that the IRFs are geographically concentrated, and so my question is, did you look at this relationship of where individuals get service as a function of where IRFs are common as opposed to not common?

MS. NEUMAN: In the analyses we did this year, we did not look at that. But I can tell you that other research that people have done has shown that the availability of an IRF in an area influences your likelihood that you'll go to an IRF.

DR. STUART: The reason for asking that, of course, is if they are concentrated, you would like to see whether that has changed over time, too. But I'll come back to that.

And then I have a question about Slide 15, on the Medicare margins. Did you also collect information on total margins?

MR. LISK: No, we did not, although when you think

about the total margins, for most of these facilities, they are hospital-based facilities, so we do have what happened -- for PPS hospitals, we did do the total margin. We do have the total margin for them.

DR. STUART: Okay. I'll just telegraph this, but I think I'd like to expand upon it in round two, is that if we have information on total margins and Medicare margins and we make a really big deal about this when we talk about inpatient hospital care, it strikes me that we also should have both sets of margins if we're going to talk about other providers, particularly when it comes to the point where we're talking about whether care should be appropriately provided in one type of setting or another type of setting.

MR. GEORGE MILLER: I have a similar question about the geographic distribution. I believe at one meeting, we had a map where the IRFs are. Do you --

MS. NEUMAN: [Off microphone.] We have it here.

MR. GEORGE MILLER: Oh, great. Great. Okay. And so my follow-up question, are there places especially where access may be a problem, if the IRF may be the only post-acute provider, they would not have a SNF or home care. Have you done that analysis? I guess with that type of map,

it may be too complex to do that type of analysis.

MS. NEUMAN: Well, we haven't gone as far down that road as you're mentioning. What I can tell you that we've done preliminarily is we've looked at the distribution of IRFs by size of the facility. So as we mentioned, IRFs that are bigger have better financial performance and every State has an IRF that is of a large size.

MR. GEORGE MILLER: Okay.

MS. NEUMAN: So we now that fact, but we haven't gone further to look at sort of within States and geographic distances and that kind of thing.

MR. GEORGE MILLER: Yes. That's where I'm leaning, especially in rural areas. Tom would always mention this. I guess the question is the access to care. If the IRF is the only post-acute care facility, there is not a SNF, or vice-versa, then this recommendation may have an impact on access to care down the road, particularly, I guess, in rural areas, looking at this map. I don't know how to answer that. I'm just raising the question.

MR. LISK: Just remember, there are about ten times as many SNFs across the country --

MR. GEORGE MILLER: Yes.

MR. LISK: -- so I think in terms of skilled -

MR. GEORGE MILLER: It would be the opposite.

MR. LISK: I don't think that's probably -

MR. GEORGE MILLER: A major problem?

MR. LISK: -- a major issue.

MR. GEORGE MILLER: Okay. Thank you.

MR. KUHN: A quick question, Kim, if you have any information on compliance. That is, now that we've landed on the 60 percent threshold for the 13 conditions, are IRFs generally able to meet that compliance threshold or is -- I guess another way to ask it is, has CMS taken any adverse actions to any IRFs that haven't hit that threshold over the last year or two? Do we know?

MS. NEUMAN: We have some proprietary data that suggests that, in the aggregate, the IRFs are slightly above the threshold, in the 62-63 percent range. I do not know if CMS has taken any action to disqualify a facility as an IRF because it didn't meet the threshold, but we can look into that.

DR. MARK MILLER: And if I could just make sure, to clarify, what that means is that they're in compliance.

MS. NEUMAN: Yes. Yes. Sixty --

DR. MARK MILLER: Right --

MS. NEUMAN: Yes. Sixty percent is the threshold.

DR. MARK MILLER: Sixty-two means you're -- right.

DR. DEAN: Back to Slide 10. Does the data about hip and knee replacements, does that come as one aggregate, because those are very different procedures in terms of rehabilitation, and I suspect that affects these data. Hip replacements, most people that are in reasonable health go straight home. They don't even require physical therapy. Having experienced that myself, I can testify to that. And that's the usual course in our area. Whereas knee replacement is a very different thing. Knee replacement requires a lot of rehabilitation. But hip replacement is usually people can go straight home if they're in otherwise reasonable health.

So I guess, going back to Slide 9, your comment about the case mix being important, it's terribly important because these things vary tremendously. And as you can see, the number of major joint replacements in these facilities has declined, and I think that's the reason, that some of these procedures really require less rehabilitation than they used to, and I guess that's an improvement in the

technology. So whereas it might be more useful to look at stroke and brain injury, where the one that tend to require more. So I don't know, but I would certainly support what you say, that the case mix is terribly important in trying to make any judgment about where we stand.

MR. LISK: Some other stuff that I've looked at shows actually with regard to hip replacements, about 90 percent -- close to 90 percent are using some form of post-acute care after their hospital stay, and the knee replacements actually is a little bit lower than that, surprisingly.

DR. DEAN: Really? That --

MR. LISK: But those are probably the type types of conditions that have almost universal -- close to universal use of post-acute care.

DR. DEAN: That is very interesting, because it is certainly not true -- the orthopedists in our area, people with hip replacements go straight home.

MR. LISK: But you are right about how the changing patterns of care have occurred also, though, over the past half-decade. Even just the past five years, there have been major shifts in terms of how --

DR. DEAN: What I am saying is --

MR. LISK: -- procedures are being done in --

DR. DEAN: -- it was not true five years ago. So I wonder if -

MR. LISK: And I'm saying, when I'm looking at that, that was 2006 data, not 2008, so -

DR. DEAN: Okay, because -

DR. MARK MILLER: When you say they go home, they go home and have therapy either on an outpatient or a home basis? Is that what you mean, or do you -

DR. DEAN: Well, I didn't, and in general -

[Laughter.]

DR. MARK MILLER: So are you a little mad about this, or -

[Laughter.]

DR. DEAN: -- except for my wife beating me to do the exercises. If someone is in reasonable health, the kind of rehabilitation you need from a hip replacement is just some fairly simple exercises --

DR. MARK MILLER: Yes, because --

DR. DEAN: -- and walking. They just tell you to walk. But that is not true with knees. Knees is a much

more demanding thing. That is why I say they probably should be separate.

DR. MARK MILLER: Yes, it's interesting, because a few years back, when all this started with the 75 percent rural and everybody was, oh, my God, what's going to happen, we put ten or 12 physiatrists - did I say that right? -- on the phone and talked to them about how they do things, and there was this one physician and he said, I don't have IRFs nearby, so what I've done is I've constructed this entire treatment pattern where all the patients exercise beforehand, before they even get into surgery. Then they go through the surgery, and then he did more of that on a home basis. And he was saying, I basically handle -- and I want to be clear. This was one person and the other physiatrists on the phone didn't agree, at that time, anyway. But it is -- there is a lot of play in how these patients can be treated.

DR. CASTELLANOS: Can I chip in just a second? Tom's point about new technology, new techniques, minimally invasive, has made a dramatic change in the post-recovery area and we can't forget that. We also can't forget that the majority of these patients are going into facilities not

based on the procedure, but on their comorbidities -- age, weight, other comorbidities, plus whether they have two joints together. So it's not just the knee replacement. It's the whole risk adjustment where they're going.

DR. DEAN: Another thing that affects that is this three-hour rule. We quite often get people who come into our swing bed program, a SNF level, because they can't meet the three-hour level. They're too frail. So sometimes, the three-hour level excludes the most frail and the sickest patients. They go to skilled nursing because they can't tolerate three hours of therapy. So, in fact, even though the inpatient rehabilitation is, in fact, theoretically a higher level of care, quite often, the sicker patients go to a lower level of care because they can't -- they don't have the endurance to take three hours of PT.

MS. BEHROOZI: Yes. I have a question about the margins on Slide 15. That's one of those sort of rather wide spreads, I guess, not as wide as some of them, but it's a little bit of a spread, and I was just wondering, since your estimation for the all-IRF margin for 2010 is five percent, which is, looking at the paper, the lowest over the period that you're giving us information for, I wonder if

that means that the range is narrowing or is it shifting downward? Are the lowest ones going to be making a bigger negative margin?

MR. LISK: It generally would be shifting downward because of how the payment system updates were done and stuff.

MR. HACKBARTH: Was it a clarifying question you wanted?

DR. KANE: Yes. It's a little confusing, because so many of these are hospital-based. And so when we looked at the hospital margins, and they were all negative, this is playing into that. And so when we make a recommendation on the hospital update of the full market basket, we are being influenced by what's happening by these guys. And so I think it might be in the future helpful -- I know allocations can greatly affect this. I mean, the fact that the hospital-based is 4.2 whereas freestanding is 18 suggests to me, if the basic function is profitable at 18 percent, then probably this is an allocation difference, not a -- who knows.

But, in other words, it might be useful in the future to, when we look at the hospital measures, if we are

going to look at these on an allocated basis, we should probably just pull out the acute, the outpatient, and all the different parts that are in their hospital-based margin, because we're now looking at the hospital margins on an aggregate basis. But then we're pulling off pieces of them for this. And so I'm just wondering if we're not getting kind of confounded --

MR. HACKBARTH: Craig, I know you've thought about this. Go ahead.

DR. KANE: I mean, this is an allocated profit --

MR. LISK: Well, you have to think about how these facilities -- in terms of how the hospital is operating this in terms of --

DR. KANE: Right.

MR. LISK: We tried to look at the allocation issue before on this, between hospital-based and freestanding. We didn't really find too much of an issue on that. But some of this is -- remember, a lot of these hospital-based units are under 22 beds, so they're smaller. We do see on -- so the ones that are larger or actually have better margins, for instance, so part of it is in size. But there is still a differential even within hospital-based and

freestanding in terms of the freestanding having higher margins. Some of that is due to one set of institutions that have very high margins, too, among the freestanding group in terms of a for-profit chain that does very well, too.

DR. KANE: I guess I'm just wondering, does it make sense to look at the IRFs -- the hospital-based IRFs with a fully allocated profit margin, but then to look at the acute sector with all the different product lines bundled in, or should we just be consistent and look at the acute sector or the outpatient sector or the skilled nursing, all of which are being bundled in into our determination about the hospital update, the acute update. But now we're pulling them apart to make decisions about the updates for each of the product lines. I'm just thinking whether that's consistent and appropriate or not overall.

MR. HACKBARTH: Your point is well made and understood. Let us think through that some more, and when we come back in January, we will have a more thoughtful response.

Peter?

MR. BUTLER: I'm confused. This is a very

important point. We showed 7.2 percent loss, on average, yesterday for -- are you saying that all Medicare business is in that number, you know, including rehab, including psych?

MR. HACKBARTH: That is the overall Medicare margin for hospitals, including all lines of business.

MR. BUTLER: Okay.

MR. HACKBARTH: So that does include where the hospital has it. We also regularly include an inpatient-only margin, but we base our update recommendation on the overall margin, in large part because of concerns about allocation issues.

MR. BUTLER: So, in fact, if we voted zero here or if we don't attend to anything in psych because we don't even address it, or any of the other ones that are hospital-based, that would pull back a little bit on the market basket update recommendation of yesterday. It would dilute it some.

MR. HACKBARTH: To the extent that a given institution has these --

MR. BUTLER: It depends if you've got a lot of this business or not.

MR. HACKBARTH: Yes, the mix and --

MR. BUTLER: Right. Okay.

MR. HACKBARTH: The proportions.

Let's go ahead. We've got to press on with round two. So we do have an update recommendation here, Ron, so if possible, I'd like to know how you feel about the recommendation and any specific questions you need answered.

DR. CASTELLANOS: I totally support the draft recommendation. You're going to think this is very naive. It's a question that's been bothering me for several years. Could you go to Slide 15. I'm just sitting here, and George kind of hit on this yesterday when we talked about margins. And here, you can see everything that we talked about yesterday and today. The margins for the difference between profit and nonprofit are very significant. And George hit it yesterday.

You know, we need to get our arms around -- besides looking at margins, but some of the nonprofits provide a community and a society basis real value, and is there any measurement that we can look at to support that, because it's just not dollars and cents in the real world. It's taking care of everybody appropriately whether they

have insurance, whether they don't have insurance, and doing the right thing for society. It bothers me, because as a physician, yes, it's important to look at margins, but there's also a very, very valuable society benefit, too.

MR. HACKBARTH: A couple reactions, and other Commissioners might have different reactions. One is that I think the categories are not very precise categories. There's a huge range of behavior within both categories, frankly, but within the not-for-profit world -- let me focus on that -- there are some not-for-profit institutions that are strongly motivated by a charitable mission and behave accordingly and there are others that are run very much to the bottom line. So to say all not-for-profit institutions are alike, I just don't think is a sound premise.

When we look at data like these -- I don't know, but I suspect that the not-for-profit number may be confounded by a disproportionate number of hospital-based, and so this is not an apples-to-apples comparison of for-profit and not-for-profit. So it's tricky stuff, is my bottom line.

MR. BUTLER: Okay. I was going to make the statement, either in this session or the next, but there are

about seven or so services that do fall into this category, and this isn't about for-profit versus nonprofit, but usually I try to step back and look at these silos and say, what are we doing and how does this relate to an Accountable Care Organization. This is a little different comment and twist on it.

First, I'll say that I can support the recommendation, just so that you know that. But there is a trend that says there is this difference in the hospital-based versus non-hospital based, and it is not just the allocation issue. And if I look at my own organization, we have shed over time the hospice, the home health, the skilled nursing, and as I said, we don't even have psych on there, but this is a huge loser, and we are hanging in there with a large number of psych beds.

Now, is this a bad trend? And we heard from California Hospital Association and the SNF. I mean, under any allocations, you just can't make it. But is this a bad trend? Not necessarily. But get back to the governance issue and nonprofit governance, and actually, this applies not just to hospitals, but actually health plans, the 11 million members, I think -- I don't know, Jay, you'd know --

like half of them are nonprofit plans, right, or something like that?

We have a governance in place in this country that is voluntary that is the only direct connection to the voice of the community in these nonprofit organizations, and I do think they're increasingly accountable with increasingly robust community health plans. They focus not on just health delivery, but health care, and they're being asked to be more accountable as governance structures. And when operated right, they are very connected to the community.

My point is, as we unwind these and cast them primarily in freestanding, primarily in for-profit entities, that oversight is gone and some of these organizations are wildly spectacular, successful, and hospice and home health and doing wonderful things and they get cast into kind of a -- by the bad actors, which we don't have any way to get oversight over, get cast into a bad light. And we do it in this meeting.

And so what I would encourage us to do, and this has come up, I think, through Jennie and some other comments, how do we get at the data? How do we get at an oversight for these things that maybe can be done cheaply,

more cheaply, perhaps better, but need some kind of oversight? It kind of reinforces to me the need to really get at understanding how we screen and evaluate these things as we try to put them in cheaper, better settings, and how can we tie that kind of knot across these services so that as we cast them away from the nonprofit kind of governance structure, that -- I think it's a theme we have to think about, because it's clouding our kind of comments and how we're addressing these things where I think we could really -- I'm just saying one more time to get the data, to get ways to evaluate these things so that we make sure that they're kind of contributing to the big picture, not just the small picture of these rates.

So I've made my statement. Thank you.

DR. SCANLON: In this regard, I think there's a great deal of interest outside of here and the whole issue of community benefit. We recently -- the IRS redesigned the 990s and for hospitals actually created a schedule for that information.

Having said that, though, there still is an issue of how we define community benefits. A lot of people equate it to care for the poor, and you can talk about prior data

on care to the poor and say some of it is truly problematic because it was charges and not at cost, and so we can correct that kind of a thing relatively easily.

But I think at the same time, community benefit goes further than that. There's many other kinds of things that we need to think about capturing relative to why we have sort of nonprofit institutions. They're more intangible and they're harder to deal with, but we need to think about sort of what they might be.

At the same time, one of the unfortunate things, I think, about the new data reporting is we are counting things as community benefit, potential community benefit, that hospitals are being paid for. Research and teaching, okay. I mean, when we think about community benefits, you might think about it, well, here is what we did with the surplus from our activities in order to reinvest it in the community as opposed to, here's a line of business and we happen to operate that on a big scale and therefore we have, quote, a lot of community benefit.

So I think this is something that we have to -- it's going to continue to be debated. There's a great deal of interest on the Hill in terms of what is community

benefit because they're asking sort of why do we have the advantages we give to nonprofits, you know, are they justified.

DR. MARK MILLER: I thought you put that very well, and I think I've heard this several times in the last few days here, and you just have a slightly different twist. Things are moving out of the hospital. It may be a good trend. But then that leaves them in an environment where potentially there's more vulnerability to certain actors who practice certain types of business models, you think home health, hospice, some of those conversations yesterday.

So I feel like I'm hearing a pretty strong theme. There were some statements made by Arnie along these lines yesterday. Bill, you've actually made this point a couple of times in the past. So my point is it's hard, and I think we'll start trying to think of that component much more rigorously as we go through. We'll be back here on home health already on the basis of your conversation, and I'll put my mind to this -- or our minds to this much more broadly.

MR. BUTLER: Can I just say one other quick thing? The data thing is the key, because on the hospital side, I

think that there's a lot of scrutiny. HCA companies, very good companies, managed costs. There are all kinds of ways to look at what they're doing. So again, it's not so much the nonprofit versus profit. It's how you have -- what we have available to evaluate what they're doing.

MR. HACKBARTH: Okay. We need to get through this. Round two. Again, I'm looking for comments on the proposed recommendation and requests for additional information. Nancy?

DR. KANE: Well, I'm getting a little uncomfortable about the fact that this rate is being presented separately from the aggregate hospital rate and I just would like -- I'd like to just see the fully allocated profit margin by line of business, pulling out the acute, the -- just, I think -- because what I suspect is that this contributes -- it lessens how negative the acute -- either the acute or the outpatient sector, I don't know which. I just think making these -- I mean, I think on the face of it, just looking at this as a line of business, this is a reasonable recommendation. But I would like to sort of see how it contributes to the whole line of business for the hospitals.

MR. LISK: We did --

DR. KANE: I'd like those profit margins broken out separately -- acute, outpatient -- just to sort of help see where in the picture this is.

MR. LISK: Just to say yesterday that we did present you with the inpatient margin and the outpatient margin components. It may have gone by really quickly, but just --

DR. KANE: Was this in the acute part, or was it just --

MR. LISK: No, it was not. It's in the overall Medicare margin, but we did present you with the inpatient margin and the outpatient margin, as well.

MR. HACKBARTH: Craig, the number for the acute inpatient was --

MR. LISK: I left those papers back in my office. I think it was minus-five-seven?

MR. HACKBARTH: Yes, several --

MR. LISK: It went down -- the inpatient went down one point from 2007 to 2008 and the outpatient went down --

MR. HACKBARTH: So you have some factors going different ways --

MR. LISK: minus-12.

MR. HACKBARTH: Here, the hospital-based is profitable and would tend to contribute to a positive overall margin. The outpatient is negative. It tends to pull down the overall margin.

DR. KANE: Yes, way down.

MR. LISK: Right.

DR. KANE: So I guess looking at this line of business, yes, this makes sense, this recommendation. I am now getting -- I'm a little more concerned about the hospital recommendations, but I'll stop there. I'm just -- you said you'd come back and maybe try to break this out a little bit more.

MR. HACKBARTH: Although --

DR. KANE: Maybe we need to update the outpatient side separately from -- you know, we are now making recommendations across some lines of business in an aggregate -- like the outpatient and the acute inpatient gets this one recommendation -

MR. HACKBARTH: Yes, but what gave me pause there, Nancy, was the reservation about the hospital recommendation. So to the extent that you're saying,

because this one is a recommended zero and that would mean for the hospitals that have this part, give them less than the full market basket. Okay.

DR. KANE: [Off microphone.] Yes. I'm just trying to get the interaction.

MR. HACKBARTH: Okay. Round two.

DR. CROSSON: I support the recommendation in the context that we're looking at it. Could I have Slide 13 just quickly? So we're going to see a slide that looks like this in a few minutes with respect to LTCHs. I just wonder whether or not, perhaps not right now, but at some point, we want to ask the question, why was the payment system changed in 2002 and was that, in fact, successful in achieving the goals, because I think the fact that we're making this kind of recommendation is a consequence of a set of dynamics here that are exemplified in this curve, and perhaps at some point, we should take on the larger question of whether or not the payment system should be changed.

DR. STUART: I share some of Nancy's concerns on this in terms of what we're actually voting on, because if you go back -- in some cases, we're voting on a service and on a method of reimbursement. But in other cases, we're

not. So when we took our votes on hospitals, we were talking about both the inpatient and the outpatient. We didn't make a distinction, even though there are separate payment methods for those two. And here, we're pulling this out.

I think there's enough concern about what we're doing here and how we're using information, and Mark, I think you picked up on this. It's not something that's going to be handled by January. It probably won't even be handled by July, or June, but it tells me that it's something that we really, really do need to address as a Commission.

And I think there are three levels here in terms of the margin. I asked for information on total margins and Medicare-specific margins simply so that we have transparency. But I think it's a bigger issue than that in terms of what we're really talking about. Part of it is an allocation or apportionment issue. It's really an accounting issue. But it's also an economic issue. I can remember Bob Reischauer saying, well, there really isn't any such thing as cost shifting, that hospitals make a distinction between -- you know, they look at their total

revenues and they look at their total costs and they make decisions about where they want to be depending upon whether they're profit or not-for-profit. And if it turns out that they spend money and it from an accounting standpoint looks like they're losing on Medicare, well, you know, they went into this making the decisions on the basis of that.

So that's not cost shifting in any real sense. And I think I buy that. But having that information is clearly important to us. I mean, we should be looking at this from the perspective, in part, about how providers make decisions and what those decisions mean to Medicare.

So I would argue that, at some point, we need a chapter that focuses upon the issues of accounting and margins and how the Commission should look at those in terms of the economic implications and the implications of looking at something that is service-specific as opposed to provider-specific, and maybe there are other ways in which this should be cut, but I think that that picks up on some of the things that Peter is involved with, as well. So that's a recommendation beyond the update.

The other recommendation is on -- it comes out of Slide 10, if you could go back to that. Yesterday, we had

this long discussion about what home health agencies do, what the product is, and I'm looking at this and I'm saying, well, ho, here's some of the answer. I mean, they're taking up hip and knee replacement cases that were being treated in other places.

And I know you've had initiatives in the past in terms of looking at post-acute care across providers, but this, to me, is something that would have been helpful in the discussion of what home care -- in terms of the home care debate. And so I would say, all right. Well, is it appropriate that there is a 50 percent increase in the number of hip and knee replacements that are done in home care? Maybe home health care shouldn't be evaluated in terms of whether it reduces hospital admissions. Maybe it should be evaluated in terms of, well, this is the right place that this kind of rehabilitation should be done.

So, again, it's kind of cutting through our silos in terms of being able to make these decisions, and we have so many different kinds of long-term care, post-acute care services that we look at independently, that I think for any -- and I'll just speak for myself -- for a Commissioner to try to figure these things out without looking at them

holistically becomes really tough. And so, again, this is not something that is going to make a decision in terms of the March report, but I think it's something that -- clearly is something that we should address for the future.

MR. HACKBARTH: Let me just comment on that. Going back a number of years now, and I think this predates your joining the Commission, Bruce, I stated my then-held, still-held view that the decision in the late 1990s to do prospective payment for post-acute services was just a very unwise decision and really wasn't thought through very well. It was a reaction to the fact that we had an apparently successful inpatient hospital system and so prospective payment seemed like a good idea. And we had cost issues with the post-acute services, so let's take our good idea, this hammer, and start whacking these nails.

The problem, as you're pointing out and as other Commissioners have pointed out, is that these are now payment systems based on provider type, but the services that the patient needs can be provided in different settings. So we've got a payment model that is inconsistent with the care delivery system and it's having bad effects and it makes the analysis very difficult.

And so, basically, we created these provider-type seams in the delivery system, and you get paid more if you go into an IRF to get care that in many cases could be just as well provided at home, or home plus home health. That's a basic design problem that we've got. I agree that this model is a mistaken model and we need to get out of it.

The demonstration that Kim was talking about, let's start developing a common assessment tool so we can start looking at the clinical needs of these patients and how those needs can be met in various settings, this sort of a foundational piece to potentially move to a whole different way of thinking about post-acute payment. But we need to start building the foundation to support a dramatically different payment system.

DR. STUART: I guess the recommendation for March would simply be perhaps to have something in these post-acute chapters that indicates that the future perspective --

MR. HACKBARTH: Well --

DR. STUART: We think the future perspective in terms of how these decisions are made should change.

MR. HACKBARTH: Yes. And my recollection is that a couple years ago, we actually ran sort of a preface to the

post-acute chapters that talked about these issues. And so let's pull that out and distribute it to the Commissioners and see if that meets part of the need that you're talking about.

MR. GEORGE MILLER: This last discussion has been very helpful. Thank God for Bruce and Peter, because I agree with them. I have some similar concerns as they already have so ably articulated.

And then I agree with Nancy. I think we need to go back and look at the hospital part, because we were recommending market basket there, but if the IRFs and the other hospital-based facilities, we say no increase for those but you recognize market basket for the hospital, I'm perplexed on whether I can support it without looking at that together. And I understand the freestanding IRFs and we're looking at that in total, both the hospital-based and the freestanding, but if you recommend -- just reiterating a point -- a market basket for the hospital and an IRF is inside of the hospital, how do you say this part of business can't get a market basket? So I don't know how we wrestle with that dilemma, but that's very well taken.

Then I'll go back and repeat my other statement

from yesterday. We talked about rewarding efficient hospitals, but my question about efficient hospitals, do they have an IRF or a SNF, home care, and if they don't, then we're comparing apples with oranges again as we measure an efficient hospital versus another type of hospital that may have all of these other facilities and may not have the same margin as an efficient hospital, as I talked to you yesterday.

MR. HACKBARTH: I went, Nancy, and looked up the inpatient-only number, and for 2008, the overall Medicare margin, including all lines of business, for hospitals was minus-7.2 versus 4.7 for inpatient only. So on balance, the inclusion of these other services, other hospital-based services in the hospital margin, is pulling down the margin. Outpatient obviously is a big contributor, both in terms of negative margin and, I would assume, large volume of dollars. I don't know that.

MR. LISK: I mean, outpatient is the bigger effect than --

MR. HACKBARTH: Right. Right. And so if you tried to say, okay, we're going to do the inpatient update solely based on inpatient costs, all other things being

equal, that would tend to lead to a lower inpatient number which will affect a much bigger part of the hospital revenue base.

DR. KANE: [Off microphone.] Well, minus-4.7 is not a great margin -

MR. HACKBARTH: Agreed. I'm just saying, all other things being equal, the financial positions of hospitals look more favorable if you look at the inpatient-only than the overall.

DR. KANE: But then you might give a higher, if you could, a higher update to outpatient, because it's very low. I mean, I guess if we're going to go by line of service, let's go by line of service. If we're going to go by aggregate, let's go by aggregate. But let's not do some line of service and some aggregate where the line of service is in the aggregate -- I'm sorry.

And the other possibility, because of the overhead issue, is to look at contribution margins, relative contribution margins by line of service, and leave overhead out of it and just say that's what will go into our consideration for what the relative update should be. These are all relative updates, you know, relative to some metric,

and maybe Medicare margin isn't the best metric. I think that's what the issue is.

MR. HACKBARTH: Let me just follow it to the next step. So we've said that our inpatient recommendation, based on the overall margin of minus-7.2, is zero with the P4P and the coding caveats, et cetera. If we say, okay, what we are going to do is take out all of the other lines of business, the inpatient is going to go up. Now, we include the hospital-based here, so this would --

DR. STUART: [Off microphone.]

MR. HACKBARTH: The inpatient margin is going to go -- it improves. The inpatient margin is better than the outpatient, and so your update recommendation, if anything, would --

DR. STUART: [Off microphone.]

MR. HACKBARTH: Microphone.

DR. KANE: They're both --

DR. STUART: The IRF is going to bring up the margin, so the total inpatient margin, if it includes the IRF, is higher than if you took it out if we were to believe that the average margin that we see --

MR. HACKBARTH: On balance, the other lines of

business are pulling down the hospital margin.

DR. STUART: Okay.

MR. HACKBARTH: IRF, yes, is contributing, but all the others swamp it.

DR. STUART: Well, that's what makes it really confusing, if they're not going all in the same direction.

DR. SCANLON: I think we're headed in a wrong direction here, because if you look, we have 980 hospitals have IRFs, okay. We can't be talking about hospitals overall and not making the distinction between hospitals with and hospitals without. In some respects, it made sense to talk about inpatient and outpatient and total, because inpatient and outpatient dominate the total, and almost by definition, you have to have both to be a hospital, okay.

But now when we start to talk about IRFs and SNFs and home health and anything else, we're talking about certain hospitals. And to make a recommendation for an update for inpatient or outpatient factoring this in seems to be relatively inappropriate.

DR. KANE: Well, that's what we are doing, though. That's what -- Bruce said, take it out.

DR. SCANLON: No, no, we're not factoring this in.

We're really -- because we can turn and look to the inpatient and outpatient margins, which I think should dominate us in terms of what our recommendation is there, and then we can look at this margin for this class of hospitals, this less than 50 percent of hospitals having IRFs. We're making a recommendation that's going to impact them. Because I think one of the problems with the PPS -- this goes back to the original one -- is we make these changes across the board and there are different circumstances and this is one of them. What's the different lines of business that a hospital has?

MR. HACKBARTH: Okay. This is complicated. I think we've gone as far as we can go right now on it. We are behind schedule and people have airplanes, so we've got to get through this and get to long-term care hospitals in the next five minutes. So if you have specific comments on the draft recommendation and requests for information, I'd like to hear them. Herb?

MR. KUHN: I'll be brief. I generally support the recommendation, and to follow up on Bruce's note about a site-neutral payment system, that we have some verbiage in the chapter on that would be -- I would support that and I

think that would be very helpful.

DR. CHERNEW: I think to address this in part, it would be nice to see the payment index so we just knew how different the payment -- I would just like to know how different it is for a different service, if you got it in an IRF or a SNF or home health. I'm not saying that we would say they have to be the same, but it would be a really good piece of information to know. That's the first point.

The second point is, not only do I support the recommendation, any recommendation that caused a greater divergence in payment between the different types of facilities that provide the same type of services will be more problematic. So I think having a similar update factor, which we do for the different types of providers offering similar types of services, I think is a good starting point, and I would need to be convinced why we should move otherwise. So in that sense, I'm supporting.

MR. HACKBARTH: Mitra, did you -- okay. Thank you very much.

So, next is long-term care hospitals.

MS. KELLEY: Good morning. You're well familiar with our update framework by this point, so I'll just start

with a little bit of background on long-term care hospitals to refresh your memory.

Patients with clinically complex problems who need hospital level care for relatively extended periods of time are sometimes treated in LTCHs. To qualify for an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay of greater than 25 days for its Medicare patients.

Due to these long stays and the level of care provided, care in LTCHs is expensive. Medicare is the predominant payer for this care, representing about 70 percent of LTCH patients.

Since October 2002, Medicare has paid LTCH under a per-discharge PPS and the LTCH PPS uses the same MS-DRGs used in the acute hospital PPS but with different weights specific to LTCHs.

Following implementation of the PPS, Medicare payments for LTCH services grew rapidly, climbing an average of 29 percent per year between 2003 and 2005. Between '05 and '07, however, growth in spending slowed dramatically. Our analysis of claims data showed that between '07 and '08,

Medicare payments rose 2.4 percent, reaching $4.6 billion in 2008.

So turning now to our update framework, our first consideration is access to care. We have no direct indicators of beneficiaries' access to LTCH services, but assessment of access would be difficult regardless. There are no established criteria for admission to an LTCH so it's not clear whether the patients treated there always require that level of care. Remember that many beneficiaries live in areas without LTCHs and so receive this level of care in other facilities.

To gauge access to services, we look at the number of facilities and beds available and the number of services used. Across the board we see the same pattern. Growth in the number of LTCHs participating in the Medicare program has leveled off in recent years. This followed a quadrupling in the number of LTCHs between 1992 and 2005.

Growth in the number of Medicare certified LTCH beds has leveled off, as well. Nationwide there were almost 26,000 certified beds in 2008.

And here we see a leveling off in the number of cases per 10,000 fee-for-service beneficiaries. This number

grew an average of 9 percent per year between '03 and '05 and then remained flat between '05 and '07. But between 2007 and 2008, the number of cases, controlling for fee-for-service enrollment, rose 3.6 percent. Taken together, these trends suggest to us that access to care has been maintained during this period.

Before I move on to quality, let's talk a bit more about LTCH facilities for a minute. You'll recall that some LTCHs are co-located within other hospitals. We call these hospitals-within-hospitals. Since the implementation of the LTCH PPS, there have been concerns about LTCHs, particularly hospitals-within-hospitals, acting as de facto units of acute care hospitals. MedPAC has attempted to keep track of growth in the number of hospitals-within-hospitals. However, as you can see here, the reliability of the hospital-within-hospital data is questionable. One gets a very different picture of the industry depending on the data used.

So this raises a couple of questions. First, we question the utility of tracking these types of facilities with these data, given the difficulty of identifying them accurately. The second, more important, question is whether

there's any merit to payment policy that's based on this distinction. Currently, under the 25 percent rule, hospitals-within-hospitals and satellites may admit only a specified percentage of their patients from their host hospitals. Once they meet that threshold, LTCh payments are reduced.

In July 2007, CMS began to extend the 25 percent rule to all LTCHs, in part in response to comments that the Commission had made. However, Congress stepped in and prevented CMS from doing this for three years.

We plan to pursue answers to these questions by assessing if there's a better way to distinguish hospitals-within-hospitals from freestanding LTCHs, but also to determine whether the distinction is particularly meaningful. Our preliminary work suggests that it may not be. Some freestanding LTCHs appear to admit large shares of their patients from one acute care hospital while some hospitals-within-hospitals admit patients from a wide network of acute care hospitals.

Okay, let's turn now to quality. Unlike most other health care facilities, LTCHs do not submit quality data to CMS. In the past, the Commission has used four AHRQ

patient safety indicators, or PSIs, to measure adverse events across all LTCHs. Even though the PSIs were developed specifically for use in acute care hospitals, we had worked with a panel to help us choose PSIs that might also be applicable for use in LTCHs.

AHRQ recently completed an evaluation of the PSIs and made recommendations regarding their use in public reporting and pay for performance activities. While many PSIs remain reliable indicators of potential quality problems, two of the PSIs we have used in LTCHs have been found to frequently capture conditions that are present on admission. These PSIs, therefore, are not reliable measures of the quality of care provided in LTCHs. The other two PSIs that MedPAC has used weren't assessed by AHRQ because new coding guidelines required major respecifications of the indicators.

So in light of this new information, we've opted not to rely on PSIs to monitor quality of care in LTCHs this year.

MedPAC also relies on in-facility mortality, mortality within 30 days of discharge, and readmission to acute care to assess gross changes to the quality of care in

LTCHs. Apparent changes in the mix of patients admitted to LTCHs make it difficult to evaluate these measures for 2008, but I hope to bring you some information on this in January.

Obviously, we're very concerned about the lack of reliable quality measures for LTCHs. Our plan going forward is to explore the development of measures. To start, we plan to convene an expert panel to help us identify meaningful measures and the data needed for measurement. We also plan to work with a contractor to assess the feasibility of risk adjusted quality measurement at the quality level. We know that LTCH chains and industry groups collect and analyze their own pro9vider level data, so our hope is to find a way to capture and use that information to improve both beneficiary care and Medicare payment policy.

Access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access capital it might, in part, reflect problems with the adequacy of Medicare payment, since Medicare provides about 70 percent of LTCH revenues. Last year, the economy-wide credit crisis meant that LTCHs' difficulty accessing capital at that time told us little about Medicare payment adequacy. One year later, credit markets are operating in a more

normal manner, as you know, but the three-year moratorium on new beds and facilities that was imposed by MMSEA has reduced, although not eliminated, both the opportunities for expansion and the need for capital among LTCHs.

Overall, it appears that relatively little equity has been raised by LTCH chains in recent months. There are two exceptions. First, one of the largest LTCH companies, Select Medical, raised $279 million in an initial public stock offering in September. Secondly, publicly owned RehabCare Group announced in November that it had completed its merger with private equity funded Triumph. And this merger makes RHB the third largest LTCH provider behind Select and Kindred.

So how have LTCHs' per case payments compared to per case costs? Under TEFRA, a cost-based system as you know, payments and costs tracked each other fairly closely. Per case payment and cost growth was relatively low and actually declined in 1999 and 2000. Under the PPS, payments have increased significantly. And as payments have gone up, so have costs. From 2002 to 2005, payments grew much faster than costs. Much of the growth in payments was due to increases in reported case mix of the patients going to

LTCHs. After 2005, lower payment updates and changes in policy began to pull down growth in payments, narrowing the gap between payments and costs. Between '07 and '08, we can see that that gap is holding fairly steady.

Consistent with this pattern of growth in payments and costs, margins for LTCHs rose rapidly after the implementation of the PPS, rising from a bit below zero under TEFRA to a peak of 12 percent in 2005. In 2008, we can see that the slope of the margin line is changing, reflecting the stabilization of that gap between payments and costs that you just saw. The aggregate margin in 2008 is 3.4 percent.

This slide shows 2005 and 2008 margins for different LTCH groups, as well as the share each represents of total providers and total cases. As you can see, there's fairly wide spread in the margins, similar to what you've seen in other settings, with a quarter of LTCHs having margins of negative 8.2 percent or less, and another quarter having margins of 11.8 percent or more in 2008. Margins for for-profit LTCHs are quite a bit higher than those of not-for-profits. I can go into this more on question if there's interest.

We haven't broken out margins by urban and rural areas because there are so few LTCHs in rural areas.

We looked more closely at high and low margin LTCHs to get a better idea of what's driving those margins. This slide compares LTCHs in the top quartile of margins with those in the bottom quartile. We found that lower per discharge costs, rather than higher payments, drove the differences in financial performance between LTCHs with the lowest and the highest margins. High margin LTCHs also have a shorter length of stay and far fewer high cost outlier cases and payments, and they are much more likely to be for profit.

For purposes of projecting 2010 margins, we modeled a number of policy changes. First, we included updates in 2009 and 2010, which were estimates of market basket less adjustments for documentation and coding improvements from earlier years of the PPS. Payment updates for 2009 and 2010 are estimated to be close to the projected rate of cost growth.

We also assumed payments would increase in 2009 and 2010 due to additional documentation and coding improvements. As you will recall, an updated classification

system, the MS-LTC-DRGs, was phased in beginning in fiscal year 2008 and was fully in effect in 2009. Our expectation is that coding will improve in the early years of this revised classification system. That will increase payments to LTCHs without a corresponding increase in provider costs.

Finally, we made a small adjustment for changes to the wage index in 2009 and 2010 and a rather substantial adjustment for change to outlier payments in 2010. Taken together, these effects will result in greater growth in aggregate payments than in provider costs. Assuming providers' costs go up at projected market basket levels, we've projected a margin of 5.8 percent in 2010.

So, to sum up, we're seeing stability in the number of facilities and beds. Use of services has increased slightly. We have no information about quality in LTCHs today, but I hope to bring some aggregated information in January. LTCHs have accessed relatively little capital in the last year, but under the moratorium, need for capital is limited.

Our projected margin for 2010 is 5.8 percent. Our projected growth in the aggregate margin is consistent with expected effects of congressional rollbacks of CMS

regulations that were designed to reduce payments to LTChs. And it's also consistent with expected improvements in documentation and coding.

So, moving on to the draft recommendation, we make our recommendation to the Secretary because there is no legislative update for the LTCH PPS. The Chairman's recommendation is that the Secretary should eliminate the update to payment rates for long-term-care hospitals for rate year 2011. CMS has historically used the market basket as a starting point for establishing updates to LTCH payments, so eliminating the update for 2011 will produce savings relative to a market basket. We don't anticipate any adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

I'll be happy to answer any questions you have.

MR. HACKBARTH: Thank you, Dana.

Round one clarifying questions?

DR. CASTELLANOS: Do you have the picture, the geographic picture? Do you have one of these?

MS. KELLEY: I don't have [off microphone].

DR. CASTELLANOS: Okay, but you did mention that it's very rare in rural areas.

MS. KELLEY: Yes. There's only about 30 LTCHs in rural areas nationwide.

DR. CASTELLANOS: I guess the clarifying question I'd like to know is case mix risk-adjusted, can you compare that from a hospital that has this to an area that doesn't and to see if there's any difference between costs, length of stay, outcomes, and, if possible, quality?

In other words, I don't have a long-term care in my community, but for some reason these patients are treated there and are doing well. I want to see if the long-term-care hospital has any benefit to this group of patients, case mix and risk-adjusted.

MS. KELLEY: This is something that MedPAC looked at several years ago using 2001 data. We looked at the total episode of care and tried to control for case mix as best we could. And we looked at patients in areas that had LTCHs compared to similar patients in areas that didn't have them. We found that patients using LTCHs generally had higher costs, but the difference in the costs narrowed significantly for the very sickest patients. We had no quality measures that we could apply and very imperfect acuity measures.

Patients who used LTCHs did have shorter acute-care hospital lengths of stay compared with similar patients who didn't use LTCHs. Since some of the patients would have stayed in an acute-care hospital, that does make sense, I think.

RTI did a similar analysis a few years later using 2004 data and, again, found similar results to ours. They also looked at mortality and readmissions and found that there was very little difference in mortality and readmissions or Part A costs per episode for ventilator patients in areas that have LTCHs versus areas that didn't.

Obviously, the quality and outcomes measures are the big missing piece to this type of analysis, so hopefully as we move forward with our own work and also await work from the PAC demonstration, we can begin to move those pieces into the puzzle as well.

MR. HACKBARTH: And the analysis that Dana just described is the analysis that led us to our recommendation that there ought to be patient and facility criteria on which patients ought to go into LTCHs. And the status of that, Dana, at this point is?

MS. KELLEY: As you'll recall, the Secretary was

required to release a report on criteria development in June of last year. My understanding is that that report is forthcoming and is in the final stages of clearance. But I don't really have an estimate for when we will see it.

MR. HACKBARTH: Other clarifying questions on this?

DR. BERENSON: Yes, just a little bit about the 25-percent rule and what that was attempting to protect against, and I guess Congress sort of overrode that, and so I guess the alternative we have now is a screening process for appropriateness of admissions, and do we know if that works very well?

MS. KELLEY: That's right. It was an attempt to ensure that long-term-care hospitals were not acting as units of acute-care hospitals and allowing them to sort of circumvent the acute-care PPS. The 25-percent rule initially for that reason was applied only to hospitals -- within-hospitals and satellites.

There has always been difficulty identifying exactly which LTCHs are hospitals-within-hospitals and satellites of acute-care hospitals. This was something the Commission pointed out several years ago, and in response to

-- we also argued that the 25-percent rule was somewhat of a blunt tool and that criteria would be better.

In response to those comments, CMS began to extend the 25-percent rule to all LTCHs, and under that rule no free-standing LTCH would be able to admit more than a specified percentage of patients from one particular acute-care hospital without receiving reduced payments for those patients.

Congress stepped in in MMSEA and prevented CMS from extending the 25-percent rule to all free-standing LTCHs, and also boosted -- rolled back the threshold which had been phased in and was at 25 percent. They rolled it back to 50 percent for the hospitals-within-hospitals and satellites.

I think I may have forgotten the second part of your question.

DR. BERENSON: So do we think that screening procedure on appropriateness is screening?

MS. KELLEY: I don't think we know yet whether the screening procedure is effective. I think that's something that will shake out in the next year or so as we see the claims data come in for 2009.

MR. HACKBARTH: Clarifying questions?

MR. KUHN: Dana, a question on the calculation of the margin for this year, and maybe you mentioned this in your presentation and I just missed it. But as I recall, on or about the 1st of June CMS made a midyear correction based on some error in the weights where they reduced, if I remember right, the LTCH by 2.7 percent or something like that. How is that captured in the margin calculation that we have right now?

MS. KELLEY: The update for 2009 was included in developing our margin, so we did have that sort of tick-down accounted for.

MR. KUHN: So even with that 2.7 percent additional reduction, we still come out with the 5.8.

MS. KELLEY: Yes

MR. KUHN: And that's all captured in there. Thank you.

MR. HACKBARTH: Other clarifying questions on this side?

Round two, comments on the draft reg request for information?

MR. BUTLER: So I can support this recommendation

as well, and then I have one suggestion, Glenn. It relates to the previous discussion, too, because here, again, this is one that we are participant in with another health care organization.

The typical hospital or health system would look at 2.5 percent market basket increase -- that's the estimate -- a 1-percent hit on the coding down to 1.5; and then to the extent that you are providers in these other -- for example, we have about 80 psych beds; we have 60 rehab beds; we have this service. That would drag it down to, you know, easily under 1 percent, and then you add in RAC and other things where people are denying payments, you're about at zero for our institution. And if you were to do IME, which we're not voting on but acknowledging as a recommendation, that would be another 3 percent for our institution. So we would be negative 3 if you added up all the efforts or something. But it is very different, as you said, depending on the institution.

And so the extent that you didn't do any of those things, then you would be looking at a 1.5, and maybe there's a way to acknowledge somehow that the full market, depending on the mix and participation in these other

services, it's more acknowledging it rather than, I think, voting on these things in a different kind of way. I do think we need to look at them as separate services one at a time, but just acknowledging to the extent that hospitals participate in some of these other things, they wouldn't, in effect, be getting full market basket for their collective set of services.

MR. HACKBARTH: Other comments on the draft recommendation?

You did a really good job, Dana.

[Laughter.]

MR. HACKBARTH: Thank you very much.

We will now have our public comment period, and let me repeat the ground rules, which are no more than a couple minutes and please begin by introducing yourself and your organization. And, again, I would remind people that this isn't the only opportunity to comment. In addition, we have a place you can go onto our website and make comments about today's discussion as well.

MR. KALMAN: Good morning. My name is Ed Kalman. I'm general counsel to the National Association of Long-Term Care Hospitals, and I'd like to make three brief points.

First, on the question of readmissions, I think it's important to acknowledge that the payment system bundles payments that LTCHs receive in various ways so that CMS does not make a second payment on some readmissions. For example, cases that go from LTCHs to acute hospitals for less than 3 days, payment is made by the LTCH to the acute hospital, not by the Medicare program. Cases that go from long-term-care hospitals to SNFs and back within 45 days, CMS does not make another payment to the LTCH. That's one matter I'd like you to consider.

A second matter is it's my understanding and recollection that when this Commission did it study in 2001 and then the data that has come out later from CMS through RTI, cases that go to long-term-care hospitals generally have a lower readmission rate. That means that when they leave the long-term-care hospital over a complete episode of care, for the ones that are appropriately admitted to long-term-care hospitals, their readmission to acute hospitals is lower than in areas where there are no long-term-care hospitals. Of course, the quintessential question is which cases should go to long-term-care hospitals.

Now, CMS responded to that question with the 25-

percent rule, which the industry regards as rather an arbitrary and, quite frankly, medically incoherent rule. What Congress did when it moderated that rule and imposed a moratorium on long-term-care hospitals was to require intensified medical review for both appropriateness of admission and continued stay. So I don't want you to think nothing is being done in that area.

Lastly, with regard to quality indicators, our association has a national database where we do collect quality indicators for the hospitals that report, and we have about a quarter of the industry or so reporting. We will probably -- we would be happy to share the outcomes of those data with the Commission, and they relate to such things as mortality, weaning, falls, things of that nature.

Thank you.

MR. HACKBARTH: Okay. We are adjourned. Thank you.

[Whereupon, at 11:49 a.m., the meeting was adjourned.]