

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
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Thursday, January 14, 2010  
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COMMISSIONERS PRESENT:

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BRUCE STUART, Ph.D.

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## 1 P R O C E E D I N G S

2 MR. HACKBARTH: Take your seats please. I'd like  
3 to welcome our guests. As I think everybody knows, today we  
4 will be voting on recommendations for our March report to  
5 Congress. Today we will review recommendations for nine  
6 different types of Medicare providers. In addition, our  
7 March report will include some past recommendations that we  
8 think are of particular importance, for example,  
9 recommendations that affect the distribution of payments  
10 among providers, and those recommendations will not be re-  
11 voted on but will be highlighted in the text of our March  
12 report.

13 The March report will also include material on  
14 Medicare Advantage and Part D, but the way the payments  
15 systems work in those sectors, annual updates are not  
16 required, so we are not voting on update recommendations  
17 there.

18 As I did in December, I'd like to remind people in  
19 the audience that MedPAC's task for our March report is to  
20 make recommendations on the Medicare program as it exists  
21 today. As such, the context for our work, the context for  
22 the recommendations that we're making, is different than

1 what Congress is doing currently on health reform. And so  
2 trying to compare MedPAC recommendations that we vote on  
3 today with comparable provisions in the health reform  
4 legislation can be misleading. Congress is voting on  
5 changes in Medicare in the context of moving towards  
6 universal coverage, and that is a materially different  
7 context and can influence the content of the decisions.

8 A notable example of that is that the hospital  
9 industry, for example, has been very clear in saying they  
10 view Medicare updates differently in the context of  
11 universal coverage than in the context of the current  
12 insurance system.

13 We are missing one Commissioner today, Mike  
14 Chernew, who couldn't be here due to a death in his family.

15 As usual, we will have a public comment period at  
16 the end of each session. As always, I'd like to remind  
17 people in the audience that that is one opportunity to make  
18 comments to the Commission, but it certainly isn't the only  
19 one or even the best one, in my view. The MedPAC staff make  
20 extraordinary efforts to reach out to get input from people  
21 affected by the Medicare program, and you should know that  
22 the staff prepare a fairly detailed summary of the input

1 that we receive from various provider organizations for the  
2 Commissioners that they can review in advance of their votes  
3 on these issues. In addition, we have a feature on our  
4 website, Medpac.gov, where people can on the website offer  
5 comments on our work.

6 So with those introductory comments, let's move on  
7 to our first session today, which is assessing payment  
8 adequacy for inpatient and outpatient hospital services.

9 DR. STENSLAND: Good morning. We are going to  
10 talk about two hospital issues this morning. The first  
11 topic is the update recommendation for hospitals. Second,  
12 we will discuss the budget neutrality adjustment to offset  
13 the increased payments associated with documentation and  
14 coding improvements. We'll present a glide path to make the  
15 counterbalancing payment reductions more gradual.

16 We will not be discussing IME at this meeting. As  
17 several of you suggested in December, we'll defer the  
18 discussion of IME until we have our broader discussion of  
19 graduate medical education during future meetings.

20 First, let's discuss the update recommendation.  
21 The update recommendation will apply to hospital inpatient  
22 and hospital outpatient payments which make up 92 percent of

1 hospital revenues. The update will affect approximately  
2 3,400 hospitals that had over 10 million Medicare fee-for-  
3 service admissions in 2008 and almost 70 million outpatient  
4 claims.

5           Recall there are many payment adequacy indicators.  
6 After reviewing the data associated with all five  
7 indicators, the Commission's judgment call as to what the  
8 appropriate update will be is made. And these are the same  
9 indicators we'll use for the other sectors as we go through  
10 their updates later today.

11           Last month, we discussed how hospital capacity is  
12 growing. We see an increase in the number of hospitals, and  
13 last year even a slight uptick in the number of hospital  
14 beds. Outpatient volumes are increasing and quality of care  
15 is improving. Access to capital, however, has been  
16 volatile. The capital markets froze at the end of 2008, but  
17 now they're starting to return to normal. While these first  
18 four indicators are generally positive signs of payment  
19 adequacy, profit margins have been low, and they're expected  
20 to remain negative.

21           Here we show the combined inpatient and outpatient  
22 margin was -6.4 percent in 2008. When we add in the other

1 hospital service lines to create an overall Medicare margin,  
2 the hospitals' margin was -7.2 percent, and we emphasize  
3 this is overall hospital margins, overall hospital Medicare  
4 margin.

5           The first point is that we see a similar trend and  
6 a similar level of margins whether we look at the hospitals'  
7 inpatient and outpatient service lines or if we look at the  
8 hospitals' overall book of Medicare business, including the  
9 hospital SNFs and other service lines. In general, the  
10 difference between the top line and the second line is one  
11 percentage point or less.

12           Now, we focused on the overall Medicare margin  
13 because it eliminates concerns regarding how the allocation  
14 of costs among departments and how one service line, such as  
15 a hospital-based SNF, can help the profitability of other  
16 service lines such as the acute inpatient services.  
17 However, looking past 2008, if we go to examine our  
18 projections, we expect overall margins to improve slightly  
19 due to a belief that cost growth slowed in 2009 but, despite  
20 this improvement in cost growth, our overall projection for  
21 2009 is still negative, at -5.9 percent overall Medicare  
22 margin in 2010.

1           Now, of course, there is a certain amount of  
2           uncertainty regarding this 2010 projection because we can  
3           never be certain about the future of patient case mix or the  
4           future of cost growth.

5           The prior slide reported on the aggregate Medicare  
6           margins for the whole hospital industry. However, you have  
7           shown a strong interest in our analysis of relatively  
8           efficient providers. As you know, we're required to not  
9           only look at the average provider, but also look at  
10          relatively efficient hospitals. In this slide, we compare  
11          the performance of 218 hospitals that we found to be  
12          relatively efficient using the criteria we talked about last  
13          month to a sample of 1,991 comparison hospitals. The  
14          relatively efficient hospitals tended to perform better on  
15          several metrics. Their mortality was 5 percent below the  
16          national median, their readmission rate was 5 percent below  
17          the national median, and their standardized costs were 9  
18          percent below the national median. The lower cost allowed  
19          them to break even on Medicare patients. The point of this  
20          slide is to show that it is possible to deliver high-quality  
21          care at a cost that is covered by Medicare fee-for-service  
22          rates.

1           Given the data presented and your discussions over  
2 the past month, the Commission's draft recommendation now  
3 read as follows: "that Congress should increase payment  
4 rates for the acute inpatient and outpatient prospective  
5 payment systems in 2011 by the projected rate of increase in  
6 the hospital market basket index, concurrent with  
7 implementation of a quality incentive payment program."

8           The current forecast for the hospital market  
9 basket is 2.4 percent; however, this forecast will be  
10 updated twice before CMS actually sets the payment rates for  
11 2011. There are no spending implications for this  
12 recommendation as it is consistent with current law. We do  
13 not see any significant impacts with respect to  
14 beneficiaries' access to care. However, there is potential  
15 for improved quality of care being generated from the  
16 incentive payment program.

17           Now we'll shift to Julian talking about the glide  
18 path for achieving budget neutrality with respect to the  
19 transition to MS-DRGs.

20           MR. PETTENGILL: Good morning. I'm going to start  
21 with the budget neutrality adjustments that are required in  
22 current law to offset the effects of hospitals'

1 documentation and coding improvements, and then I'll present  
2 the Commission's draft recommendation, which would smooth  
3 the required payment adjustments out over a transition  
4 period.

5           As we discussed at the December meeting, here is  
6 the background: Following a MedPAC recommendation, CMS  
7 adopted MS-DRGs in 2008. The policy goal was to improve  
8 payment accuracy and thereby reduce the gains that hospitals  
9 could achieve by engaging in patient selection.

10           The MS-DRGs substantially changed the way cases  
11 are grouped for payment. Cases with very costly major  
12 complications or comorbidities are grouped separately, and  
13 CMS also extensively changed the lists of secondary  
14 diagnoses that qualify as complications or comorbidities.

15           These changes created incentives for hospitals to  
16 improve their documentation and coding of secondary  
17 diagnoses because hospitals would receive higher payments if  
18 cases with complications or comorbidities were reported  
19 accurately.

20           The documentation and coding improvements, or DCI,  
21 shifted cases from relatively lower severity and cost MS-  
22 DRGs to higher severity and cost groups and thereby

1 increased measured case mix and payments.

2 We expect and encourage hospitals to improve their  
3 documentation and coding, and the hospital industry has  
4 recognized the need to make these improvements to fully  
5 capture the revenue available under the MS-DRG system.  
6 Still, Medicare's payments should not increase because there  
7 has been no real change in patient complexity or in  
8 treatment costs.

9 To counterbalance the higher payments, current law  
10 requires large, disruptive payment adjustments. So the  
11 issue is not whether to make budget neutrality adjustments  
12 but how to make them in a way that smooths them out and  
13 makes them more manageable for hospitals, while still  
14 achieving true budget neutrality.

15 Now, I want to remind you of the legislative  
16 history behind the current law budget neutrality  
17 adjustments.

18 Based on past experience, CMS actuaries estimated  
19 that DCI would be essentially complete by the end of 2009  
20 and that it would increase inpatient payments by 4.8  
21 percent. To offset the expected increase in payments and  
22 preserve budget neutrality as required by law, CMS said that

1 it would reduce inpatient payments by 4.8 percent over three  
2 years.

3 The hospital industry argued that this estimate  
4 was too high, and Congress responded and the current law now  
5 reflects the following agreement:

6 CMS would prospectively lower the base payment  
7 rates by 1.5 percent over two years; that is 0.6 percent in  
8 2008 followed by an additional 0.9 percent in 2009.

9 However, if 1.5 percent turned out to be too  
10 little based on actual data, two things would happen:  
11 First, CMS would change the base rates in 2010, 2011, and/or  
12 2012 to recover the difference in payments, with interest.  
13 Second, CMS would also adjust the base rates to prevent  
14 further overpayments from continuing. The next slide  
15 summarizes the size and timing of the required adjustments.

16 To determine the size of the budget neutrality  
17 adjustments required under current law, we need to know how  
18 large the overpayments were in 2008 and in 2009. We know  
19 that DCI resulted in overpayments of about 1.9 percent in  
20 2008. We don't know yet what happened in 2009. But to  
21 determine the potential size of the required budget  
22 neutrality adjustments, we are assuming that the CMS

1 actuaries' projection of 4.8 percent DCI is correct. Of  
2 course, the actual outcome could be different.

3 We also know that CMS decided not to make a DCI  
4 adjustment in 2010 to either recover overpayments or to  
5 prevent further overpayments going forward. That means that  
6 the required adjustments must be made in 2011 and 2012. It  
7 also means that overpayments are continuing during 2010.

8 Without going through all the details, the  
9 conclusion is that in 2011 or 2012 CMS must make a temporary  
10 adjustment to recover the 2008 and 2009 overpayments, and in  
11 addition to that, they must make an adjustment to prevent  
12 future overpayments.

13 We are assuming that the actuaries' projection is  
14 correct and that CMS would split the recovery of the  
15 overpayments equally over 2011 and 2012. If that is the  
16 case, the total adjustment required in 2011 would be 5.9  
17 percent and it would remain in place for 2012.

18 In 2013, the base payment rates would rise by 2.6  
19 percent as the temporary recovery adjustment expires. By  
20 the way, although we are not showing the details, we have a  
21 slide for that if anyone wants to see it.

22 These adjustments result in two problems. First,

1 under the draft update recommendation of 2.4 percent, we  
2 would expect to see IPPS payment rates fall by 3.5 percent  
3 in 2011. Under current law, hospitals would get the full  
4 updates in following years, plus the 2.6 percent bump up in  
5 2013. The second problem is that current law would not  
6 fully restore budget neutrality because the overpayments  
7 during 2010 would not be recovered. The next slide lays out  
8 an alternative to current law.

9 DR. MARK MILLER: Julian, can I catch you just for  
10 one second? You've said twice that we are assuming that the  
11 actuaries' estimate is correct, but I also just want to  
12 reinforce for the Commissioners and the rest of the people  
13 in the room, we -- and by that, I mean you guys -- have gone  
14 through this and independently done your own estimates and  
15 come to the same place. Is that correct?

16 MR. PETTENGILL: That's correct.

17 DR. MARK MILLER: Okay. Thanks.

18 MR. PETTENGILL: The adjustments required under  
19 current law are very large, and many hospitals may not be  
20 able to easily manage substantial payment reductions even if  
21 they're of short duration. So we thought it might be  
22 desirable to develop an alternative schedule of adjustments.

1 The guiding principle here is to preserve budget neutrality,  
2 but do it in a way that is manageable for hospitals.

3 Budget neutrality could be restored by following  
4 different paths that trade off the size of the payment  
5 reductions against how long they persist. One path would  
6 reduce the base payment rates by 2 percent each year for  
7 three years, beginning in 2011. If the CMS actuaries'  
8 projection of 4.8 percent is correct, overpayments would be  
9 fully recovered in 2015. In 2016, the temporary recovery  
10 adjustment would end, and the payment rates would increase  
11 by 2.7 percentage points above the annual update for that  
12 year.

13 Compared with current law, this policy would  
14 provide a series of smaller predictable adjustments over a  
15 longer period, making them more manageable for hospitals.  
16 Under the draft update recommendation, payment rates would  
17 increase by 0.4 percent in 2011. Payment increases in the  
18 next two years would equal the full market basket update  
19 minus two percentage points.

20 The downside of this policy is that overpayments  
21 would continue to accumulate through 2011, which would add  
22 to the amount that would need to be recovered and thereby

1 lengthen the time needed to restore budget neutrality. The  
2 upside is that budget neutrality would be restored,  
3 adjustments would be more manageable for hospitals, and the  
4 payment rates would still increase somewhat each year as  
5 long as the update was greater than 2 percent.

6           Of course, if actual DCI in 2009 turns out to be  
7 lower than 4.8 percent, it might be a good idea to give CMS  
8 the flexibility to achieve budget neutrality over the same  
9 time period with smaller adjustments in 2011, 2012, and  
10 2013. If actual DCI turns out to be higher, the adjustments  
11 would still be limited to 2 percent each year, but the time  
12 period would be extended beyond 2015.

13           With these thoughts in mind, the Commissioners'  
14 draft recommendation is as follows: "To restore budget  
15 neutrality, the Congress should require the Secretary to  
16 fully offset increases in inpatient payments due to  
17 hospitals' documentation and coding improvements. To  
18 accomplish this, the Secretary must reduce payment rates in  
19 the inpatient prospective payment system by the same  
20 percentage (not to exceed 2 percentage points) each year in  
21 2011, 2012, and 2013. The lower rates would remain in place  
22 until overpayments are fully recovered."

1           In the accompanying text, we would describe how  
2 this policy would play out and how long it would take to  
3 achieve budget neutrality. As I mentioned, prevention and  
4 recovery together could take as much as 5 years, but we  
5 won't know exactly how long it will take until we have the  
6 2009 data. Note also that we are assuming that the  
7 recoveries would include accumulated interest, which is  
8 consistent with current law. This recommendation would  
9 increase spending more than \$2 billion over one year, and it  
10 would reduce spending from \$1 to \$5 billion over 5 years.

11           The recommendation has no major direct  
12 implications for beneficiaries. It would improve the  
13 stability of the IPPS payment rates over time and make the  
14 burden of compensating for the effects of DCI predictable  
15 and more manageable for providers.

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

18           MR. HACKBARTH: Julian, I just want to go through  
19 the payment adjustments for the DCI again just a little bit  
20 more to make sure that I've got it correct and that the  
21 audience understands it.

22           In fiscal year 2011, the rates would be adjusted

1 downward up to 2 percent but no more than 2 percent.  
2 Hospitals would be eligible to receive the market basket,  
3 which would tend to increase the base rates. Based on  
4 current estimates of the case mix adjustment and the market  
5 basket, there would be a small net increase in the hospital  
6 base rate. In 2012, again, there would be a 2-percent  
7 downward adjustment. That's not cumulative. It's just that  
8 the rates would be adjusted 2 percent lower. Same for 2013.

9 Now, here is the point I wanted to zero in on. In  
10 2014 and 2015, there would be no adjustment for a case mix  
11 change.

12 MR. PETTENGILL: That's correct.

13 MR. HACKBARTH: And so the rates would be -- there  
14 would be zero adjustment in 2014 and 2015, and then in 2016,  
15 there would be an upward adjustment reflecting the fact that  
16 the collection of the past overpayments is complete, and  
17 those are temporary adjustments, and so the rates would  
18 increase by about 2.7 percent based on current estimates.  
19 Is that correct?

20 MR. PETTENGILL: That's correct.

21 DR. MARK MILLER: And I just want --

22 MR. PETTENGILL: Go ahead.

1 DR. MARK MILLER: To be clear, though, in 2014,  
2 2015, and then 2016 when the bump-up occurs, the zeroes that  
3 he was referring to -- and I know you know this. I just  
4 want to make sure everybody knows this. The zeroes he's  
5 referring to are the DCI adjustments. There would still be  
6 updates in those years, and then in that last year, the 2.7,  
7 or whatever number you said, is -- and you said this very  
8 clearly -- in addition to the update.

9 MR. PETTENGILL: That's right.

10 DR. STENSLAND: Just one other point. The way  
11 it's worded is there is some flexibility for the Secretary  
12 depending on what the actual data turn out to be. For  
13 example, if they find that the DCI is lower than their  
14 current estimates, they might not have to stretch it out  
15 that full '14 and '15. It might be able to stop is sooner.  
16 Or if they find out the DCI was higher than their estimates  
17 when they actually look at the data, it might stretch out a  
18 little farther. So what's firm is that they have to come to  
19 budget neutrality in the end. Exactly how long it takes to  
20 get there, there might be a little play, shorter or longer,  
21 depending on the actual data that they find.

22 DR. MARK MILLER: [off microphone] -- the nature

1 of the recommendation is however they're doing it that it's  
2 not to exceed 2 percent in any year.

3 MR. HACKBARTH: Okay. Let's have hands for  
4 clarifying questions. We will start over here.

5 MR. BUTLER: So really our net recommendation when  
6 you take into account the 2.4 estimated market basket and  
7 then you have the 2 percent, which is a reduction in payment  
8 per se, it's a change in coding. But then we are also  
9 reminding us that we're taking out a percent of the market  
10 basket to save for pay-for-performance, quality. So really  
11 the base recommendation is really 1.4 increase in market  
12 basket and then an additional 1 percent to be paid out in --  
13 I'm just reminding what we've said, we're holding out a  
14 percent -- that's our recommendation, to -- it stays in the  
15 system, but it is tied to value-based purchasing.

16 MR. HACKBARTH: You are correct. So the  
17 guaranteed update for an individual hospital would be the  
18 full market basket minus the set-aside for pay-for-  
19 performance. An individual hospital based on their  
20 performance --

21 MR. BUTLER: They might get 2 percent.

22 MR. HACKBARTH: They could get all of that or even

1 more than that.

2 MR. BUTLER: Right. Okay. So --

3 DR. STENSLAND: One clarifying point. The 2.4  
4 percent we're talking about applies to all the inpatient and  
5 outpatient payments, and this budget neutrality adjustment  
6 is just on the inpatient side. So there's a difference  
7 between the inpatient and outpatient here.

8 MR. BUTLER: Right. Good point. So my other  
9 question, which is just curiosity around -- we don't talk  
10 much about the components of the market basket update here  
11 and don't need to get in a lot of detail, but is it somebody  
12 who sits there and budgets for our institution and you look  
13 at the supply and drug in particular, not the labor piece,  
14 but -- and, you know, you look at what drug companies  
15 reportedly are doing, and we see it, you know, getting the  
16 prices up in advance of health reform and the day-to-day  
17 battles with the device companies that certainly don't come  
18 forward and say 2 percent next year.

19 I'm just curious on that component of the market  
20 basket update, how you look at that, particularly in a year  
21 like this.

22 MR. LISK: We have to look at what -- I don't know

1 exactly what those numbers were in the current forecast. I  
2 can get back to you on that. But basically it's all a share  
3 of what total costs are within the hospital, and those are  
4 integrated in there. And what's anticipated to happen in  
5 2011 may be different than what happened currently in terms  
6 of adjustments that hospitals are making -- that the  
7 industry might be making to health reform, too. But it's  
8 all in there as a share of your cost in terms of what's in  
9 there, and sometimes those have been high and have been a  
10 contributor to higher market baskets, but it all depends.

11 DR. CASTELLANOS: Getting back to the  
12 recommendation -- and I agree with Recommendation 1 -- I  
13 really appreciate we're looking at an efficiency factor on  
14 all the Medicare providers. And you talk about a quality  
15 incentive program which is pay-for-performance. I wonder  
16 where we stand on that and what are we doing with that, just  
17 briefly. I hear you talking about it, but I don't see any  
18 details of it.

19 MR. HACKBARTH: It is one of the issues that  
20 Congress is trying to resolve in the health reform  
21 legislation. The Senate bill provides for a hospital value-  
22 based purchasing program. As I recall, the House bill does

1 not, and so it's an issue that they're trying to reconcile  
2 as we speak.

3 DR. CASTELLANOS: I guess my question is what is  
4 MedPAC recommending on that. Or are we just waiting for  
5 Congress to come through?

6 MR. HACKBARTH: We have been recommending a move  
7 towards what we referred to as pay-for-performance and what  
8 the Senate refers to as value-based purchasing for at least  
9 four or five years. And we have recommended that the  
10 program be budget neutral, be funded with a reduction in the  
11 base rates, and then the dollars be redistributed based on  
12 performance.

13 DR. CASTELLANOS: And that will be in the chapter?

14 MR. HACKBARTH: Yes. In fact, that's  
15 Recommendation 1, the last phrase, "concurrent" --

16 DR. CASTELLANOS: And that will be --

17 MR. HACKBARTH: Yes, and it will be explained in  
18 the text of the chapter.

19 DR. MILSTEIN: One of the topics not addressed --  
20 and maybe you can just refresh my memory on this -- is the  
21 fate of what is ordinarily a productivity adjustment  
22 expected of all industry sectors that we pay. What happened

1 to that? Why isn't that part of our recommendation? How  
2 did that get dropped out?

3 MR. HACKBARTH: That's a question for me, not for  
4 them, and it relates to what we were just discussing with  
5 Ron. The Commission has recommended for at least several  
6 years now the combination of full market basket concurrent  
7 with the introduction of a pay-for-performance program  
8 funded, as I just said to Ron, on a budget-neutral basis.  
9 And some Commissioners, I think including yourself, have for  
10 several years now advocated for productivity adjustments for  
11 hospitals notwithstanding the fact that hospital Medicare  
12 margins have been negative and declining; whereas, other  
13 Commissioners have been concerned about the negative margins  
14 and believe that that justified a full market basket  
15 increase.

16 And so the compromise, if you will, that we have  
17 come to for the last several years is full market basket,  
18 but in the context, in conjunction with movement towards a  
19 pay-for-performance program. And as I said in response to  
20 either Ron or Peter, one of the implications of that is that  
21 the guaranteed update is less than full market basket, which  
22 is a point that I've emphasized numerous times in

1 congressional testimony when people say you're simply  
2 recommending full market basket.

3 I know when we first worked through this -- and it  
4 wasn't easy to try to forge this compromise -- there were a  
5 number of Commissioners -- and you may have been one of  
6 them, Arnie -- who said, "I won't vote for a full market  
7 basket recommendation unless it's concurrent with pay-for-  
8 performance." So some people -- and I won't put these words  
9 in your mouth, but some people saw this combination of full  
10 market basket with pay-for-performance saying, "We're  
11 willing to do full market basket to help grease the skids  
12 for movement towards pay-for-performance, but we're not  
13 willing to give guaranteed full market basket updates for  
14 everybody. We want them to earn that based on some  
15 performance."

16 Like any agreement of this sort, it is not perfect  
17 in everybody's eyes, but it has been the consensus of the  
18 Commission now for several years.

19 DR. BERENSON: This is for Julian. I understood  
20 the whole explanation of what you laid out except the 2.7  
21 percent one-time bump that occurs. Where does that come  
22 from? And can't we in a sense spend that earlier to reduce

1 the magnitude of the earlier year reductions?

2 MR. PETTENGILL: The 2.7 percent comes from the  
3 expiration of the temporary adjustments needed to recover  
4 the overpayments. So you are reducing payments to  
5 accomplish two things. The first one is to stop the  
6 bleeding, in effect, by preventing further overpayments from  
7 occurring. But then after that, you're also reducing the  
8 payments some more in order to recover the overpayments that  
9 have already occurred and are, in fact, now occurring.

10 And so when you come to the end of that, that's  
11 temporary, and you get the bump-up in the rates. And I  
12 don't think there's anyway that you can smooth that out.

13 MR. HACKBARTH: Other clarifying questions?

14 MS. BEHROOZI: I think it's sort of related to  
15 Bob's question. Did I hear you say that the two percentage  
16 points in each of 2011, 2012, and 2013 are not cumulative,  
17 it is just two percentage -- whatever it would have been, it  
18 is going to be --

19 MR. HACKBARTH: Yeah, they are not cumulative, so  
20 the rates, the base rates, whatever they would be in 2011,  
21 are adjusted downward by 2 percent. In 2012, it's 2  
22 percent. It's not cumulative. It's not 2 plus 2. It's 2

1 percent below what it would otherwise be. Then the same in  
2 2013.

3 MS. BEHROOZI: I'm having a conceptual problem.  
4 I'm sorry. I see how that could achieve recoupment of an  
5 absolute dollar amount, but I don't see how it adjusts going  
6 forward. I'm missing that.

7 DR. MARK MILLER: Okay. This is what I would say,  
8 Jeff, based on conversations you and I have had. Okay? One  
9 way you can think about current law is you basically have to  
10 get six points kind of immediately, if you follow the  
11 current law construct. This is in a sense ticking two  
12 points at a time to that point, then holding it; and  
13 although updates are occurring -- I just want to keep  
14 reinforcing that -- and then you get the bump-up that Bob  
15 said.

16 So I'm not exactly sure what you guys are saying  
17 to each other, but it's down 2, then down 2, then down 2  
18 again. Jeff?

19 DR. STENSLAND: Maybe you could think about it, to  
20 simplify things, imagine that we had a 2.4-percent market  
21 basket every year and they got a full market basket every  
22 year, just to make things simple. Then you would take this

1 2 percent off of that every year, so their inpatient  
2 payments, rather than going up 2.4 percent for those three  
3 years, would go up 0.4 percent this year, 0.4 percent the  
4 next year, and 0.4 percent the next year.

5 MS. BEHROOZI: And then that's how the cumulative  
6 effect is realized.

7 PARTICIPANT: The base is [off microphone].

8 MS. BEHROOZI: On the rate, yeah. Okay. Thanks.

9 MR. GEORGE MILLER: Just a quick question on the  
10 top performers. That is on Slide 7. That margin is 0.2  
11 percent and that is the median, so that means even the top  
12 performing hospitals had negative margins. Some of them had  
13 negative margins as well. Can you give me the distribution  
14 of those? Or is it just mathematical --

15 DR. STENSLAND: It's going to be about half of  
16 them are making some money on Medicare, half of them aren't  
17 making money on Medicare, and part of the reason for that is  
18 we've said in other meetings that the Medicare payment  
19 system isn't perfect. You know, we think there are some  
20 issues with the wage index which might send too much money  
21 to some place and not enough to another. There are other  
22 issues with the IME payments; you know, if you get a lot of

1    IME and DSH payments, you're more likely to be making money  
2    than other hospitals. So that explains why some of them  
3    might be on the winning side and some might be on the losing  
4    side.

5           MR. GEORGE MILLER: But we highlight these  
6    efficient performers, and we want other hospitals to be like  
7    them. Am I correct in following that? So I was just struck  
8    by that.

9           And then do we know if those efficient hospitals  
10   have the other services like a SNF and/or home care, our  
11   earlier discussion about Medicare margins for those entities  
12   and how they impact it?

13          DR. STENSLAND: They do, but I'd have to make a  
14   run of that to see what share of them have SNF and home  
15   health and those kinds of services. Certainly some of them  
16   do.

17          MR. GEORGE MILLER: Okay. Very good. Thank you.

18          MR. HACKBARTH: Other clarifying questions?

19          DR. DEAN: Just to follow up on that same issue --  
20   and I don't know whether this is round one or round two, but  
21   that group, which, of course, is a relatively small group  
22   and actually is a smaller group, I think, than you reported

1 before, but I think your criteria were a little more  
2 stringent this time around. Is that true? But I'm curious,  
3 and maybe it's way too early to know, but is that a stable  
4 group or are there hospitals moving in and out of that  
5 group? And I guess the basis for the question is obviously  
6 our intent would be to try and figure out incentives that  
7 would draw hospitals into that group, and my concern at  
8 least would be to know, to try to pin down -- I know we've  
9 talked about this before, and it's still a little nebulous  
10 as to what the basic factors are that get hospitals into  
11 that group. But I guess we need to -- it would be helpful  
12 to know is it a constant group. Are there hospitals moving  
13 in and out? And are we making any progress to determine  
14 what leads hospitals to do that?

15 DR. STENSLAND: There is probably from last year  
16 to this year -- I don't remember the exact number, but  
17 something on the order of 60 to 70 percent of the hospitals  
18 in that group are the same, and there could be a couple of  
19 things that drive the change. One thing that might drive  
20 the change is we did change the criteria because this year  
21 we have more data on readmissions, and so readmissions plays  
22 a bigger weight this year, so the hospitals, to get in that

1 group, it's a little more stringent on who gets in on  
2 readmission criteria. And then also there is a change in  
3 administration, and we've seen that in some of the hospitals  
4 we visited, that if the administration changes and the  
5 objectives of the administration change, sometimes the  
6 performance of the hospital can change. So there will  
7 always be some movement in and out of there.

8 MR. HACKBARTH: Jeff, as I recall, another change  
9 in the criteria was that we looked at Medicare expenditures  
10 per capita, per beneficiary, and excluded hospitals that  
11 were low on inpatient costs but the total expenditures were  
12 high. Is that correct?

13 DR. STENSLAND: The two other criteria that we put  
14 in, one is we eliminated anybody that was -- the 10 percent  
15 of hospitals that were in counties with the highest per  
16 capita spending because we didn't want people to have low  
17 per unit costs just by having lots of units.

18 MR. HACKBARTH: This was the suggestion that Arnie  
19 had made.

20 DR. STENSLAND: And then the other thing that we  
21 did is there's been some criticism of others of some  
22 analysis like this of saying, Well, the way you get low cost

1 and good outcomes is you only treat high-income folks. And  
2 what we also did is then, okay, just to be conservative, we  
3 eliminated everybody in terms of the 10 percent of hospitals  
4 that had the lowest Medicaid shares. So basically all the  
5 hospitals that are in this group are also serving Medicaid  
6 patients. So we're trying to get to that point of can you  
7 have good outcomes at a low cost while serving a broad  
8 spectrum of the community, including Medicaid folks.

9 DR. MARK MILLER: Just in case this is not clear,  
10 as each year we arrive and show you this group of hospitals,  
11 it can be that membership has changed. But the criteria to  
12 be in this group at any point in time is that you've  
13 performed with these characteristics for three years  
14 running. So it's not, you know, in and out from year to  
15 year. We're looking at a group of people -- and this is  
16 somewhat stringent -- and saying you have to be consistently  
17 looking this way in order to get into this group.

18 MR. GEORGE MILLER: Excuse me, Mark. I apologize.  
19 But that could mean, though, that half of that group for  
20 three years could have negative Medicare margins.

21 DR. MARK MILLER: I wanted to say something about  
22 that, but I didn't want to be argumentative, but since you

1 brought it up again.

2 [Laughter.]

3 DR. MARK MILLER: Another way to look at this --  
4 and this goes in part also to Tom's question about what  
5 incentives, and there are two incentives, I think, that are  
6 in play here that we're trying to push. Number one is the  
7 pay-for-performance and getting some of the payments to move  
8 on quality because then you want to move into that group  
9 because then your payments would go up. But the other one -  
10 - and this is the more, you know, unhappy one -- is this  
11 broader sense of fiscal pressure on controlling cost. One  
12 response to the median point is, well, look, some of those  
13 people have negative margins. Absolutely. But the other  
14 way to look at the entire cost distribution is that if  
15 there's a lack of fiscal pressure -- and we've been making  
16 this argument that broadly there is -- the whole cost  
17 distribution is kind of sitting potentially in the wrong  
18 place, moved to the right as opposed to what we're trying to  
19 do is push it more to the left.

20 And so you're absolutely right, and that was a  
21 very astute comment on the 50 percent at the median. But  
22 the other argument is the underlying distribution of cost

1 has not had a lot of pressure on it for the last several  
2 years.

3 MR. HACKBARTH: Let me --

4 MR. GEORGE MILLER: Not to debate you at all --

5 DR. MARK MILLER: [off microphone].

6 [Laughter.]

7 MR. GEORGE MILLER: But you have inefficient, poor  
8 quality, making much higher margins, so I'm trying to  
9 understand --

10 MR. HACKBARTH: Who are you referring to there,  
11 George, as the inefficient, poor-quality group? Have you  
12 identified -- what are your criteria for that? We've  
13 identified our criteria for the efficient --

14 MR. GEORGE MILLER: I haven't yet. I'm just  
15 taking the --

16 MR. HACKBARTH: Okay, so this is --

17 MR. GEORGE MILLER: -- opposite of his argument  
18 that I think that there are some folks that may have -- it's  
19 a case mix issue. And I don't know how to drive them -- I  
20 mean, your goal is to drive more hospitals like the  
21 efficient providers by definition.

22 MR. HACKBARTH: Right.

1           MR. GEORGE MILLER: But there are some that may  
2 not have the greatest quality, but they're making a higher  
3 margin because of case mix, and only because of case mix.

4           MR. HACKBARTH: Yeah, well, two dimensions --

5           MR. GEORGE MILLER: You're not going to penalize  
6 them by --

7           MR. HACKBARTH: Well, a few dimensions to this.  
8 One, if they're achieving their higher margin through poor  
9 quality, skimping on care, that's one of the reasons we  
10 believe that pay-for-performance is important.

11          DR. MARK MILLER: It would be.

12          MR. HACKBARTH: And it would redistribute money  
13 away from those institutions towards the higher-quality  
14 institutions.

15           I do want to do a quick round two, but one last  
16 clarifying question. The spending implication for  
17 Recommendation 2 -- and maybe I missed this, Julian, when  
18 you went through it. So it increases spending by more than  
19 \$2 billion over one year, and that's because we're reducing  
20 the case mix, the DCI reduction relative to current law,  
21 which you explained would be 5.9 percent.

22          MR. PETTENGILL: That's right. It's 2 percent

1 instead of 5.9, and so we'd spend more.

2 MR. HACKBARTH: Yeah. And then reduces spending  
3 by \$1 to \$5 billion over five years. Now, is that a  
4 reference to the combination of Recommendations 1 and 2?

5 MR. PETTENGILL: No.

6 MR. HACKBARTH: Or is that just 2 --

7 MR. PETTENGILL: That's just 2.

8 MR. HACKBARTH: That's the piece that I didn't --

9 MR. PETTENGILL: And the reason for that is that  
10 current law would not recover the overpayments that are  
11 occurring in 2010 and 2011; whereas, Recommendation 2 would  
12 recover them.

13 MR. HACKBARTH: Yes, okay. Got it. Thanks.

14 Okay. Hands for round two comments?

15 MR. BUTLER: Okay. One quick comment on the  
16 productivity issue. Remember that if you were to take our  
17 collective recommendations -- not recommendations but work  
18 that relate to things like readmissions, bundling, and so  
19 forth and look at the potential savings there, as is being  
20 done in health reform, and look at the collective payments  
21 to hospitals, you'd be getting a lot less than the full  
22 market basket that you would be paying for hospital care

1 because you're getting savings from another side of the  
2 equation, which is a little different than we're looking at  
3 updates in other areas.

4 I would say I'd like to see us look at, one thing  
5 in the future to keep our eyes on, and that's IT for a lot  
6 of ways going forward. The stimulus rules are out there.  
7 The budgets are ramping up in this area. And it's not just  
8 the operating expense. It's the capital expense. And I  
9 think we really should think about -- because as the  
10 stimulus dollars come in, assuming they do, they come  
11 through -- and they're not small -- on the operating side,  
12 yet they're often going to be spent on the capital side.  
13 And how this is all playing out is, I think, by itself  
14 invites a rigorous examination of how hospitals are  
15 responding, behaving, and using this in terms of a very, an  
16 extremely important lever in our agenda. I'd just encourage  
17 us to kind of really understand both the financial pieces of  
18 this going forward and its impact on the bottom line as well  
19 as how it's helping, or maybe not as much as we'd like in  
20 some of the rest of our agenda.

21 DR. MILSTEIN: Yeah, I mean, obviously consensus  
22 is only reached through compromise, but I sense there will

1 be a number of editorial comments made along the way. And,  
2 you know, as Pete just made one, I'd like to make one as  
3 well, and that is the -- maybe I could frame it in terms of  
4 Pete's language, that if we're going to study issues such as  
5 the one that Pete recommended we study, I think we should  
6 also -- I'd like to see a countervailing recommendation that  
7 we also study the overall impact of -- what's the word? --  
8 low expectations of an industry having an impact on the  
9 industry's performance and long-term productivity growth.

10 I completely understand the political wisdom of  
11 Glenn's response to me, but at the end of the day, if you  
12 were to in the private sector say, well, we realize you want  
13 better performance from your suppliers, but you're not  
14 allowed to ask of your suppliers recovery of overpayments  
15 that you tried to block in the first place but the industry  
16 overrode you; two, the emphasis on quality and purchasing  
17 and a reasonable expectation of productivity growth that is  
18 sort of consonant with what's expected of the rest of  
19 American society; and essentially say you can't have all  
20 three of those as a purchaser, you have to make trade-offs  
21 among them. People in the private sector would look at that  
22 and be puzzled, this notion that, you know, it's too much to

1 expect of a generally well paid and rapidly growing  
2 industry. It doesn't -- it wouldn't foot in a private  
3 sector calculation. I realize we're not in a private sector  
4 environment, but, you know, I think I will support the  
5 compromise, but my reservations are in some ways, you know,  
6 on the complete opposite side of the ledger than the  
7 understandable reservations of those whose empathy is more  
8 with the industry.

9 DR. MARK MILLER: Just to put that in context for  
10 both the public and for everybody else, what you're speaking  
11 to directly is on the DCI recommendation, you would be more  
12 inclined to go up front and say, okay, I'm taking out  
13 everything prospectively, then do a recapture, so you would  
14 have deeper cuts at the beginning or deeper recapture at the  
15 beginning.

16 DR. MILSTEIN: And I would also add an expectation  
17 of productivity growth.

18 DR. MARK MILLER: Oh, from [off microphone].

19 DR. MILSTEIN: Yes.

20 DR. MARK MILLER: I see.

21 DR. MILSTEIN: Both.

22 MR. BERTKO: I'm just going to express some

1 support for Recommendation 2 and remind everybody coding  
2 adjustments have been recovered in Medicare Advantage plans  
3 in much the same way. Glenn, I support your idea that we  
4 should do it in an orderly and I will call it moderate  
5 fashion, so it seems like an acceptable compromise there.

6 MR. HACKBARTH: Other comments?

7 [No response.]

8 MR. HACKBARTH: Just before we go on, I want to  
9 just make a couple comments, one on the issue of case mix  
10 and then more broadly related to Arnie's point and George's  
11 as well.

12 On the issue of case mix and how we adjust for  
13 that, to me the important principle is that when we change  
14 our case mix systems, whether it be for hospitals or for  
15 other providers, those changes should be by definition  
16 budget-neutral changes. That's a principle that MedPAC has  
17 stood for, endorsed consistently across all of Medicare's  
18 payment systems.

19 There's room for reasonable people to disagree  
20 about the schedule for making those reductions, and there's  
21 no real right answer to that. Depending on your logic, your  
22 framework, you can arrive at different readily defensible

1 conclusions, and obviously the recommendation that I'm  
2 offering that Julian described is one that I think is  
3 appropriate, reasonable, and readily defensible, and, most  
4 importantly, it reemphasizes our conviction, our collective  
5 conviction that this ought to be a budget-neutral change in  
6 the case mix system.

7           On the broader issue of how much pressure to  
8 apply, like you, Arnie, I believe applying pressure, whether  
9 it's to hospitals or any other group of providers, is a  
10 critically important thing to do.

11           In the competitive marketplace that exists for  
12 most other goods and services, that pressure comes  
13 automatically through competition, and especially in  
14 manufactured products, increasingly competition with  
15 producers in other countries that have dramatically lower  
16 labor costs. And that pressure is relentless, it's  
17 unforgiving, and it's cost countless Americans their jobs,  
18 their health benefits, their retirement. And you know that  
19 story as well as I do.

20           Those people and the businesses that employ them  
21 are the people who pay the taxes that fund the Medicare  
22 program, and it seems to me that it ought to be a goal of

1 the Medicare program to assure that the providers who  
2 provide services to Medicare face some of the same  
3 relentless pressure to improve their efficiency and  
4 productivity.

5           Now, that doesn't lead you automatically to the  
6 right answer for an update for any given sector, whether  
7 it's hospitals or physicians or any other. But it does mean  
8 that the Congress, who ultimately makes these decisions,  
9 needs to be prepared to resist the cries of underpayment,  
10 this is not fair, our costs are not covered, all those other  
11 firms out in the economy facing competition. It doesn't  
12 work. What are your costs? We'll pay a price that covers  
13 your costs. That's just not how the economy works. And  
14 what we're trying to do is introduce some of that same  
15 pressure into Medicare's administered price systems.

16           It's not easy, and certainly for the Congress,  
17 it's a very difficult thing, faced with constituents, people  
18 that they know and trust, saying, you know, we're suffering  
19 financially because of Medicare payment policies. But it's  
20 inherent in running this sort of system, and so not just in  
21 the hospital case but across all of the recommendations that  
22 we'll be considering today, I think that needs to be a

1 consistent element, and I personally feel that the package  
2 as a whole is consistent with that objective.

3 So it's time to vote on the hospital  
4 recommendations. We have two. Would you put up number 1,  
5 please?

6 Okay. All in favor of Recommendation 1, please  
7 raise your hands. Opposed to Recommendation 1?  
8 Abstentions? Okay.

9 Recommendation 2. All in favor of Recommendation  
10 2? And I forgot to raise my hand. I'm voting for both of  
11 them. Opposed to Recommendation 2? Abstentions?

12 MR. HACKBARTH: Okay. Thank you. Good work,  
13 guys.

14 Next up is physicians.

15 MS. BOCCUTTI: Okay. So for this session, Hannah  
16 and I are going to review the payment adequacy analysis for  
17 the update and then you can discuss the recommendation, and  
18 Kevin is going to review some of the items he discussed last  
19 month on payment accuracy and equity for physician payments.

20 So just a bit of background. Physician services  
21 include office visits, surgical procedures, and a broad  
22 range of other diagnostic and therapeutic services.

1 Physicians can provide these services in all settings, so  
2 not just physician offices.

3 In 2008, Medicare spent about \$61 billion on fee-  
4 for-service physician services, and that counts for about 13  
5 percent of total Medicare spending in 2008.

6 Among 950,000 practitioners who billed for  
7 physician services, physicians accounted for 570,000, about,  
8 of them. The other practitioners that are billing Medicare  
9 for physician services are limited license practitioners --  
10 those are optometrists, podiatrists, chiropractors, oral  
11 surgeons, and others -- and other health professionals who  
12 bill are nurse practitioners, physical therapists, and  
13 physician assistants.

14 Almost all fee-for-service Medicare beneficiaries  
15 received at least one physician service in a year, so that  
16 is about 97 percent in 2008.

17 So now, Hannah is going to talk about the MedPAC  
18 survey.

19 MS. NEPRASH: As we discussed at the December  
20 meeting, results from our 2009 survey indicate that most  
21 beneficiaries have reliable access to physician services,  
22 with the majority reporting few or no access problems.

1 However, access to primary care physicians remains a  
2 concern.

3 As in previous years, we continue to find that  
4 most Medicare beneficiaries are able to find a new physician  
5 and get timely appointments when needed. Medicare  
6 beneficiaries report better access on these indicators than  
7 privately insured individuals. For example, among survey  
8 respondents seeking an appointment for routine care, 77  
9 percent of Medicare beneficiaries and 71 percent of  
10 privately insured individuals reported that they never  
11 experienced delays finding that appointment.

12 When we asked about the ease of finding a new  
13 physician, we heard that most people are not looking for  
14 one. Only six percent of Medicare beneficiaries and eight  
15 percent of privately insured individuals reported that they  
16 had looked for a new primary care physician in the past  
17 year. However, among those who did look for a new  
18 physician, finding a new PCP was more difficult than finding  
19 a specialist.

20 This year, we also oversampled minority  
21 individuals and analyzed the survey results by race. We  
22 find that all minorities surveyed experienced more problems

1 finding a new physician and getting timely appointments.  
2 For example, minorities in both insurance categories were  
3 more likely to report always experiencing routine  
4 appointment delays. We observed roughly a four percentage  
5 point differential between white and minority respondents in  
6 both insurance categories. Minorities within Medicare  
7 reported better access compared with privately insured  
8 minorities.

9 In response to questions at last month's meeting,  
10 we also analyzed these survey results by urban and rural  
11 residents. In both urban and rural areas, Medicare  
12 beneficiaries reported similar or better access than  
13 privately insured individuals. We will continue to track  
14 these questions closely in future surveys, but for now, I'll  
15 turn it back over to Cristina.

16 MS. BOCCUTTI: This slide summarizes findings on  
17 access to physician services from other studies, and I've  
18 separated them into the patient studies and physician  
19 studies. With regard to the patient studies, we certainly  
20 probed some of the same -- or the other studies probed some  
21 of the same issues that Hannah just discussed for our survey  
22 and findings were similar. I'm not going to review those

1 because I have last month and they're also in your chapter.

2 But I do want to follow up on a point that Nancy  
3 Kane brought up last month about wait times. Work by HSC  
4 has found that wait times have increased, but this is true  
5 for both Medicare and for privately insured patients. So  
6 it's difficult to pin these wait time increases on Medicare  
7 payment. More recent research -- that HSC research is a bit  
8 dated -- more recent research that we have, and I think that  
9 Nancy pointed us to, does not distinguish between Medicare  
10 and private insurance, so it's tricky there.

11 It's also interesting to note that although wait  
12 times are increasing, beneficiaries in our survey and in  
13 HSC's survey are showing that the patients are not  
14 necessarily complaining about these increases. You know, we  
15 ask these same questions about are delays beyond what you  
16 expected and they're not going up. So think of that as a  
17 concurrent to wait time increases.

18 Then back to the slide on the focus groups for  
19 patients. As we discussed last month in our focus groups,  
20 we found that most beneficiaries had longstanding  
21 relationships with physicians and they didn't have trouble  
22 finding one. However, lower-income patients were more

1 likely to say that they experienced problems than higher-  
2 income patients. Beneficiaries said that they were  
3 satisfied with Medicare and some even said that they  
4 preferred it to the private insurance that they had previous  
5 to Medicare.

6           And then regarding the physician studies, surveys  
7 have also shown that most physicians are accepting Medicare  
8 patients, as we also found in our focus groups, and  
9 physicians told us that they were accepting some private  
10 insurance -- or they accepted -- all the physicians said  
11 that they were accepting private insurance, but they didn't  
12 accept all private insurance plans, and that, of course,  
13 varied by market area.

14           We also found that there was considerable  
15 agreement on their likes and dislikes regarding Medicare.  
16 All physicians complained that their payments were low  
17 relative to private insurance rates, but they did like the  
18 predictability and reliability of Medicare payments and  
19 coverage.

20           I want to take a minute now just to go over one  
21 issue on physician access that was raised last month. As  
22 you recall, in our focus groups, physicians cited psychiatry

1 most frequently as being difficult for getting Medicare  
2 referrals, and several of you concurred with this point.  
3 Two issues are at play here.

4           The first is that beneficiary cost sharing for  
5 these services is quite high. Prior to January 1 of this  
6 year, it was 50 percent. Researchers have attributed access  
7 problems for Medicare beneficiaries for these outpatient  
8 psychiatric services to this high cost sharing. The  
9 research has found that psychiatrists may be reluctant to  
10 accept Medicare patients who do not have supplemental  
11 insurance that fully covers their cost sharing because it  
12 can be hard to collect these cost sharing payments from some  
13 patients, and also from Medicare and from Medicaid in  
14 several States. However, in MIPPA passed a few years ago,  
15 Congress enacted legislation to lower this cost sharing. So  
16 over the next four years, the cost sharing is going to go  
17 down to 20 percent, which will be equal to Part B -- most  
18 Part B services.

19           But note, however, that this MIPPA payment change  
20 does not affect the overall payment rate allowed in the fee  
21 schedule. So the second issue that could be affecting  
22 access to psychiatric services would be the overall fee

1 schedule rate. Further research on Medicare's payment for  
2 these services would be needed to determine if they are  
3 undervalued relative to other Medicare services.

4 Also regarding Medicare fees, our analysis of  
5 Medicare fees relative to private insurers shows that  
6 averaged across all services and geographic areas, Medicare  
7 fees are lower, but the gap, which is around 20 percent, has  
8 been generally steady over the last decade.

9 And to Bob Berenson's question last month, for  
10 this analysis, we do compare allowed fees. That includes  
11 the insurer payment and the patient's cost sharing, but it  
12 doesn't include balance billing. And balance billing, just  
13 to say, is very uncommon for Medicare. Among patients and  
14 other practitioners billing Medicare, 95 percent of these  
15 practitioners agree to accept Medicare rates as payment in  
16 full, so they don't have balance billing.

17 Kevin is going to next review some of the volume  
18 components of our analysis.

19 DR. HAYES: We've been talking about fees,  
20 Medicare's fees for physician services, but, of course,  
21 physician revenues are influenced also by the number and  
22 intensity of services billed. As we see here, the data

1 through 2008 show that the volume of physician services has  
2 continued to grow. However, growth has been somewhat lower  
3 for evaluation and management services and major procedures  
4 relative to other services, imaging, other procedures, and  
5 tests.

6           Specific to your vote today, volume growth  
7 provides context for considering the disparity in recent  
8 years between payment updates for physician services and  
9 changes in input prices for those services. Under the SGR  
10 policy, the update was a minus-five percent in 2002, and  
11 since then, as the Congress has overridden the SGR formula,  
12 the updates have been fairly modest.

13           But for the two years before 2002, physician  
14 updates exceeded the Medicare Economic Index, a measure of  
15 input prices for physician services. So to get a fuller  
16 perspective, we compare on this slide the updates and the  
17 MEI starting in 1997, the first year of the SGR policy.  
18 Still, over this 12-year period, the updates totaled 17  
19 percent while the MEI went up 34 percent.

20           What's missing in such a comparison, however, is  
21 the role of volume growth. Over the same 12 years, Medicare  
22 spending for physician services went up by a total of 90

1 percent. That's growth in spending per beneficiary. Volume  
2 growth is what makes up that difference between the updates  
3 and spending growth, and it's the combination of volume  
4 growth and the updates that determines growth in physician  
5 revenues.

6 Cristina will now continue with our presentation.

7 MS. BOCCUTI: So this slide, you've seen before.  
8 It's on quality and summarizing the quality assessment.  
9 This shows that most quality indicators were stable or  
10 improved slightly from 2006 to 2008.

11 So then on to the next slide, has the second part  
12 of our adequacy framework. These are changes in costs for  
13 2011. CMS's forecast for input price inflation is 2.1  
14 percent, and their forecast for the MEI, which includes a  
15 productivity adjustment, is 0.9 percent. And as always,  
16 these forecasts are updated quarterly.

17 Next slide. So on to the recommendation that you  
18 reviewed last month. Given the array of indicators we  
19 reviewed in our assessment, which is generally good access,  
20 stable quality, increasing volume, and a need to be fiscally  
21 disciplined while maintaining access to physicians'  
22 services, you discussed a modest update of one percent.

1 Specifically, the draft recommendation reads, "The Congress  
2 should update payments for physician services in 2011 by one  
3 percent."

4           Regarding the implications of this recommendation,  
5 the spending effects are, of course, very large because any  
6 increase is scored relative to the cuts in current law that  
7 are called for by the SGR. So it would increase Medicare  
8 spending by more than \$2 billion for 2011 and more than \$10  
9 billion over five years. Additionally, the update would  
10 increase beneficiary cost sharing and would maintain current  
11 supply of and access to physicians.

12           And then this slide here shows the reprinting of a  
13 recommendation that you've made in two previous reports.  
14 This is the recommendation to emphasize the importance of  
15 access to good primary care in a well-functioning delivery  
16 system. So we'll be putting this recommendation in the  
17 report, and I think it's going to be held in a position  
18 that's prominent with the recommendation for the update, and  
19 it calls for budget-neutral increases in payment for primary  
20 care services provided by practitioners who focus on primary  
21 care.

22           And now, Kevin is just going to finish up with the

1 work he talked about last month.

2 DR. HAYES: To close the presentation, we just  
3 wanted to give a reminder that while today you are  
4 considering the update for physician services, we are also  
5 considering distributional issues. In other words, we are  
6 looking at how payments are distributed among different  
7 types of services in the fee schedule. Recall that at the  
8 December meeting, you discussed questions about the accuracy  
9 of the fee schedule's estimates of the time physicians spend  
10 in furnishing services. For the physician update chapter,  
11 there will be an appendix on these issues.

12 Meanwhile, staff work on the issues is continuing.  
13 For example, we have had a discussion of technical issues  
14 with the AMA. At future meetings, your deliberations could  
15 lead to recommendations, say, on alternative data services  
16 for physician time. You could also consider options for  
17 improving the valuation process more generally.

18 That concludes our presentation. We look forward  
19 to your discussion.

20 MR. HACKBARTH: Good job.

21 Clarifying questions, starting on this side.  
22 Jennie, and then George.

1 MS. HANSEN: Yes, thank you. Thank you for all  
2 the added kind of deeper focus groups that were done on  
3 beneficiaries, and I can see the access has been relatively  
4 good. So this is more of a contemporary press item that  
5 came up, I think it was last month, about the Mayo Clinic  
6 beginning not to take on new Medicare. So that is beginning  
7 just to draw some attention. I wonder if there was any more  
8 review of what that might mean or plans to review that.

9 MS. BOCCUTTI: Yes, we did we look into that. I  
10 want to say a couple of things about how that worked.  
11 First, the clinic is about a five -- at least what they're  
12 showing on the website, it's about a five-person, or five-  
13 physician family practice clinic. It is in Arizona and  
14 there are other physicians affiliated with Mayo that are in  
15 Arizona. I think it's over 200. You know, you have other  
16 specialists, others. But this is a five-person, five-  
17 physician practice.

18 I want to be clear that what they did specifically  
19 is now said that they're going to be charging the patients  
20 that want to stay with that practice a fee, an  
21 administrative fee, and those physicians have opted out of  
22 Medicare, which means that they're entering into a private

1 contract with their patients. Excuse me. My glasses just  
2 broke, so it's a little fuzzy.

3 But what I want to be clear on is that this is  
4 part of a model that we've been looking into regarding  
5 retainer-based care or concierge care, which we do see in  
6 more affluent communities so that they're able to see  
7 patients that are able to come up with the financial  
8 resources to pay out of pocket for all their services.

9 So what this clinic has talked about is that they  
10 have -- in addition to the fee that the patients have to pay  
11 to be able to stay, and these are for -- they're Medicare  
12 patients -- they would also be paying for all the services  
13 out of pocket, and their estimate would be if they had their  
14 physical and a few office visits, it would be about \$1,500  
15 in the year.

16 So we have been looking into concierge practices  
17 or retainer-based care and we can discuss that further if  
18 you want more details on this.

19 MR. GEORGE MILLER: Thank you, and very good work.  
20 I really appreciate the information about minorities in the  
21 chapter. I'm struck by something the chapter -- and I  
22 support the recommendation, but I was struck by something in

1 the chapter that said that patients attribute problems with  
2 referring patients because they were either uninsured or  
3 underinsured to specialists and they consider that a barrier  
4 because of that reason. Did I misunderstand the chapter? I  
5 thought we were only talking about Medicare patients. But  
6 is that broad-based patients and all insurances, or just  
7 Medicare patients who are having a problem -- physicians  
8 that take Medicare patients?

9 MR. HACKBARTH: What page is that on?

10 MR. GEORGE MILLER: That's on page ten and 11, the  
11 bottom of page ten and the top of page 11, because I thought  
12 we were talking about Medicare patients and I said, why  
13 would they have a barrier if they had the same insurance?  
14 But then it did refer to the fact that they were uninsured  
15 or had low insurance, and that was the access barrier, and I  
16 was just wondering why.

17 DR. CASTELLANOS: [Off microphone.] Because they  
18 had Medicaid.

19 MR. GEORGE MILLER: Because they had Medicaid?  
20 And if that's the case, then what happens to those patients  
21 who don't get specialists to take care of them?

22 MS. BOCCUTI: Okay. You're referring to the work

1 by the Center for Studying Health System Change.

2 MR. GEORGE MILLER: Yes. I'm sorry.

3 MS. BOCCUTTI: And I think in order to show a  
4 complete picture, we discuss what their practices or what  
5 the patients in their practices are facing.

6 MR. GEORGE MILLER: So it's not just Medicare  
7 patients?

8 MS. BOCCUTTI: Right. As -- I think if I -- right.  
9 It talks about their minority patients and then their  
10 difficulty --

11 MR. GEORGE MILLER: Right.

12 MS. BOCCUTTI: -- because when you think about sort  
13 of the other work that Hannah has been working on, there are  
14 practices that have higher shares of minority patients --

15 MR. GEORGE MILLER: But they were Medicare  
16 patients and they still had an access problem, so when I  
17 read this, I was comparing that with the original study and  
18 then wondered what happens to those patients if they can't  
19 get referred for specialists.

20 MS. BOCCUTTI: Right. It's hard for us to know,  
21 really, what happens to them after they leave that office  
22 because we're not surveying them.

1 MR. GEORGE MILLER: Yes.

2 MS. BOCCUTTI: I mean, we do find that in Medicare,  
3 they may have some problems, but in most cases, they do find  
4 a physician, specialist and primary care, but there may be  
5 more phone calls that they have to make.

6 MR. HACKBARTH: So just reading that entire  
7 passage on the bottom of page ten --

8 MR. GEORGE MILLER: Ten.

9 MR. HACKBARTH: -- and top of 11, it looks to me  
10 like the Center for Studying Health System Change work is on  
11 all patients, all minority patients, not Medicare patients  
12 only.

13 MR. GEORGE MILLER: It's just not Medicare. Okay.

14 MR. HACKBARTH: That's the way I read it.

15 MR. GEORGE MILLER: But even earlier on, it said  
16 that minority Medicare patients had a problem  
17 disproportional to white patients to get referral to  
18 specialists.

19 MR. HACKBARTH: Right. Yes. The reasons there  
20 would obviously be something different, other than they're  
21 uninsured --

22 MR. GEORGE MILLER: Yes.

1 MR. HACKBARTH: -- because by definition, they are  
2 insured.

3 Other clarifying questions?

4 DR. BERENSON: Yes. I wanted to follow up. I was  
5 going to ask Jennie's question, also, about that Mayo Clinic  
6 article, which I got myself quoted on. I got some quite  
7 interesting e-mail related to that.

8 But I wanted to take the more general point about  
9 opt-out. The last I looked a few years ago, there were only  
10 a few thousand physicians, and a good portion were  
11 psychiatrists, who had opted out. Is that something you are  
12 monitoring and do you have current data on that?

13 MS. BOCCUTI: Well, I called CMS with that exact  
14 question, and so far, they've been tracking opt-out. They  
15 have to get it from -- these are information that are with  
16 each carrier, so they have to get a summarized report from  
17 the carriers. And they've been tracking it quarterly, but  
18 they haven't really summed it up and they have already  
19 started the process of giving summary amounts and get  
20 numbers.

21 The other problem with what they've been  
22 collecting is that the numbers are only on new activity, new

1 opt-outs. So if a physician renews their opt-out status,  
2 which they need to do every two years, they're not really  
3 capturing that in the data that they have. But they have  
4 already started -- and this didn't just happen because of  
5 this news item -- they've started, I think, with this  
6 quarter, or with this calendar year, to be collecting more  
7 data that includes current opt-outs and new opt-outs.

8           But with the data or the reports that I've read,  
9 we're definitely talking about a very small number of  
10 physicians. Certainly with the concierge opt-out, we're  
11 talking about around a thousand. There are some reports  
12 that are higher, some that are lower, around the United  
13 States. Now, these are more often in urban areas, more  
14 coastal. But they do have a relationship to opt-out. I  
15 think they are more likely to be opted out if they are in a  
16 concierge practice.

17           But we have tried to get on top of understanding  
18 the number of opt-out physicians and we don't have a really  
19 good number for tracking year after year, but just for  
20 changes.

21           DR. BERENSON: And just to follow up on that  
22 family practice in Arizona --

1 MS. BOCCUTTI: Right.

2 DR. BERENSON: -- they have a separate Tax ID

3 number, separate business entities, presumably?

4 MS. BOCCUTTI: I can look into that.

5 DR. BERENSON: I mean, I'd be interested in how --

6 MS. BOCCUTTI: The other is --

7 DR. BERENSON: I mean, is the Mayo Clinic the Mayo

8 Clinic or are these just affiliated practices? I mean, I

9 think it's -- it wasn't clear from the reporting.

10 MS. BOCCUTTI: Right.

11 DR. BERENSON: It's not that urgent a thing, but

12 if you could look into it, that would be great.

13 MS. BOCCUTTI: But you are right about the opt-out

14 being focused in certain specialties, as well, and

15 psychiatry is one of the highest specialties that has opt-

16 out.

17 DR. MARK MILLER: The other thing is, we have a --

18 you can't see me --

19 MS. BOCCUTTI: I can hear you.

20 [Laughter.]

21 DR. MARK MILLER: All right, don't tell her we're

22 going to make faces, okay?

1 [Laughter.]

2 DR. MARK MILLER: We also have a contractor report  
3 coming forward on this issue--

4 MS. BOCCUTI: Right.

5 DR. MARK MILLER: -- so we may have some more  
6 information, but I think you do raise a good point. In  
7 conjunction with that report, which you will, as we work  
8 through it, eventually see, we ought to think about how  
9 we're going to monitor it just some more on this exchange.

10 So the take-away from the Mayo thing is these  
11 physicians, there are still Mayo physicians accepting  
12 Medicare, in fact, broadly in Arizona. It's these five who  
13 have chosen to opt out, is that right?

14 MS. BOCCUTI: Right. There's two facilities or  
15 Mayo Clinics, main places, and this is just one of them, and  
16 it's five of hundreds that are affiliated with Mayo that  
17 they've said in their information that cardiologists, all  
18 other specialties, it's simply -- it's this family practice  
19 clinic that is --

20 MR. HACKBARTH: So is it all of the family  
21 practice physicians affiliated with Mayo in that Medicare,  
22 or just one unit?

1 MS. BOCCUTTI: No. It's just this unit.

2 MR. HACKBARTH: So there are other family practice  
3 physicians affiliated with Mayo in Arizona that continue to  
4 participate in Medicare?

5 MS. BOCCUTTI: That's true in Arizona, but they  
6 would be with a different clinic in Arizona. So they have  
7 two --

8 MR. HACKBARTH: But they still have Mayo.

9 MS. BOCCUTTI: There's like a Scottsdale -- right.

10 MR. HACKBARTH: Right, yes.

11 MS. BOCCUTTI: So in Arizona, but in a different  
12 town.

13 DR. MARK MILLER: [Off microphone.] Thank you.

14 DR. KANE: It seems like we need a little  
15 misinformation media function somewhere.

16 On Slide 11, I just kind of had a disconnect  
17 between the relationship between the input price inflation  
18 and the MEI. So I don't understand how we get from 2.1 to  
19 0.9, because isn't it the MEI that we're using to measure  
20 inflation and the --

21 MS. BOCCUTTI: The input price inflation is not  
22 adjusted for productivity.

1 DR. KANE: Oh, okay. So that's --

2 MS. BOCCUTTI: When you have a productivity  
3 adjustment, which is what the MEI is, that includes a  
4 productivity adjustment and it comes to 0.9 percent.

5 DR. KANE: Okay. So --

6 MR. HACKBARTH: I had the same question about the  
7 slide that Kevin went through on nine. It lists -- this is  
8 MEI. Does it mean literally MEI with the productivity  
9 adjustment as opposed to just the input price? Okay.

10 DR. KANE: Okay. Thanks.

11 DR. CASTELLANOS: Just a couple of clarifications.  
12 I am going to have a lot more comments in round two. One is  
13 the time estimates. I just hope that we have the  
14 opportunity to discuss this. Bob, I know you have done some  
15 work on that because I've been reading. I looked at the  
16 MGMA study that was quoted last time and I think we need to  
17 look at that a little bit more carefully. And there's a  
18 Cromwell thing that was -- a gentleman that was quoted, too,  
19 and we have to look at that more carefully. So my  
20 clarification point is, before we put it in the text, I  
21 would hope that we could have the opportunity to discuss it  
22 a little more.

1           The second point, and again, it's really  
2   commenting on some of the points that were made up about  
3   opting out, you know, one of the things I read in Part A in  
4   the material that was sent around is 92 percent of the  
5   primary cares participate in Medicare. So there's eight  
6   percent of the primary cares that have opted out. Those 92  
7   percent that participate, only 73 percent accept Medicare.

8           DR. MARK MILLER: [Off microphone.] Where are you  
9   looking?

10          DR. CASTELLANOS: Part A data, the material that  
11   was sent to us in Part A in the material -- Tab A, excuse  
12   me. Tab A. I was surprised, and I can show you those  
13   articles.

14          DR. MARK MILLER: [Off microphone.] We will look  
15   at it.

16          DR. CASTELLANOS: Okay. the other point about the  
17   Mayo Clinic, you know, there's a big clinic in Seattle,  
18   Washington, that has opted out totally. So it's not unusual  
19   to have people doing that, and psychiatry is the highest  
20   specialty for opting out. And George, just for your  
21   comments about the Medicare and Medicaid, this is the real  
22   world experience. The minority and the Hispanic and the

1 black are having trouble, even with Medicaid and Medicare,  
2 or Medicare and Medicaid as secondary. This is a real world  
3 experience.

4 DR. BERENSON: Ron, I just wanted to point out,  
5 nonparticipation doesn't mean opting out. It means you're  
6 not taking Medicare rates. I know you're able to --

7 DR. CASTELLANOS: I guess you didn't clarify that.  
8 I need to look at it.

9 DR. BERENSON: Okay.

10 DR. CASTELLANOS: That's how I interpreted it.

11 MS. BOCCUTI: Maybe, if I could just have it for  
12 one second, I'd distinguish between the two. So as Bob was  
13 saying, you can sign a participation agreement and that  
14 means that if you sign a participation agreement with  
15 Medicare, then you agree that for all the services you  
16 provide to Medicare patients, you accept the full -- the  
17 Medicare amount as payment in full. You do not balance bill  
18 the patients. And we have 95 percent of physicians are  
19 doing that -- or 95 percent of physicians and other  
20 practitioners.

21 The opting out means that you can enter into  
22 whatever charges you want with the Medicare patient, but the

1 Medicare patient can no longer get any reimbursement for  
2 those services himself or herself, nor can the doctor. So  
3 they become out of pocket.

4 DR. CASTELLANOS: I appreciate you saying that and  
5 I'm aware of that. I guess it wasn't clear in Tab A  
6 material. I'd like to look at that again.

7 MR. HACKBARTH: Bruce?

8 DR. STUART: I support the recommendations and  
9 you've done a good job on this. I was really intrigued by  
10 some statistics on Slide 2, and it's the third bullet point,  
11 and if you do the math, it looks like 60 percent of  
12 practitioners who are billing for physician services are  
13 physicians, which means that 40 percent are not physicians,  
14 which raises a couple of questions. The first is, when we  
15 look at changes in rates of physician reimbursement and the  
16 updates, these are for physician services whether provided  
17 by physicians or not, is that correct?

18 And then the second question would be, do we have  
19 any sense of the volume of services that are billed by  
20 physicians versus not physicians in this sector? I'm  
21 assuming it's overwhelmingly physicians, but I really don't  
22 have any sense of that.

1           And then, third, and I'll let you see where this  
2 line of reasoning is going, if that volume of services that  
3 are provided by non-physicians is growing, then it would  
4 suggest that if you're doing your focus groups, you would  
5 also want to be talking to the non-physicians that are  
6 providing these services, and then the question is, are you  
7 doing that?

8           DR. HAYES: So we do -- when we do our volume  
9 analyses, we included all services billable under the fee  
10 schedule, and so that would incorporate services -- take  
11 office visits, for example, that are billed by nurse  
12 practitioners and PAs. It would include -- a big category  
13 is outpatient therapy, including therapy billed by  
14 therapists billing independently. There are other  
15 categories that are billable -- chiropractic services and on  
16 and on. But I just don't have any figures offhand, but I  
17 take your point about making that differentiation between  
18 physicians and non-physicians. But the vast majority, you  
19 are right, would be physicians billing for services, of  
20 those categories.

21           DR. STUART: I guess where I'm going here is that  
22 to the extent that some of these practitioners are providing

1 primary care, and this would be largely the nurse  
2 practitioners and physician assistants, and we focus just on  
3 physicians, primary care physicians, we may be undercounting  
4 the availability of services.

5 DR. HAYES: Well, just on that point, certainly in  
6 our volume analyses, we are including the services billed by  
7 the non-physicians, and then recall on the fee schedule  
8 adjustment for primary care, we identified nurse  
9 practitioners and PAs, advance practice nurses, as among  
10 those that would be -- among those that would have the  
11 specialty designations that we thought should be eligible  
12 for the adjustment.

13 DR. MARK MILLER: A couple of clean-up points.  
14 I'm going to look at Joan. I don't think in our focus  
15 groups we focused on this group of providers yet.

16 DR. SOKOLOVSKY: [Off microphone.] That's not  
17 something --

18 DR. MARK MILLER: Okay. Yes, and again, so we  
19 take your point there.

20 But then I wanted to ask you, on participation  
21 rates and the PAR rates and all of that, is that just  
22 physicians or is that also going to be the non-physician

1 providers?

2 MS. BOCCUTTI: It includes some non-physician  
3 providers. It includes, yes, other limited license  
4 practitioners, yes.

5 DR. MARK MILLER: [Off microphone.] So we might  
6 not be completely off.

7 MS. BOCCUTTI: But notice, also, I think Carol also  
8 speaks with some other professionals, like physical  
9 therapists, and there's been other opportunities for  
10 practitioners who bill on the physician fee schedule to talk  
11 with other analysts here, if you wanted to -- okay.

12 MR. BUTLER: Okay. This is a tad of round two,  
13 but then you won't hear from me in round two. Just on the -  
14 - everybody is talking about the Mayo example, and I don't  
15 want to further cloud the issue, but I do think that, sure,  
16 it's just five physicians in one site with 3,000 or so  
17 Medicare people, but also in those announcements, it said,  
18 we lose \$120 million in our Phoenix market on Medicare, I  
19 think was the statement, and that it came in the context  
20 like this may be a strategic direction of a large nonprofit  
21 multi-specialty group practice. And if that, in fact, is  
22 something that is emerging, it is something that we should

1 understand as Commissioners and try to stay ahead of it.

2           The second comment, just a little bit on the  
3 concierge, I'm pretty familiar with these, and I think the  
4 most prevalent model actually is you get -- you charge  
5 \$1,500 or so a year and for that you get a comprehensive  
6 exam, but you're not opting out. You are still staying in  
7 Medicare and charging Medicare fees, but you are taking --  
8 you are suddenly managing far, far fewer patients.

9 Therefore, you are reducing your capacity because you're  
10 getting the \$1,500 fee, but you're still participating in  
11 Medicare. So it's a little different model than just  
12 saying, I'm out.

13           Thirdly, a good thing to keep track of, I think,  
14 would be all of those that I know have opted out truly and  
15 just aren't taking any. I don't know of a single one that  
16 has opted back in. So it would be interesting to know, if  
17 you lose them, are there any examples where we can find you  
18 can get them back, and my guess is there's not much, but it  
19 is something that would be interesting to know if we could  
20 get it in the future.

21           DR. BORMAN: Well, Bruce pretty much asked one of  
22 my two questions, but I'd just like to speak just a little

1 bit further to this breakdown between physicians and other  
2 people billing under the physician fee schedule. Now that  
3 it's 60-40, I think that it would be informative in the  
4 future to perhaps look at some of the practice patterns  
5 because there may, in fact, be growth in different sectors.  
6 We need to know that a little bit, and particularly as we  
7 talk about some of the workforce discussions that we've had,  
8 the right mix of workforce and so forth. Some of this  
9 conversation and some of these data would be very helpful to  
10 that conversation, I think, going forward. So we may not  
11 have something or need it for this particular conversation.

12           The other thing would be, for example, we heard  
13 mentioned a couple of times access to psychiatry services  
14 and, for example, the psychology-psychiatrist breakout and  
15 some of that might also be of interest. So there's multiple  
16 levels at which that breakout might be of some interest.

17           The one other question I have is more of a process  
18 one. Since the proposal is to reiterate the budget-neutral  
19 primary care bonus and, I believe you said, feature it  
20 prominently, whether we will formally reaffirm that vote or  
21 not, I know we did once when we re-mentioned it previously,  
22 although I think we have not always re-voted when we have

1 reaffirmed prior recommendations. So if we could clarify  
2 that, that would be helpful.

3 MR. HACKBARTH: On the process question, Karen, we  
4 will not be re-voting on the primary care recommendation.  
5 As with other recommendations we are rerunning, it will be  
6 included in the text, offset in a text box, which is what is  
7 meant by highlighting, and it will be included on the facing  
8 page that begins each chapter where we have, you know, the  
9 gray page that says the recommendation is X and the vote was  
10 Y, and then there will be language there that refers the  
11 reader to prior recommendations of interest in that sector.  
12 So the primary care would be referenced there. Does that  
13 answer your question?

14 DR. BORMAN: It does. It is just my recollection  
15 that we did actually --

16 MR. HACKBARTH: Last year --

17 DR. BORMAN: -- re-vote on it once, and I wasn't  
18 sure --

19 MR. HACKBARTH: Yes.

20 DR. BORMAN: -- what the rationale that applied  
21 and whether or not it was applicable again this year.

22 MR. HACKBARTH: Yes, and I won't be able to

1 reconstruct all of the circumstances a year ago, but a year  
2 ago, our plan was not to re-vote it. But as the discussion  
3 evolved that day, there were some Commissioners who asked  
4 that we re-vote on it as a way of emphasizing the  
5 Commission's -- the importance the Commission attaches to  
6 it. And so last year, we did actually re-vote it.

7           Rather than get into questions this year of which  
8 ones we re-vote and which ones we just run in text boxes,  
9 the general rule I laid out at the beginning was we are not  
10 going to re-vote the old recommendations. We will put them  
11 in text boxes. We will highlight them on the facing page  
12 and we'll handle all of them the same. Okay?

13           DR. BORMAN: I appreciate the clarification.

14           MR. HACKBARTH: Okay. Before we go to round two,  
15 I just wanted to focus in on the issue of access to primary  
16 care services for Medicare beneficiaries. In your  
17 presentation, you made some broad statements about that, but  
18 for the benefit of the audience, I just wanted to walk  
19 through some of the data more specifically.

20           This question of whether Medicare beneficiaries  
21 have adequate access to primary care services in particular  
22 is one of the questions that I get asked most frequently

1 when I testify on these issues, and that's why I think it's  
2 very important.

3 So for Commissioners who have the draft chapter,  
4 it's the table on page nine of the chapter, and this is  
5 based on survey data where we ask Medicare beneficiaries and  
6 then people with private insurance about their access to  
7 care. Remind me about the timing and the sample size of  
8 this survey.

9 MS. NEPRASH: The survey happens every fall and  
10 4,000 people on Medicare and 4,000 people on private  
11 insurance were posed these questions.

12 MR. HACKBARTH: Okay. And then we did some  
13 oversampling to get enough numbers for minority questions  
14 and the like.

15 MS. NEPRASH: We did. This year, we oversampled  
16 African Americans, Hispanics, and the "other" category,  
17 which includes Asians, Alaskan Natives, Hawaiian Pacific  
18 Islanders, and Native Americans, and in each of those three  
19 categories, we oversampled to make sure that we had at least  
20 450 respondents.

21 MR. HACKBARTH: Okay. So the part that I want to  
22 focus on is finding a new primary care physician, which, as

1 the Commissioners know and those in the audience who follow  
2 our work know, that's been the area that's most troubling,  
3 where we see the potentially most worrisome numbers.

4 The number of Medicare beneficiaries seeking a new  
5 primary care physician in any given year is about six  
6 percent -- or it was six percent in this sample, this  
7 national sample, let me put it that way, is that right?  
8 Okay. So we're talking about six percent of Medicare  
9 beneficiaries here.

10 And so for the last four years, we've asked the  
11 same question about whether a beneficiary has a problem in  
12 finding a new primary care physician if they need to find a  
13 new one, and they're asked to say whether they have no  
14 problem, a small problem, or big problem.

15 For 2009, the survey done last fall, 78 percent of  
16 Medicare beneficiaries said they had no problem finding a  
17 new primary care physician. Twenty-two percent, therefore,  
18 said that they had some problem and characterized it either  
19 as a small problem or a big problem.

20 The comparable number for privately insured  
21 patients ages 50 to 64 is 71 percent said they had no  
22 problem, so 71 percent less than the Medicare number. So

1 the private patients are having more problems. So 29  
2 percent, by definition, of the privately insured patients  
3 said they were having a problem finding a new primary care  
4 physician as opposed to 22 percent of the Medicare  
5 beneficiaries.

6 This is national survey data. In any given market  
7 around the country, the results could be different from  
8 this, and it's very important to emphasize that. Among the  
9 reasons that the numbers can be different than this is that  
10 the local dynamics, the local supply and demand for health  
11 care services in general and primary care services in  
12 particular can differ market by market.

13 So an example that I've cited in the past is a  
14 rapidly-growing community, like my home town, Bend, Oregon,  
15 where we have also a lot of retirees moving into the market,  
16 areas like that are particularly vulnerable to an imbalance  
17 in supply and demand of services. So in Bend, Oregon -- I  
18 don't know what the numbers are, but you could have a much  
19 higher percentage of Medicare beneficiaries looking for a  
20 new primary care physician because there are a lot of  
21 retirees moving newly into the area. With the supply  
22 relatively fixed or lagging behind the demand, you could

1 have much different numbers in Bend or any number of other  
2 communities around the country than these.

3           And when you're talking about the Medicare  
4 population, with 40-plus million people, even small  
5 percentages of beneficiaries having problems, it's a lot of  
6 people that can generate a lot of Congressional mail and a  
7 lot of appropriate Congressional concern, a lot of newspaper  
8 stories.

9           But looked at on a national basis, from these data  
10 in this most troublesome area of getting access to primary  
11 care physicians, Medicare beneficiaries report to us that  
12 they have access that is as good as or better than privately  
13 insured patients age 50 to 64. That's not to say that  
14 access to primary care services for Medicare beneficiaries  
15 is not a problem and we shouldn't worry about it. Far from  
16 it. I think the trends in primary care for all types of  
17 patients are bad, and as a society, we need to be  
18 intervening to try to improve that. But what this does  
19 suggest to me is that on a national basis, to the extent we  
20 have problems, it's not because of Medicare payment rates  
21 being too low. It's much more likely to be because of  
22 market-specific factors related to the imbalance in supply

1 and demand.

2 Okay. So let's go on to round two. Jennie?

3 MS. HANSEN: If I can just add one more factor of  
4 studying this phenomenon of access to primary care services  
5 is in 2011, it will be the first turn of the Baby Boomers  
6 cohort turning 65. So I just wonder if that factor of  
7 numbers will increase, as well, rather than that it's beyond  
8 the six percent we will be looking at. So I think if we  
9 just factor in some of the demographic changes of who is  
10 going to start qualifying for Medicare.

11 And in a separate context, I think part of the  
12 reason there is more mail being generated about -- concern  
13 about primary care include the context of health care  
14 reform, that if another 30 million people enter into the  
15 health care access system, there has been some reaction, I  
16 know, by current beneficiaries over concern of further  
17 access if, in fact, certain pockets are already experiencing  
18 that.

19 So I just want to -- that's part of the reason of  
20 studying it further and tying together Bruce's question  
21 about who actually gets defined as a primary care provider.  
22 So somehow, perhaps some way to look at this in a broad

1 context, because it is about preparing people and then who  
2 also provides the primary care and what the demographics  
3 are. So it's a more composite picture to really begin to  
4 take a look at.

5 MR. HACKBARTH: And I agree with those points,  
6 Jennie. Just for the record, again, I want to emphasize,  
7 nothing that I said should be interpreted as, oh, I think  
8 there aren't any problems with access to primary care. I  
9 think that as a country, we're facing serious problems,  
10 potentially, with access to primary care. I think they're  
11 going to have to be met at least in part through changes in  
12 how we deliver primary care, more use of advanced practice  
13 nurses and other non-physician practitioners. There's no  
14 way we're going to be able to ramp up the number of M.D.s,  
15 nor would it be efficient and appropriate to do so, in my  
16 view. So I'm concerned about these issues, but I just want  
17 to be clear about what the data show currently on access for  
18 Medicare patients versus others nationally.

19 DR. BERENSON: Just one little thing to add is the  
20 impending retirement of many of the Baby Boom doctors who  
21 are treating the Baby Boom patients who are coming in, which  
22 needs to be looked at, too.

1 MS. BEHROOZI: Yes, actually, thank you. That's  
2 one of the things that I wanted to talk about. Glenn, you  
3 emphasized the word "current" and Jennie is looking forward  
4 to the future. I'm concerned that when we look back and ask  
5 people if they had a problem, they had a problem that we are  
6 now looking at in the past and it's probably getting worse  
7 as we speak. So I don't necessarily mean to say that the  
8 data in that patient survey is inevitably getting worse.  
9 I'm just concerned with only using a backward look and  
10 rather trying to figure out what are the canaries in the  
11 coal mine kind of things that will help us plan better for  
12 the future, and so things like doctors retiring.

13 Maybe drilling down a little bit more or figuring  
14 out some better way to get information from the physicians  
15 themselves, because the -- on, I guess it's pages 18 and 19,  
16 it's really kind of all over the map. You really can't tell  
17 whether physicians are accepting new Medicare patients  
18 consistently. It's many of the paragraphs refer to some or  
19 all new patients. In what ways are they being selective?  
20 Maybe there's a different way to -- I don't know to what  
21 extent those surveys drill down. Maybe there's a different  
22 way to do it. Maybe you call a physician's office and say,

1 I would like to schedule an appointment. I'm a patient  
2 whose coverage is Medicare.

3 I've recently been having this experience on  
4 behalf of my parents, and ultimately, I can find someone who  
5 will take them, but I always get a no or two along the way,  
6 and I don't know if that means things are getting worse.  
7 It's so anecdotal and I feel like there's a way to get  
8 better information somehow from physicians about what's  
9 going on out there and what's likely to be happening as we  
10 go forward.

11 MS. BOCCUTI: Can I just mention a couple things?  
12 You know, I think about this a lot, as you might imagine,  
13 and I think it's good that we look at both the physician  
14 reports and the patient reports, because they're not always  
15 going to match, because, you know, you could have  
16 beneficiaries all being able to ultimately find physicians,  
17 but it doesn't mean that all physicians are taking those  
18 patients. So I think it's important to look at the whole  
19 picture, and if you're only surveying physicians, you're not  
20 actually getting what the beneficiaries are experiencing.  
21 But if you're only surveying the beneficiaries, you are  
22 getting that look-back issue. So I think it's helpful when

1 we look at both of these. The National Ambulatory Medical  
2 Care Survey does ask these to physicians annually and we try  
3 to put that in.

4 But I do want to say that, as Hannah mentioned,  
5 our survey coming out in the fall that we report is the  
6 freshest that you are going to find. It is as close to  
7 real-time as we can get, and it's in the same vein that you  
8 say of trying to look for canaries in the coal mine. You  
9 know, when we're getting data that's three years old, that's  
10 not going to be helpful. So we're trying as best we can to  
11 get at this.

12 Some people do get at the canary in the coal mine,  
13 ask physicians what they're planning to do, you know, will  
14 you consider dropping these patients, and that has some  
15 value, but it can get very overstated and it doesn't -- it  
16 cannot be what we rely on, what they're responding to those  
17 kinds of questions.

18 DR. SCANLON: Yes. To follow up on what you were  
19 saying about the idea that there are differences in access  
20 issues with respect to local markets, I mean, I think that  
21 raises two different sort of conclusions. One is that  
22 there's a need for much better data about what's happening

1 in local markets, because to look at things from a national  
2 picture does not provide sort of us with the right  
3 information to guide sort of policy.

4           The second one, though, is kind of then what do we  
5 do about it when we have local problems as opposed to sort  
6 of a national problem, and the idea that we then raise fees  
7 nationally is too blunt, too inefficient of an instrument to  
8 think about in terms of dealing with all local problems  
9 because some of those local problems are really because  
10 markets there are distorted.

11           As we had a session a few months ago on  
12 consolidation in markets, and while a lot of that work has  
13 been done on the hospital side, there's also some of the  
14 same kinds of things going on on the physician side, and for  
15 Medicare to become, in some respects, the next victim of  
16 that is not something that we want to do. So that, I think,  
17 are two important sort of implications for the future, need  
18 for refinement in our thinking and in our instruments.

19           To go to this question about primary care, though,  
20 I think, and since we're repeating the recommendation,  
21 today's discussion has for me sort of been more in a  
22 direction that I've been comfortable with than where we were

1 in the past, and that is to recognize other types of  
2 personnel, other types of professionals that may substitute,  
3 because a lot of the discussion in primary care shortage has  
4 been in terms of the number of people that go into residency  
5 programs and number of primary care physicians. And some of  
6 that discussion has been in spite of the fact that GAO  
7 reported we've had a bigger increase in the number of  
8 primary care physicians per capita over a ten-year period  
9 than we did in terms of the number of specialists per  
10 capita. And on top of that, we almost doubled the number of  
11 nurse practitioners and we had a very large increase in sort  
12 of the number of physicians assistants. So there's this  
13 issue of sort of what are the data telling us about sort of  
14 primary care supply.

15 I think you then also need to combine that with  
16 what's the optimal sort of for the future, and as you said,  
17 we can't necessarily afford the number of physicians that  
18 we've had in the past to do these kinds of tasks, and the  
19 idea of substituting nurse practitioners is one step. We're  
20 now seeing -- we've had at least one piece in JAMA about  
21 sort of more disruptive technology. It doesn't even have to  
22 be someone trained as extensively as a nurse practitioner to

1 do some of the things that we're talking about.

2           And we need to think about these for the future,  
3 because if you look at other countries that have had a much  
4 better record in terms of controlling costs and keeping  
5 costs down, it's not because they've had more primary care  
6 physicians or had fewer physicians necessarily. Germany,  
7 which has one of the best records, has a lot more physicians  
8 and has more specialists as a share than we do. It's how  
9 you use your personnel that's the key to sort of this as  
10 well as the types of personnel that you have, and I think we  
11 have to think about that for the future.

12           DR. CROSSON: While I support the recommendation,  
13 I'd just like to underscore one point that was made in the  
14 presentation and that has to do with the question of whether  
15 we have a problem in the adequacy of the fee schedule for  
16 psychiatrists, and that's not to take away from Bill's point  
17 about other mental health professionals. But I think as we  
18 focused in the last few years on primary care, adult primary  
19 care particularly, and we recognize that perhaps there were  
20 growing inequities, if you want to use the term, in the fee  
21 schedule, a lot of that was caused by the ability of some  
22 providers, some specialists, to increase their volume to

1 participate in that 90 percent growth curve, volume per  
2 beneficiary curve, that we saw in Slide 9 and others not.  
3 And certainly adult primary care physicians fell in that  
4 category.

5 I would believe, without the evidence, but I would  
6 believe that psychiatrists also fall into that category, and  
7 Karen has mentioned general surgeons and there are others.  
8 But if, in fact, in the opt-out category, as you noted  
9 earlier, there's an overrepresentation of psychiatrists,  
10 perhaps that's an additional indication that there may be a  
11 problem. And if you add Jennie's point that we're going to  
12 see through health care reform an introduction into the  
13 stream of care of people who have not had care before, some  
14 portion of those, whether that's overrepresented or not,  
15 some portion of those are individuals with mental health  
16 problems.

17 So it just seems to me that as an add-on to the  
18 work that we've done with respect to primary care, perhaps  
19 in the future, we should dig deeper into the issue of the  
20 adequacy of access to psychiatric and other mental health  
21 services.

22 DR. BERENSON: Yes. Just picking that up, I mean,

1 one lens to look at an issue is primary care and non-primary  
2 care. Another lens is physicians who predominately do  
3 evaluation and management rather than procedurally-oriented  
4 services.

5 One of the more interesting articles I've read in  
6 recent years was a Wall Street Journal piece a few years ago  
7 about the demise of the specialty of neuro-ophthalmology,  
8 who basically are cognitive doctors. And there were some  
9 quotes from some of them saying they gave up that specialty  
10 and are now taking out cataracts.

11 So that, I think, is what Kevin's agenda would  
12 help us get at, is not only the primary care issue, but the  
13 balancing of E&M and procedural. And I know the RUC is  
14 spending a lot of time trying to get that right, as well,  
15 but I think that may be one of the things we want to look  
16 at, as well.

17 DR. KANE: Yes. I'd like to pick up on something  
18 that Bill was starting down the path of. I was just  
19 recently in two different markets, one in South Florida and  
20 one in Louisiana, where I was told that the private rate for  
21 physician fees were 70 percent of the Medicare rate, which  
22 means in other markets, if we're on average 80 percentage of

1 private, that there's a huge disparity going the other way,  
2 as well.

3           And I think we really owe it to ourselves to look  
4 at the private-to-Medicare payment rates across different  
5 markets and also correlate that to the degree of  
6 consolidation of the physician market, because it's pretty  
7 clear to me, as with the physician side, that the failure to  
8 enforce antitrust is a huge problem for Medicare access.  
9 And I think the only way we can make that case is to really  
10 start collecting the data. Even if we can't do local  
11 adjustments, we can say there is a problem here and it looks  
12 like it's got to -- I'm pretty sure you're going to find it  
13 has to do with consolidation of systems. And physicians are  
14 often consolidated within the hospital systems. And people  
15 have literally told me that, too, that that's why they are  
16 in a consolidated system, is not to provide better  
17 integrated care, it is to get better private sector rates.

18           So I think we just can't keep pretending that  
19 looking at the national picture gives us a view of anything,  
20 and it certainly doesn't give us a view of the remedies or  
21 potential remedies that would be nationwide if we could  
22 actually insist on the enforcement of antitrust, and perhaps

1 it needs better definition of what a market is, but there's  
2 a real problem, it seems to me.

3           The second observation I'd like to make, and this  
4 comes -- I've already told Glenn this -- from going to the  
5 doctor with my mother, and I'm sure all of us have these  
6 examples, but only a part of the visit was about my mother's  
7 medical problem and the other part, and I would say the  
8 longer part, was about this physician's dissatisfaction with  
9 Medicare and telling my mother falsehoods about Medicare,  
10 that Medicare is eliminating cardiology services.

11           So we have a real need -- I mean, you know, it was  
12 hard to keep a straight -- I didn't keep a straight face.  
13 But there is a lot going on in the local markets of terrible  
14 misinformation, including in the physician's office. And at  
15 a minimum, I think seniors need to be educated to, A, resist  
16 that, maybe even report on providers who do that, and  
17 perhaps we need some kind of PR contract or effort to better  
18 educate seniors as to the level -- I mean, this is really  
19 making the seniors think that the government -- just  
20 reinforcing this whole thing that government is bad and  
21 Medicare can't do anything right, and it is being  
22 perpetuated by physicians.

1           So I'm still furious that this person said that.

2   Of course, I reeducated my mother immediately.

3           [Laughter.]

4           DR. KANE: I think we really need to take this  
5   seriously, because I think if you're thinking about what's  
6   the pressure on Congress, it's coming from these massive  
7   misinformation campaigns and they've got to be taken  
8   seriously. Even though you and I think it's outrageous, my  
9   mother doesn't know. So I think there's a lot of seniors  
10  out there who are being manipulated into thinking Medicare  
11  is out to destroy their medical care and we need to, I  
12  think, at least recommend something be done about it.

13          DR. CROSSON: And Nancy, I just want to suggest  
14  perhaps changing physicians.

15          DR. KANE: Oh, absolutely.

16          [Laughter.]

17          DR. KANE: I've already talked to Ron about  
18  another cardiologist reference. But I don't think this is  
19  uncommon, and I think Ron will agree with that. I mean,  
20  he's said the same.

21          MR. HACKBARTH: Yes. I want to just ask Cristina  
22  and company to pick up on that first point. I recall that

1 the Center for Health System Change did a study, I don't  
2 know, probably four or five years ago now, looking at the  
3 variation in the relationship between Medicare and private  
4 fees, and as Nancy says, in some cases, it's like the  
5 national average. Medicare is 80 percent to private. In  
6 other cases, it goes the other direction.

7           And I recall what they found, though, was that  
8 access -- satisfaction with access to services for Medicare  
9 beneficiaries was not correlated to the gap between private  
10 and Medicare fees. Is that -- do I remember --

11           MS. BOCCUTI: That's exactly the results that they  
12 found, yes.

13           MR. HACKBARTH: Yes. It might be useful to sort  
14 of update that analysis and maybe add some new wrinkles to  
15 it.

16           DR. MARK MILLER: If I could just say something  
17 about that, so I think we've had some of this discussion  
18 here. I'm forgetting exactly what I've heard in the office  
19 and here. But we do have work coming forward on the kind of  
20 consolidation and looking at the relationship to pricing and  
21 we're going to try to be looking at it both on the hospital  
22 and physician side of things. Anne Mutti and Carlos and

1 probably a couple other people are involved in that. So  
2 that first thought about consolidation and what's going on,  
3 you should see more of that.

4 DR. STUART: Thank you. Just to emphasize  
5 basically on Jennie's point and Bob's point about let's not  
6 just focus in on primary care, let's focus in on all  
7 doctors, I think that's important.

8 Nancy brought up a very good point about what's  
9 happening in the little pockets, and I was involved a little  
10 bit with Nancy in a discussion. I've never seen so much  
11 distrust, misinformation, and outward contempt by the  
12 physician community. I'm not quite sure why, and one of the  
13 efforts that I've always said is not just educating the  
14 patient or the Medicare beneficiary, but somehow we're way  
15 up here with, as, Jay, you mentioned, where the eagles fly,  
16 and where the doctors are down in the barn picking out corn.  
17 And there's a --

18 [Laughter.]

19 DR. STUART: The information is never getting down  
20 there and we need to do a better job on that.

21 Glenn, you did such a good job with Arnie  
22 explaining some issues, and one of the things I want you to

1 kind of make a point on when we talk about equity and  
2 sustainability, especially when it applies to the physician  
3 side in the face of -- and this is how physicians look at  
4 things. We have an SGR cut of 22 percent coming up. Now,  
5 whether it will happen or not, I don't know.

6 Medicare pays 80 percent of primary care.  
7 Hospital payments over the last nine years have gone up 34  
8 percent. Physicians have gone up 1.6 percent. Our costs  
9 have risen anywhere, depending on MEI or NGA, 20 to 30  
10 percent. These low Medicare payments are making a big  
11 difference to physicians and a lot of us are now trying to  
12 affiliate with hospitals or that. I think the AHA had some  
13 pretty good studies on that.

14 In my discussions with Glenn earlier this week, we  
15 talked about this and I asked him if he would perhaps put  
16 this in a better context for the physician community and for  
17 the public.

18 MR. HACKBARTH: Well, I won't repeat the part  
19 about why I think our hospital recommendations are  
20 appropriate and apply appropriate pressure there, and so let  
21 me focus on the physician half of it, and I'd ask Kevin to  
22 put up Slide 9.

1           So you had made this point at the December  
2 meeting, that there's a disparity between the updates that  
3 physicians have received and the increase in their input  
4 prices, so I had asked Kevin to put together the data for  
5 the full period of the SGR, and that's what this slide is.

6           Now, this does use the MEI, and earlier I asked  
7 whether that includes the productivity adjustment and I  
8 understood the answer was yes. So if you just did input  
9 prices without the productivity adjustment, that MEI line  
10 would be moved up, and so the gap between the updates and  
11 the MEI would become larger.

12           However, to me, a very important line is the red  
13 line, and it's the red line that determines total physician  
14 income from the Medicare program. And there, as you well  
15 know, and as illustrated by the line over the dozen or so  
16 years since SGR went into effect, notwithstanding SGR, we've  
17 had consistent growth, fairly rapid growth, in per  
18 beneficiary Medicare expenditures for physician services,  
19 which means higher Medicare income for physicians. And if  
20 you did a comparable line for hospital services, you would  
21 see some growth in hospital, but the slope would be much  
22 less than this. So one of the ways that physicians are

1   benefitting from Medicare beyond the update factors is  
2   through the growth in volume.

3           You and I agreed when we talked the other day that  
4   this isn't the right way to run the system, to squeeze the  
5   unit prices and let the volume run free. SGR was a poorly  
6   conceived effort to try to bring together pressure on volume  
7   with unit prices. It was flawed in conception, from the  
8   outset. It was destined not only not to work, but probably  
9   to make the problem worse, and it has.

10           But we need other payment methods that encourage  
11   the efficient delivery of services, address the problem of  
12   volume directly, so we don't have just unit prices the only  
13   tool that we can use to try to keep Medicare's expenditures  
14   reasonable.

15           Given this slide, as I said to you on the phone, I  
16   think we are being equitable in our treatment of physicians.  
17   Even though they're getting less than input price increase  
18   and the health care recommendation is short of full market  
19   basket in the context of P4P, I think we're being equitable.

20           Other comments? Tom, last one, and then we need  
21   to vote.

22           DR. DEAN: Just a couple of comments that sort of

1 follow on what you just said, and to follow up a little bit  
2 what Bill said, I think we talk about the shortage of  
3 primary care, and obviously it's real, but I think if we're  
4 really going to deal with that, and it's probably already  
5 been said, we really need to sort of restructure how we do  
6 primary care, because we know that the way it's being  
7 handled today is very inefficient and we're not using our  
8 skills either at the physician level or the PA-nurse  
9 practitioner level anywhere nearly as effectively as they  
10 could be, and a lot of it has to do with the payment system.  
11 I'm sort of repeating a lot of things that have already come  
12 up, but it's so important that I think we've got to keep it  
13 in the forefront, because if we just operate on the basis of  
14 the structures that we've used, we're just going to get  
15 ourselves deeper in the hole, I think.

16           And I guess just on that, PAs and nurse  
17 practitioners can do a tremendous amount. They've saved my  
18 practice many times. On the other hand, the reality is that  
19 today, the majority of PAs and nurse practitioners are going  
20 into specialty practice and not into primary care, so I  
21 don't know. We could go on forever on this. But we really  
22 need some major restructuring. I'm a little hesitant -- I

1 mean, we could get into a long discussion even on the time  
2 issues. I think, to me, that's a waste of time, because I  
3 don't think we'll ever get it right and it's the wrong  
4 direction in terms of really moving the incentives toward a  
5 more efficient system.

6 MR. HACKBARTH: I agree, Tom. Although I think  
7 the primary care bonus is a good thing to do, I think we  
8 need a change in the payment method for primary care. I  
9 don't think it's a service that's best purchased or funded  
10 on a fee-for-service basis, as Bob Berenson and many other  
11 people have argued. A medical home is an effort to begin  
12 directing moving us towards a new way of purchasing primary  
13 care.

14 Okay, time to vote. So will we put the  
15 recommendation up, and I think we just have one this time,  
16 correct? All in favor of the recommendation on physician  
17 update, please raise your hand. I forgot to raise mine.

18 All opposed?

19 Abstentions?

20 MR. HACKBARTH: Okay. Thank you very much.

21 I've got us behind schedule again.

22 So, the last session before lunch is Ambulatory

1 Surgery Centers.

2 DR. ZABINSKI: Today, Ariel and I are going to  
3 discuss payment adequacy in ambulatory surgical centers, or  
4 ASCs, and before we start, we'd like to thank Hannah Miller  
5 for her excellent assistance on this project.

6 As we begin our discussion of payment adequacy,  
7 important factors to remember about ASCs include per set  
8 total Medicare payments to ASCs in 2008 with \$3.1 billion.  
9 The total number of fee-for-service beneficiaries served in  
10 2008 was 3.3 million.

11 ASCs are a source of revenue for many physicians,  
12 as 90 percent of ASCs have some degree of physician  
13 ownership. Also, CMS substantially revised the ASC payment  
14 system in 2008, linking the payment for most services to the  
15 payment rates in the outpatient perspective payment system,  
16 and increasing the number of services covered by 32 percent  
17 and allowing for separate payment for many services that had  
18 been packaged into the payment rate for the associate  
19 surgical service.

20 Finally, ASCs will receive a payment update of 1.2  
21 percent in 2010, which equals the full CPIU as mandated  
22 under current law.

1           Over the coming slides, we will discuss some of  
2   our standard measures of payment adequacy, including  
3   beneficiaries' access to care and the supply of ASCs, ASCs'  
4   access to capital, and Medicare payments to ASCs; however,  
5   we were not able to evaluate ASCs quality or costs because  
6   ASCs do not submit those data to CMS.

7           We have found evidence that indicates that access  
8   to and supply of ASC services has been increasing in recent  
9   years. Looking at the first row of numbers on the table,  
10   from 2003 through 2007, the number of fee-for-service  
11   beneficiaries served grew at a robust rate of 6.4 percent  
12   per year. This growth slowed to 2.8 percent in 2008, but  
13   this number was held down because total fee-for-service  
14   enrollment declined by 2 percent in 2008.

15           In the second row, you can see that, over 2003  
16   through 2007, service volume for fee-for-service  
17   beneficiaries increased by 10.2 percent per year, and growth  
18   in this measure remained high at 10.5 percent into 2008.

19           The third and fourth rows show that the number of  
20   ASCs increase at a robust rate over 2003 through 2007, but  
21   that growth slowed in 2008, and is slowing in the growth of  
22   the number of ASCs maybe due to the downturn in the capital

1 markets in the economy that occurred at the end of 2008.

2 Also, it's plausible that some investors are  
3 waiting to see how the revised payment system implemented in  
4 2008 affects the existing ASCs before they enter the market.

5 And now, Ariel will talk about some demographic  
6 profile of the beneficiaries who receive ASC services.

7 MR. WINTER: At last month's presentation, George  
8 asked us to examine the payer mix and patient mix of ASCs  
9 and hospital outpatient departments. The available evidence  
10 shows that ASCs are less likely to treat Medicaid patients  
11 than hospital outpatient departments.

12 The first evidence we have comes from a 2005  
13 survey conducted by the Medical Group Management  
14 Association, which includes responses from about 100 ASCs in  
15 multiple states. This survey found that Medicaid accounted  
16 for 4 percent of the average ASC's patients in 2005, while  
17 Medicare and commercial plans accounted for about 87  
18 percent.

19 These numbers are similar to data collected by  
20 Pennsylvania in 2008, which showed that Medicaid patients  
21 accounted for 3.4 percent of ASC procedures, compared with  
22 10.4 percent of HOPD procedures.

1           Commercially insured and Medicare patients  
2 represented about 87 percent of ASC services versus 79  
3 percent of HOPD services.

4           We also looked at a study conducted by John Gabel  
5 and colleagues that examined referral patterns for  
6 physicians in Pennsylvania who sent most of their outpatient  
7 surgery patients to physician-owned ASCs. These physicians  
8 referred more than 90 percent of their commercial and  
9 Medicare patients to an ASC rather than a hospital, compared  
10 to only 55 percent of their Medicaid patients.

11           This table presents results from an analysis we  
12 did using Medicare claims data. Among Medicare  
13 beneficiaries who receive care in ASCs, 13 percent were dual  
14 eligibles -- in other words, they also had Medicaid  
15 coverage. Among beneficiaries who were treated in HOPDs, 21  
16 percent were dual eligibles.

17           Other groups who were less likely to receive cares  
18 in ASCs than HOPDs included African Americans, beneficiaries  
19 under age 65 who are eligible because of disability, and  
20 beneficiaries who are age 85 or older.

21           The fact that ASCs are less likely to treat dual  
22 eligibles and less likely to treat patients who have more

1 comorbidities, they help explain why they treat a lower  
2 share of African American and older beneficiaries.

3 Now, go back to Dan.

4 DR. ZABINSKI: Another measure of payment adequacy  
5 is access to capital. For ASCs, the best measure of access  
6 to capital is the net change in the number of ASCs in a  
7 given year; that is, the number of new ASCs minus the number  
8 of ASCs that closed.

9 As we saw earlier, growth in this measure over  
10 2003 through 2007 was strong, but that slowed in 2008, which  
11 was caused, at least in part, by the downturn in capital  
12 markets in the general economy, but those downturns are  
13 unrelated to Medicare payments, so changes to access to  
14 capital in 2008 may not be a good indicator of payment  
15 adequacy for that year.

16 Our analysis also shows that payments to ASCs has  
17 been growing at a strong rate. Over 2003 through 2007,  
18 payments per fee-for-service beneficiary increased by 8  
19 percent per year. The strong growth continued into 2008,  
20 increasing by 9.7 percent over the 2007 level , and the  
21 services that were newly covered in 2008 under the revised  
22 payment system accounted for 2.9 percentage points of the

1 2008 growth.

2           As part of our analysis, we found that the number  
3 of surgical services per beneficiary and the number of  
4 beneficiaries served has grown quickly in ASCs but has  
5 remained largely flat in HOPDs, which is the sector with the  
6 greatest overlap of surgical services with ASCs. This may  
7 suggest that migration of surgical services from HOPDs to  
8 ASCs, which may present some benefits.

9           In particular, ASCs may offer efficiencies for  
10 both patients and physicians relative to HOPDs. In  
11 addition, cost per service and cost sharing per service are  
12 lower in ASCs than in HOPDs; therefore, a shift of services  
13 from HOPDs to ASCs has the potential to reduce aggregate  
14 program spending and aggregate beneficiary cost sharing.  
15 However, we are also concerned that the ASC/ growth does  
16 have the potential to increase the total volume of  
17 outpatient surgical procedures, which could in turn increase  
18 program spending and beneficiary cost sharing.

19           For example, most ASCs have some degree of  
20 physician ownership, and this could raise the possibility  
21 that physicians have an incentive to perform more procedures  
22 than they would if they had to provide all outpatient

1 surgical services in HOPDs.

2 An important issue regarding ASCs is that, in  
3 contrast to other healthcare facilities, ASCs do not submit  
4 cost or quality data to CMS. However, these data are  
5 important for three reasons:

6 First, they would allow us to fully evaluate the  
7 adequacy of Medicare payments to ASCs; they will allow for  
8 payments to be based on quality; and it would allow for an  
9 effective evaluation of an ASC market basket. This final  
10 point is important because, as we discussed at the December  
11 meeting, the variable that CMS uses to estimate CMS cost  
12 growth, the CPI-U, may not be an accurate measure.

13 So, to summarize our analysis of payment adequacy,  
14 our measures indicate that access to ASC services has been  
15 increasing and that ASC access to capital has been at least  
16 adequate.

17 In addition, we lack cost and quality data to do a  
18 fully effective evaluation of payment adequacy.

19 And as the Commission considers an update on ASC  
20 payment rates, several goals should be balanced. On the one  
21 hand, you want to maintain beneficiaries access to ASC  
22 services by paying providers adequately so that they are

1 willing and able to render services, but at the same time,  
2 you want to hold down the burden on taxpayers, maintain  
3 Medicare sustainability and keep providers under financial  
4 pressure to hold down their costs.

5           Then, in response to the Commission's discussion  
6 at the December meeting, we have the following draft  
7 recommendation: The Congress should implement a 0.6 percent  
8 increase in the payment rates for ambulatory surgical center  
9 services for calendar year 2011.

10           In addition, the Congress should require ASCs to  
11 submit to the Secretary cost data such as through a random  
12 sample of ASCs and quality data from all ASCs.

13           In regard to the first part of the recommendation,  
14 given our findings of payment adequacy and our stated goals,  
15 we believe a moderate update is warranted. Also, the  
16 patterns of access measures haven't changed much since last  
17 year; therefore, we propose last years recommended 0.6  
18 percent update.

19           In regard to the second part of the  
20 recommendation, the Commission has recommended in the past  
21 that ASCs submit cost data to the Secretary.

22           And in a response to a request by Bob and Glenn in

1 December, we have modified the recommendation to recognize  
2 the potentially large burden on CMS and ASCs from collecting  
3 cost reports from all ASCs. Therefore, we suggest that cost  
4 data be collected through a random sample.

5           Finally, in regard to the quality data, the  
6 Secretary does have the authority to collect quality data  
7 from ASCs, and quality measures are available, but CMS has  
8 decided to delay the collection of that quality data to  
9 allow ASCs time to get adjusted to the revised payment  
10 system.

11           Implications of spending for this recommendation  
12 are that ASCs are poised to receive an update in 2011 equal  
13 to the projected CPI-U of 1.4 percent. Therefore, this  
14 recommendation would produce small budget savings of less  
15 than \$50 million over 1 year and less than \$1 billion over 5  
16 years.

17           For beneficiaries and providers, we found strong  
18 growth in the number of ASCs and the number of beneficiaries  
19 treated in ASCs, as well as providers being willing and able  
20 to furnish services under the revised payment system  
21 implemented in 2008. Therefore, we anticipate this  
22 recommendation having no impact on beneficiaries' access to

1 ASC services or providers' willingness or ability to furnish  
2 those services.

3 And now, we turn things over to the Commission for  
4 their discussion.

5 MR. HACKBARTH: Perhaps you guys mentioned this  
6 while I was out, but I just wanted to go back over the CPI-U  
7 as the statutory index for the update.

8 In past discussions, and I think this goes back at  
9 least a year, we said the CPI-U doesn't make much sense as  
10 the index for ASC services, in part because it's a much more  
11 volatile factor. It includes consumer products, gasoline,  
12 and all those things, and as recent times have shown, with  
13 the economy, those numbers jump around a lot. They are  
14 quite sensitive to factors that really aren't relevant for  
15 how much ASCs should be paid. And so, we need, as the  
16 recommendation says, to get on with the task of developing a  
17 better index for ASCs.

18 The reason I wanted to highlight this is to  
19 highlight the fact that a recommendation here is a number as  
20 opposed to market basked minus something. And the projected  
21 CPI-U is 1.4 percent and so the .6 is not the statutory  
22 market basket minus productivity; it's a different number,

1 because we believe that it would not be appropriate to peg a  
2 recommendation to a volatile consumer price index. And so,  
3 this is a number not linked to a formula that seems a  
4 reasonable increase to me given all of the payment adequacy  
5 factors. So, I just wanted to make that explicit.

6 Can I see hands for clarifying questions.

7 DR. CASTELLANOS: Just two clarifying questions.  
8 I read, but I can't find it, that MedPAC previously  
9 recommended that ASC rates be dated to hospital outpatient  
10 rates.

11 MR. HACKBARTH: That was -- what we specifically  
12 recommended -- actually, I should shut up and let Ariel --

13 MR. WINTER: Recommended not that the rates should  
14 be the same, but rather the two payment systems should be  
15 harmonized and made more consistent, and we're referring  
16 there to the procedure groupings and the relative weights,  
17 not that the rates themselves should be equal.

18 MR. HACKBARTH: Yes, so the conversion factors are  
19 different.

20 MR. WINTER: Right.

21 MR. HACKBARTH: But the relative values are --

22 DR. CASTELLANOS: That was the recommendation.

1           And second one is, as you said, 90 percent of  
2 these have some degree of physician ownership, I was  
3 wondering, do you have any percentage of joint ownership,  
4 hospitals and physicians, because there's a good percentage  
5 of hospitals that also participate in this.

6           MR. WINTER: Yes. The MGMA asks about ownership  
7 and they ask about joint ventures, but they don't specify --  
8 the way they report the data doesn't specify whether it's  
9 for the hospitals or corporate entities. So, we really  
10 can't distinguish between the two.

11           I think the estimate was 20 to 30 percent. I  
12 mean, it was fairly high but they don't distinguish between  
13 hospitals versus corporate chains.

14           DR. KANE: So, historically, Congress set the  
15 rates for ASCs and said they shouldn't go -- I mean, what  
16 was the historic update that Congress had in law before we  
17 took over this function?

18           MR. WINTER: The statute was that CMS -- the  
19 Secretary was supposed to rebase ASC payments every five  
20 years. And in between that rebasing, they were supposed to  
21 provide a CPI-U -- an update equal to the increase in the  
22 CPI-U. However, there were several statutory reductions to

1 that CPI-U update. The BBA reduced them for five years.  
2 So, for those five years it was either zero -- between zero  
3 and 1 percent. The MMA eliminated them for 6 years, from  
4 2004 through 2009.

5 And so, there was this -- the default was the CPI-  
6 U, but in fact the default rarely was the actual update.

7 DR. KANE: So, I guess, if you look at the history  
8 of this sector and its expansion and its increasing numbers  
9 of volume per beneficiary, why would we raise it at all and  
10 not just stick with the zero that historically has been so  
11 successful in generating an enormous growth in this  
12 industry?

13 MR. HACKBARTH: Let me address that.

14 As always, what we're trying to do or what I'm  
15 trying to do -- whether you folks agree is another question  
16 -- what I'm trying to do is strike a balance. I think the  
17 fact that we have had significant growth is an indicator  
18 that the rates are probably not absurdly low.

19 On the other hand, it's always important to keep  
20 in mind that there are other factors driving this growth  
21 other than people just seeking profit, and there are changes  
22 in technology, changes in anesthesiology that mean that more

1 patients can be appropriately treated in outpatient  
2 settings.

3 And so, there are legitimate reasons for a lot of  
4 this growth, and as somebody who ran a physician group,  
5 including a large surgical practice, I know why our  
6 physicians love to work in ASCs, because they could be much  
7 more productive, and I wanted them to be much more  
8 productive, and so, those are very legitimate reasons.

9 Now, if we had zero update, would it mean that,  
10 oops, they'd stop treating Medicare patients or that  
11 positive growth would turn negative? I do not think it  
12 would, at least not in the short run. It does seem to me  
13 that after years of zero a modest update is the reasonable  
14 thing to do, and .6, I think, is such a modest update.

15 DR. KANE: I'm not saying it's inappropriate that  
16 they've had the growth. I'm suggesting perhaps that --  
17 first of all, we don't have their cost reports, so we really  
18 don't know what's going on the productivity side or on the -  
19 - and I would guess -- I mean, I would think there are  
20 technological changes that are pushing things into  
21 ambulatory surgery center, having observed some of them  
22 myself with family surgeries, is that they're cheaper and

1 easier to do and much more easy to schedule, bang, bang,  
2 bang, bang, bang without a whole lot of emergency  
3 intervention.

4 I mean, in other words, I think it probably is  
5 quite a bit cheaper to do it. And, as you say, physicians,  
6 it's much more convenient and allows them to see many more  
7 patients in a window. And I'm just thinking one reason we  
8 see this enormous growth is probably because the rates are  
9 not only adequate but the cost to function is moving down,  
10 not up. And so, I'm just reluctant to give an update  
11 without any information on the cost side. That's all.

12 I mean, I agree there are wonderful reasons why  
13 it's happening, but I'm just wondering if we're really  
14 keeping up with the cost function side, given that it is  
15 technologically driven and is lower cost and has higher  
16 volume and higher productivity for the physician.

17 MR. HACKBARTH: Just a couple of reactions.

18 Just to be absolutely clear, and I know you know  
19 this, we don't pay the same rate even though the relative  
20 values are synchronized with hospital outpatient department  
21 services, we're paying less when the services are provided  
22 in ASCs.

1           If Mike Chernew were here, I'm sure he would renew  
2 the point that he made at the last meeting, which was that  
3 he's concerned about growing disparities in what we pay for  
4 the same service depending on the location of that service,  
5 and he was actually concerned about our squeezing -- causing  
6 that gap to grow by providing more in the hospital  
7 outpatient department than we do for ASCs.

8           The solution to that problem is to pay at the  
9 lowest provider -- the words that you're mouthing, which may  
10 be to pay everybody at the ASC rate. The challenge there is  
11 that -- as I said earlier, I run a group that did a lot of  
12 this business, and we knew that the patients we were  
13 treating in the ASCs were different from the ones that we  
14 were sending to the hospital. The procedure may be the  
15 same, but the patients are different. We were sending the  
16 easy cases to the ASCs and the patients where we might have  
17 complications, we might need backup, we were doing it to  
18 bring them in the hospital outpatient department. And so,  
19 there is some unmeasured selection here.

20           So, we've got a lot of imprecision in these  
21 parallel payment systems. Over time, we need to try to  
22 better synchronize them. All things considered, again, I

1 think this is a reasonable number.

2 MS. BEHROOZI: This is a really boring clarifying  
3 question, sorry about that.

4 On the recommendation, spending implication, in  
5 the paper it made it clear that because the assumption would  
6 be CPI-U that this is actually a savings, this is a  
7 decrease, in anticipated spending, the \$50 million for one  
8 year. I'm not sure it's clear on the slight, right?

9 MR. WINTER: Yes.

10 MS. BEHROOZI: Yes. It looks like it is  
11 additional spending rather than a decrease in spending,  
12 right?

13 MR. GEORGE MILLER: If you could put up slide 6  
14 and let me see if I can amplify on a couple things that  
15 Nancy said to bring clarity, at least in my mind, on this  
16 issue, because, Glenn, to your last points, though, while  
17 Michael talked about paying all providers the same, in my  
18 view you have to be in the same game and all things should  
19 be equal. The hospitals are required to have a lot more  
20 things than the ambulatory surgery center, including the  
21 quality point.

22 We hire staff to generate all that information;

1 currently, the ASCs don't. We have to have an ER; they  
2 don't. And this slide will hopefully make part of my point.

3           There is a significant difference between the  
4 makeup of the patients that the ASC choose and they don't  
5 choose, and they have the capability of making that  
6 selection, and most community hospitals or rural hospitals  
7 don't have that choice to self-select, as you just said, for  
8 any number of reasons.

9           I'm struck by the difference between the Medicaid  
10 patients that they select or don't select between the two.  
11 That is a significant difference, and I'm concerned about  
12 the statement that there's complete access. Well, it's not  
13 complete access for all beneficiaries, if you look at the  
14 ratio composition. And I don't understand why that would be  
15 a difference, especially if you're still serving the same  
16 population. I realize in ASC we're only talking about 20  
17 percent of the total volume is Medicare; am I correct on  
18 that?

19           DR. ZABINSKI: Yes.

20           MR. GEORGE MILLER: Just 20 percent, okay.

21           But, and these numbers on this document is all  
22 patients; correct?

1 DR. ZABINSKI: Yes.

2 MR. GEORGE MILLER: Okay.

3 MR. WINTER: All Medicare.

4 DR. ZABINSKI: It's all Medicare patients.

5 MR. GEORGE MILLER: These are only all Medicare?

6 DR. ZABINSKI: Yes.

7 MR. GEORGE MILLER: Well, this even makes my point  
8 even stronger, right?

9 So, how do we say that all Medicare beneficiaries  
10 have great access when, according to this graph, and I  
11 appreciate you doing this, they don't?

12 DR. MARK MILLER: I think the --

13 MR. GEORGE MILLER: They don't.

14 DR. MARK MILLER: No, I hear you. I hear you.

15 MR. GEORGE MILLER: Okay. I'm sorry.

16 DR. MARK MILLER: We're not arguing yet.

17 MR. GEORGE MILLER: No, we're not.

18 DR. MARK MILLER: I mean, I think this goes back  
19 to the question that came up in the physician analysis. I  
20 mean, I think the blanket statement is, when you look at the  
21 numbers of users per enrollee in the program and you look at  
22 the volume of services, there's no indication that, for the

1 Medicare population broadly, and I'll come to your point in  
2 just a second, that this is going down or slowing down.  
3 It's still pretty much headed north.

4           Like some of the other conversations we've had on  
5 the physician side, that's a statement about national  
6 trends, and what we're trying to illustrate here is that  
7 you've picked up on a different point. We're trying to say,  
8 it's a different mix of population, going to these relative  
9 to the hospital, which is a point that you've made, and then  
10 you've said, and on top of that, there are differences of  
11 who makes it.

12           So, the access point is a national trend point.  
13 You, like in the physician world, are picking up on the fact  
14 that that's not every market, every person, in this case  
15 particular groups of people.

16           So, I think you're right, it does make that point,  
17 as well.

18           MR. GEORGE MILLER: Then, I guess I agree with  
19 Nancy. Quite frankly, then, if all Medicare beneficiaries  
20 don't have the equal access, why do we give them an update  
21 and the program is growing by leaps and bounds?

22           DR. MARK MILLER: Well, again, that kind of goes

1 back to the balance point which you -- I mean, the hard part  
2 of this, as much as -- we've talked about this between you -  
3 - among ourselves and between you. I mean, this always  
4 comes down to, in the end, we can put up data, but you guys  
5 actually have the hard job of drawing a judgment.

6           And to the exchange between Glenn and Nancy, I  
7 mean, the other point -- the last time we went through and  
8 talked about this and got to this midpoint, there were  
9 concerns expressed on the other side of the argument which,  
10 like Glenn mentioned, how far do we want these rates to  
11 drift apart, and a little bit of the driving blind, we don't  
12 have the cost data.

13           In some ways, you can interpret that as, like,  
14 well, no update until you give me the cost data. This is  
15 pressure to get the cost data, that type of thing. But  
16 that's what the judgment is, is striking a balance between  
17 all of those kinds of factors. And there were some  
18 arguments on the other side. I haven't heard them here  
19 today, but there were some arguments on the other side when  
20 we considered this last time.

21           MR. KUHN: Just one clarifying question on the  
22 issue of the CPI-U.

1 I've heard it referenced as a statutory  
2 requirements, but as I recall, when CMS put the provisions  
3 in place, that was a discretionary decision on CMS. So, is  
4 that correct?

5 DR. ZABINSKI: Yes, it's sort of a default. If I  
6 read the law correctly, it's that CMS can do anything it  
7 wants, but if it doesn't do anything, then it's the CPI-U,  
8 and CMS has just decided to do nothing.

9 MS. HANSEN: Same chart here, probably the point  
10 on age. This is a question more on when people are more  
11 complex, and oftentimes, the people who are 85 plus, here,  
12 might be.

13 Is there a risk adjusted rate that goes along with  
14 it?

15 DR. ZABINSKI: No.

16 MS. HANSEN: No? Because if that's the case, one  
17 of the things I think I would support, George, and as we  
18 continue to array information on all these kinds of programs  
19 where there seem to be some selection of subgroups to be  
20 treated and other groups that perhaps go back to hospitals  
21 or outpatient departments, I'd like to keep this kind of  
22 visible tracking there, because it does convey who people

1 would prefer doing, and I can understand if somebody can get  
2 to a doctor's office on their own easily and not be  
3 confused. You can really do the scheduling of the  
4 procedures quickly, but it does convey an access slash some  
5 aspects of consideration of quality by virtue of whether --  
6 to George's point about race and ethnicity, but in my case,  
7 you know I tend to bring up the whole issue of older people  
8 with multiple complex issues.

9           So, I appreciate this chart a lot and I just hope  
10 that we continue to keep it front and center as to what it  
11 means for access.

12           MR. WINTER: And we've done our own research into  
13 the issue of medical complexity and comorbidities and  
14 research that we funded with RAND, and we could bring some  
15 of those findings into the paper to flesh that out more.

16           And in terms of the risk adjustment question,  
17 there is no risk adjustment within ASCs for ASCs that chose  
18 more or less medically complex patients or older patients,  
19 but one could argue that some of the 40 percent differential  
20 between the outpatient conversion factor and the ASC  
21 conversion factor might reflect a difference in the severity  
22 of patients.

1           MR. HACKBARTH: It seems like we've had round one-  
2 and-a-half, here. Hopefully, that means that round two will  
3 be quick.

4           DR. BORMAN: You mention in the draft chapter the  
5 potential here for geographic confounding because of the  
6 heavy concentration of ASCs in five states, and I just  
7 wonder, we've mentioned in the past a little bit about  
8 periodically considering the effect of geographic or  
9 regional variation, and I just wonder -- it might be  
10 interesting, it might be totally nonproductive at some point  
11 to know if we can tease out an effective geography here, so  
12 that where there's not a whole lot of ASCs, is the  
13 differential the same? Does it reflect some inherent  
14 property, as we have all posited a bit about the nature of  
15 the patient, the nature of the procedure, the kinds of  
16 things a physician can achieve by concentrating his or her  
17 procedures there, or is it as much a reflection of the local  
18 market and the forces in the regional market.

19           DR. ZABINSKI: Just one point on Karen's comment.

20           One thing we did here is that we weighted the ASC  
21 population so that the states that have a lot of ASCs don't  
22 disproportionately count more than states that don't. I

1 think that might eliminate some of your concern, but I don't  
2 know if it does all of it.

3 MR. BUTLER: So, on behalf of George, one more  
4 comment on this.

5 I think if you looked at the Medicaid spread in  
6 particular and you were to take out the 20 or 30 percent of  
7 the ASCs that were -- where there's a hospital ownership,  
8 that number would drop a lot more, because most hospitals  
9 that are participating in joint ventures feel obliged  
10 because of their tax exempt status and their threats to make  
11 sure that they accommodate the same kinds of payer mix they  
12 are having in their hospital themselves. So, I think if you  
13 separated that out, you'd see a different payer mix in the -  
14 - I'm not saying it would be as high a percentage as in  
15 their hospital outpatient, but you would see a Medicaid  
16 presence in the way that you don't in some of the  
17 freestanding ones without hospitals' involvement.

18 DR. CASTELLANOS: First of all, I own an ASC, and  
19 I'm very proud of it because it allows me to provide an  
20 expert service to my patients expediently with good quality  
21 and cost containment. I have nothing to be ashamed about  
22 that at all. Similar to Glenn's comments, it really helps

1 the physician community.

2 I remember Bob Reischauer, we had this comment,  
3 and one of his comments were -- and I really appreciated  
4 that -- he said, it didn't really make a difference where  
5 the site of service was, what's important is the  
6 appropriateness. What's the best site to take care of that  
7 patient? And I think we need to focus into that a little  
8 bit.

9 From a MedPAC viewpoint, as we all know, we're  
10 prudent spenders of the taxpayers' money. Now, the data I'm  
11 going to give is I have not verified it. I got it from  
12 something that was circulated by the ASC community. There  
13 is a -- Medicare spending alone was 42 percent by doing  
14 these cases in the ASC. For the beneficiary, because of  
15 copayments, there's a savings of almost 56 percent. And to  
16 switch back from the ASC to the hospital is going to be a  
17 cost of 72 percent to the Medicare.

18 So, I think we need to consider that, also, but I  
19 think most importantly, we need to think about what Bob  
20 said, where it is most appropriate to do that patient.

21 DR. KANE: I mean, I'm still just not convinced,  
22 and I have nothing against ASCs, I think they're wonderful,

1 but I just don't feel that the update, particularly when you  
2 look at the updates for the post-acute sector, where there  
3 are largely zeroes, and largely because we say, hey, they're  
4 growing fast, therefore profit, the volume per beneficiary  
5 is -- and we're sort of saying -- but we can happen to  
6 measure their profits there, so we're giving them a zero  
7 update. I'm having trouble, and Mike's not here, but I  
8 don't think giving it a zero update affects this issue of  
9 the proper site. I think people are doing -- physicians  
10 have every desire to put the patient in the right site,  
11 because if they can get them in the ASC, they can do a much  
12 more efficient -- they can have a much more efficient day.

13           So, I'm not so worried that we're going to lose  
14 Medicare access to ASCs, I'm just thinking in this -- given  
15 our rationale for zero updates in some of the other sectors,  
16 I don't -- I am just not yet convinced that there should be  
17 a positive update in the ASCs, and I'm still waiting for  
18 that, oh -- and I hear you, that after eight years, maybe  
19 it's just time, but it is nowhere as near convincing as some  
20 of the other arguments we've had, and so -- and we've given  
21 zero updates quite a bit in the post-acute sector, too. So,  
22 I don't -- I'm just trying to get the consistency of the

1 argument for why there should be an update in this sector  
2 and not in, say, the SNF, where there's also a very  
3 different case mix in the hospital versus the --

4 MR. HACKBARTH: Just one clarification on that  
5 point. In the number of the post-acute sectors, we've  
6 recommended zero updates for a number of years, but they  
7 have not received zero updates. They have, in fact,  
8 received significant updates from the Congress.

9 Here, when we talk about zero updates, we're  
10 talking about what they actually got, zero updates for a  
11 long period of time.

12 Now, that's not necessarily dispositive of your  
13 issue, but I just wanted to make that contextual point  
14 clear.

15 DR. MILSTEIN: As you have pointed out, this is  
16 because we have so little objective -- we have a shortage  
17 relative to our usual update recommendations, objective  
18 facts on which to base our recommendation and therefore  
19 we're left with subjective factors, and I'm sure -- and  
20 notions -- including notions of fairness between providers  
21 and consistency. And I have to say I share Nancy's view  
22 that, given, when I look at the full array of what's here, I

1 would be more inclined in view of the limited facts we do  
2 have toward a zero update.

3 Another option that occurs to me would be, if  
4 we're going to be what some of us may regard as more  
5 generous in relation to this sector, should we up the ante  
6 in terms of what we want back?

7 I mean, Ron's pointed out, someone who is really  
8 an insider, that there's a major problem in this potentially  
9 larger problem in this sector with appropriateness, and  
10 should we up our trade so that we're giving essentially a  
11 blind .6 percent, which to my mind seems more generous than  
12 -- and somewhat inconsistent with some of our other  
13 categories, but the notion is the trade is cost data, random  
14 sample, quality, and use this sector as our maiden voyage,  
15 as it were, to collect appropriateness data. So, we've  
16 never had a meter for appropriateness, it's not easily done,  
17 but there are certainly ways that the specialty societies  
18 have approached this. And we also, when listening to our  
19 presentations on shared decisionmaking, appreciate there's  
20 really two dimensions of appropriateness. It's, A, does it  
21 meet professional guidelines; and, B, granted that it meets  
22 professional guidelines, has the patient really had a

1 balanced discussion of risks and benefits versus a non-  
2 neutral -- so, two different notions, and I will -- again, I  
3 mean, you have to keep the process moving in terms of  
4 whether it's too late or something like that.

5 MR. HACKBARTH: It seems to me that the cost  
6 report and the appropriateness are maybe a little bit  
7 different. So, let me just explore that.

8 One way to approach this would be to rephrase the  
9 recommendation and say .6 only if cost reports are  
10 concurrently required by legislation, with CMS left to  
11 address the issues about making that as efficient as  
12 possible and avoiding unnecessary burden.

13 We have some concreteness about cost reports and  
14 what that might entail. The appropriateness thing strikes  
15 me as a bit different. That's more imagining something that  
16 we'd like to see that doesn't necessarily exist on the shelf  
17 anywhere.

18 Ron and I talked about the importance of  
19 appropriateness and I absolutely agree in principle. I am  
20 maybe a little bit more suspicious of specialty developed  
21 appropriateness standards than others might be. In fact, I  
22 fear that that whole path leads to justification of low-

1 value services developed by people that have an interest in  
2 more of those low-value services.

3 So, I want appropriateness guidelines but I want  
4 them developed based on the best available evidence and I  
5 wish we were further along on that. I don't think that  
6 we're going to have that next year.

7 DR. MILSTEIN: Can I modify my recommendation and  
8 borrow from one of Jay's solutions in the last session and  
9 say that we would like the span of quality reporting to  
10 include appropriateness subject to the Secretary's  
11 determination of its feasibility. That way, I have a  
12 different view: I think it probably could move in that  
13 direction. I completely support your notion as to what the  
14 basis of judgment of appropriateness ought to be.

15 MR. HACKBARTH: I saw you nodding your head  
16 earlier, concurring with a change that said, .6 only in the  
17 context of cost reporting data.

18 So, we'll come back and take a vote and who would  
19 like --

20 DR. MILSTEIN: Plus the equality.

21 MR. HACKBARTH: Plus the equality, yes.

22 Let's finish the other comments, first.

1 DR. BERENSON: Yes, I'm persuaded that, after  
2 years of zero updates, a pretty modest increase is  
3 warranted, and if we then tie it to now new burdens to  
4 produce some data, I think that's -- I could support that.

5 I could just say, and this is for a future  
6 discussing, and in the context of the physician fee  
7 schedule, I've focused on imaging services where there is  
8 huge volume growth and we're not able to capture the issue  
9 of fixed cost being spread over much larger volume and  
10 making any adjustments when you have major equipment. It  
11 seems to me ASCs are a comparable situation where you have -  
12 - if in fact we can isolate how much of the volume is from  
13 new facilities versus how much is from increased volume at  
14 established facilities, I think we have an issue where we  
15 could learn and maybe make some adjustments with cost  
16 reports about the difference between average and marginal  
17 costs.

18 So, none of that is relevant for today's  
19 recommendation, but I do think that this is a ripe area for  
20 understanding a little more about that volume/marginal cost  
21 tradeoff.

22 DR. SCANLON: Yes, I'm not convinced that the

1 random sample is a good way to deal with the burden. I  
2 mean, filing a cost report is not the same as responding to  
3 a survey where somebody calls you up and you give your  
4 instantaneous answer, but if it was a constant sample, then  
5 the people that are in the sample know that they've got to  
6 keep their books a certain way and then it's not going to be  
7 an issue, but then there's the drawbacks of a constant  
8 sample.

9           So, I think that designing a relatively efficient  
10 cost report and one that's going to readily -- easy to  
11 complete -- would be an approach in terms of trying to  
12 reduce the burden on the facility.

13           In terms of CMS, there's the issue of rolling  
14 oversight and not attempting to audit all cost reports every  
15 year but to sort of move through the universe over time,  
16 auditing so that you both provide instruction in terms of  
17 how this should be done, and secondly to assure the  
18 integrity of the data, and you could even think about when  
19 you want to have an estimate for policy purposes, you deal  
20 with the audited cost reports or you deal with the audited  
21 cost reports and an audit adjustment to the unaudited ones.

22           So, I guess I take a different tact to trying to

1 make the burden smaller, but insisting on getting the cost  
2 issue.

3 MR. HACKBARTH: Yes, and I think those are good  
4 points.

5 So, what I hear you saying is that there are  
6 multiple variables, multiple dials that you can twist with a  
7 goal of minimizing the burden while still collecting  
8 necessary data, and I don't think that we should try to spin  
9 those dials here, and what I would envision is that we would  
10 include a paragraph that says, in essence, they ought to be  
11 looking at those dials to try to find an appropriate minimal  
12 burden that we need reliable information these dimensions.

13 MS. BEHROOZI: I just want to highlight a line in  
14 the draft on page 20, which is the only evidence we have of  
15 cost-to-revenue balance, where it says, in Pennsylvania  
16 where there was a study done, ASCs' average operating  
17 margins from 2007 to 2008 increased from 24.1 percent to 26  
18 percent.

19 So, I thought it was around two issues, but I'm  
20 glad you raised it around one. I wasn't sure where the .6  
21 came from, in light of the only evidence we have is that,  
22 yeah, this lower-cost alternative is producing savings, but

1 they're going to the providers rather than to the Medicare  
2 program.

3           So, I don't have a problem with a gap between  
4 HOPD and ASC rates. I don't have a problem with them  
5 growing. I'm happy that beneficiaries have a lower-cost  
6 alternative in terms of their cost sharing, and I think that  
7 the Medicare Program should be getting the benefit of the  
8 lower-cost alternative.

9           As far as appropriateness, being -- we certainly  
10 don't want the appropriateness determination being driven by  
11 that kind of profit available to the providers, and until we  
12 have an ACO kind of payment model where the provider has the  
13 incentive to chose the lower-cost alternative, but Medicare  
14 is also not paying too much for it, I think we have to live  
15 with the silos like we do in post-acute care where you're  
16 paying very different rates to different types of providers  
17 for providing what might be considered the same service,  
18 even if it is to different types of patients.

19           So, having said all of that, yes, I also would  
20 have supported a zero or, as Mike or somebody once said, can  
21 we do negative updates, but -- not because I want to punish  
22 them, but it seems like there's a lot of extra money in it,

1 but that's not necessary and I understand they haven't  
2 gotten updates in a long time, and I think with the  
3 modification that there's a requirement of cost and quality  
4 data attached to it, I would support the .6.

5 MR. HACKBARTH: I'm going to come back for a show  
6 of hands on a couple of questions here in a minute.

7 But Dan, do you want to just say a little bit more  
8 about that Pennsylvania data?

9 DR. ZABINSKI: Yes, right.

10 The size of the margins for the ASCs is -- the  
11 difference between those margins and the margins, say, for  
12 hospitals, isn't as great as meets the eye, because the ASC  
13 margins -- let's see, they pay the physician owner's  
14 salaries out of that, and then taxes come -- then the owner  
15 pays income taxes on top of that. While for the hospital,  
16 that sort of costs is already reflected in the margin  
17 itself. So, it's not as great as meets the eye.

18 MR. HACKBARTH: That the Pennsylvania data doesn't  
19 include all of the costs for --

20 DR. ZABINSKI: It includes different costs than  
21 what are included in a hospital operating margin because --  
22 or it excludes some costs because it's not anything they can

1 really track.

2 MR. HACKBARTH: And the Pennsylvania data are for  
3 private patients or for Medicare patients or some  
4 combination?

5 DR. ZABINSKI: It's for all patients. It's for  
6 all patients.

7 MR. HACKBARTH: Other round two comments.

8 MR. BUTLER: I'm chomping at the bit.

9 I'm a little concerned at the direction we're  
10 headed. The difference between .6 and zero isn't a lot to  
11 begin with, but we need to worry about the Medicare side,  
12 and I don't want us to get in a position where these centers  
13 are going to say, forget about Medicare, we don't need it.

14 We've got a momentum as I mentioned last meeting  
15 of getting appropriate cases like cataracts into these  
16 centers, and if you go as far as cost report, here -- we've  
17 got one of these, and I'm thinking, my God, even a cost  
18 report like that, that's going to cost me \$100,000-200,000  
19 to produce, which would way overwhelm any -- I mean, that  
20 could be, in a \$5 million operation, you're talking about a  
21 6 percent number or something of -- it's a big expense.

22 So, leaping to, say, only if you get cost reports

1 could have a lot of marginal places that don't have a lot of  
2 Medicare, I'm not going to participate, forget it, and it's  
3 not worth it, and they may back off altogether. So, would  
4 worry a little -- cost data -- so, I just worry about that  
5 qualifier. I don't feel strongly between .6 and zero,  
6 but...

7 MR. HACKBARTH: Did you have something to say on  
8 that? How do you get to the \$100,000 or \$200,000?

9 MR. BUTLER: Any time you have a cost report that  
10 you have to produce and you've got -- these operations are  
11 likely to have one maybe outsourced, if that -- FTE doing  
12 the accounting on these things. Now, I'm into hiring  
13 another FTE to have to produce the cost report or -- I don't  
14 know of a Medicare cost report that's simple. Now, here  
15 we're doing it on the fly, but I know any time you have a  
16 regulatory requirement where you've got to put something  
17 official, it's not, like, well there's a couple of thousands  
18 of dollars to produce this thing. That's my guess. I don't  
19 know that, but it would concern me.

20 DR. CROSSON: Just before we take up the  
21 suggestion, I thought I heard something of what Peter said  
22 that confused me and we want to make sure we know what we're

1 saying.

2 In terms of linking the .6 to the cost  
3 recommendation, I thought, when we said it, that the .6  
4 increase would only go into effect if in fact CMS goes ahead  
5 with requiring the sampling, not only those facilities who  
6 provide the cost data would get the .6 percent increase,  
7 right? Is that right? Okay.

8 MR. BUTLER: The recommendation we have on the  
9 table has the sampling as part of it.

10 DR. STUART: Yes, but it's not conditional.

11 MR. BUTLER: But if you say it's conditional upon  
12 that, saying the cost data, only if, versus cost report,  
13 that sends -- a sample using cost data is a very different  
14 recommendation than cost report, unless I missed --

15 DR. CROSSON: Again, maybe I'm missing what you're  
16 saying, but I thought what I heard you saying was that you  
17 think the recommendation of linkage means that you would  
18 only get the .6 if you happened to submit as part of the  
19 sampling process the cost data. I don't think that's what  
20 is being discussed.

21 MR. BUTLER: No. No, I understand that.

22 DR. CROSSON: Okay.

1           MR. BUTLER: The recommendation as it stands is  
2 fine with me, even if you change it to, the .6 won't go out  
3 unless Congress follows through with the sampling and the  
4 cost data; that's fine.

5           MR. HACKBARTH: Okay. So, now I think I'm  
6 starting to understand.

7           What I hear you saying now, Peter, is it is the  
8 specific language cost report which is content developed  
9 over years from the hospital sector and others. You want to  
10 avoid that language because it means to you something big  
11 and burdensome and expensive.

12           You are willing, if I just understood your last  
13 comment, to say that any update should be contingent on some  
14 approach for systematically gathering data on ASC costs, but  
15 you don't want to refer to it as cost report.

16           MR. BUTLER: Yes, I'm not only willing to support  
17 that reluctantly, I would be a strong advocate for that,  
18 yes.

19           MR. HACKBARTH: Okay.

20           So, with that clarification, it seems to me one  
21 path would be that one, stay with .6, make it contingent,  
22 and rather than write the language on the fly, what I'd

1 suggest is that we vote after lunch and we'll work on the  
2 specific words, make sure they're comfortable.

3 An alternative path is zero update, and I suppose  
4 you could do zero update plus the contingencies, as well.

5 And so, let me get a show of hands. Who would  
6 prefer the zero update approach, including the contingencies  
7 about collecting data?

8 Who would prefer the path, .6 with the  
9 contingencies?

10 Okay. Let us, during the lunch break, try to  
11 develop the specific language on the contingencies and then  
12 we'll come back and vote after lunch.

13 Okay. Before we break -- you have some proposed  
14 language?

15 DR. CROSSON: Well, no.

16 MR. HACKBARTH: All right. Let's do our public  
17 comment period before we break for lunch.

18 The usual ground rules, which Sharon could recite  
19 for us, but let me go ahead and do it so she doesn't have  
20 to.

21 Please keep your comments to no more than two  
22 minutes. Begin by identifying yourself and your

1 organization.

2 When you see the red light --

3 MS. McILRATH: Sharon McIlrath, AMA.

4 I just wanted to respond to some of the comments  
5 on the volume. I think that, if there is a discussion of  
6 volume in the paper, in the March report, that maybe it  
7 needs to be a little more nuanced. I think you would want  
8 to point out that, during that time frame, there were some  
9 very significant increases in coverage and that, at the same  
10 time, the deductible was held steady for a long, long time.  
11 So, more and more people were meeting the deductible, and  
12 part of the increase is, I believe, in the number of  
13 beneficiaries that are actually using the benefit and  
14 exceeding the deductible.

15 A lot of other things, technology, obesity, have  
16 contributed to that, but then also there is a shift in the  
17 side of service which was mentioned in the discussion about  
18 the growth in the outpatient departments and I think that  
19 the comparison that it would be more appropriate to make  
20 would be the comparison between what's happening on the  
21 physician side and what's happening in the outpatient part  
22 of the hospital world, and I think you would find that the

1 expenditures are actually -- expenditure increases are  
2 actually double. The volume increases over the last five  
3 years are slightly higher on the physician side, but the  
4 overall expenditures are probably about double, and I  
5 suspect, though I don't know this that if you looked at just  
6 the last year that the volume is slightly smaller on the  
7 physician side.

8           And then, to just also say that, if you really  
9 want to get a control on imaging or any other spending, you  
10 really do need to be looking at what's happening in all of  
11 the sites. Right now, with what has happened with the DRA  
12 cuts, with what's happened with the practice expense  
13 changes, and some of the impact that that has had on  
14 cardiology and on radiology services, you had some  
15 discussion in October, I think, on consolidation, about the  
16 number of services and physicians that are moving back into  
17 the hospitals and it does cost you more when that happens in  
18 the hospital, in part because there is a facility fee that  
19 is associate with the -- when the hospital owns the  
20 physicians, or employs the physicians, and also because, for  
21 those services, they are now considerable higher in the  
22 hospital side for most of those services than they are in

1 the physician side. So, you might want to do, when you're  
2 looking at volume, the same kind of analysis on the hospital  
3 -- on the hospital outpatient side that you do on the  
4 physician side.

5 I mean, we know that, in 2007, some of that  
6 imaging started shifting back into the hospital. What  
7 happened in 2008? Are there other services that are  
8 shifting back, because otherwise -- we always say that, you  
9 push on the balloon on one side, it comes out on the other  
10 side. You're not seeing what's happening. You are only  
11 seeing what's happening on one side, you're not seeing the  
12 full impact. So, just to suggest that the appropriate  
13 comparison is between hospital outpatient and physician, not  
14 between hospital and physician, and then to say, maybe you  
15 need to look in a little more depth.

16 MS. HIATT: I'm Joanna Hiatt with the American  
17 Hospital Association.

18 We appreciate the Commission's recognition of  
19 hospitals' negative Medicare margins which have been  
20 declining over a number of years by recommending a full  
21 market basket update for hospitals, but we are concerned  
22 about the recommendation on the documentation and coding

1 cuts.

2           The Congress has already given CMS appropriate  
3 authority on this matter. The issue at hand is really the  
4 timing of the cuts, and CMS indicated in their Inpatient  
5 Final Rule last year that they were considering a transition  
6 of five years to implement the documentation and coding  
7 cuts. They did not indicate, as was implied here today that  
8 they would implement all the cuts in either one or two  
9 years.

10           MedPAC's recommendation of spreading the cuts over  
11 only three years is therefore more aggressive than CMS is  
12 likely to be.

13           MedPAC recognizes that hospitals' negative  
14 Medicare margins are enough of a problem to necessitate a  
15 full market basket update, but then essentially takes that  
16 full update away by recommending these very aggressive  
17 documentation and coding cuts resulting in a negative  
18 guaranteed update that will further push hospital margins  
19 down into the negative territory.

20           So, we look forward to a discussion in the March  
21 report around this apparent paradox.

22           MR. SHIPLEY: Hi, Nick Shipley [phonetic] on

1     behalf of the ASC Association.

2                   I just wanted to talk very briefly and echo some  
3     of the Commission's comments about the CPI index.  
4     Obviously, we agree that is a volatile index that does not  
5     cover a lot a lot of the issues that we're dealing with, the  
6     housing, the gasoline prices that cause it to swing, and it  
7     has created this large gap between HOPD reimbursement rates  
8     and the ASC reimbursement rates.

9                   And as that gap continues to grow, as was cited  
10    with what was a multiyear freeze coming out of the statute  
11    from Congress, that does put increased pressure to offer  
12    Medicare or to cover Medicare beneficiaries in the ASC  
13    setting.

14                  The ASCs are obviously providing a very efficient  
15    site of care. They do save to Medicare and to the patient  
16    as well, and we want to be able to continue that and  
17    hopefully the Commission will recognize that as it comes  
18    back from lunch and looks at the languages dealing with the  
19    update they're going to do.

20                  MR. HACKBARTH: Okay. Let's go to lunch and we  
21    will reconvene at -- how about 1:45.

22                  Okay. I'm for 1:30.

1                   [Whereupon, at 12:45 p.m., the meeting was  
2 recessed, to reconvene at 1:30 p.m., this same day.]  
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1 before, you and I. I think those issues are really  
2 important. I don't think that they're unique to ASCs by any  
3 stretch.

4 MR. GEORGE MILLER: No.

5 MR. HACKBARTH: Okay?

6 MR. BUTLER: One quick question. Is it calendar  
7 year? I thought most of these are all October 1, federal  
8 fiscal years. Is this a different --

9 MR. WINTER: It's a calendar year. It's out on a  
10 calendar year, the ASC update. It was fiscal year. They  
11 moved it to calendar year in the MMA.

12 MR. HACKBARTH: There's some variety, so the  
13 physicians are on a calendar year basis, hospitals are on a  
14 fiscal year basis, federal fiscal year basis, and there's  
15 some variation among them.

16 Okay. Are we ready to vote? All in favor of this  
17 ASC recommendation? Opposed? Abstentions? Okay. Thank  
18 you very much.

19 And now we can move on to outpatient dialysis  
20 services.

21 MS. RAY: Good afternoon. During today's  
22 presentation, I'm going to first discuss two new pieces of

1 information that you did not see during last month's  
2 presentation. Then I'm going to summarize information about  
3 the adequacy of Medicare's payments for dialysis services. I  
4 will present a draft recommendation for you to consider  
5 about updating the composite rate for calendar year 2011.  
6 This is the last presentation before the March report.

7           Just a brief overview of the outpatient dialysis  
8 sector. In 2008, there were about 330,000 dialysis  
9 benefits, and they received care at nearly 5,000 dialysis  
10 facilities. Medicare spending on dialysis, called composite  
11 rate services, and dialysis drugs administered during  
12 dialysis was \$8.6 billion.

13           Okay. So now moving to the first new pieces of  
14 information, George, you had some questions about kidney  
15 transplantation I'd like to address. On average, it is  
16 widely believed that kidney transplantation is the best  
17 option for individuals with end-stage renal disease. It  
18 reduces mortality and improves the quality of life.

19           With respect to trends, I'd like to parse through  
20 a couple of items here. First, as we saw in 2006, the 2007  
21 data indicates that African Americans do not receive kidney  
22 transplantation in proportion to their prevalence in the

1 ESRD population. In 2007, African Americans accounted for  
2 32 percent of end-stage renal disease patients yet receive  
3 25 percent of kidney transplants. In the paper we summarize  
4 the myriad of factors that affect an individual's ability to  
5 get a transplant, and it is complicated. For example,  
6 clinical comorbidities can contraindicate some individuals  
7 from being candidates. There is the tissue matching  
8 process. However, there is research that shows that even  
9 after adjusting for some clinical factors and other patient-  
10 level factors, access to kidney transplantation varies by  
11 race, sex, and income.

12 In terms of longitudinal trends, between 2002 and  
13 2007, we see that the rate of kidney transplants increased  
14 for Asian Americans and Native Americans, remained about  
15 steady for African Americans, and decreased for whites. We  
16 will continue to monitor trends in this area as well as new  
17 research and report back to you once new data are available.

18 Here is the second new piece of information we  
19 have to share with you. This is the Medicare margin for  
20 2008 by provider type. You can see it varies across the  
21 different provider types. It was larger for the largest two  
22 dialysis chains than for everybody else, and this is linked

1 to economies of scales. For rural facilities it is a bit  
2 lower than zero. We think this finding may be linked to two  
3 factors. First, the phase-in of the changes in the ESRD  
4 wage index and the decrease of the wage index floors.  
5 Second, the volume of erythropoietin stimulating agents --  
6 that is, EPO and Aranesp -- declined overall but, in  
7 particular, for the two largest dialysis chains, and they  
8 account for a greater proportion of freestanding facilities  
9 in rural areas than other freestanding providers.

10           The decline in the volume of erythropoietin  
11 stimulating agents is not surprising. It is linked to  
12 continued clinical evidence that suggests that patients with  
13 chronic kidney disease are at increased risk for  
14 cardiovascular events when they receive higher doses of  
15 these drugs.

16           We are concerned about the direction of margins  
17 for rural facilities. That being said, under the new  
18 payment method that begins in 2011, a low-volume adjuster  
19 will be implemented. This is mandated by law. Under CMS'  
20 proposed rule, rural facilities will disproportionately  
21 benefit from the low-volume adjuster, and for those rural  
22 freestanding facilities that receive payments through the

1 low-volume adjuster, payments will increase by an average of  
2 12 percent.

3 So, to summarize, this is the first year we have  
4 seen this type of drop for rural facilities. We will  
5 continue to watch their margins and report back to you next  
6 year about the direction. In addition, because of the  
7 critical importance of ensuring benefit access to dialysis,  
8 we will be putting some additional thought and study into  
9 this subject.

10 To summarize the information that I presented  
11 about payment adequacy in December, overall our adequacy  
12 indicators are positive. The supply and capacity of  
13 providers is increasing as measured by the increasing number  
14 of facilities and dialysis stations.

15 Beneficiaries' access to care appears to be good.  
16 There is little change in the mix of beneficiaries providers  
17 treat. For example, the demographic and clinical  
18 characteristics of beneficiaries treated by freestanding  
19 facilities did not change between 2007 and 2008.

20 In terms of volume of services, we see that the  
21 growth in dialysis treatments matches beneficiary growth.  
22 Looking at the volume of dialysis drugs, as I previously

1 noted, we did see a decline in the volume of erythropoietin  
2 stimulating agents. We are not surprised by that, again,  
3 based on the new clinical evidence available. We do see,  
4 though, that other dialysis drugs, the volume continues to  
5 increase.

6 In terms of quality it is mixed. Some measures  
7 are high or improving, like dialysis adequacy and the use of  
8 AV fistulas for vascular access. Other areas need  
9 improvement, including, as we've discussed, kidney  
10 transplantation, and rates of hospitalization and mortality  
11 remain high.

12 Access to capital appears to be good, as suggested  
13 by independent investor analysts, as well as the continued  
14 growth in the sector.

15 The projected Medicare margin for 2010 is 2.5  
16 percent. This projection reflects the 1-percent composite  
17 rate update in 2009 and 2010. Our projection assumes that  
18 providers' costs will increase more than the composite rate  
19 update. Our projection does not take into account the 2-  
20 percent budget neutrality provision that is mandated under  
21 MIPPA and that will begin in 2011 with the phase-in of the  
22 new dialysis payment method. The biggest reason we did not

1 include this provision is that it is very unclear how  
2 providers' will react to the new payment method. We would  
3 expect that providers will become more efficient  
4 particularly in the provision of services that are now  
5 currently billable under Part B, including dialysis drugs.

6           The evidence on payment adequacy suggests that a  
7 moderate update of the composite rate is in order and that  
8 dialysis providers can achieve efficiency gains similar to  
9 the economy at large. The draft recommendation reads that  
10 the Congress should update the composite rate by the  
11 projected rate of increase in the ESRD market basket index  
12 less the adjustment for productivity growth for calendar  
13 year 2011. The current value of the market basket is 2  
14 percent, so this draft recommendation would update the  
15 composite rate by 0.7 percent.

16           In terms of implications, this would decrease  
17 spending relative to current law between \$50 million and  
18 \$250 million in 2011 and by less than \$1 billion over five  
19 years. And in terms of beneficiaries, it would lower their  
20 cost sharing relative to current law.

21           MR. HACKBARTH: Okay. Thank you, Nancy.

22           Clarifying questions, beginning with Herb.

1           MR. KUHN: Just a quick question, Nancy, on the  
2 use of ESAs. I think I read a couple weeks ago where FDA is  
3 now beginning a new look into this area. Do you have any  
4 more information of what they're looking at or how long this  
5 investigation might take with FDA now?

6           MS. RAY: I don't. The only piece of information  
7 that I know is what was in the -- there was an article in  
8 the New England Journal of Medicine that suggested that they  
9 are planning on holding a public advisory meeting about the  
10 use of ESAs among chronic kidney disease patients, and  
11 particularly -- I know that the article discussed the need  
12 for more clinical trials that would try to better look at  
13 the target hemoglobin levels. I know they raised concern  
14 about 13 as the target hemoglobin levels, as well as the  
15 oscillation in the dosage of ESAs.

16           MR. KUHN: I guess I was just curious if we think  
17 or based on information that anybody has seen thus far, the  
18 last time FDA did a hard look at ESAs, it led to a new  
19 national coverage decision by CMS for oncology services. We  
20 don't know if that's the direction where this ultimately  
21 could lead. That would be pure speculation, I would assume.

22           MS. RAY: Yes.

1 MR. KUHN: Okay. Thanks.

2 MS. RAY: But also to make a point, CMS did revise  
3 its ESA monitoring policy for dialysis as well, first, I  
4 believe, in 2006 and then again in 2007. So that has also  
5 kept up with the FDA evidence.

6 MR. GEORGE MILLER: First of all, I've got a  
7 question about Slide 3 and certainly appreciate the effort  
8 to get this information and provide it for me and the  
9 Commission. I'm very pleased that transplants increased for  
10 Asian Americans and Native Americans. I'm concerned that  
11 for African Americans it has not increased and want to know  
12 if you have any of the reasons why it hasn't. And I'm a  
13 little bit concerned it declined for whites. I'd like to  
14 know the reasons. Obviously, the goal is to maintain the  
15 increase in each one of the segments, not for them to go  
16 down. And then, what can be done to increase transplants  
17 across the spectrum of every American who has -- but I'm  
18 real concerned about the fact that 32 percent of African  
19 Americans are getting end-stage -- have end-stage renal  
20 disease but yet don't get -- the percent is very poor for  
21 kidney transplants.

22 MS. RAY: Well, the more I get into this area, the

1 more I see that it's a very, very complicated area to get  
2 into. I think kidneys are a scarce resource, and there  
3 certainly are not enough for the demand. So I guess I  
4 wasn't completely surprised to see an increase for one group  
5 with a decrease for another group. That being said, I  
6 definitely would like to do more study about that trend.

7           With respect to the decline for whites, there was,  
8 at least in the recent two years, a decline in the -- so  
9 this is between 2006 and 2007, to be clear, a decline in --  
10 the live donor procedures declined more than the cadaver  
11 procedures. That being said, you know, I think we need to --  
12 -- that's just a one-year drop, and we need to see, you know,  
13 what develops.

14           MR. GEORGE MILLER: I think that's a good point.  
15 Wasn't that the case with African Americans also in the  
16 chapter that the percentage of live donors versus cadaver  
17 donors, which is much lower among all groups, if I remember  
18 reading correctly?

19           MS. RAY: Right. If you're talking about the  
20 split in -- if you're looking at all transplants for African  
21 Americans, I believe that what the numbers suggest is they  
22 tend to get more from cadaver than from live donors. And so

1 that's another reason for the difference that we see in the  
2 rates. But, again, this is such a complicated area and  
3 there's such a lot of different factors affecting what we're  
4 seeing that I think I would feel a little bit more  
5 comfortable studying this a little bit longer and then  
6 coming back to you.

7 MR. HACKBARTH: Other clarifying questions for  
8 Nancy?

9 [No response.]

10 MR. HACKBARTH: Nancy, can I just ask you about  
11 Slide 4 for a second? In talking about the difference  
12 between the two largest chains and others, you said  
13 economies of scale were a factor, and I just wanted to  
14 pursue that a little bit further. Is it economies of scale  
15 in running dialysis facilities, or is it purchasing power in  
16 buying drugs, that the big chains have much more power and,  
17 thus, lower unit prices, or some combination?

18 MS. RAY: Some combination of both.

19 MR. HACKBARTH: Is there any way to try to  
20 disentangle those two?

21 MS. RAY: I mean -- yes. Yes. I think the --

22 MR. HACKBARTH: I think it might have different

1 implications, and so we don't need to go into it now.

2 MS. RAY: Right, right.

3 MR. HACKBARTH: But maybe we could talk about it  
4 later.

5 MS. RAY: The cost report data is complex in doing  
6 that, though, because of where some administrative costs are  
7 put, and so that's where my hesitancy comes from.

8 MR. HACKBARTH: Okay. Well, we can talk some more  
9 about that. And then a question about the urban/rural, and  
10 maybe I just missed it in your presentation. Wasn't there  
11 also an issue with a wage index floor for the rurals?

12 MS. RAY: Yes.

13 MR. HACKBARTH: And would you just explain that a  
14 little bit more?

15 MS. RAY: Yes, yes. Beginning in 2006, CMS has  
16 started to lower the wage index floor. In 2005, it was 0.9,  
17 and so beginning in 2006, it has been lowering it year by  
18 year. So that has resulted in some change, yes.

19 MR. HACKBARTH: And then when we transition to the  
20 new payment method, there won't be any wage index floor, but  
21 there will be a low-volume adjustment.

22 MS. RAY: That's what CMS has proposed.

1 MR. HACKBARTH: Okay.

2 MS. RAY: That's correct. CMS has proposed for  
3 the broader bundle to do away with the wage index floor and  
4 to continue to phase out the floor for those facilities that  
5 don't completely opt into the new payment method.

6 MR. HACKBARTH: Okay. Round 2 comments on  
7 dialysis?

8 [No response.]

9 MR. HACKBARTH: We are ready to vote. Would you  
10 put up the recommendation, Nancy? All in favor of the  
11 recommendation, please raise your hand. Opposed? And  
12 abstentions? Okay. Thank you.

13 Next is skilled nursing facilities.

14 DR. CARTER: Okay. I want to start with a  
15 thumbnail sketch of the industry. SNFs furnish services to  
16 about 1.6 million beneficiaries. In 2008, Medicare spent  
17 about \$25.5 billion on these services. There are just over  
18 15,000 providers, and most of them are also nursing homes.  
19 Medicare pays providers for a day of care using 53 case mix  
20 groups.

21 Last month, we considered the adequacy of Medicare  
22 payments using our standard update framework. I'll briefly

1 review that information and the draft recommendation.

2 Several of you asked for additional information which I've  
3 tried to incorporate where possible.

4           The indicators we examined suggest that payments  
5 are more than adequate. Our measures of access indicate  
6 that access is adequate for most beneficiaries. Supply has  
7 been fairly stable for several years, and volume -- in terms  
8 of days and admissions -- has increased between 2007 and  
9 2008. As we discussed last month, access for two groups of  
10 beneficiaries warrant further examination -- minorities and  
11 patients with medically complex conditions.

12           Quality has increased slowly, and access to  
13 capital has improved from last year but is restrained due to  
14 factors unrelated to the adequacy of Medicare payments. A  
15 comparison of payments and costs indicate that Medicare  
16 payments are more than adequate.

17           Bill, you asked about the geographic patterns of  
18 minority beneficiaries, SNF users, and SNF beds, and we will  
19 add that to future analyses but didn't have time to do that  
20 for this month.

21           Mitra, you asked about whether minorities are  
22 concentrated in medically complex case mix groups.

1           Here you can see we found that minorities do make  
2 up a larger share of medically complex admissions compared  
3 to therapy and all admissions. On this slide, African  
4 Americans are shown in the middle group. They made up 16  
5 percent of medically complex admissions -- the last bar, the  
6 one in red -- compared with 10 percent of therapy and total  
7 admissions -- that's the yellow and the green bars. Last  
8 month, I reported that fewer SNFs admit medically complex  
9 patients than admit rehab patients. Therefore, minorities  
10 could face delays in placement because they make up a larger  
11 share of medically complex patients. CMS plans to make  
12 changes in 2011 to the case mix groups that will improve the  
13 payments for these patients. Your standing recommendation  
14 to target payments for non-therapy ancillary services such  
15 as drugs would further improve payments for these patients.

16           Two trends in service use underline the need to  
17 revise the SNF PPS. First, the concentration of medically  
18 complex cases in fewer SNFs indicates the need to better  
19 target payments for non-therapy ancillary services and to  
20 base therapy payments on patient care needs, not service  
21 provision. Second, the large increase in the intensity of  
22 rehabilitation services reflects the financial incentives to

1 furnish therapy services and the payment biases in the  
2 current PPS.

3           You'll recall that, while budget neutral overall,  
4 your recommended changes to the PPS would redistribute  
5 payments from rehabilitation stays to medically complex  
6 stays. As a result, payments would increase for facilities  
7 with high shares of medically complex cases and those with  
8 high non-therapy ancillary costs. And it turns out that  
9 these are disproportionately facilities with low margins,  
10 hospital-based units, and nonprofit SNFs.

11           Turning to our analysis of margins, the aggregate  
12 Medicare margin for freestanding SNFs was over 16.5 percent  
13 for 2008. This was the eighth year in a row that  
14 freestanding facilities had aggregate margins exceeding 10  
15 percent. Like other sectors, there is wide variation in the  
16 financial performance, which you can see on the slide. This  
17 variation would partly be addressed by the recommended  
18 changes to the PPS. Payments to hospital-based facilities,  
19 for example, would increase 20 percent, and payments to  
20 nonprofit facilities would increase 7 percent.

21           George, you asked about the impact of hospital-  
22 based units on hospitals with SNFs. Past interviews with

1 hospital administrators of hospitals with SNFs revealed that  
2 they think about their SNFs in the context of how these  
3 units complement their inpatient business. They told us  
4 they look at the SNF's impact on their inpatient margin, the  
5 inpatient length of stay, and whether the unit helps free up  
6 inpatient space to treat other patients. In recent  
7 conversations, you've mentioned that this is how you think  
8 about hospital-based SNFs as well.

9           We also looked at 2008 hospital data to see how  
10 inpatient margins compare for hospitals with and without  
11 SNFs, and we found that hospitals with SNFs have inpatient  
12 margins that are at least one percentage point higher than  
13 hospitals without SNFs.

14           We estimate that the Medicare margin for  
15 freestanding SNFs in 2010 will be 10.3 percent. We think  
16 this projection is conservative because we used the actual  
17 average annual cost increases over the past five years,  
18 which is higher than the forecasted market basket increase,  
19 and we did not factor in any behavioral offset that may  
20 increase payments.

21           Tom, you asked what we knew about the differences  
22 between high- and low-margin SNFs, and I'll go over that.

1 Compared with low-margin SNFs, facilities with high Medicare  
2 margins had much lower total, ancillary, and overhead costs  
3 -- 25 to 30 percent lower. They also treated a more  
4 profitable mix of patients, with higher shares of intensive  
5 therapy days and lower shares of the medically complex days.  
6 These SNFs had higher daily censuses (over which to spread  
7 their fixed costs) and were much more likely to be for-  
8 profit.

9           Turning to our analysis of "efficient" SNFs, we  
10 examined SNFs with low costs and high quality. After  
11 multiple years of average margins above 10 percent, it is  
12 not clear if we have identified facilities that are actually  
13 efficient since there is little Medicare pressure to be so.  
14 That said, when we examined relatively efficient SNFs, we  
15 found that they had costs that were 15 percent lower and  
16 quality measures that were 20 to 40 percent higher than  
17 other SNFs. Relatively efficient SNFs were  
18 disproportionately nonprofit, more likely to be rural, and  
19 smaller. Their Medicare margins were considerably higher  
20 than other SNFs indicating that it is possible to have well-  
21 above-average financial performance and provide high quality  
22 of care.

1           This leads us to the draft recommendation. The  
2 Congress should eliminate the update to payments for SNF  
3 services for fiscal year 2011. Our rationale is consistent  
4 with recommendations from previous years: margins continue  
5 to exceed 10 percent and are more than adequate to  
6 accommodate the expected cost growth.

7           This recommendation would lower program spending  
8 relative to current law by \$250 to \$700 million for 2011 and  
9 by \$1 to 5 billion over five years. It is not expected to  
10 impact beneficiaries or providers' willingness or ability to  
11 care for Medicare beneficiaries.

12           At the last meeting, the Commission discussed the  
13 update recommendation as part of the SNF package of  
14 recommendations that together consider the level and  
15 distribution of payments. The update recommendation  
16 addresses the level of payments and aggregate spending,  
17 while the recommendations to revise the PPS are key to  
18 redistributing payments away from therapy cases and towards  
19 medically complex stays and patients with high non-therapy  
20 ancillary costs. The adoption of a pay-for-performance  
21 program would raise and lower payments based on outcome  
22 measures such as rates of rehospitalization and discharge to

1 the community. We plan to re-print these previous  
2 recommendations in the front of the chapter, like Glenn  
3 talked about this morning.

4 And with that, I'll put up the draft  
5 recommendation.

6 MR. HACKBARTH: Okay. Round one clarifying  
7 questions.

8 DR. STUART: Let me see if I can get this right  
9 about the relationship of margin and having an inpatient  
10 SNF. I thought you just said that if you have an inpatient  
11 SNF, then your profits are higher than if you did not have  
12 an inpatient SNF. Is that overall Medicare margin?

13 DR. CARTER: No. It's the inpatient margin.

14 DR. STUART: The inpatient margin.

15 DR. CARTER: So it helps you manage your inpatient  
16 business.

17 DR. STUART: Okay. So your inpatient -- but did  
18 you look at the overall margin?

19 DR. CARTER: We saw that this morning during the  
20 hospital, right? -- well, not merely just SNF, but that --

21 DR. STUART: Well, that's what I'm trying to get  
22 at, because if the SNFs, in fact, do improve overall margin

1 and they reduce -- even if they lose money, if they lose  
2 less money on the SNF side than they make up on the  
3 inpatient side, then overall they're profitable. We're  
4 going to come up against a number of these post-acute  
5 providers, and in most of them, I think we're recommending  
6 zero updates because the profit margins seem adequate enough  
7 across the board. But then we come back, and we saw that  
8 slide earlier that said that when you add all of these other  
9 factors together, then the overall Medicare margin drops.  
10 So it's just trying to get this thing in my head.

11 DR. MARK MILLER: Well, and just to go through  
12 this again, when you have those other lines of business  
13 collectively, the margin moves, you know -- is, you know, a  
14 point or less than a point worse overall.

15 The second point that we made this morning and  
16 made just now -- and this triggers off of some comments over  
17 here George and some other people have made of, well,  
18 particularly -- you know, using the hospital-based SNF as  
19 the example, people tend to think of that as complementary  
20 to their inpatient line of business. And when you look at  
21 the inpatient margin, that is actually better in the  
22 presence of a hospital-based SNF.

1           So the hospital-based SNF can be -- there's a  
2 question about the cost allocation there, but putting that  
3 aside, be negative in and of itself, the hospital-based SNF.  
4 But when you think about it in the present -- the inpatient  
5 margin in the presence of that, the inpatient margin is  
6 better.

7           MR. LISK: We also looked, though, at the overall  
8 Medicare margin with SNF and without, and actually the  
9 overall Medicare margin is a little bit higher for hospitals  
10 that have a SNF compared to hospitals without.

11          DR. STUART: [off microphone].

12          MR. LISK: Yes.

13          DR. STUART: Then how important is the SNF to the  
14 contribution of the overall margin across all hospitals  
15 compared to other post-acute services? Because what you  
16 just said goes against what we saw earlier in hospitals.

17          MR. HACKBARTH: I think what Craig is pointing out  
18 is if you look at the overall margin, that includes the  
19 hospital inpatient, the hospital outpatient, hospital-based  
20 SNF, hospital-based IRF and so on, that total margin is  
21 lower than the inpatient alone. So all of the other  
22 services in combination tend to pull down.

1           Now, the degree to which those other services help  
2 the hospital on the inpatient side varies, and what I hear  
3 Craig saying is that in terms of helping a hospital manage  
4 its inpatient costs, SNFs have a particularly strong effect.  
5 So if you just isolate hospital-based SNF, that can help a  
6 hospital considerably in terms of managing inpatient costs.  
7 The effects for the others are weaker or even on net  
8 negative.

9           MR. LISK: You have to remember the margin goes  
10 down when you add in those other services in there, just as  
11 the performance actually with a SNF, actually hospitals  
12 perform a little bit better on average.

13           MR. BUTLER: Okay. So along those lines, the data  
14 is what it is, and I would agree that you look at this in a  
15 complementary way, but most institutions are not reaching  
16 the conclusion that there's an overall positive impact  
17 because they're getting out of these businesses. So the  
18 data is what it is, and I would like to know if it's so  
19 helpful on the inpatient side, can anybody name a hospital  
20 that has started a SNF, a hospital-based SNF in the last  
21 couple of years? Because if you really knew your numbers,  
22 you'd see this being put in place as an overall positive

1 impact, and I can't name anybody that's done that.

2 MR. HACKBARTH: Nor can I --

3 DR. CARTER: But I did look at that.

4 MR. HACKBARTH: Nor can I, and I think that's a  
5 good point. It also --

6 MR. BUTLER: We're not stupid. We'd do it if we  
7 felt it was overall coordinating the --

8 MR. HACKBARTH: Wait. I'm going to quote  
9 something that I heard from somebody I really trust, and  
10 it's Peter. Actually what you would look at is the  
11 alternative uses of that same capacity, and if you could use  
12 that same capacity to produce -- use it for even higher-  
13 margin lines of business, you might say, oh, a SNF can  
14 marginally help us on the inpatient side, but if we use that  
15 building capacity to expand our cardiology unit, we can make  
16 even more profit.

17 So the mere fact that hospitals are not adding  
18 SNFs in and of itself does not belie Craig's statement, not  
19 in the business world that I used to operate in.

20 DR. MARK MILLER: The only other thing I would say  
21 is a couple years ago, we -- you know, this issue has come  
22 up times before, and so in addition to sort of looking at

1 the data, we went out and talked to hospitals and sort of  
2 identified different models and roles for, you know,  
3 hospital-based SNFs, like how do you guys think about this,  
4 and went to different models and kind of identified  
5 different strategies that people use.

6 But the other thing that came out of the work --  
7 Corbin Liu did this with us at that point in time, if people  
8 remember him. At that time people were actually -- there  
9 were a few people who had made the decision, even though the  
10 trend was decidedly get out of this business, who were  
11 opening a hospital-based SNF for the reason that we're  
12 making -- the point that we're making here. I don't mean to  
13 overstate this. This was decidedly not the trend, but that  
14 we were going to hospitals that actually said, okay, we're  
15 opening one because, and it was kind of this inpatient line  
16 of business, thought process.

17 MR. HACKBARTH: And I think the other thing that  
18 has happened in recent years that has an effect here is the  
19 transfer policy and tightening up of transfer policy, which  
20 I think -- and tell me if I'm wrong here, Craig -- the  
21 tighter transfer policy as of several years ago reduces the  
22 value of the hospital-based SNF in managing inpatient costs,

1 because if you're aggressively moving patients out of  
2 inpatient into the hospital-based SNF side with short  
3 lengths of stay, Medicare has now started to reduce the  
4 inpatient rates accordingly. So there are lot of things  
5 going on here, I think.

6 DR. CARTER: And I did want to just add one fact  
7 to this.

8 MR. HACKBARTH: I'm sorry.

9 DR. CARTER: Of the 108 new facilities that opened  
10 between 2008 and 2009, six were hospital-based, so that's  
11 about 5 percent of the industry, which is about where they  
12 are in the industry overall.

13 MR. HACKBARTH: I should have let Carol go -- I  
14 rudely interrupted when she first started to speak, and she  
15 had the answer for you all along.

16 [Laughter.]

17 DR. KANE: Two questions. One, what proportion of  
18 hospitals have SNFs?

19 DR. CARTER: Well, there are about 700 hospital-  
20 based SNFs, and depending on -- are you talking about PPS  
21 hospitals?

22 DR. KANE: Yes, so maybe --

1 DR. CARTER: 20 percent?

2 DR. KANE: Because it is hard to understand all  
3 these numbers that are -- you know, some include all lines  
4 of business, some include -- it would be helpful in the  
5 future if the hospitals with hospital-based SNF margin could  
6 be calculated, just so we can -- and then the total -- and  
7 then the hospital in, out, and SNF margin could be  
8 calculated, just to sort of get us past getting hung up on  
9 this, I think that would be helpful.

10 The question was what have -- we have been  
11 recommending zero updates. What have been the updates for  
12 the last three or four years?

13 DR. CARTER: They have been getting market basket.

14 DR. KANE: Market basket without even a  
15 productivity adjustment.

16 DR. CARTER: Right.

17 DR. KANE: And is there some obvious reason for  
18 that, or it's just --

19 DR. CARTER: It's the law. I mean, they've been  
20 doing what they've been legislated to do.

21 DR. KANE: So they are getting full market basket.

22 MR. HACKBARTH: Yeah, and I think one of the

1 reasons for that is that the SNFs, as you know, have been  
2 urging us and the Congress to look at total margins,  
3 including the Medicaid business, which are lower. And while  
4 we have insisted that the sensible thing to do is to focus  
5 on the Medicare margin, because using Medicare dollars to  
6 try to offset Medicaid shortfalls doesn't make good sense  
7 for reasons that, you know, we've gone through multiple  
8 times. The Congress has not necessarily gone along with  
9 that, and they've tended to give higher updates to help  
10 offset Medicaid. That's at least one of the reasons.

11 Round one.

12 DR. SCANLON: This is a little bit of round one  
13 and a half. I mean, there is the question here, and the  
14 question is, What is a hospital-based SNF? Because I know  
15 of hospitals where they own a SNF which is miles and miles  
16 from the hospital. And from a CMS perspective, does that  
17 get counted as hospital-based or is that an independent SNF?  
18 One of the problems I know we've had with nursing homes in  
19 the past is being able to link ownership and get chain  
20 information.

21 The other thing, which is more of a comment, is I  
22 don't think that we really can fully understand what the

1 realities are from the numbers that we've seen, particularly  
2 sort of the numbers where we said when we added in sort of  
3 post-acute services to the hospital and we've combined sort  
4 of hospitals that have them and hospitals that don't. The  
5 decision that a hospital is going to make -- and I am  
6 projecting, even though I've never worked for a hospital --  
7 is what it would have been if we didn't do this, not what it  
8 is -- I mean, in a measurable sense in terms of this is what  
9 our prior experience is. And so I think it goes back to  
10 what we talked about physicians. It's very, very sort of  
11 idiosyncratic in terms of the markets you're in. What's  
12 your ability managing inpatient care to place people when  
13 you could into a SNF that is going to provide them sort of  
14 adequate services? And if the market is such that that's  
15 not a problem, then your calculation is very different than  
16 if you know that you're going to be stuck with these people,  
17 they're not going to be able to be discharged, you're not  
18 going to get any additional PPS payment except for sort of  
19 limited outlier payments, and, therefore, you think about  
20 it's much better to have the SNF take losses, but I have an  
21 increase in revenue.

22 MR. HACKBARTH: Carol, do you want to address

1 Bill's first question about how it would have a  
2 freestanding, separate, miles-away facility owned by the  
3 hospital count as a hospital-based SNF or is that counted as  
4 a freestanding --

5 DR. CARTER: I don't know, expect that they would  
6 be on the -- if they're in the hospital cost report, then  
7 they're considered hospital-based, and that's how we count  
8 them.

9 DR. SCANLON: Right. But it's possible that they  
10 aren't on the hospital cost report, right? I mean, because  
11 we've got hospitals and then we've got holding companies.

12 MR. LISK: If it's part of the hospital  
13 corporation, it would generally be on the hospital cost  
14 report. There was an example at one place we went and  
15 visited. We thought that they had the hospital-based SNF --  
16 we thought we were visiting a hospital-based SNF because of  
17 its name and some other things. In fact, the hospital did  
18 have a hospital-based SNF, but it was actually 35 miles  
19 away. So they had none of their patients actually going  
20 there.

21 So when we talked about, let's say, the models of  
22 the hospital-based SNFs, we kind of had three different

1 models. There's ones that operate just like regular  
2 freestanding nursing homes in terms of what they look like,  
3 and sometimes they may not be -- they're connected to the  
4 hospital. And then there's the ones that were connected to  
5 the hospital that were operating more as subacute care  
6 units. And then there are ones that are operating kind of  
7 like dealing with rehab patients and dealing with that line  
8 of business. We kind of had those three models that we  
9 outlined in our report several years ago and stuff. But  
10 that's kind of what kind of happens. So there can be --  
11 there's many that look like freestanding, and their margins  
12 are higher relative to the hospital-based ones when you look  
13 at those kinds, when we factor those different types of SNFs  
14 into play.

15 MR. HACKBARTH: Round one.

16 MR. GEORGE MILLER: I was very pleased with Slide  
17 5 that talked about minorities make up the largest share of  
18 the medically complex. Do you have a similar demographic on  
19 patients that get therapy, the demographic make-up of those  
20 who get therapy? Because it seemed to be quite a bit of  
21 cost difference between those who get therapy, the payments  
22 are higher, versus medically complex.

1           And a second question, still a round one question,  
2 but you identified what would be a more efficient SNF and  
3 thereby the cost is 15 percent lower. Do you know what  
4 percentage of complex patients those more efficient SNFs  
5 would have?

6           MR. GEORGE MILLER: Is it the same percentage of  
7 all the other SNFs? Is it lower? Is it higher?

8           DR. CARTER: Yeah, yeah, I understand the  
9 question. I'm looking to see whether I calculated that, and  
10 I don't see that in here, and it's possible I have it back  
11 in the office, but I don't have it with me.

12           And then your other question about -- you asked  
13 about racial make-up of therapy --

14           MR. GEORGE MILLER: Patients, yes.

15           DR. CARTER: So they make up -- I think that's on  
16 this slide, right? It's the green bar. So they make up 10  
17 percent of therapy cases.

18           DR. CARTER: 10 percent

19           MR. GEORGE MILLER: Why would that be? Why would  
20 there be such a huge disparity in African Americans and  
21 other Americans getting therapy versus whites?

22           DR. CARTER: You mean why are more --

1 MR. GEORGE MILLER: Am I reading this correctly?

2 DR. CARTER: It's the mix of all patients, right?

3 So they make up 16 percent of medically complex --

4 MR. GEORGE MILLER: And they only get 10 percent  
5 of the therapies.

6 DR. CARTER: And 10 percent.

7 MR. GEORGE MILLER: So I'm reading it right.

8 DR. CARTER: Right.

9 MR. HACKBARTH: I think, George, the way to look  
10 at the African American columns is that they represent 10  
11 percent of all patients, but they're 16 percent of the  
12 patients receiving -- that are medically complex. So  
13 African Americans are disproportionately represented among  
14 medically complex.

15 If you look at the white column, whites represent  
16 85 percent of all patients, but only 80 or less than 80 of  
17 the medically complex, so they're underrepresented.

18 MR. GEORGE MILLER: I got it.

19 MR. KUHN: Therapy, they're almost even --

20 MR. HACKBARTH: And therapy -- yes.

21 MR. GEORGE MILLER: I got it. All right. But  
22 that doesn't explain the medically complex.

1 MR. HACKBARTH: No.

2 MR. GEORGE MILLER: Got it. Therapy is not the  
3 issue.

4 MR. KUHN: A quick question on the high-margin  
5 SNFs. I was interested about the characteristics of the  
6 more profitable mix of patients and the intensive therapy  
7 days, and that was pretty clear. I'm curious also in terms  
8 of was there any characteristics of SNFs -- because many of  
9 them are dual licensed for long-term care as well as skilled  
10 nursing, and obviously we have a mix here of kind of the  
11 services, whether it's medically complex or intensive  
12 therapy. Is there any characteristics in terms of mix of  
13 payers, like 20 percent of the patients would be SNF, 80  
14 percent would be long-term care? Is that an indicator  
15 that's worth looking at as well?

16 DR. CARTER: I didn't look at that. I understand  
17 the question, but I didn't look at it. So you're asking  
18 sort of what share of the total facility is SNF as opposed  
19 to nursing home care?

20 MR. KUHN: Right.

21 DR. CARTER: I haven't looked at that.

22 MR. KUHN: Okay. Thanks.

1 MR. HACKBARTH: Other clarifying questions?

2 [No response.]

3 MR. HACKBARTH: Okay, round two comments.

4 MR. BUTLER: Actually, I'd support the  
5 recommendation, and despite the negative margins in the  
6 hospital base, the fact is -- and we've pointed this out, I  
7 think, before -- that it's not just the salary levels that  
8 are higher -- I'm thinking of ones that are physically in  
9 the same institution versus the freestanding. If I were to  
10 set up a system of care, except capitation, and have the  
11 components of care, I'd be a big proponent of having a  
12 freestanding skilled nursing as an important part of  
13 managing the care. When it's in the same facility, I find  
14 it's very hard to manage it at an arm's-length way so that  
15 you both have the lower salaries and the culture. You  
16 typically would put it under the same head of nursing will  
17 say, well, we've got to have these staffing levels, we've  
18 got to have these kinds of things, and even the physician  
19 and medical direction tends to kind of trickle over into  
20 that hospital base so that you are even practicing a little  
21 bit of the inpatient kind of medicine on that unit, which  
22 makes it expensive. It's good, but it is more expensive

1 than a freestanding would be, whether it's under the  
2 umbrella of, you know, technically hospital-based or not.

3 So, you know, I'm not thinking that we should be  
4 making up these inpatient rates rapidly for this particular  
5 area, so for those kinds of reasons I'm supportive of the  
6 recommendation.

7 DR. CASTELLANOS: Page 8, I look at that slide,  
8 and my first comment was, "I'm in the wrong business."  
9 Those margins are pretty high.

10 DR. KANE: Instead of an ASC, do you want to run a  
11 nursing --

12 DR. CASTELLANOS: Those are high margins, and I  
13 know we made some previous recommendations to revise the PPS  
14 and to adopt a pay-for-performance. Where do we stand with  
15 those recommendations?

16 DR. MARK MILLER: We made two sets of  
17 recommendations. One is on adjusting the payment for  
18 complex medical care patients relative to therapy because we  
19 think that the payment system is incenting the therapy and  
20 that some people are tracking to that line of business.  
21 Those changes would rebalance that out, and as I understand  
22 it, they are included in the House bill, or a good piece of

1 them are included in the House bill and still in play. And,  
2 of course, they're reconciling between the two bills.

3 DR. CASTELLANOS: Okay.

4 DR. MARK MILLER: On the pay-for-performance  
5 stuff, we've made that recommendation -- you seemed to want  
6 to get into this -- but I'm not sure that -- so I'll stop if  
7 you want me to.

8 [Laughter.]

9 MR. HACKBARTH: I'll tell you when you are doing  
10 bad.

11 DR. MARK MILLER: Again? I'm not aware that  
12 that's included in any legislation. I'm not aware that  
13 that's in any of the legislation.

14 DR. CARTER: Yeah, I think both for the House and  
15 Senate, both have -- require CMS to come up with a plan for  
16 value-based purchasing.

17 DR. MARK MILLER: I see.

18 DR. CARTER: But CMS has a demonstration underway  
19 for nursing home pay-for-performance that started this past  
20 summer.

21 MR. HACKBARTH: What I was going to ask was that  
22 my recollection is on SNF pay-for-performance, our views

1 underwent some evolution, and a couple years ago, three  
2 years ago, we recommended that the focus be on sort of  
3 outcome measures, discharged to the community and  
4 readmission to hospital as opposed to some of the softer  
5 measures that are included in, for example, the CMS website.  
6 Is that correct?

7 DR. CARTER: Well, and some of those measures are  
8 probably better measures for long-term care patients, things  
9 like pressure sores.

10 MR. HACKBARTH: Right, and that was the rationale,  
11 was to really focus the Medicare measures on the skilled  
12 population.

13 DR. CARTER: Right. And the demonstration has  
14 both sets of measures.

15 DR. CASTELLANOS: I guess my question is, if this  
16 falls through the cracks, has there been any discussion on -  
17 - like we're going to be discussing a little later this  
18 afternoon about rebasing --

19 MR. HACKBARTH: Well, you know, that's something  
20 we can come back to and take a look at. One of the reasons  
21 from my perspective for focusing on home health is that we  
22 see some different characteristics between the home health

1 marketplace and SNF marketplace. SNF, the supply is  
2 relatively constant, growing slowly, in some areas there may  
3 even be issues about getting access to skilled nursing beds.  
4 Whereas, on the home health side, generally speaking,  
5 setting aside some areas of the country, we've got rampant  
6 growth, rapid entry. And so between the two high-margin  
7 areas, it seemed to us that home health -- it seemed to me  
8 that home health was a much more pressing sort of problem.

9 DR. CASTELLANOS: Thank you.

10 DR. MARK MILLER: There was also just a little bit  
11 more of evidence which just made it easier to analyze the  
12 issue where you could track sort of the count of the visits  
13 that were used to construct the episode and the count of  
14 visits that actually were being delivered under the episode.  
15 But this is not no. I mean, we can continue to think about  
16 this. It won't be this afternoon. I do want to be clear  
17 about that. But we can think about this.

18 MR. HACKBARTH: Other comments?

19 MS. HANSEN: Yes, I'm supportive of the  
20 recommendation, and earlier this morning I asked about just  
21 how -- with the realignment of making sure some payments go  
22 toward complex individuals, and I had some concern about

1 that on the part of just the volume side of doing it well,  
2 for example, if you only had a few. But, Peter, just a  
3 light bulb came on for me when you said that. I can see why  
4 hospitals, you know, wouldn't do it because the culture and  
5 the pattern and the staffing and the operation is so much  
6 the same that the kind of style would be better done in a  
7 very focused group of, like, a stand-alone, if that was the  
8 case to be able to focus on it well. So that actually made  
9 sense, but I just would hope that how those nursing homes  
10 would get funded, they'd be funded adequately to deal with  
11 the complexity with the kind of competence that was needed.

12           So I just wanted to close the loop on that because  
13 I was thinking originally of seeing whether that 20 percent  
14 added pay would make that difference for the hospital side,  
15 and it's not just the money, it's really the whole cultural  
16 way that a hospital would operate as compared to something  
17 that would be freestanding. So I just wanted to pull that  
18 back from an earlier comment I made today.

19           DR. CARTER: I just wanted to add that CMS in the  
20 new case mix system that it plans to implement this fall  
21 has, I think, 13 or 16 new case mix groups that are much  
22 more focused for medically complex patients. So I think

1 that will help also in directing payments for these  
2 medically complex patients. But that said, I took your  
3 comment very seriously about how do you ensure competency in  
4 sort of hiring and reducing turnover and the chronic issues  
5 in this sector.

6 MR. HACKBARTH: Okay. Before we vote, I just want  
7 to go back to Nancy's question about why the Congress has  
8 given full market basket updates, and, you know, I explained  
9 I thought part of the reason probably had to do with  
10 Congress being sympathetic with the argument made by the  
11 industry that you ought to focus on total margins, including  
12 Medicaid, as opposed to just Medicare, as we do. And for  
13 the benefit of the people in the audience who haven't heard  
14 me talk about this before, it just occurs to me that I ought  
15 to explain our thinking there.

16 If you try to offset low Medicaid payments by more  
17 generous Medicare payments, there are a number of potential  
18 bad side effects, but let me focus on two.

19 Number one is that the skilled nursing facilities  
20 that would benefit most from such a policy are, by  
21 definition, those that have the highest proportion of  
22 Medicare patients and the lowest proportion of Medicaid

1 patients. So the biggest checks go to the ones who actually  
2 have the fewest Medicaid patients. So it's a very poor  
3 system of targeting money to the institutions presumed to be  
4 in need.

5 A second problem is that if the federal government  
6 says, Well, we take responsibility for the bottom line of  
7 institutions, which, after all, are primarily Medicaid --  
8 Medicare represents 12 percent or something like that, on  
9 average, of the patients -- then, in effect, the federal  
10 government has said to the states, go ahead, you know, feel  
11 free, you have a license to cut your Medicaid payment rates  
12 to SNFs because we're responsible for the bottom line, and  
13 we'll just keep bumping up our payment rates to the 12  
14 percent to offset your costs. And that is, you know,  
15 inconsistent with the basic design of Medicaid and sharing  
16 between the federal government and the states.

17 There are some other issues as well, but those are  
18 our two principal reasons for thinking higher Medicare rates  
19 is not a good way to deal with low Medicaid payment.

20 Okay, time to vote. Would you put up the  
21 recommendation? All in favor of the recommendation, please  
22 raise your hand? Opposed? Abstentions?

1 Thank you, Carol.

2 Okay, next is inpatient rehab facilities. Kim,  
3 are you going first?

4 MS. NEUMAN: Yes. Good afternoon.

5 We will now turn to payment adequacy for inpatient  
6 rehabilitation facilities. Craig and I are going to  
7 summarize our findings concerning supply of providers,  
8 occupancy rates, volume of services, quality, access to  
9 capital, and margins.

10 Before doing that, though, we would like to thank  
11 Jae Yang for his substantial work on the analyses in this  
12 presentation.

13 Also, before turning to payment adequacy, I'd like  
14 to address a question from the December meeting. Herb, you  
15 asked whether many providers had lost their IRF status due  
16 to the compliance threshold.

17 As you all will recall, the compliance threshold  
18 requires a certain percentage of IRF patients to have one of  
19 13 diagnoses in order for a facility to be paid as an IRF.  
20 In 2004, CMS began phasing in this percentage with the  
21 ultimate goal of it reaching 75 percent. But in late 2007  
22 Congress permanently set the threshold at 60 percent.

1           Since the threshold has been 60 percent, only two  
2 out of roughly 1,200 IRFs have lost their status due to  
3 noncompliance.

4           So, now for a quick overview of IRFs. As you  
5 know, IRFs provide intensive inpatient rehabilitation  
6 services such as physical, occupational, and speech therapy.  
7 Over 332,000 fee-for-service Medicare beneficiaries were  
8 admitted to about 1,200 IRFs in 2008, with Medicare spending  
9 exceeding \$5.8 billion dollars.

10           As we discussed in December, our indicators of  
11 payment adequacy for IRFs are generally positive.

12           In terms of the number of providers: the number  
13 of IRFs was stable in 2008, unchanged from the 2007 level.

14           Looking at occupancy rates: We see IRF occupancy  
15 rates had been on a downward trend throughout the decade,  
16 until 2008 when they increased slightly. The 2008 occupancy  
17 rate still remains below levels earlier in the decade.

18           The stable supply of IRFs and relatively low  
19 occupancy rates suggest that the supply of IRFs is adequate  
20 to meet demand.

21           In terms of the volume of Medicare FFS patients  
22 served by IRFs: after a sharp decline in FFS patient volume

1 from 2004 to 2007, the decline in volume tapered off  
2 significantly in 2008, decreasing by less than 1 percent.  
3 The volume declines in earlier years reflect changes in IRF  
4 admission patterns to meet the compliance threshold.

5 For example, as demonstrated in this next slide,  
6 IRFs have significantly reduced their admissions of hip and  
7 knee replacement cases which generally do not count toward  
8 the compliance threshold. There have been questions of  
9 whether this decline in volume constitutes an access  
10 problem, but our analysis of hospital discharge patterns  
11 suggest that such patients are receiving care in other  
12 settings, such as home health and SNFs.

13 In terms of quality, we have seen that functional  
14 gain between IRF admission and discharge has increased in  
15 each of the last five years. While this may suggest an  
16 improvement in IRF quality, we cannot conclude that  
17 definitively because IRF patient mix has changed  
18 substantially over this period and our data are not risk-  
19 adjusted.

20 We have contracted with RTI to analyze risk-  
21 adjusted functional gain and other potential quality  
22 measures, which we anticipate will help us better measure

1 trends in IRF quality in the future.

2 With respect to capital, credit markets have begun  
3 to ease relative to the credit crisis of 2008 and are  
4 operating in a more normal manner. Hospital-based IRFs,  
5 through their parent institutions, and chains of  
6 freestanding facilities exhibit continued access to capital.

7 Now, I'll turn it over to Craig to discuss  
8 margins.

9 MR. LISK: In 2008, the aggregate IRF Medicare  
10 margin was 9.5 percent. This slide shows a breakdown of IRF  
11 margins by different categories of providers, in which you  
12 can see there is substantial variation in IRF margins across  
13 providers and the different types of IRFs.

14 Freestanding and for-profit IRFs have the highest  
15 margins. Hospital-based IRFs and non-profit IRFs have  
16 comparatively lower margins. Urban IRFs have somewhat  
17 higher margins than rural. And to remind you, the Rural  
18 IRFs receive a 20 percent add-on payment under the IRF PPS.

19 Margins also vary by the size of the IRF, with  
20 smaller IRFs having the lowest margins and the larger IRFs  
21 having the highest. This relationship is seen within the  
22 different IRF groups, including hospital-based and

1 freestanding, and urban and rural IRFs. In fact, actually,  
2 if you look by bed size, rural IRFS have slightly higher  
3 margins than urban IRFS if you control for bed size.

4           Interestingly, we also see that smaller IRFs -- if  
5 we look at occupancy rates -- smaller IRFS actually have  
6 lower occupancy rates than the larger IRFs. If you look at  
7 the hospital-based IRFs, the average occupancy is 67 percent  
8 in units with 60 or more beds and 51 percent in IRFs with 10  
9 or fewer beds.

10           This next slide shows our project margin for 2010.  
11 We have modeled our IRF margins using 2011 policies except  
12 for the update and project a margin of 5 percent. In  
13 projecting this margin, we take our most recent available  
14 data and then consider the policy changes that have taken  
15 place between 2008 and 2010.

16           In this analysis, we took account of the rates in  
17 2009 being held to 2007 levels, and a technical outlier  
18 adjustment that was made in 2009. We also accounted for the  
19 market basket level update IRFs received in 2010. We also  
20 assumed that costs would rise at market basket.

21           Taking all of this into account, we project a  
22 margin of 5 percent in 2010. The projected decrease in

1 margin is driven almost entirely by hospital rates being set  
2 at 2007 levels in 2009, a provision that was enacted under  
3 MMSEA.

4           If IRFs react to these payment provisions by  
5 holding down cost increases below the market basket rate of  
6 increase, due to the financial pressure of these lower  
7 payment rates, we would expect the margins to be higher than  
8 the 5 percent we project. In the past, we have seen that  
9 IRFs have been able to control their cost growth when placed  
10 under financial pressure, such as when the IRF PPS was first  
11 implemented and the uncertainties created by that new  
12 payment system.

13           So with that, we will move on to the Commission's  
14 draft recommendation which is based on your discussion from  
15 the last meeting. The recommendation reads: the update to  
16 the payment rates for inpatient rehabilitation facilities  
17 should be eliminated for fiscal year 2011.

18           The spending implications are that it would  
19 decrease program spending relative to current law by \$50  
20 million to \$250 million over one year in 2011 and by less  
21 than \$1 billion over 5 years.

22           We see no adverse impact on beneficiaries. We do

1 see increased financial pressure -- we do see that there may  
2 be some increased financial pressure on some providers, but  
3 overall a minimal effect on providers' willingness and  
4 ability to provide care for Medicare beneficiaries.

5 And with that, we would be happy to answer any  
6 questions you may have and look forward to your discussion.

7 MS. HANSEN: This is a clarifying question and I  
8 don't know why, in the course of reading this, it struck me  
9 more here than other segments or lines of Medicare business.  
10 But this is fee-for-service reporting of services, but when  
11 you have health plans who want to have IRF services for  
12 their enrollees, how does that get captured in terms of any  
13 of this here?

14 MS. NEUMAN: In the data we have, we're looking at  
15 only Medicare fee-for-service beneficiaries. You know, from  
16 talking to folks about how the private sector does this, I  
17 think in general the model in the private sector is a per  
18 day payment rather than a per discharge payment. So it's a  
19 little bit of a different model.

20 We don't have data on how that all falls out, but  
21 it is a different approach.

22 MS. HANSEN: It struck me, having also been on the

1 purchase side when I was purchasing services -- I paid per  
2 diem, as well. So that was kind of my normal rate.

3 But I just wonder how that affects the operations  
4 of these entities, whether it's home health -- it could be  
5 any segment. But it just struck me as what impact that has  
6 on any of these lines of business, in terms of the  
7 proportionality of a capitated payment versus a -- either  
8 capitated or negotiated payment versus a fee-for-service  
9 impact.

10 DR. MARK MILLER: Would you give me another pass  
11 at that?

12 MS. HANSEN: I'm just thinking about, say you have  
13 a nursing home -- but for some reason it just struck me much  
14 more with the IRF. You have a nursing home who has maybe 30  
15 percent of its business on negotiated payments with a health  
16 plan, as compared to a fee-for-service approach.

17 Does that have any impact at all, in terms of the  
18 cost margins, in general? I know we don't probably have  
19 access to that, because that's private information. But it  
20 just struck me about what impact does a higher penetration  
21 of contracts that are negotiated contracts versus fee-for-  
22 service contracts have on any of these lines of business?

1 DR. MARK MILLER: And also, I would take your  
2 question as negotiated contracts that have a capitated fee,  
3 as opposed to a per diem or something like that?

4 MS. HANSEN: It could be either one.

5 DR. MARK MILLER: Either one.

6 DR. MARK MILLER: I'm going to take a shot here.  
7 We don't know. We take your question -- unless I'm missing  
8 something, that you guys have been up to that I'm unaware  
9 of.

10 I do take your question now and let us see what we  
11 can find on it.

12 MR. GEORGE MILLER: Yes, I would ask a similar  
13 question I ask most times. Do you have the demographic  
14 information on -- at least I didn't read it, I don't know if  
15 I missed it -- on those patients that go to IRFs? And also  
16 age distribution, as you did last time, as well.

17 MS. NEUMAN: We do not have that information right  
18 now, but it's something we could add for the future.

19 MR. GEORGE MILLER: Thank you.

20 DR. CROSSON: Yes, Kim, just on slide number 10 as  
21 the numbers, in the first column, the breakdown. The  
22 breakdown between non-profit, as you have it, and for

1 profit, sums to 85 percent. Is there a third category  
2 there, government hospitals? What's the third category?

3 MS. NEUMAN: It's government and other kind of  
4 ownership structures.

5 DR. CROSSON: Thank you.

6 DR. KANE: What proportion of the IRF is Medicare?

7 MS. NEUMAN: It's about 60 percent Medicare fee-  
8 for-service.

9 DR. KANE: Do we know, is the rest mostly Medicaid  
10 or is it private pay? It's about 60 percent.

11 MR. LISK: It's a combination of private pay and  
12 Medicaid.

13 DR. KANE: We don't have a sense, though? Unlike  
14 skilled nursing, it's not as high --

15 MR. LISK: Medicare is the largest payer in this  
16 sector.

17 DR. KANE: And what have been the actual updates  
18 for the last three to five years for IRFs?

19 MS. NEUMAN: The Congress froze the payment rates  
20 for IRFs for the last half of 2008 and all of 2009 at the  
21 2007 levels. So they fell back to the 2007 levels for that  
22 year-and-a-half period.

1           There was a full update in 2010.

2           DR. KANE: Do we know why they froze the rates?

3           MR. HACKBARTH: It had to do with the deal around  
4 the transition to the 75 percent rule. And they froze them  
5 at 60-what percent; right? They didn't have to go all of  
6 the way to the 75 percent rule.

7           MS. NEUMAN: There were kind of two freezes going  
8 on. There was the compliance threshold idea, where they  
9 were phasing the compliance threshold up to 75 percent and  
10 Congress decided to set it at 60 and leave it there  
11 permanently because of, you know, concerns about what is the  
12 right number.

13           Then there was also the issue of the update to the  
14 standardized amount. That was frozen or set back to the  
15 2007 levels for that year-and-a-half period, I think because  
16 of concerns about the higher margins that have been in the  
17 sector.

18           MR. HACKBARTH: Yes, and so Congress felt that  
19 they were giving them something on the 75 percent rule and  
20 exacted something on the rate side as compensation.

21           DR. CASTELLANOS: With the increase in the  
22 severity of the patients and the case-mix, where do we stand

1 with quality? What are we looking at?

2 I'll be very honest, the reason I'm asking this  
3 question is I have a colleague that goes around the country  
4 and looks at these. I just had a conversation with him. He  
5 said there's a tremendous variation in quality in the units.

6 I'm just wondering, we don't seem to be addressing  
7 that.

8 MS. NEUMAN: Quality is an area that we want to  
9 get into in more depth. We have contracted with RTI to do a  
10 study to try to look at risk-adjusted quality measurement in  
11 the IRF sector. So one of the things we would be looking at  
12 is the risk-adjusted change in functional status between  
13 admission and discharge.

14 In addition, as a part of that study, we're also  
15 looking at potentially other things like discharge to the  
16 community, because that's one of the key functions of IRFs  
17 is to get people back home. And then also seeing what we  
18 can do in the area of readmissions.

19 So that's all underway and still in development.  
20 I can't tell you how it will end up but we are trying to  
21 make headway in that area.

22 MR. HACKBARTH: Other round one -- Mitra?

1 MS. BEHROOZI: Yes, just on the payer mix. You're  
2 very precise about saying that 60 percent of the payer mix  
3 is fee-for-service Medicare. Do we know anything about the  
4 Medicare Advantage side? Do Medicare Advantage plans use  
5 IRFs? Do we know to what extent?

6 MS. NEUMAN: They do use IRFs and we've had some  
7 access to some proprietary data which suggests that there  
8 has been sort of an increase in the use of IRFs among the  
9 managed care population. Now, we know the managed care  
10 population has grown, so to the extent to which that's  
11 population growth versus use growth, it's hard to know.

12 But it does seem to be used within the Medicare  
13 Advantage population.

14 MR. LISK: And just to say, in terms of the total  
15 for the Medicare Advantage, it's kind of a little bit of an  
16 unknown. But actual total IRF volume actually increased for  
17 the first time between 2007 and 2008, since the 60 percent  
18 rule has been in effect. So for total -- so actually, that  
19 slight decline in the Medicare fee-for-service, it actually  
20 was an increase overall.

21 MR. HACKBARTH: okay, round two comments?

22 MR. BUTLER: Okay, left to myself, I'd vote for --

1 on the hospital side -- a market basket minus productivity.  
2 But in the spirit of compromise, I won't. But I did want to  
3 make a point, nevertheless.

4 This is an area that's undergone a lot of change  
5 and appropriately, through the 75 percent rule and other  
6 things, got the joint replacements out of these places and  
7 into a more appropriate setting.

8 There's also certain kinds of cases that are  
9 rehabbed, say a traumatic brain injury, that a long stay can  
10 clearly be better done in a free-standing place.

11 I think there are some specific chronic diseases  
12 or acute episodes, I should say, that can be uniquely done  
13 by hospital-based SNF, like stroke, that are far superior  
14 than sending them to, for example, a free-standing unit or a  
15 nursing home.

16 And I think this is part of -- I think we need to  
17 understand a little bit better the kinds of complex patients  
18 that could be best treated in a hospital-based unit over  
19 time so we understand these difference a little bit better.  
20 I think we've made good progress in this area overall of  
21 sorting these out. But if we can really get down to that, I  
22 think that would be a great addition in the future.

1           That's how we look at it, at least in our own  
2 institution.

3           MR. HACKBARTH: Would you put up the draft  
4 recommendation? Thank you.

5           All in favor of the recommendation, please raise  
6 your hand? Opposed? Abstentions? Thank you.

7           And next is long-term care hospitals.

8           MS. KELLEY: Okay. So first, I'm just going to  
9 give a quick sketch of the long-term care hospital industry.  
10 You'll recall that LTCHs furnish care to patients with  
11 clinically complex problems who need hospital-level care for  
12 relatively extended periods.

13           In 2008, about 115,000 beneficiaries had about  
14 130,900 LTCH stays and Medicare spent \$4.6 billion on this  
15 care. Three-hundred-and-seventy-nine LTCHs filed Medicare  
16 cost reports in 2008. Medicare's payments to LTCHs are made  
17 on a per discharge basis based on the MS-LTC-DRGs, and these  
18 are the same groups that are used in the acute inpatient  
19 PPS, but with relative weights that are specific to LTCH  
20 cases.

21           Now, I'll just go through and summarize the  
22 results of our analysis of beneficiaries' access to care,

1 the quality of care, providers' access to capital, and  
2 Medicare's payments and providers' costs for these services.

3 First, to assess beneficiary access, we looked at  
4 capacity and supply. As you can see here in green, the  
5 supply of LTCH facilities has stabilized after a period of  
6 rapid growth, and growth in the number of LTCH beds, shown  
7 here in red, has also remained fairly steady.

8 This slide shows that growth in the number of LTCH  
9 cases per fee-for-service beneficiary has been fairly  
10 stable, suggesting that access has been maintained. It's  
11 not shown here, but growth in payments per case remain  
12 positive while length of stay declined very slightly between  
13 2007 and 2008.

14 Last month, we discussed the Commission's previous  
15 use of four AHRQ patient safety indicators to measure  
16 adverse events across all LTCHs and our decision not to use  
17 PSIs this year for LTCHs in light of a recent AHRQ report  
18 about the validity of those four PSIs. So as we promised  
19 last month, we did examine trends in in-facility mortality,  
20 mortality within three days of discharge, and readmission to  
21 acute care to address aggregate unadjusted changes in  
22 quality of care in LTCHs. We examined trends in these

1 measures rather than levels because levels can reflect both  
2 planned readmissions and unplanned incidents, as well as  
3 coding practices.

4           We looked at these measures for the top 15 LTCH  
5 diagnoses and for all diagnoses combined. We found that  
6 readmission rates have been stable or declining for most of  
7 the top 15 diagnoses. Trends in rates of death in the LTCH  
8 and death within 30 days of discharge are more difficult to  
9 interpret on a diagnosis basis, but over all diagnoses, both  
10 death rates remain stable, as did readmission rates over all  
11 diagnoses.

12           As we also discussed last month, we're very  
13 concerned about the lack of reliable quality measures for  
14 LTCHs, and our plan going forward is to explore the  
15 development of these measures beginning with an expert panel  
16 to help us identify meaningful measures in the data that  
17 would be needed for measurement, and we also plan to work  
18 with a contractor to assess the feasibility of risk-adjusted  
19 quality measurement at the provider level. So that's  
20 something we hope to report to you on in the coming cycle.

21           Last year, the economy-wide credit crisis meant  
22 that LTCHs' difficulty access capital at that time told us

1 little about Medicare payment adequacy. One year later, as  
2 you've heard previously today, credit markets are operating  
3 in a more normal manner, but the three-year moratorium on  
4 new LTCH beds and facilities imposed by MMSEA has reduced  
5 both the opportunities for expansion and the need for  
6 capital, though, of course, not eliminated totally those  
7 opportunities or needs.

8 Overall, the 2008 margin was 3.4 percent. You can  
9 see here that margins vary across different types of LTCHs.  
10 Rural LTCHs and nonprofit LTCHs have significantly lower  
11 margins, on average, than urban and for-profit LTCHs. Rural  
12 facilities are very small in number. There are about 30 or  
13 so rural LTCHs, and as you can see, they care for about four  
14 percent of all LTCH cases. They also care for a lower  
15 volume of patients in their facilities, as do nonprofit  
16 LTCHs compared with the urban and for-profit counterparts.  
17 So that may result in poorer economies of scale for those  
18 facilities.

19 We looked more closely at high- and low-margin  
20 LTCHs to get a better idea of what's driving the margins.  
21 This slide compares LTCHs in the top quartile of margins  
22 with those in the bottom quartile. There's a lot going on

1 here, so let me walk you through it.

2           The first two columns show average standardized  
3 cost per discharge and the average Medicare payment per  
4 discharge. You can see that the big difference underlying  
5 the financial performance of these LTCHs is per discharge  
6 cost, not higher payments. In the third row, you can see  
7 that high-margin LTCHs care for a higher volume of patients,  
8 on average, than do low-margin LTCHs, 372 discharges  
9 annually versus 242. As with urban facilities, this higher  
10 volume in high-margin facilities may allow for better  
11 economies of scale.

12           The Commission has hypothesized in previous  
13 reports that because the medically complex patients  
14 requiring lengthy hospital stays are relatively rare, that a  
15 critical mass of these medically complex patients might be  
16 necessary to ensure that providers have adequate experience  
17 in caring for these patients. The comparison of high- and  
18 low-margin LTCHs suggests that a critical mass of patients  
19 might also be needed to achieve economies of scale. This is  
20 something we are going to look at more in the future, but if  
21 this holds true, it might be most appropriate to view LTCHs  
22 and other providers of medically complex care as referral

1 centers serving wider catchment areas. Such referral  
2 centers might be able to provide more value for the Medicare  
3 program by achieving better outcomes with greater  
4 efficiency. Obviously, the development of quality measures  
5 will be necessary to evaluate whether this care model would  
6 work.

7           Returning to the slide for just a minute, as you  
8 can see in the fourth row, high-margin LTCHs had shorter  
9 average lengths of stay while maintaining the required  
10 length of stay of greater than 25 days. The next two lines  
11 show high cost outlier payments per discharge and the share  
12 of short-stay outlier cases. You can see that low-margin  
13 LTCHs had high cost outlier payments that were more than  
14 twice those of high-margin LTCHs. At the same time, a  
15 larger share of low-margin LTCHs cases are short-stay  
16 outliers, 35 percent versus 28 percent. So low-margin LTCHs  
17 care for a disproportionate share of patients who are high  
18 cost outliers and a disproportionate share of patients who  
19 are short-stay outliers. Both types of patients can have a  
20 negative effect on LTCHs' margins. LTCHs lose money on  
21 high-cost outlier cases since by definition they generate  
22 costs in excess of their payments. And LTCHs also typically

1 receive reduced payments for their short-stay outlier cases.

2           And finally, in the last row, you can see that  
3 high-margin LTCHs are much more likely to be for-profit  
4 facilities than low-margin LTCHs.

5           Our projected margin for 2010 is 5.8 percent. In  
6 the absence of behavior changes, we do expect that payments  
7 will grow more quickly than costs in 2009 and 2010. This is  
8 due to Congressional rollbacks of CMS regulations that were  
9 designed to reduce payments to LTCHs. With these  
10 regulations on hold under MMSEA, we expect payments to rise.  
11 In addition, we anticipate improvements in documentation and  
12 coding will increase payments, particularly in 2009, and  
13 changes to high cost outlier payments in 2010 will also  
14 boost aggregate payments.

15           So moving on to the draft recommendation that you  
16 discussed last month, it reads as follows. "The Secretary  
17 should eliminate the update to payment rates for long-term  
18 care hospitals for rate year 2011."

19           CMS historically has used the market basket as a  
20 starting point for establishing updates to LTCH payments.  
21 Thus, eliminating the update for 2011 will produce savings  
22 relative to the market basket. We don't anticipate any

1 adverse impact on beneficiaries or on providers' willingness  
2 and ability to care for patients.

3 So that concludes my presentation and I am happy  
4 to answer any questions.

5 MR. HACKBARTH: Thank you, Dana.

6 Let's start on this side over here, round one  
7 clarifying questions. Nancy?

8 DR. KANE: Yes, on page nine, when you're talking  
9 about average yearly discharges, is that all patients or  
10 just Medicare discharges?

11 MS. KELLEY: Medicare only.

12 DR. KANE: So they could have comparable lines f  
13 you looked at all patients?

14 MS. KELLEY: Medicare counts for about 70 percent  
15 of LTCH patients in aggregate.

16 DR. KANE: But you'd have to look at -- I mean,  
17 you'd have to --

18 MS. KELLEY: Yes.

19 DR. KANE: It would be useful to see whether that  
20 is the case --

21 MS. KELLEY: Okay.

22 DR. KANE: -- that they're just low volume

1 overall, because that would help spread the costs.

2 And you said -- and what proportion of hospitals  
3 have LTCHs?

4 MS. KELLEY: I don't know offhand.

5 DR. MARK MILLER: So I thought you had a problem  
6 with the hospital within --

7 MS. KELLEY: Yes. We talked about this last time.  
8 Thank you, Mark. We talked about this last time, about our  
9 difficulty determining what are hospital within hospital  
10 facilities and what are LTCHs -- what are freestanding  
11 facilities. So this is something that I have been working  
12 on with the help of Jae Yang, and we're trying to get some  
13 better clarification of that and that will allow us to make  
14 a more accurate estimate of how many hospitals have LTCHs,  
15 and it will also -- we hope going forward to be able to look  
16 at how having an LTCH affects an acute care hospital margin,  
17 so --

18 DR. KANE: Yes. So just generally for all these  
19 post-acute providers, it would be really nice to have the  
20 group that does hospital stays --

21 MS. KELLEY: Yes.

22 DR. KANE: -- taken out and looked at so that we -

1 - just so we can get a sense of what's going on, even though  
2 we want to look at the margins combined at some point. But  
3 it's nice to see them broken out. It really helps think  
4 about what it means.

5 DR. CROSSON: Yes. Dana, also on Slide 9, as I  
6 look at the difference in the standardized cost, which is 50  
7 percent, about, higher in the low-margin LTCHs, try to think  
8 about what might be causing that. It's hard for me to  
9 believe that the difference in volume between 372 and 242 is  
10 -- I mean, that's different, but it's not different by an  
11 order of magnitude or anything close to that. It's hard to  
12 believe that that's the cause of it, and that the high cost  
13 outliers is more a consequence, isn't it, of the cost  
14 phenomenon than the cause, right? So I can't -- and the  
15 short-stay outlier difference is not so great, either, just  
16 intuitively to suggest that that's the cause. So it seems  
17 to me that perhaps we, if we're going to look at this, we  
18 need some more information about what that difference might  
19 be due to.

20 MS. KELLEY: Absolutely, and one thing we're  
21 looking at more closely is just the different types of cases  
22 that might be in these different facilities and also within

1 DRGs, severity levels, and that will be something that will,  
2 I hope, will help us tease out a little bit more of this.

3 I think there's a lot going on here. I think that  
4 some preliminary numbers that I've looked at suggest that,  
5 to the extent that we can trust our hospital within a  
6 hospital, that low-margin LTCHs are more likely to be in  
7 hospitals within hospitals or associated with a hospital and  
8 we do -- I do see a difference in the shares of patients  
9 from different DRGs. So one thing that will be -- RTI did  
10 do some work previously suggesting that there's quite a  
11 difference in profitability across different types of cases,  
12 so these are all things that I hope we can tease out.

13 DR. CROSSON: Just one follow-up, then. So the  
14 idea that if you have a long-term care hospital within  
15 another hospital versus free-standing, it's then carrying  
16 greater overhead, is that the difference, or don't know?

17 MS. KELLEY: I don't think we would know. You  
18 know, it may be a case similar to what I think Carol was  
19 talking about in SNFs, where you see that margins in the  
20 LTCH might not be very high, but they might be reflected in  
21 higher margins on the acute inpatient side. So, you know,  
22 this is all something we're hoping to get a better handle

1 on.

2 DR. MARK MILLER: In this area, I know, Nancy, you  
3 know, what you keep saying that we need to understand.  
4 Here, I think even the marriage between these two is even  
5 murkier. Even when you're a hospital within a hospital --  
6 if I say something wrong, somebody is going to say something  
7 right. I know Glenn will.

8 A hospital within a hospital, you are supposed to  
9 be financially separate from the facility. So here, it's  
10 even yet a different animal than some of the ones, because  
11 even though it might be on the campus, and as I understand  
12 it, they don't even have to necessarily be on the campus, or  
13 they can be some distance from one another. So the  
14 complexity here is I'm a hospital within hospital. By the  
15 way, I'm not located in the hospital. So that's the first  
16 problem. Not to mention that we can't count these things  
17 very well.

18 And then, number two, even though I'm a hospital  
19 within a hospital and we've been talking about these  
20 relationships, financially, they are supposed to be separate  
21 entities. But then they could have this effect in their  
22 presence, being present in the hospital, on the inpatient

1 side.

2           The other thing I'm just going to throw in for  
3 good measure here is this animal also may be different in  
4 the sense that, you know, there's a sense that the patient  
5 who shows up here is a unique patient or relative -- do you  
6 want to jump in?

7           MR. HACKBARTH: Well, that was going to be -- I  
8 was going to mention is that one of our issues about LTCHs  
9 is whether the patients -- which patients are going into  
10 these institutions that the appropriate patients are not,  
11 and absent a real clear patient criteria, it could be that  
12 these institutions are used for very different types of  
13 patients depending on the local health care setting and  
14 alternatives, and so that may account for the extraordinary  
15 heterogeneity in cost per case even after adjusting for case  
16 mix.

17           MS. KELLEY: Right, and I think that the  
18 difference in high cost outliers in the low-margin  
19 facilities and those short-stay outlier cases, as well,  
20 although the short-stay outlier difference is not enormous,  
21 I do think that suggests that there's a different kind of  
22 selection perhaps going on in different kinds of facilities.

1 DR. MARK MILLER: The last thing I will say, and  
2 I'm sorry, but there's also this notion of kind of the  
3 volume and bed size where we do see -- we're going to look  
4 at these relationships. A conversation we've been having  
5 internally is whether you want to think of these things more  
6 as a referral center type of concept, where it's like you  
7 need a critical mass to deal with these types of patients  
8 well, and one policy idea we want to start talking through  
9 is do you want to sort of almost have a Centers of  
10 Excellence concept to these types of operations and sort of  
11 -- again, trying to get behind some of the economy of scale.  
12 And if the quality tracks the scale, then that would be kind  
13 of one direction we'd be back here talking to you about.

14 MS. KELLEY: Yes. I guess the last thing I would  
15 say is just to underline your point, Mark, about the totally  
16 separate financial entities. They file their own cost  
17 reports. They're supposed to have their own boards. And so  
18 it's much more difficult to match these up with hospitals.  
19 And I think when we first started thinking about the  
20 hospital within hospital concept, we were thinking about a  
21 wing of a hospital or a floor. It becomes more and more  
22 difficult to kind of -- as an LTCH springs up across the

1 street from the hospital, is that a hospital within hospital  
2 or is it a freestanding facility, and what about if it's  
3 down -- you know, it just becomes more and more difficult to  
4 figure out what the entities are and what the relationship  
5 with the acute care hospital is.

6 DR. KANE: Aren't they constrained by how many  
7 admissions they can take from their hospital host? So don't  
8 they have to define who that is --

9 MS. KELLEY: Yes.

10 DR. KANE: -- or has that just gone by the  
11 wayside?

12 MS. KELLEY: Yes, they do, and we're not convinced  
13 that CMS does a very good job with that.

14 MR. BERTKO: Okay. A similar kind of question.  
15 These hospitals are only in about ten percent of the  
16 counties in the U.S., so when you don't have one, who treats  
17 the patient and how is it done? And then to Mark's concept,  
18 or Glenn's, about referral, are there any examples where  
19 there are already referral centers, or do people just get  
20 treated by a totally different group of providers?

21 MS. KELLEY: To your first question, that's right,  
22 that these are located in very specific areas of the

1 country. Where there aren't LTCHs, we think that it appears  
2 that similar patients that are cared in LTCHs stay in the  
3 hospital longer. They have longer acute-care hospital  
4 lengths of stay. And then to some extent, they use SNFs a  
5 little bit longer. But I suspect -- it looks as if most of  
6 the care is taking place in the acute-care hospital.

7 The referral center idea is -- I think that's  
8 something we could try and take a look at by identifying  
9 communities, sort of matching communities in which there's  
10 one LTCH versus one with many and be able to look at perhaps  
11 the distribution of patients and costs.

12 MR. BERTKO: So I guess the follow-up for this  
13 year would be it would be interesting to look at the cost in  
14 those non-LTCH areas where you might be paying some outlier  
15 payment for the hospital stay plus some SNF stay --

16 MS. KELLEY: Well, that is something that MedPAC  
17 did several years ago, I believe, using 2001 data, and what  
18 we've -- what?

19 MR. BERTKO: And the answer is?

20 MS. KELLEY: The answer was that for the most  
21 severely ill patients, for example, when we looked at  
22 ventilator patients, you know, difficult-to-wean ventilator

1 patients, the cost between -- the costs in LTCHs versus  
2 patients who didn't use LTCHs were actually rather similar.

3 MR. BERTKO: Okay.

4 MS. KELLEY: What we, of course, didn't really  
5 know was how outcomes and quality compared. But when we  
6 looked at other patients, as severity fell off, the value of  
7 using an LTCH -- the LTCH became much more costly --

8 MR. BERTKO: Yes.

9 MS. KELLEY: -- than acute care hospital care.

10 MR. HACKBARTH: And that analysis was the origin  
11 of our recommendation that there be a patient and facility  
12 criteria.

13 MS. KELLEY: Right. Right.

14 MR. HACKBARTH: Actually, Karen was going to ask  
15 the same question as John. George and then Herb.

16 MR. GEORGE MILLER: John asked my question, so  
17 like the last presentation, do you have maps that you could  
18 show where LTCHs are across the United States?

19 MS. KELLEY: I don't have it in my presentation  
20 today, but I do have that --

21 MR. GEORGE MILLER: Yes --

22 MS. KELLEY: -- and we did publish a map in our

1 report last year.

2 MR. GEORGE MILLER: Yes, but --

3 MS. KELLEY: We can do that this year, as well,  
4 and that shows clearly the areas that have them.

5 MR. HACKBARTH: That isn't in the chapter --

6 MR. GEORGE MILLER: No.

7 MR. HACKBARTH: -- this year's chapter?

8 MS. KELLEY: It's not in this year's chapter --

9 MR. GEORGE MILLER: No.

10 MS. KELLEY: -- but it can be, yes, certainly.

11 MR. GEORGE MILLER: It would just be helpful,  
12 because, again, John hit my question, where do patients go,  
13 so I won't repeat that. But do you also have the  
14 demographic information and age --

15 MS. KELLEY: I'm sorry, George. I don't have it  
16 with me today, but I do have that information and I will add  
17 it to the chapter.

18 MR. GEORGE MILLER: Okay. Great. Great. Great.  
19 I'll wait until round two. Thank you.

20 MS. KELLEY: Okay.

21 MR. KUHN: Dana, just two quick things. One,  
22 thank you for the chart here on page nine that's up here. I

1 thought this was really helpful information. And I  
2 appreciate hearing the fact that you're going to look at  
3 conditions, whether it's wound care, vents, different things  
4 like that. I think that will be very helpful to us.

5 I guess the question, and Glenn talked about this  
6 earlier, the assessment instrument, the criteria instrument.  
7 CMS is charged to develop one, and where are they in that  
8 process and when is the due date for that particular  
9 product?

10 MS. KELLEY: I think you are referring to the  
11 report on criteria for LTCHs?

12 MR. KUHN: Yes, right.

13 MS. KELLEY: That report was due last June and my  
14 understanding is that it's in the final stages of clearance.

15 MR. KUHN: Thank you.

16 MR. HACKBARTH: Herb, I thought you were supposed  
17 to finish that report.

18 [Laughter.]

19 MR. KUHN: Are you going to give me a pass on that  
20 one?

21 MR. HACKBARTH: Other clarifying questions?

22 Round two comments? Peter?

1           MR. BUTLER: So I find the referral concept as a  
2 very good one. I think the clear population in my mind that  
3 -- and maybe it's a lot narrower than that being currently  
4 treated -- is the difficult-to-wean ventilator patients,  
5 that I think these institutions can do better in.

6           I would suggest that I can support the  
7 recommendation, but I also would suggest that perhaps we  
8 should look at the few big systems that have -- they are  
9 both integrated systems that have large capitated lives. So  
10 if you take a Henry Ford or if you take Intermountain or  
11 Presbyterian Albuquerque, it would be interesting to look at  
12 where you have a critical mass of population, how they are  
13 managing those high-end ventilator patients, whether they  
14 are leaving them in the ICUs and not -- but they have enough  
15 to do that, and I wonder if they're doing --

16           MR. HACKBARTH: Kaiser.

17           MR. BUTLER: Well, Kaiser a little bit in one of  
18 your concentrated markets, maybe, and it could apply, for  
19 that matter, to all these post-acute things. We might learn  
20 a little bit more about the decisions that have been made  
21 voluntarily when you are driven -- you are at the tipping  
22 point and the capitation dollars are driving the decisions,

1 not the Medicare payment system.

2 MR. HACKBARTH: That intrigues me, as well. I  
3 think that might be interesting research.

4 Other round two comments? Tom?

5 DR. DEAN: I had the same thought that Peter did.  
6 Just to reemphasize that, we've got a concept here that it  
7 would appear is not a totally proven concept, and I think  
8 it'd be really important to try to look at how this is  
9 handled in other settings and try to figure out which, both  
10 in terms of outcome measurements as well as cost  
11 measurements, what works the best, because it seems to me we  
12 clearly don't know at this point.

13 MR. HACKBARTH: Okay. I think we're ready to  
14 vote. Please put up the recommendation. All in favor,  
15 raise your hand. Opposed? Abstentions?

16 Thank you, Dana. And on we go to hospice.

17 MS. NEUMAN: Good afternoon. We are now going to  
18 going to take a look at payment adequacy for hospice  
19 services. This seems to be stuck.

20 MR. HACKBARTH: Mark and I had a bet whether we  
21 could finish on time, and I said we were going to finish on  
22 time, and he has intentionally sabotaged it.

1 DR. MARK MILLER: Throw the ball out of bounds.

2 [Laughter.]

3 MS. NEUMAN: So go ahead?

4 MR. HACKBARTH: Yes, and I apologize to folks in  
5 the audience. We'll get it up and going as quickly as we  
6 can.

7 MS. NEUMAN: For a brief overview of hospice,  
8 hospice provides palliative and supportive services to  
9 terminally ill beneficiaries who choose to enroll. In 2008,  
10 more than 1 million Medicare beneficiaries received hospice  
11 service from over 3,300 hospices, with Medicare spending  
12 exceeding \$11 billion.

13 As we discussed in December, our indicators of  
14 payment adequacy are generally positive. In terms of the  
15 supply of hospices, the number of hospices increased  
16 substantially in the last decade, growing from about 2,300  
17 providers in 2001 to more than 3,300 providers in 2008. The  
18 increase in the number hospices has been driven largely by  
19 growth in for-profit, freestanding providers.

20 Hospice use among Medicare decedents has also  
21 grown substantially. From 2000 to 2008, the percent of  
22 Medicare decedents using hospice grew from 23 percent to 40

1 percent. Over this time period, hospice use increased  
2 across all demographic characteristics we examined --  
3 gender, age, race/ethnicity -- although there continues to  
4 be a lower prevalence of hospice use among racial and ethnic  
5 minorities.

6           Between 2000 and 2008, Medicare hospice spending  
7 almost quadrupled, as the number of hospice users and  
8 average length of stay increased. During this time period,  
9 the number of hospice users doubled from just over 500,000  
10 to just over a million, and average length of stay increased  
11 from 54 days to 83 days.

12           As you'll recall, the increase in length of stay  
13 reflects largely an increase in very long hospice stays. At  
14 the 90th percentile, hospice length of stay increased from  
15 141 days to 235 days between 2000 and 2008. The increase in  
16 long hospice stays is partly the result of the enrollment of  
17 more beneficiaries with non-cancer diagnoses for whom it may  
18 be harder to predict life expectancy. But that does not  
19 explain all of the increase. Some providers -- particularly  
20 providers that exceed Medicare's aggregate cap on hospice  
21 payments -- have more long-stay patients across all  
22 diagnoses.

1           We estimate that the share of hospices exceeding  
2 the cap in 2007 was about 10 percent. Above-cap hospices  
3 are almost entirely for-profit. They have very long lengths  
4 of stay and unusually high rates of discharging patients  
5 alive. This may suggest that above-cap hospices are  
6 enrolling beneficiaries before they are ready for the  
7 Medicare hospice benefit.

8           In our discussion at the December meeting, a  
9 couple Commissioners had questions about above-cap hospices.  
10 Glenn, you asked about the high discharged-alive rates.  
11 Included in the mailing materials are data on the rates of  
12 live discharges by patient diagnosis for above- and below-  
13 cap hospices, which showed that above-cap hospices have very  
14 high live discharge rates, even after controlling for  
15 diagnosis.

16           John, you asked if CMS was doing any additional  
17 scrutiny of above-cap hospices. In talking with CMS staff,  
18 they indicated that the claims processing contractors have a  
19 number of medical review activities currently underway in  
20 this area, with efforts to look at both patients with long  
21 stays in general and patients in cap hospices.

22           Finally, one last point on the hospice cap. As we

1 discussed in detail at the December meeting and in your  
2 mailing materials, we have looked at the relationship  
3 between hospice use rates and the share of hospices hitting  
4 the cap by state and have found no evidence that the hospice  
5 cap impedes access to care overall or for racial and ethnic  
6 minorities.

7           Now moving on to hospice quality, we are currently  
8 unable to assess hospice quality of care, as there are no  
9 publicly available data on hospice quality that cover all  
10 hospices. Some hospice industry associations have surveys  
11 of family members and patients, but the data are not public  
12 and do not cover all hospices. A hospice foundation is  
13 developing a public report card that will use some of this  
14 survey data, but participation will be voluntary. And CMS  
15 is currently testing 12 hospice quality measures in seven  
16 hospices in New York.

17           Now looking at access to capital, with regard to  
18 hospice, it is important to keep in mind that hospice is  
19 less capital intensive than some other provider types.  
20 Overall, access to capital appears to be adequate for large  
21 publicly traded hospice companies, for-profit freestanding  
22 hospices, and for hospital-based and home health-based

1 hospices. Access to capital for nonprofit freestanding  
2 providers is more difficult to discern, but, Nancy, we are  
3 exploring your idea about using data from the 990 data to  
4 try to look at that.

5           The next slide shows our estimates of aggregate  
6 Medicare margins for hospice over time. From 2001 to 2007,  
7 the aggregate hospice Medicare margin oscillated between  
8 roughly 4.5 percent and 6.5 percent. In 2007, the aggregate  
9 margin was 5.9 percent, down slightly from 6.4 percent in  
10 2006.

11           A couple points to remember about how we've  
12 estimated margins:

13           First, we do not count Medicare overpayments to  
14 cap hospices in our estimate of hospice revenues since cap  
15 hospices must ultimately pay these payments back to the  
16 government.

17           Second, consistent with our methodology in other  
18 Medicare sectors, we calculate margins based on Medicare  
19 reimbursable costs.

20           As we discussed at the December meeting,  
21 bereavement costs are considered nonreimbursable and are  
22 consequently not included in our margin estimates. The

1 statute requires that hospices offer bereavement services to  
2 the family members of their deceased Medicare patients, but  
3 the statute also specifies that bereavement services are not  
4 reimbursable. If bereavement costs were included in our  
5 margin estimates, it would reduce the aggregate margin by  
6 about 1.5 percentage points.

7           The next slide shows hospice margins by type of  
8 provider. In 2007, freestanding hospices had a margin of  
9 8.8 percent compared with 2.3 percent for home health-based  
10 hospices and minus 10 percent for hospital-based hospices.  
11 Part of the reason for these margin differences is the  
12 higher indirect costs among provider-based hospices, which  
13 are likely inflated due to the allocation of overhead from  
14 the parent provider. If home health-based and hospital-  
15 based hospices had indirect cost structures similar to  
16 freestanding hospices, we estimate it would increase their  
17 margins by 6 to 10 percentage points. And it would increase  
18 the overall industry-wide Medicare margin by 2 percentage  
19 points.

20           In terms of margins by type of ownership, for-  
21 profit hospices had margins of 10.5 percent compared to non-  
22 profit with 1.8 percent. If we look at nonprofit

1 freestanding hospices, which would not be affected by  
2 overhead allocation issues, nonprofit margins are higher --  
3 5.6 percent.

4 Our projected aggregate Medicare margin for  
5 hospice in 2010 is 4.6 percent. This projection takes into  
6 account the effect of the seven-year phase-out of the wage  
7 index budget neutrality adjustment, which will reduce  
8 Medicare payments to hospices by about one percentage point  
9 in 2011.

10 With that I'll read the draft recommendation:

11 "The Congress should update the payment rates for hospice  
12 for fiscal year 2011 by the projected rate of increase in  
13 the hospital market basket index less the Commission's  
14 adjustment for productivity growth." Based on the current  
15 market basket projection, this draft recommendation would  
16 result in an update of 1.1 percent for 2011.

17 In terms of the impact, the draft recommendation  
18 would decrease federal spending by between \$50 million and  
19 \$250 million over one year and between \$1 billion and \$5  
20 billion over five years. We anticipate no adverse impact on  
21 beneficiaries. There may be increased financial pressure on  
22 some providers, but overall we expect a minimal effect on

1 providers' willingness and ability to care for Medicare  
2 beneficiaries.

3           As you know, the draft update recommendation would  
4 affect aggregate payment levels. The Commission also made  
5 recommendations in March 2009 to reform the hospice payment  
6 system that would affect the distribution of payments. The  
7 payment system reform recommended by the Commission would  
8 have the effect of increasing payments for hospices that  
9 tend to have fewer very-long-stay patients, which would  
10 increase payments to rural hospices and nonprofit hospices.

11           We plan to reprint the March 2009 recommendations  
12 in the 2010 report, and to review them briefly:

13           First, there was the payment system reform  
14 recommendation which would change the payment stream from a  
15 flat stream to a U-shaped stream that more closely matches  
16 hospices on level of effort throughout the episode of care.

17           Then there were also recommendations concerning  
18 increasing accountability, so this included steps like  
19 requiring that a physician narrative be included in all  
20 hospice certifications and recertifications, and CMS has  
21 adopted this piece of the recommendation. It also included  
22 requiring that a physician or APN visit a long-stay patient

1 prior to recertifying their eligibility, and also increased  
2 medical review of claims for hospices with many long-stay  
3 patients, and, additionally, OIG studies of nursing home and  
4 hospice relationships. The final piece of the  
5 recommendation was additional data reporting in the areas of  
6 the claims and the cost reports to facilitate payment system  
7 reform as well as better oversight of the benefit.

8 With that, I'll conclude the presentation and look  
9 forward to your discussion.

10 MR. HACKBARTH: Nice job, Kim.

11 Clarifying questions?

12 DR. DEAN: On Slide 6, that rise in cost is pretty  
13 dramatic. Are those constant dollars? Is that inflation  
14 adjusted or --

15 MS. NEUMAN: Those are not inflation adjusted.

16 DR. DEAN: Okay, so some of it would be inflation,  
17 but I suppose -- is the biggest issue to account for that  
18 jump in cost is just the change in length of stay? Would  
19 that be the biggest issue? Or do you know?

20 MS. NEUMAN: It's really a combination of the  
21 number of users -- you can see the number of users has gone  
22 up substantially.

1 DR. DEAN: The number of users has doubled and the  
2 cost quadrupled.

3 MS. NEUMAN: Right. So you've got the number of  
4 users doubling. You've got the average length of stay going  
5 up by -- what? -- roughly 50 percent as well. And then you  
6 have the payment updates, and the payment updates, you know,  
7 it's the hospital market basket. So we are talking, you  
8 know, 2, 3 percent a year, that would be impacting it as  
9 well.

10 MS. HANSEN: Kim, relative to the ones that exceed  
11 the cap and people get discharged back out from the hospice  
12 program, is there any description as to where they go?

13 MS. NEUMAN: It's a hard question to answer in a  
14 couple of respects. What I can tell you is that we can look  
15 and see how long folks lives after they've been discharged  
16 from hospice, and, you know, we see that especially for the  
17 above-cap hospices, more than half are alive a year after  
18 they're discharged. So we can look at things like that. We  
19 can also look at re-enrollment. Some of these people do  
20 wind up re-enrolling back into hospice.

21 As far as looking at if they then go on to receive  
22 lots of physician services or what kind of services that

1 they receive from the Medicare program once they're out of  
2 hospice, I haven't looked at that, but that's something that  
3 we could look at.

4 MS. HANSEN: Okay, great. Thank you. And then  
5 just another question relative to the profiles of the  
6 hospice programs themselves. Are we able to look at how  
7 many of them serve both dual payers like Medicare and  
8 Medicaid as well?

9 MS. NEUMAN: I think we should be able to. I  
10 haven't looked at that, but I can check into that.

11 MS. HANSEN: Thank you.

12 MR. GEORGE MILLER: I have a similar question to  
13 Jennie concerning those folks who live longer than expected,  
14 and I don't know what that has to do with your  
15 recommendation about having the OIG look at it, but I'm  
16 wondering -- I'm not picking on physicians, but just  
17 wondering if the physician has to certify that a hospice  
18 patient probably -- the growth in those folks living longer  
19 seems to be contraindicated to a physician's guesstimate  
20 they only have six months to live. But is there a reason  
21 you tied that to OIG inspection of hospice programs, or am I  
22 way off base?

1 MS. NEUMAN: We would expect some benefits to --

2 MR. GEORGE MILLER: Some.

3 MS. NEUMAN: -- live beyond sort of the 180-day  
4 presumptive kind of eligibility period because diseases  
5 don't always run their normal course.

6 MR. GEORGE MILLER: Right.

7 MS. NEUMAN: So that is completely to be expected,  
8 and there's nothing necessarily inappropriate -- well, there  
9 is nothing inappropriate about that, obviously.

10 MR. GEORGE MILLER: Right.

11 MS. NEUMAN: The question really becomes when we  
12 start to see patterns that are very different from what we  
13 see among the majority of the industry, that's where you  
14 start to wonder whether the benefit is being used  
15 appropriately in certain cases, and so the Commission  
16 recommended in March 2009 to have the OIG look at a number  
17 of issues, including aberrant utilization patterns. So for  
18 hospices that have very unusual utilization patterns, to  
19 look at those kinds of things and see if there are some  
20 issues going on there.

21 In the chapter, we have a discussion about how  
22 perhaps that should include looking at hospices that have

1 very high rates of patients being discharged alive.

2 MR. GEORGE MILLER: Right.

3 MS. NEUMAN: To similarly get someone to take a  
4 look at that issue.

5 MR. GEORGE MILLER: Thank you.

6 DR. MARK MILLER: We also at that time made some  
7 recommendations to try and put, you know, greater  
8 accountability on the physician having to have a visit in  
9 order to certify the patient, so it wasn't just the IG  
10 looking at the patterns. There were a few other things that  
11 were trying to get at that as well.

12 MR. GEORGE MILLER: There's a correlation between  
13 the increase in length of stay and the increase in payments.

14 DR. MARK MILLER: And an increase in what?

15 MR. GEORGE MILLER: In payments to the program.

16 MR. HACKBARTH: And increase profitability as  
17 well.

18 MR. GEORGE MILLER: Absolutely, yeah.

19 MR. HACKBARTH: Let me just make what has become a  
20 standard comment for people in the audience who have not  
21 been at prior MedPAC discussions of hospice. We are focused  
22 on the growing length of stay and, in particular, as Kim

1 says, hospices that seem to have a real pattern of extra  
2 long stays.

3 The issue is the timing of the entry into hospice.  
4 Nobody is looking for earlier deaths for people. It's  
5 really the timing of the admission to hospice that's the  
6 issue.

7 MS. BEHROOZI: Forgive me if this has been asked  
8 and answered a million times in prior presentations and, you  
9 know, prior years even. But why is it the hospital market  
10 basket that we're using to judge the inflation in the input  
11 side?

12 MS. NEUMAN: I don't know if I know the history of  
13 why the hospital market basket was chosen.

14 MS. BEHROOZI: I don't know how important the  
15 history is. Really, the follow-up question is: Do we think  
16 that is a problem the same way in ASCs, you know, we thought  
17 we should relook at it? But I don't know if there has been  
18 thinking about whether it's appropriate or a problem to use.  
19 That's more my question.

20 DR. MARK MILLER: I think the answer is -- and I  
21 probably will garble this -- we did some work a couple years  
22 ago on reforming the wage index for hospitals. That was our

1 primary focus. But at the time, given the way we  
2 recommended to change it, we also said that given the -- you  
3 could fairly easily within that context shift the relative  
4 weights of mixes and use a comparable index across these --  
5 I'm not describing this right, David?

6 MR. HACKBARTH: Would you come to a microphone,  
7 David?

8 MR. GLASS: That analysis actually affected the  
9 relatives between two areas, and those stayed about the same  
10 despite the mix of occupations. But we didn't look at the  
11 levels.

12 DR. MARK MILLER: Right. You're right. I'm  
13 sorry.

14 That was just a delay.

15 MR. HACKBARTH: Another one. A good point. We'll  
16 think about that issue.

17 Other round one comments?

18 DR. BERENSON: And again, like Mitra, if this was  
19 asked in December, I apologize. But why is it that Congress  
20 excluded payment for bereavement and I guess the mandatory  
21 volunteerism programs? Is it because these are services  
22 provided to non-Medicare benefits or some other reason?

1 MS. NEUMAN: On the bereavement, from what we  
2 understand from talking to folks who were involved in sort  
3 of the development of all this back in the early 1980s,  
4 there was concern about making a payment for services once  
5 the beneficiary for whom the benefit is really being -- you  
6 know, sort of the entitlement for the benefit attaches to  
7 has been deceased. So that was the reason for nonpayment  
8 for bereavement. And, in general, the volunteer services  
9 are not paid for under the Medicare program.

10 DR. BERENSON: And the follow-up question: Have  
11 we -- I mean, how far back has MedPAC's policy gone that --  
12 I guess my specific question is: The hospice margins that  
13 you're citing going back a number of years have used the  
14 same definition of excluding bereavement and volunteerism  
15 programs?

16 MS. NEUMAN: The hospice margins that we have  
17 published previously included those costs. What we did in  
18 preparing for putting this in the update framework for the  
19 first time this year was to go back and take a look at our  
20 methodology to examine how it compared to our methodology in  
21 the other sectors and to make it as consistent as possible  
22 to that, and that's why these margins now are based on only

1 Medicare reimbursable costs.

2 MR. HACKBARTH: And that's true for the whole time  
3 series, all the different years in this series.

4 MS. NEUMAN: Yes. Everything you see on the  
5 screen --

6 DR. BERENSON: So it is true for the whole time  
7 series that you're using.

8 MS. NEUMAN: Yes.

9 MR. HACKBARTH: Other clarifying questions?

10 [No response.]

11 MR. HACKBARTH: Round two comments on the  
12 recommendation?

13 DR. BERENSON: I support the recommendation, and I  
14 just wanted to make an observation that I'm as impressed by  
15 the data you haven't emphasized, which is that the median  
16 length of stay hasn't changed in eight years. It's still 17  
17 days. And, in fact, at the 25th quintile, it has gone down  
18 from six to five. So our focus, which I think is fine, on  
19 these outliers in trying to address it I think masks the  
20 issue that we still have a problem of too late referrals and  
21 that in our work going forward we want to not miss that.  
22 And I don't have a glib solution today, but I think we

1 should be dealing with both ends, that the means sort of  
2 masks what's going on with the majority of patients.

3 DR. KANE: I guess I would like to be convinced  
4 that the hospice with a projected margin of 4-point-whatever  
5 -- I can't read this very well -- 4.8 or 4.9 -- 4.6 deserves  
6 an update, whereas the LTCHs and the IRFs with margins in  
7 the 5- to 6-percent projected don't deserve an update, and  
8 the supply characteristics and everything else, you know, I  
9 mean, people seem to be very happy to offer hospice, maybe  
10 more hospice than we want them to offer for the wrong  
11 patients, there's a mismatch, but not early enough for the  
12 right ones. But, anyway, I guess I'm a little confused as  
13 to why we have market basket minus productivity, and is  
14 there some historic -- you know, what the actual updates  
15 have been piece? And if that's going to be in our  
16 recommendations what the historic actual was, we should have  
17 it in here as a consideration every time? So I guess I'm a  
18 little -- I don't feel convinced that they should have --  
19 that they are any more deserving of an update than the other  
20 post-acute.

21 MR. HACKBARTH: Good question. As in previous  
22 cases, you know, there is no right answer to these, although

1 trying to achieve some consistency is important.

2 DR. KANE: I'm trying to be consistent.

3 MR. HACKBARTH: The second comment is the 4.6  
4 here, as I recall, includes the bereavement costs, and as I  
5 said in December, part of my thinking about this -- or,  
6 excuse me, without the bereavement costs. Kim was giving me  
7 that look. The 4.6 does not include the bereavement costs,  
8 and as I said in December, I'm troubled. I understand the  
9 rationale for it, that these are services to non-Medicare  
10 beneficiaries, but they are required services. And so in my  
11 own personal calculation and trying to think about what an  
12 appropriate recommendation was, I took them into account.  
13 So if you reduce the 4.6 by 1.5, you know, you're down to  
14 3.1. So that was one consideration.

15 The second factor in my mind is looking at the  
16 history, and not the history of what actual updates they got  
17 so much as what the margins, historical margins have been.  
18 If you look at the LTCHs and the IRFs, although their  
19 margins have come down to within a reasonable distance now  
20 of the hospice, the history going back a number of years has  
21 been much higher margins, often double-digit margins. And  
22 so in my mind, that was also a factor in formulating our

1 recommendations.

2 DR. KANE: Well, I mean, I guess -- I mean, I  
3 understand the bereavement piece. I'm not sure that  
4 historic margins helps. So your assumption in the others,  
5 when there is a zero update, is that because they had these  
6 double-digit margins, they should have nothing going on -- I  
7 mean, I'm --

8 MR. HACKBARTH: Well, you know, that's money in  
9 the bank. I'd much rather have, you know, 12, 12, 12, and  
10 be able to put that in the bank.

11 DR. KANE: If they put it in the bank, yeah.

12 MR. HACKBARTH: Or, you know, distribute it to  
13 shareholders in the case of for-profit providers. I do  
14 think trying to look at equity on these things, some look at  
15 the history of the payment and how well people have done is  
16 a relevant consideration. Reasonable people can disagree  
17 with that.

18 DR. KANE: And what is -- do we have a sense --  
19 oh, you must know what the actual updates have been the last  
20 three to five years.

21 MR. HACKBARTH: For hospice?

22 DR. KANE: Hospice.

1 MS. NEUMAN: Just a second. It is right here. It  
2 would be the hospital market basket, which I can tell you  
3 was --

4 DR. KANE: It did not take out productivity in the  
5 past.

6 MS. NEUMAN: No. So we had a 3.3 percent in 2008,  
7 3.6 percent in 2009, and then in 2010, the market basket was  
8 2.1 percent, but because of the start of the phase-out of  
9 the wage index budget neutrality adjustment, it was only a  
10 1.4-percent update in 2010.

11 DR. KANE: So it was -- we're asking to take out  
12 productivity, and historically it has been market basket.

13 MR. HACKBARTH: And since we're on this  
14 comparability point, which is an important one and the  
15 reason we prepared this side by side for the Commissioners,  
16 sort of the other direction is, well, is this high enough?  
17 I suspect many of the hospice providers are disappointed  
18 that it's not full market basket, which they've gotten in  
19 recent years. Another reference point on that side in my  
20 mind is dialysis facilities where we're projecting margins  
21 of 2.5 percent. Dialysis facilities have a history of  
22 margins sort of in that level, maybe a little bit higher,

1 and it doesn't seem to me that you'd want to give hospice  
2 any higher update factor than you would for dialysis at  
3 comparable levels of margins. So I've tried to look both  
4 directions. Those are my reasons and --

5 DR. KANE: Although some could argue that because  
6 dialysis is capital intensive or, you know, there may be  
7 potentials for productivity that aren't there in the hospice  
8 side. So I'm -- okay, well, I just wanted to get the reason  
9 out there on the table because it's a little bit obscure.

10 MR. HACKBARTH: Other comments before we vote?

11 DR. SCANLON: This is sort of on the issue of  
12 comparability, and I think Nancy raises a good point. In  
13 some ways, we shouldn't be, I think, looking at averages.  
14 We should be looking at the distribution. Because if we got  
15 to the average because we've got, you know, 10 percent of  
16 the organizations with extremely high margins and we're  
17 using this one policy instrument, the update, we may be sort  
18 of understating the increase that really is appropriate for  
19 the people at the low end. And so, you know, I don't know  
20 whether the best thing to do is to look at medians, to take  
21 out the top 10 percent, to take out the top 20, something  
22 like that. But I think one needs more of a sense of the

1 distribution to really understand comparability well.

2 MR. HACKBARTH: And in there is a question of if  
3 you have a distribution where do you set it on the  
4 distribution. And, you know, part of our thinking about  
5 that, as you well know, is let's look at a distribution,  
6 let's not use averages, let's see if we can define efficient  
7 providers, low cost, high quality, and increasingly over  
8 time peg to that point on the distribution. And, you know,  
9 that's an evolving piece of work. We're further along in  
10 that in some sectors than in others.

11 DR. DEAN: Well, I would just echo what Bill just  
12 said. I have been troubled as we've had some discussions  
13 about the use of averages because they can hide a lot of  
14 things. But the question I really had was do we know what  
15 the productivity adjustment might be, or do we have an idea  
16 of that? And how is productivity measured in this context?

17 MR. HACKBARTH: For all of the sectors, the  
18 productivity measure we use is the increase -- the ten-year  
19 moving average and total factor productivity for the economy  
20 as a whole, which is about 1.3 percent.

21 DR. DEAN: [off microphone] It's nothing specific  
22 to --

1           MR. HACKBARTH: Right. And just to emphasize a  
2 point that we touched on here, when we make productivity  
3 adjustments, we are not trying to estimate the actual  
4 productivity change in any particular sector, whether it's  
5 hospice or hospital or any other. The purpose of the  
6 productivity adjustment is as a policy expectation that, as  
7 we discussed this morning, health care providers ought to  
8 feel the same sort of pressure to improve their efficiency  
9 as do the people who pay the bills, the taxpayers. And  
10 that's the reason for the link to economy-wide productivity.  
11 So it's not an empirical estimate of actual productivity  
12 change but, rather, a policy adjustment.

13           Other comments before we vote?

14           [No response.]

15           MR. HACKBARTH: Okay. All in favor of the hospice  
16 recommendation, please raise your hand. Opposed?  
17 Abstentions?

18           Thank you, Kim.

19           And last for today is home health.

20           MR. CHRISTMAN: Good afternoon.

21           I am going to walk you through the framework.

22           Also, I would note that there are a few items that we're

1 going to follow-up on specific interests of the  
2 Commissioners. I'll not those as I come to them.

3           Quickly, just a reminder of the basic elements of  
4 home health. A beneficiary must be homebound and have a  
5 skilled need, which includes nursing or therapy to qualify  
6 for home health services, and in 2008, Medicare paid for  
7 services for about 3.2 million beneficiaries, about 6.1  
8 million episodes for a total of \$16 billion in expenditures,  
9 and we had about -- in 2008, we had a little over 10,000  
10 providers.

11           Now, we began with supply, and as in previous  
12 years, the supply of providers and the access to home health  
13 continues to increase. 99 percent of the beneficiaries live  
14 in an area served by one home health agency, 97 percent live  
15 in an area served by 2 or more. The number of agencies was  
16 over 10,400 by the end of 2009, and since 2002, the number  
17 of agencies has increased by about 50 percent, which comes  
18 out to about 480 additional agencies a year.

19           Now, similar to previous years, almost all of the  
20 new agencies are for-profit and located in a few states,  
21 really in a few regions within states. The concentration of  
22 agencies in certain areas, especially those with a history

1 of fraud and abuse concerns prompted CMS to implement a  
2 number of initiatives, but last month several Commissioners  
3 indicated that more could be done in this area, and I will  
4 say more about that when we come to recommendations.

5           Next, we look at volume. As you can see from this  
6 slide, the use of the home health benefit has increased  
7 significantly. The number of users, again, it's reached 3.2  
8 million or about 9 percent of fee-for-service beneficiaries  
9 in 2008. The number of episodes has risen by about 50  
10 percent since 2002 to 6.1 million again in 2008, and the  
11 episodes per user has risen by 20 percent, implying that  
12 beneficiaries are staying on service for longer periods.

13           For quality, we discussed some issues with the  
14 quality measures at the meeting last month. While the  
15 current measures suggest a generally positive trend for most  
16 outcomes, we discussed several concerns that indicate  
17 additional analysis and refined measures may be appropriate.

18           First, the measures are very broad and do not  
19 focus on the skilled care that is provided in home health,  
20 and they do not focus on patient types that are most likely  
21 to benefit.

22           For example, the measures here show improvements

1 in function for all home health users. Given the number of  
2 users who receive therapy in home health, it would be useful  
3 to see functional improvement just for those patients.

4           Second, the measures present conflicting trends as  
5 they show improvement in the functional measures and no  
6 change in the adverse event rates. This disconnect seems  
7 troubling, as one might expect that quality care, which  
8 improves functioning, would also have a positive effects on  
9 adverse events; however, that does not appear to be the  
10 case, and we would like to understand the reason for this  
11 trend.

12           Third, some work by a contractor for ASPE raised  
13 questions about the accuracy of the risk adjustment for  
14 these measures. This research raised questions about the  
15 ability of the measures to control for differences in  
16 patient risk among agencies, and I can say a little bit more  
17 about that if you have questions.

18           For these reasons, we are being more guarded in  
19 our conclusions on quality this year. The current measures  
20 do show improvement, but additional analysis and revised  
21 measures would be beneficial.

22           In terms of access to capital, it appears that

1 home health agencies appear to have adequate access. It is  
2 worth noting that home health agencies, even publicly traded  
3 ones, are less capital intensive than other healthcare  
4 providers. Most home health agencies are too small to be  
5 studied by capital market analysts, but for the fraction of  
6 agencies that are publicly traded, analysts have concluded  
7 that the major firms have access to the capital that they  
8 need on reasonable terms.

9           For the non-publicly traded agencies, the  
10 continuing entry of new agencies reflects that smaller  
11 entities are able to get the capital they need to expand.  
12 As I mentioned earlier, the number of agencies has increased  
13 by about 50 percent or an average increase of about 480  
14 agencies a year.

15           Next, we turn our attention to margins. You can  
16 see that the overall margin in 2008 is 17.4 percent, but  
17 there is some variation as we've discussed before. The  
18 agency on the 25th percentile on the margin distribution and  
19 the -- had a margin of about 2 percent while the agency at  
20 the 75th percentile had a margin of 26 percent, and this is  
21 a spread that we've seen in previous years.

22           I would note that we only project margins for

1 freestanding providers. Hospital-based providers, whose  
2 margins were included in those reported during the review of  
3 hospital payments this morning averaged a margin of -4.6  
4 percent in 2008.

5           And then, finally, the table at the bottom shows  
6 our projected margins of 13.7 percent in 2010. These  
7 projections include the effects of planned payment policies  
8 including market basket updates and reductions for  
9 improvement in coding.

10           The next two slides address some questions about  
11 the range in margins for very rural providers and negative  
12 providers.

13           Questions raised by Tom at the last meeting, but I  
14 believe shared by a few other Commissioners. Tom was  
15 concerned about the financial performance of providers that  
16 serve the most rural areas. In this chart, providers have  
17 been split into quartile groups based on the share of their  
18 caseloads that come from the most rural areas, those with an  
19 urban population -- those counties with an urban population  
20 of less than 2,500 people. Though there is some variation,  
21 the overall margins for providers that serve these areas was  
22 no different than the national average I reported on the

1 prior page, 17.4 percent.

2 The agencies in the lowest quartile, those for  
3 which very rural patients comprised 1 to 24 percent of their  
4 population had the lowest margins with 12.7 percent, while  
5 those in the third quartile had the highest margins with  
6 22.7 percent. These margins suggest that even agencies  
7 which server very rural areas can earn significant margins  
8 under current payment levels.

9 Commissioners were also interested in  
10 understanding how the --

11 MR. HACKBARTH: Evan, before you leave that, can I  
12 just make sure I've got that.

13 So, as you move down the slide to the 75 to 100  
14 percent, the way I'm interpreting that is that in the  
15 agencies in that group are the ones where between 75 to 100  
16 percent of their patients are from the remote areas, if I'm  
17 reading that correctly.

18 MR. CHRISTMAN: Exactly. That's it exactly.

19 We also looked at the characteristics of negative  
20 margin agencies compared to agencies with positive margins,  
21 and this slide walks through that.

22 As you can see, the non-profits tended to be a

1 slightly higher share of negative -- non-profits tended to  
2 be negative at a slightly higher rate than for-profit  
3 agencies, and rural agencies tended to be negative at a  
4 slightly higher rate than urban agencies.

5           And then, several Commissioners have also  
6 expressed concern about the variation in the margins under  
7 the payment system. Remember that in a presentation last  
8 November, we walked you through an analysis that examined  
9 the difference between high- and low-margin providers. We  
10 found that the variation in the home health payment system  
11 was about the same as the variation in margins in other  
12 PPSs. We plan to do more analysis in this area, but the  
13 primary factors we identified were differences in agency  
14 cost per visit and, to a much smaller extent, case mix.

15           Overall, here is a summary of our indicators:  
16 Beneficiaries have widespread access to care; the number of  
17 agencies continues to rise, reaching over 10,400 in 2009.  
18 The number of episodes in rate of use continues to rise, and  
19 existing quality shows improvement on most measures but we  
20 believe better measures are needed. The access to capital  
21 is adequate and margins for 2010 are projected to equal 13.7  
22 percent. For the most part, these findings are very

1 similar to prior years, and that leads me to the draft  
2 recommendation.

3           The recommendation reads, "The Congress should  
4 eliminate the market basket update for 2011 and direct the  
5 Secretary to rebase rates for home healthcare services to  
6 reflect the average cost of providing care." Now, the  
7 spending implications of this are that it would save \$750  
8 million to \$2 billion in 2011, and more than \$10 billion  
9 over 5 years. The beneficiary and provider implications, we  
10 expect some contraction from the current high level of  
11 supply. The remaining supply should be adequate to provide  
12 adequate access to care.

13           I would just note that we expect a change of this  
14 magnitude may result in some agencies leaving the program;  
15 however, almost all beneficiaries had access to home health  
16 six years ago when there were significantly fewer agencies  
17 than we have today, and for this reason we expect that  
18 access to care would remain adequate, even if supply  
19 contracts in the future.

20           This next recommendation is similar to one we made  
21 last year, but we changed it around a little bit to reflect  
22 comments from the last meeting. The point of this

1 recommendation is to set up financial safeguards that would  
2 mitigate incentives to reduce services when payments drop  
3 due to the rebasing.

4           The recommendation reads, "The Congress should  
5 direct the Secretary to expeditiously modify the home health  
6 payment system to protect beneficiaries from stinting or  
7 lower quality of care in response to rebasing. The  
8 approaches considered should include risk corridors and  
9 blended payments that mix perspective payment with elements  
10 of cost-based reimbursement."

11           In terms of spending implications, there would be  
12 some administrative costs, but we expect it be budget-  
13 neutral impact on benefits payments.

14           In terms of the beneficiary and provider  
15 implications, we expect that this could potentially improve  
16 beneficiary access to care because it would encourage  
17 agencies to maintain the level of services they provide, and  
18 we don't believe it should affect appropriate access to home  
19 health care services.

20           Also at the last meeting, a few -- let's see --  
21 the other one is -- this is the quality recommendation, and  
22 this would charge the Secretary with developing additional

1 measures by identifying patients who would benefit from home  
2 health. This would also address some of the concerns about  
3 the definition of the benefit mentioned by Commissioners  
4 last December.

5           It reads, "The Secretary should identify  
6 categories of patients who are likely to receive the  
7 greatest clinical benefit from home health and develop  
8 outcomes measures which measure the quality of care for each  
9 category of patient."

10           The spending implications are that we would expect  
11 some administrative costs, and the beneficiary and provider  
12 implications are that we expect no impact on appropriate  
13 beneficiary access to care or providers' willingness to care  
14 for Medicare beneficiaries. It does have the potential to  
15 improve the quality of care.

16           And then, finally, at the last meeting, there was  
17 also some interest in some fraud and abuse recommendations.  
18 There was concern that CMS and others needed to be more  
19 aggressive in identifying and recovering fraudulent  
20 payments. It appears that under current authority, CMS has  
21 had difficulty addressing fraud, even in areas that have  
22 rampant patterns of abuse, such as Miami.

1           MedPAC and others have witnessed patterns of  
2 utilization that are anomalous, such as the significant  
3 variation in home health use among regions, suggesting the  
4 need for greater vigilance.

5           With these concerns in mind, here is a draft  
6 recommendation that expands the Secretary's authority to  
7 act, and it reads, "The Congress should direct the Secretary  
8 to review home health agencies that exhibit unusual patterns  
9 of claims for payment. The Congress should provide the  
10 authority to the Secretary to implement safeguards, such as  
11 moratoriums on new providers or suspension of prompt payment  
12 requirements in areas that appear to be high risk."

13           And the spending implications are that there are  
14 some administration costs, and it is not on the slide, but  
15 last night, CBO sent us some scoring for this that suggested  
16 the savings would be somewhere less than \$250 million and  
17 less than a \$1 billion over 5 years for this recommendation.  
18 We expect no impact on beneficiary access to appropriate  
19 care or providers' willingness to care for Medicare  
20 beneficiaries.

21           Now, another area that came up, and I think this  
22 was a concern of Arnie's and perhaps some others, was the

1 accountability of the physicians in ordering home health,  
2 and let me recap a little bit the role of physicians in home  
3 health.

4 Under the Medicare Act, physicians have to certify  
5 eligibility and the need for care every 60 days. In the  
6 review of eligibility, the physician must certify that, to  
7 the best of their knowledge, the beneficiary is homebound  
8 and has a need for skilled care. This is a formal  
9 attestation, and physicians are liable under the Stark Self  
10 Referral Act, the Anti-Kickback Statute, and the False  
11 Claims Act for the attestation they make; however, despite  
12 the emphasis Medicare places on the physician's judgment and  
13 the ambiguity in Medicare's definition of the benefit, there  
14 are no requirements that the physician examine the  
15 beneficiary in person. They may rely on medical records or  
16 other communication to make this judgment. For these  
17 reasons, it may be appropriate to require a physician or  
18 nurse practitioner to personally assess a patient when  
19 making these certifications.

20 Here is a draft recommendation which reads, "The  
21 Congress should require a separately billable in-person  
22 visit with the physician certifying or recertifying a

1 patient's need for home health, and this visit should occur  
2 within the 30 days' prior to the episode start, and the  
3 spending implications of this -- and again, this is another  
4 one where the scoring came in late last night from CBO and  
5 they indicated that they expected this would save somewhere  
6 less than \$250 million in the first year and less than \$1  
7 billion over 5. The beneficiary and provider implications  
8 are that there be no impact on appropriate access to care  
9 and no impact on providers' willingness to care for Medicare  
10 beneficiaries.

11           And then, finally, another issue is ensuring that  
12 physicians are aware of their responsibility under the home  
13 health benefit.

14           Prior to 2002, Medicare had a standardized form  
15 that physicians had to sign which reinforced their  
16 responsibility and culpability when certifying for home  
17 health, but this form was eliminated.

18           Current policy sets forth guidelines for the  
19 format of the certification, but they do not lay out a  
20 single form. Agencies may use the old form, but they are  
21 not required. This creates an opportunity for manipulations  
22 that unscrupulous home health agencies may attempt to

1 exploit. Given that the program counts on physician  
2 oversight, ensuring that physicians understand their  
3 responsibility and other benefit -- is critical to  
4 appropriate use and integrity of the home health benefit.

5 Reinstating the form is a requirement that would  
6 ensure physicians are being consistently and completely  
7 informed of their responsibility. And this brings me to the  
8 last draft recommendation.

9 It reads, "The Secretary should require that  
10 physicians must complete a standard form when certifying the  
11 need and eligibility for home healthcare. The Secretary  
12 should develop procedures for reviewing the certification to  
13 ensure that physicians are exercising appropriate judgment  
14 when certifying home health services."

15 And the spending implications are that there'd be  
16 limited administrative costs. I don't believe CBO had a  
17 score for this or expected no score.

18 The beneficiary and provider implications are that  
19 there would be no impact on beneficiary access to care or  
20 providers' willingness to care for Medicare beneficiaries.

21 That completes my presentation. I look forward to  
22 your questions.

1 DR. DEAN: You assume I have a question. Just to  
2 start, this has obviously been a concern of mine.

3 On slide 8, compared with page 38 in the chapter,  
4 the table on page 38 -- it lists the range of margins from -  
5 9 to 37 percent. These are quintiles and I realize these  
6 are quartiles, but there's a huge difference between the 2  
7 percent to 26 percent and -9 to 37 percent.

8 What is the explanation?

9 MR. CHRISTMAN: Okay. Right. There are two  
10 different measures. What you see on the screen here is the  
11 average margin for the agency that is the 25th percentile of  
12 the margin distribution. So, it's a single agency's margin.

13 DR. DEAN: Okay.

14 MR. CHRISTMAN: And what you're seeing on the  
15 sheet of paper is it is a margin for the cost and payments  
16 of all the agencies in the bottom quintile. So, there is  
17 about, I guess, around 800 agencies in there.

18 So, that's why what you see there is higher,  
19 because it is the very tippy-top of that quartile group,  
20 whereas down at the bottom there are a bunch of agencies  
21 with -10 and -20 that will be the 1st percentile in the  
22 margin distribution.

1 DR. DEAN: So, looking at the agencies with the  
2 low margins, it would seem maybe the -9 is more  
3 representative of the group than the 2 percent.

4 MR. CHRISTMAN: Well, yes, but I guess we're --  
5 and this is a fair comment, but I think what we're just  
6 trying to -- we're trying to do -- it's two different ways  
7 of showing the margin distribution. I think there's been  
8 discussion of what the -- of variations in performance in  
9 the home health system, and we've always shown the 25th and  
10 75th. I could show the 10th and the 90th, and you would see  
11 a lower number, obviously, on the low end, and a higher  
12 number on the on the high end.

13 DR. DEAN: Okay.

14 MR. HACKBARTH: I can see why that's confusing.  
15 So, you hear the issue that Tom's raising: We need to help  
16 people understand when we're subtly changing the measure  
17 like that. And I would agree with Tom's statement, that the  
18 -9, because it's the average of the whole quintile --

19 DR. DEAN: It's the composite of the group.

20 MR. HACKBARTH: -- that is more representative of  
21 the group as a whole as opposed to this way of measuring,  
22 which, as Evan says, is one agency.

1 DR. MARK MILLER: Well, just one second on this.

2 This is the quartile break, and the other one is  
3 the quintile break.

4 DR. DEAN: Quintile break, yes.

5 DR. MARK MILLER: I mean, if you broke this at the  
6 quintile, you could very well come up with a negative  
7 number. So, I'm not sure there's a misrepresentation of the  
8 actors in that -- I mean, the quintile just breaks it  
9 further down the distribution into the negative.

10 DR. DEAN: I understand that.

11 MR. GEORGE MILLER: No, and this only includes  
12 freestanding, where this one in the chapter is all-  
13 inclusive, which would be including hospital base.

14 DR. MARK MILLER: That's not right?

15 MR. GEORGE MILLER: No?

16 DR. DEAN: I think all your margins just include  
17 freestanding.

18 DR. MARK MILLER: Freestanding.

19 DR. DEAN: Because that was my next issue.

20 MR. BERTKO: One percentile, one percentile.

21 MR. HACKBARTH: Yes, yes. The misrepresentation  
22 word caught my ear, Mark. And if I understand Evan

1 correctly, neither is a misrepresentation. They are  
2 different statistical measures of the distribution. One is  
3 focusing at a particular point on the distribution; in this  
4 case, the 25th percentile, and saying, what is the margin of  
5 that agency, or the agencies are at that point in the  
6 distribution, whereas --

7 DR, CROSSON: See, it's akin to means and medians.

8 MR. HACKBARTH: Yes, whereas the other measure is  
9 saying, let's look at everybody in the quintile, the lowest  
10 quintile, and then average up, take the mean of the people  
11 in the bottom quintile. There are different measures,  
12 neither is right or wrong, but they are different. There  
13 could be some distortion in the comparison by the fact  
14 you're using quartile at one place, the 25th, and the other  
15 you're using the quintile, the 20th.

16 DR. MARK MILLER: And I follow all that, and with  
17 all respect, all I'm saying is that you could break that at  
18 the quintile and you would get a lower number; you could  
19 break it at the 10th percentile and you would get a lower  
20 number; that's all I'm saying.

21 MR. HACKBARTH: Yes, yes. Agreed.

22 DR. SCANLON: I think the more important issue,

1    though, is that when you do the average for a group that's  
2    in the bottom 25 percent or the top 25 percent, you --  
3    there's an influence of what the most extreme value is. And  
4    having worked with some of these kinds of data before -- I  
5    don't know whether you've done this, but sometimes we would  
6    throw out the top five observations or the top ten  
7    observations, because they're absurd. I mean, and so you  
8    get to this point where you're bringing in data that may be  
9    suspect and it's driving that average where it doesn't drive  
10   the percentile point.

11           MR. HACKBARTH: [Off microphone] -- point, and  
12   Evan, do you just want to address it? Do you trim the  
13   extreme values when you do these?

14           MR. CHRISTMAN: We do a lot of trimming, yes.  
15   These cost reports are not audited, in general, so we clean  
16   them out. I mean, there's about 5,000 agencies in our final  
17   sample of 7,000-8,000 cost reports that we start with. So,  
18   we do.

19           DR. DEAN: I'll wait for round two.

20           MS. HANSEN: Yes, thank you, Evan. This is --  
21   actually, the language of all the recommendation threes, and  
22   it has to do with having the physician role certified. Is

1 it specified in statutory language that it's a physician or,  
2 given our earlier discussion today about primary care  
3 providers, is there -- it is really about having somebody  
4 who is qualified, and if it is, in some places, an advanced  
5 practice nurse who could be part of this.

6 MR. CHRISTMAN: I do not believe at this point  
7 that an advanced practice nurse can do it. I believe the  
8 law specifies a physician.

9 DR. MARK MILLER: Actually, I thought we were  
10 having a conversation, at least based on some of our  
11 discussions yesterday, where we were going to try and  
12 parallel what we did on the hospice side, where we said  
13 "physician or advanced practice nurse." We can recommend  
14 what we want, but I did not realize -- you think it's  
15 specifically precluded by law for someone to do it.

16 MR. CHRISTMAN: Well, yes. I think that the  
17 current law -- I believe it does not permit a nurse  
18 practitioner. I believe it would have to be a physician who  
19 does it.

20 DR. SCANLON: I think there may be a provision in  
21 either the House -- I think it might be in the House bill  
22 that may expand the numbers of people that can certify, or

1 the types of people that can certify, but I wouldn't swear  
2 to that.

3 MR. HACKBARTH: I want think a little bit more  
4 before I commit to doing something.

5 The idea of having advanced practice nurses  
6 practicing under the supervision of a physician being able  
7 to have the face-to-face visit is appealing to me. This was  
8 something Ron and I talked about, also.

9 And so, if we think that they are prohibited from  
10 doing that by statute, we could recommend that the statute  
11 be altered to accommodate that. So, let's just put a marker  
12 on that and continue with comments.

13 MS. BEHROOZI: I guess it's kind of related, and  
14 maybe it's a dumb question, but that physician who does  
15 this, does it matter whether it's an employee of the home  
16 health agency or a discharging physician at a hospital? And  
17 I noticed that in hospice it requires two; it requires  
18 somebody who is not employed by the hospice to also make  
19 that determination and does that have any applicability in  
20 this situation?

21 MR. CHRISTMAN: The current law doesn't allow --  
22 will allow a physician who is employed, say, as a medical

1 director. My understanding is the way that this prohibition  
2 works right now is that the Stark Act allows for you to -- a  
3 home health agency to hire a physician to be a medical  
4 director and the -- where the line is drawn is that their  
5 reimbursement is not supposed to be tied to the volume or  
6 value of any referrals that they send.

7 Now, in practice, sometimes, the reason a doctor -  
8 - a medical director at home health agency assigning for the  
9 patient is there may not be a regular physician for them to  
10 go to for that person. Some doctors I talk to say -- that  
11 are medical directors -- say they don't want to, but  
12 sometimes it is what they are called on to do to make sure  
13 people get care that they are supposed to get.

14 MR. KUHN: Two quick questions, and getting really  
15 down to weeds here and Mitra asked one of my thoughts here,  
16 but on the current coding that's available, current CPT  
17 codes, do we think that the current codes have the  
18 appropriate descriptors and valuations for them to do this  
19 certification process?

20 MR. CHRISTMAN: I guess, in terms of -- I'm really  
21 not familiar enough with CPT to really answer that question.  
22 I know broadly that codes exist that allow physicians to

1 bill for doing the paperwork for home health, for example,  
2 and this is one of the rare instances when Medicare does not  
3 require a face-to-face service. So, they can get paid to do  
4 the paperwork. My understanding is it is not a very  
5 frequently billed code.

6 MR. KUHN: And the second question on the  
7 recommendation 3C for that certification, I guess, for lack  
8 of a better term, a certificate of medical necessity, I  
9 guess, why did that -- what was it replaced with in 2002, or  
10 was it replaced with anything?

11 MR. CHRISTMAN: It was. What it was replaced with  
12 was just sort of broader guidance. They got rid of the form  
13 and they said, the form needs to -- there's no longer a  
14 requirements that you use the -- it was called the 485 -- no  
15 longer a requirements to use the 485, but, oh, by the way,  
16 here's a bunch of guidance that says when you fill out --  
17 when you take the certification, it must have all these  
18 elements look very similar to the 485, and then even that  
19 guidance was retired.

20 And so, it is much more -- broader, higher level  
21 statements now that govern what the content of the form is.  
22 My understanding is that some contractors rely on the old

1 from when they're auditing and saying -- telling the  
2 agencies what they expect. But the point of this  
3 recommendation is just that right now there's a little bit  
4 of leeway in what agencies might do and a concern that  
5 unscrupulous agencies might seek to manipulate this  
6 uncertainty to not fully inform physicians of their  
7 responsibilities, and that's what we're trying to close.

8 DR. BORMAN: Just to try and come at the CPT  
9 question, Herb, I think that you could probably use the  
10 mandated services modifier that, for example, goes on an E&M  
11 visit doing an EMTALA, screening, stable enough evaluation.  
12 There's a mandated services modifier, so presumably some  
13 application of that could work for that and you wouldn't  
14 have to create a new series or anything since it's face-to-  
15 face.

16 DR. BERENSON: We created a care plan oversight  
17 code for this purpose when I was at CMS. In fact, my  
18 understanding is that it's not billed very much, but at  
19 least some physicians are grateful. The idea at that time  
20 was, if we're expecting the doctors to take responsibility  
21 for this certification, we should at least pay them for  
22 their professional services, and it was one of the first CPT

1 codes -- it was actually HCPCS -- CMS generated one  
2 initially, made its way into CPT, one of the few non-face-  
3 to-face codes. Whether it's adequate to what we're now  
4 expecting, and whether if we start now talking about a face-  
5 to-face visit -- whether it should have other things in  
6 there.

7           What I was going to say in round two, but I've got  
8 the platform here, is that if ever there's a need for a  
9 medical home-like activity, it is having a physician knowing  
10 -- in many cases, it's not the primary care physician who is  
11 taking care of the diabetes and the heart failure who is  
12 requesting skilled nursing. It may be the surgeon who  
13 debrided an ulcer and needs wound care, and suddenly there's  
14 this form showing up with the medications all wrong. The  
15 surgeon is doing what the surgeon is doing. There is a need  
16 here for real coordination, preferably, in my view, through  
17 the primary care physician, but it can be another physician  
18 taking responsibility, and it should be paid adequately, and  
19 we need to get code descriptors that are specific for this  
20 activity in my point of view.

21           MR. GEORGE MILLER: In general, I support the  
22 recommendations. I'm a little bit concerned for rule and

1 frontier hospital-based home care. I think you made the  
2 comment that most of the beneficiaries in America would not  
3 be affected; however, in those remote areas of the country  
4 where the hospital-based home care may be the only provider  
5 of care -- well, I should have asked that question.

6 Do you know if you can identify those places in  
7 America where the -- other than Tom's -- where the hospital  
8 provides all of the home care for a community or a region or  
9 whatever the descriptor would be, and how many there are and  
10 how they would be impacted by this regulation, particularly  
11 since they are the ones, I believe, with the negative  
12 margins?

13 MR. CHRISTMAN: Okay. So, there are a couple of  
14 questions in there, and let me make sure I get them all.

15 MR. GEORGE MILLER: I only tried --

16 MR. CHRISTMAN: One is I believe there's about  
17 1,300 hospital-based agencies, and we can see where they  
18 provided are in a given year. Let me back up.

19 It is always challenging to figure out what a home  
20 health service area is, because we can run the tapes and we  
21 can see where they provided are, but obviously their service  
22 areas could extend to places where people didn't live or

1 didn't demand services. So, we -- it's not a perfect  
2 process with that.

3           In terms of how this would affect their margins,  
4 obviously it would be challenging for them. I think the  
5 difficulty we -- the thing that really trips me up with  
6 hospital-based agencies is they have a higher cost per visit  
7 than freestanding agencies, and it's -- the number off the  
8 top of my head -- can't summon it, but trying to understand  
9 why it cost them more just to provide a visit in the same  
10 side of care that a frontier operating freestanding agency  
11 would go to is something that we've never really been able  
12 to satisfactorily explain. And so, I appreciate that this  
13 is going to have a higher -- they have negative margins, so  
14 it will hit them, but we see another cost structure that  
15 operates in the same environment that, as you saw in the  
16 next slide, was getting the same margins as providers  
17 overall.

18           So, I guess that's why I think that obviously the  
19 draft recommendation is perhaps in the right place, but the  
20 difference in --

21           MR. GEORGE MILLER: But I guess my question, I'm  
22 sorry -- is, are there -- do you have the number where they

1 are the only provider of that service area.

2 MR. CHRISTMAN: I'm sorry, I don't know that. I  
3 don't know that.

4 MR. GEORGE MILLER: And with this recommendation,  
5 how many will we put out of business, because the commercial  
6 providers aren't covering that role of small frontier?

7 Even though I agree -- I mean, I believe you that  
8 the difference providing that care may be different but if  
9 they are not providing that service in that community,  
10 you're going to leave them without any services, and I think  
11 this is Tom's point, yeah.

12 DR. DEAN: I mean, just speaking to that with the  
13 South Dakota example, South Dakota is a pretty big state.  
14 The only freestanding providers that exist are in two  
15 corners of the state, in Sioux Falls and the Black Hills  
16 area. The rest of the state, the only providers that are  
17 available are hospital-based.

18 MR. CHRISTMAN: Yes, I mean, I guess that what we  
19 don't understand well enough is why there are some areas  
20 that are very rural that are going to have a freestanding  
21 agency and some areas that don't. And what we know about  
22 the freestanding areas -- excuse me, the frontier areas

1 where a freestanding area will operate is that they can take  
2 a lot of patients from these areas and they can do pretty  
3 well. And maybe we owe you a better path at that question,  
4 but it doesn't suggest to us that -- I guess we don't have  
5 an obvious answer as to why they're avoiding those areas,  
6 because there are areas that are that sparsely populated  
7 where they're diving in and doing all right.

8 MR. HACKBARTH: I just want to go back and ask a  
9 question about something you said. So, you said, when you  
10 compare the per visit cost of the hospital-based agency and  
11 the freestanding, the hospital-based are significantly  
12 higher, are you talking about average costs, including the  
13 allocated overhead when you do that calculation?

14 MR. CHRISTMAN: Yes, yes.

15 MR. HACKBARTH: Okay. So, if you're including the  
16 allocated overhead, it pretty much explains why the per  
17 visit cost -- or at least part of the reason why the per  
18 visit cost is higher.

19 Now, if I'm running a hospital-based agency, the  
20 question that I'm asking about whether I want to continue  
21 this line of business or not is whether my direct costs are  
22 covered and whether this operation is contributing to my

1 overhead costs. And so, even if on an average costs, fully  
2 allocated basis, it's losing money, it could be a good thing  
3 to continue to do if it's helping the hospital spread those  
4 fixed costs over a larger base, and can we shed any light on  
5 that?

6 MR. CHRISTMAN: We haven't done that analysis.  
7 That's something that we could look at.

8 DR. MILSTEIN: I have a frame of reference  
9 question. If you were -- can someone else remind me whether  
10 or not the physician who is authorized to do the  
11 certification for hospice eligibility, do we allow that  
12 physician to be on the payroll of the hospice, because  
13 obviously -- you know where I see this question is leading.

14 DR. MARK MILLER: Yes, I do, and Glenn and I were  
15 talking a little bit offline. We may have more to say about  
16 this, but I believe the following is correct: When the  
17 initial certification is done for the patient for hospice,  
18 it is supposed to be a community-based doc involved in that  
19 with a hospice-based doc. Well, after that point, it can be  
20 just a hospice-based doc.

21 Did I answer you question? I thought that I did.

22 DR. MILSTEIN: Let me ask the follow-up.

1           In our last discussion in December we talked about  
2 what -- given what we know about this area, whether this  
3 might be something else we might layer into either A, B, or  
4 C -- it could go in any of these places -- about essentially  
5 saying that the physician doing the certification cannot be  
6 on the payroll of the home health agency.

7           Could you just share the rationale for not doing  
8 that.

9           MR. HACKBARTH: What gave us some pause there was  
10 thinking about integrated systems where there's common  
11 ownership, a physician on the payroll, a salaried staff  
12 member of an integrated system that also owns the home  
13 health agency. So, it is those sorts of cases.

14          DR. CASTELLANOS: I guess on page 19, I just want  
15 to really make sure that I understand this.

16          The physician -- I hope it's not an either/or  
17 situation where the physician is certifying or recertifying.  
18 I would hope that could be the same physician. It can't --  
19 he doesn't have to be one that just certifies and another  
20 one that doesn't. It is just semantics that I'm concerned  
21 about.

22          MR. CHRISTMAN: Well, there's some interesting

1 transition of care questions that come up around that  
2 exactly. And this -- for example, is someone coming out of  
3 the hospital? Maybe in an ideal situation they're being  
4 returned to their -- the community physician will take over.  
5 But in terms of moving the -- getting home health to that  
6 person as soon as possible, you might expect that the  
7 hospital physician will certify that, and then maybe the  
8 community-based physician would recertify. Now, maybe  
9 that's not an ideal situation and that's something to talk  
10 through, but that's -- the current approach does allow some  
11 flexibility and I guess it shouldn't be thought of as all  
12 bad, necessarily.

13 DR. CASTELLANOS: What you are saying, the mix,  
14 and the hospital and -- just to stress, Glenn, your point is  
15 that, as far as a physician goes, if it is by statute, it  
16 has to be a physician, I think we need to make a  
17 recommendation to change it to that statute.

18 MR. HACKBARTH: We'll come back to that. Mark has  
19 some clarification on that.

20 MR. BUTLER: So, once you get past the update  
21 recommendations, we're saying, Secretary, we want you to do  
22 something, we're going to authorize you to do it, and so

1 we're trying to guess with as great as precision as we can  
2 on some of the options, and that's where we're struggling a  
3 little bit here.

4 But I have a couple of clarifying questions. So,  
5 there's 86 -- and your slide 8, I think, it says 86 are for-  
6 profit -- 86 percent, 14 percent non-profit of the  
7 freestanding, although the same chart in the chapter does  
8 not say that these are just freestanding.

9 So, is that about the right -- the chapter of  
10 documents says that 86 -- it has some of the same numbers,  
11 but it doesn't say it's just freestanding.

12 MR. CHRISTMAN: Yes, no. They're just  
13 freestanding in the --

14 MR. BUTLER: So, if you added in the 1,300 that  
15 are hospital-based and that --

16 MR. CHRISTMAN: That are for -- right, I'm sorry.  
17 Go on.

18 MR. BUTLER: -- they're not all non-profit,  
19 either. Probably some are associated with for -- I'm just  
20 getting a sense. Is it roughly --

21 MR. CHRISTMAN: It would -- I think the share of  
22 non-profit would rise.

1           MR. BUTLER: Right. So, it might -- but it is  
2 still predominantly not -- my next question then would be,  
3 going to page 17 and the recommendation.

4           So, I'm curious because we've discussed in various  
5 settings various ways -- maybe the inspector general isn't  
6 one to look after this in some way, but in -- I think it  
7 came out of 41 investigations in Dade County alone, would  
8 you know anything about whether those are almost exclusively  
9 for-profit, the generated ones, or are the non-profits been  
10 the source of some of these, too?

11           I'm getting at the moratorium. Maybe this is an  
12 example of where we should have a moratorium maybe on the  
13 for-profit side of this if that's where all the problem is  
14 versus the non-profit.

15           MR. CHRISTMAN: Well, my understanding is that  
16 most of the troubles that they have found so are in non --  
17 or, excuse me, for-profit agencies. That's not to say that  
18 they may find something else coming down the line, but I  
19 guess that's -- in terms of the facts, that's what I know.

20           MR. BUTLER: I would just hate of us to throw out  
21 there, well, let's have a moratorium on everything if in  
22 fact where you see this coming up is in a specific segment

1 of the business.

2 MR. HACKBARTH: Yes, and I understand what you're  
3 saying.

4 When I look at this recommendation, what I see is  
5 that we're urging Congress to broaden the Secretary's  
6 discretion, give her more tools to use where investigation  
7 identifies problems.

8 One of the things that presumably she would want  
9 to do is examine these patterns.

10 MR. BUTLER: I understand. It says "such as,"  
11 too. It doesn't say this one specifically.

12 MR. HACKBARTH: Right, right, right.

13 Do you want --

14 DR. MARK MILLER: And just -- yes, I will. And  
15 just the other clarification, it says, new providers, and  
16 the growth in this area has been dominated by for-profits or  
17 not?

18 MR. CHRISTMAN: Oh, yes, absolutely.

19 DR. MARK MILLER: So, you may be closer to where  
20 you wanted to be, anyway.

21 MR. BUTLER: As long as we make sure -- and I  
22 think the chapter does say this. It helps steer them in a

1 direction where to look, then I think it's fine.

2 DR. MARK MILLER: And that can certainly be  
3 written about.

4 MR. HACKBARTH: Okay. So, before we go back and  
5 start round two, I want to address the issue of the  
6 physician/advanced practice nurse in making the  
7 certification.

8 Mark.

9 DR. MARK MILLER: Okay. And I need eye contact  
10 with Kim and Evan, okay? Since I've been kind of tired here  
11 and missing --

12 MR. HACKBARTH: You need to be wall-eyed, I think,  
13 to do that.

14 DR. MARK MILLER: All right. Okay. So, what I'm  
15 suggesting here -- could you put up 3B. Sorry about that.

16 So, what I would suggest here is we, in the second  
17 line, take out the clause that says "with the physician."  
18 So, what this becomes is a separately billable in-person  
19 visit certifying or recertifying, okay?

20 And so, this would leave the flexibility for that  
21 visit to be done by a physician or a nurse, advanced  
22 practice nurse, and we would continue to be fairly -- or be

1 consistent with our hospice approach.

2           And what would be important to add to that is that  
3 -- and this is also consistent with the hospice approach,  
4 assuming I've still got the right eye contact here is, in  
5 our next recommendation where it says "somebody must  
6 certify," it does have to be certified by a physician. So,  
7 in other words, you could have an advanced practice nurse go  
8 out and visit the patient and come back with notes and so  
9 forth about the condition of the patient, but the  
10 certification in the end is by a physician.

11           So, 3B would be the visit can be made by  
12 either/or, or a set of people, 3C would be, but the  
13 certification is the physician only, and I believe that's  
14 consistent with the tact we took in hospice.

15           Okay. Even, I realize this is a switch while  
16 you're right up at the plate. So, if you have reactions,  
17 the time is now.

18           MR. CHRISTMAN: I think that that follows what I  
19 expected it to do.

20           MR. HACKBARTH: Bob, on this issue?

21           DR. BERENSON: Yes, on this issue -- I'm thinking  
22 out loud here a little bit. What I think happens in -- I

1 mean, where's the other one?

2 DR. MARK MILLER: 3B.

3 DR. BERENSON: 3B.

4 So, you would say, Congress should require a  
5 separately billable in-person visit certifying -- I mean,  
6 the issue is when -- if things were working well and you had  
7 a medical home physician practice and the patient was  
8 seeing, let's say, a surgeon for a procedure for a  
9 debridement and that surgeon thought the patient needed  
10 skilled nursing and home health services, that that would  
11 constitute the visit and that that primary care physician  
12 wouldn't have to separately see but was able to certify or  
13 somebody working -- so, this is not saying the visit has to  
14 be done with the physician who is -- or with anybody who is  
15 certifying. It's saying a visit has to be done, right?

16 I mean, I want to give some flexibility, and at  
17 the same time, I'm worried that we're opening the door for  
18 something here. I mean, if it were working well -- if the  
19 medical home could have that conversation, understand the  
20 purpose for the home health but not be the one who was  
21 actually seeing that patient in that 30-day window.

22 DR. MARK MILLER: As I understand, what we just

1 constructed here, the scenario he talked through would be  
2 allowable. I would have gone to a surgeon, the surgeon  
3 would have said, you need -- after this, you need home  
4 health visit, and either that visit could certify or another  
5 physician could certify on the basis of the information.

6 Kim, are you having a heart attack.

7 MS. NEUMAN: [off microphone] No.

8 DR. MARK MILLER: Okay. I just need to know. I  
9 can't always read you.

10 DR. SCANLON: Yes, I think we have to worry about  
11 -- that the perfect does not exist and the medical home is  
12 not available to a lot of people and that a MedPAC meeting  
13 sometime down the pike could be talking about how dual  
14 eligible, other low-income people, minorities, are not  
15 accessing home healthcare because they can't get, in a  
16 timely way, at least -- they cannot get this physician visit  
17 30 days before the episode starts. There's a particular  
18 problem for people that end up hospitalized because the  
19 hospital is a source of care of last resort. They don't  
20 have -- and they don't have a usual source of care or they  
21 use a community health center, they are not going to be able  
22 to necessarily get the home healthcare they need the day

1 they leave the hospital, unless it's the physician in the  
2 hospital that plays a role in the certification. And I  
3 think we should, at least in the text, talk about that as an  
4 expectation. There is a condition of participation for  
5 hospitals about discharge planning and this should -- there  
6 should be a consideration that you just don't say to people,  
7 check off a box, you should go find home healthcare. You  
8 should help support them in terms of required documentation.

9           Now, let me just say that I know from the advanced  
10 nurse practice nurse community that they very much feel that  
11 they should be able to certify here, and I have mixed  
12 feelings about that. I mean, on one level I think it  
13 potentially is perfectly appropriate because we're not  
14 talking about the same kind of decision that we're talking  
15 about in hospice care.

16           With hospice care, we are talking about something  
17 that is much more medical, and here we may be talking about  
18 something that is much more related to nursing and they may  
19 be in a better situation to talk about -- particularly if it  
20 comes to the plan of care -- is this appropriate or not, as  
21 opposed to a physician looking at that.

22           At the same time, we've got this issue that we've

1 had such loose oversight of home health agencies, I worry  
2 about affiliations. I mean, it's not that physicians are  
3 all to be trusted and nurses not, it's this question of,  
4 we've got to have adequate oversight, and our only line of  
5 defense at this point is the certification process, and it's  
6 not really an adequate line of defense.

7 MR. HACKBARTH: Where do you come down on what to  
8 do, Bill?

9 DR. SCANLON: I don't know. I mean, I'm really  
10 torn by this.

11 MR. HACKBARTH: So, I think Bill has made a good  
12 point. The decision about the prognosis and whether a  
13 patient has six months to live -- that is a physician's  
14 decision, whereas certification for home health, I would  
15 think could be appropriately be done in many instances by an  
16 advanced practice nurse. I do think they're a little bit  
17 different, it seems to me, as a non-clinician.

18 We're making this increasingly complex. My  
19 inclination would be to use the language as modified by Mark  
20 and have some discussion of this in the text.

21 MS. HANSEN: I can hear, definitely, what was said  
22 by Bill, and the difference with hospice and home healthcare

1 is there.

2 I do like the way Mark has characterized it, and  
3 then I want to offer one more way to think about this is the  
4 aspect of home health in the future will be possible through  
5 whether it's an ACO or a medical home will have  
6 opportunities for people to get home healthcare  
7 appropriately, perhaps not just from the hospital. So, if  
8 that's the case, then it's not always going to be the  
9 surgeon who sees this wound care that is absolutely  
10 necessary. It is going to be based on the functional and  
11 clinical needs of home health traditionally that could be  
12 ascertained by a skilled person who is an advanced practice  
13 nurse, with ultimate, at this point, if it is statutory,  
14 still signed by being connected to a physician. So, I'm  
15 just looking at it, frankly, also from a beneficiary side  
16 that, beyond what was talked about access issues, but there  
17 is just a flow of care that should be timely, clinically  
18 appropriate, and have accountability to it.

19 So, I think what Mark does offer right now offers  
20 us that room plus the text.

21 MR. HACKBARTH: On this issue of the availability  
22 of the visit, I think given the issues around access to

1 primary care, that is, as Bill says, a legitimate concern,  
2 and allowing an advanced practice nurse to do the visit if  
3 not the certification, does at least somewhat expand the  
4 pool of available clinicians to do this piece of work.

5 DR. DEAN: As you and I talked about on the phone,  
6 I hate this kind of stuff. This, I think, it's --

7 MR. HACKBARTH: You're talking about certification  
8 of home health, not MedPAC meetings.

9 [Laughter.]

10 DR. DEAN: Not MedPAC, no.

11 MR. HACKBARTH: Be clear.

12 DR. DEAN: I think if we're going to go in this  
13 direction, we have to have some explicit criteria as to who  
14 qualifies and who doesn't and some guidance. If we're going  
15 to sign a form with some significant accountability, we need  
16 to know what it is, who are we supposed to certify, and who  
17 are we not.

18 And I guess I'm reacting to the certification for  
19 DME stuff drives us crazy, because we get these laundry  
20 lists from the supplier about the diabetes supplies, and  
21 they include everything you could think of on there, and the  
22 easiest thing is just to sign the form, but that authorizes

1 the provider to deliver all kinds of supplies, and I have  
2 people coming in to -- well, I've got this meter that -- I  
3 don't need a meter. And it gets even worse when you get  
4 into some much more significant equipment like scooters and  
5 wheelchairs and that kind of stuff.

6           So, I think that the idea that, in some ways, an  
7 in-office visit might be the least valuable in terms of  
8 trying to make this judgment, what we need is knowledge of  
9 what is this person's functional capacity at home; can they  
10 make a legitimate decision about their medications; are they  
11 truly homebound and what does that mean; can they go to  
12 church; can they come to the doctor; can they get their  
13 groceries. And those are the things that we're supposed to  
14 verify with a certification, and frequently we may not know.  
15 So, like I say, I cringe a little bit, even though I  
16 understand that somebody needs to make that judgment, but it  
17 needs to be someone that really knows what that person's  
18 capabilities are, and a visiting nurse probably knows better  
19 than we do. And so, either we need some direct information  
20 from them which sometimes we get and sometimes we don't, but  
21 anyway, that's my frustration.

22           DR. MARK MILLER: You are tracking that that's an

1 in-person visit. So, the way this is constructed, a nurse  
2 could go to the home and gather that information.

3 DR. DEAN: If we had a good clarification of what  
4 information we really need and what are the criteria, it  
5 would be much more doable.

6 MR. HACKBARTH: [off microphone] -- some of the  
7 same concerns that Tom has, and then Bob, who has thought  
8 about this a bit, then Jay. So, let's do some doctors for a  
9 while.

10 DR. BORMAN: I think part of the problem we're now  
11 coming back to, and I'm very happy with Mark's modified  
12 language, because I think it's flexible, we can cite some  
13 scenarios and be a little bit vague, but the problem we're  
14 bumping up against fundamentally is we don't have a good  
15 definition of this service. That's the problem. Since we  
16 don't have a good definition of the service, all the roll-  
17 out from that about what you should do in order to enable  
18 it, who should do it, how it should be done becomes very  
19 difficult because you don't know.

20 For example, if I look at it from the perspective  
21 of a practicing surgeon, as I look at home health, there is  
22 basically a dichotomous population of visits. One is very

1 sharply delimited for the most part, almost mono-task  
2 focused. The individual, for example, that has a wound in a  
3 location on their body they can't reach that needs regular  
4 dressing changes, and at X time, the wound is going to heal,  
5 or maybe the other thing they have with it is the  
6 administration of preventable antibiotics. So, they get a  
7 shot, they get an IV, something, while the caregiver is  
8 there. That's pretty definable. That probably is better  
9 served by being the person who is going to make the judgment  
10 about that wound and it's healing and whatever, and I will  
11 say that it's been my observation that many of the forms  
12 that come to me under these circumstances have these people  
13 getting wound care twice a day for weeks on end or they're  
14 getting their wheelchair certified for 99 years or whatever  
15 the longest thing it is on there so they can have it  
16 indefinitely. And so, I find that what comes -- and  
17 typically, those are -- other than physician advanced  
18 practitioners that are filling out those forms upfront, and  
19 I think they are somewhat hobbled by their limited  
20 information about the patient when they go to fill out the  
21 form. But I do think part of the problem is we don't -- we  
22 haven't defined the benefit.

1           And we really have two kinds of benefits. We have  
2 this rather finite, shorter-term, mono- or duo-problem  
3 focus, and then we've got this person over here who is 85  
4 years old, has 5 chronic illnesses, 22 pills a day, it's  
5 starting to get into an issue of medication management.  
6 They really do need their blood pressure taken two times a  
7 day, whatever it may be, and unfortunately, in my part of  
8 the real world, to use Ron's phrase, these people come with  
9 paperwork that looks very similar. The 33-year-old with the  
10 wound he or she can't get to comes with a form that says,  
11 take vital signs twice a day and visit them four days a  
12 week for four weeks and da, da, da. So, I think we're  
13 fundamentally at the problem of defining the benefit, which  
14 in some way we're turning back around to the Secretary, and  
15 so maybe we need to be careful just how far down this detail  
16 road we go so that we don't preclude the opportunity to  
17 redefine rebase.

18           MR. HACKBARTH: Before I turn to Bob, you said at  
19 the outset, though, that you felt that Mark's  
20 modification....

21           DR. BERENSON: Yes, I think we will want to  
22 continue this sometime in the future because this is -- let

1 me just agree mostly with Tom and Karen on the frustration  
2 around this benefit.

3 I would consider myself, when I was in practice,  
4 relatively policy savvy. By some standards, I was already a  
5 policy wonk. And I had no clue as to what I was signing for  
6 what purpose. There may have been a form that instructed  
7 me, but I did not know that the patient needed to have a  
8 particular skilled need, whether it was nursing or therapy.  
9 I didn't ever hear the term home-bound, that is supposedly  
10 there. I just knew these forms were coming in front of me,  
11 usually with the wrong medications. They had been filled  
12 out in the hospital. And by the time it got to me, usually  
13 for a recertification, all of medications had been changed  
14 without any opportunity to get involved.

15 So I like the fact that you have put in the  
16 chapter that there's a real issue here. I think we're going  
17 to have to go beyond just reinstating a form or something.  
18 I think there's got to be a real education activity  
19 associated with -- if, in fact, we are going to continue to  
20 see the physicians or advanced practice nurses as the  
21 gatekeeper for home health.

22 It is important enough, it seems to me, with the

1 kind of money that we are putting out the door and the  
2 clinical services being provided, probably for as much as  
3 you don't know that -- I mean, all these things are  
4 happening and you have no control. I think we want to force  
5 the physicians, somebody, to actually take responsibility in  
6 this area.

7 I learned towards the end of my practicing career  
8 the way to deal with this often was actually by spending the  
9 time talking to the home health nurse -- who loved talking  
10 to me once I finally figured out that that was a possibility  
11 -- to find out what was going on with this patient. I  
12 started taking responsibility to understand what the surgeon  
13 was ordering.

14 And it is the concept of the medical home, and I  
15 agree with Bill, it's going to take us a long time to have  
16 medical homes around the country. But it does seem to me,  
17 if we can't start here -- and compensation has to be part of  
18 this -- to ask for a serious professional effort by medical  
19 practice to take responsibility for complicated patients in  
20 home health, it's got to be paid appropriately and held out  
21 as a very important professional service. And if that means  
22 the time to be on the phone with lots of people, then that's

1 what we want to be doing.

2 That's different from the whole medical home  
3 infrastructure that we're talking about. But I think, as an  
4 interim, we could probably create some CPT codes and, with  
5 education, I think make some good progress.

6 I share with Arnie some concern about physicians  
7 who are sort of double agents in this area, who are also  
8 working for the agency. I don't have a way out of this  
9 integrated care system. But an integrated care system  
10 that's doing fee-for-service only makes me nervous. But I  
11 understand there's no easy way to get around that.

12 So I'm comfortable with all of the language. I  
13 think, if anything, we want to strengthen what you've  
14 already put into the text on this physician -- on education,  
15 on reinstating the forms, and on paying appropriately for  
16 what's a very serious professional activity.

17

18 DR. CROSSON: I agree with everything that Bob has  
19 said. I have a similar vision. And I think with the  
20 combination of recommendations 3B and 3C, we very well could  
21 get there.

22 However, in addition to taking time, I'm also

1 concerned that maybe that's not going to happen everywhere.  
2 We already have evidence that because the benefit is ill-  
3 defined, and for other reasons, there appears to be  
4 progressive overuse of the benefit.

5           So I've sort of come to something that I never  
6 thought would escape my mouth, and that's the possibility of  
7 preauthorization. I have been, as a physician, generally  
8 quite reluctant to see that used because I don't think it's  
9 very successful. However, there are some characteristics  
10 here which are a little different.

11           First of all, we've already described that, in  
12 fact, this benefit could be adjudged by someone other than a  
13 physician. In fact, some have made the case maybe it should  
14 be done so by someone other than a physician. So it's a  
15 little different from some of the areas that  
16 preauthorization has failed in, I think, in the past.

17           By the way, I'm going to speak against  
18 preauthorization tomorrow in the quality discussion, just  
19 for the record.

20           [Laughter.]

21           DR. CROSSON: I don't think we should muck up  
22 recommendations 3B and 3C with that, however. So I have one

1 suggestion, and that's on recommendation 3A, on slide 17,  
2 that we consider inserting in the panoply of actions that  
3 the Secretary could take in situations where things seem to  
4 not be working to institute independent preauthorization and  
5 perhaps in certain geographies at certain times, and perhaps  
6 something could be learned from that. It either would work  
7 as a temporary solution, a focused solution, or it wouldn't.

8           So my proposal would be to insert after the word  
9 providers on line four "comma, independent  
10 preauthorization."

11           MR. HACKBARTH: Okay. Herb.

12           MR. KUHN: Just one general thought here that  
13 might be helpful is we talked about putting additional  
14 things in the text that might be available here. One model  
15 that we might want to look at or explore is about three  
16 years ago CMS did get rid of the certificate of medical  
17 necessity for DME because of all of the problems they were  
18 having with wheelchairs and powered mobility devices.

19           So that model, that process of education,  
20 redefining, educating the physician community, et cetera,  
21 might be a model that could be amplified in the text of the  
22 report, to help us kind of understand.

1           MR. HACKBARTH: Just say a little bit more. You  
2 say CMS got rid of it?

3           MR. KUHN: They eliminated the certificate of  
4 medical necessity and replaced it with a physician just  
5 regular prescription for the product or the device and  
6 services, and I think went through a national coverage  
7 determination for better clarification of what the benefit  
8 really was.

9           At least to my recollection, that seemed to clean  
10 up that space, or helped a lot in terms of better defining  
11 what was out there.

12          DR. DEAN: I still get requests to sign the blamed  
13 thing.

14          MR. KUHN: Now I will tell you, some suppliers  
15 have created your own and said here's what we want you to  
16 sign as part of the process, and that is a way of dealing  
17 with it. But the Agency itself got rid of it and went this  
18 different way. But some suppliers go ahead and create their  
19 own form that they feel will protect them in terms of  
20 ordering. But it's still a physician prescription in terms  
21 of the process.

22          So it's something, a model that we could look at.

1           MR. HACKBARTH: What I would like to do is -- Ron,  
2 did you have a comment? Go ahead.

3           DR. CASTELLANOS: To get somebody on home health,  
4 in the hospital you have to write an order. In the office  
5 you have to write a prescription. So you have to authorize  
6 it by a physician.

7           My only comments are very similar to Tom. It is a  
8 frustrating issue. Fortunately, we have a large practice, I  
9 have 10 people practicing. And we allocate all of those  
10 material to a nurse practitioner who predominantly we trust.  
11 And it's a lot easier for us to allocate that to that one  
12 individual who really looks over everything to make sure.

13           You know, if you look at page 21, 3C, I think  
14 we're covering ourselves here by saying the Secretary should  
15 develop procedures for reviewing the certification to ensure  
16 that the physicians are exercising appropriate judgment. So  
17 we have that already in line.

18           DR. MILSTEIN: I would just like to speak in favor  
19 of Jay's suggestion. I think if you then think about the  
20 array of such as, I think it would cause some of the  
21 marginal or abusive players to think twice because now the  
22 Secretary has a variety of stated tools, not tools that

1 later the Secretary has to overcome industry opposition to  
2 initiate. So I think it's a very good idea.

3 And what's nice about it is we're not instituting  
4 it across the board, which would obviously be a nightmare  
5 from a physician autonomy and cost perspective.

6 MR. HACKBARTH: Okay, we have got a number of  
7 different things laying on the table here, some of which I  
8 think I hear agreement we ought to try to capture more in  
9 the text, as opposed to in the bold-faced recommendation.

10 What I'd like to do is just start going through  
11 the recommendations, the first couple I don't think have any  
12 pending modifications. Once we get to some of the others we  
13 can talk about specific amendments.

14 So let's put up recommendation one and go ahead  
15 and vote on recommendation one. All in favor of  
16 recommendation one? Opposed? Abstentions?

17 Okay, let's do number two. I don't think we have  
18 any pending modifications on this one, so all in favor of  
19 recommendation two? Opposed? Abstentions?

20 And then 2B, I think, is good as written here. So  
21 all in favor of recommendation 2B? Opposed? Abstentions?

22 Okay. Now 3A...

1 DR. MARK MILLER: This is Jay's idea here. So if  
2 you wanted to include that, put your eye on the next to the  
3 last line where it says "such as a moratorium on new  
4 providers, preauthorization, or suspension of prompt pay  
5 requirements."

6 MR. HACKBARTH: Okay. Any discussion of that  
7 language? Any clarification needed?

8 As Peter has noted, these are all such as, these  
9 are examples, as opposed to specific requirements.

10 Okay, with that amendment, all in favor of 3A?  
11 All opposed? Abstentions?

12 Okay, 3B. Mark?

13 DR. MARK MILLER: Cast your eye to the second line  
14 where it says "visit with a physician" and you take out the  
15 clause "with a physician." It would be a billable in-person  
16 visit certifying or recertifying, et cetera. So we just  
17 take out the three word clause "with a physician."

18

19 MR. HACKBARTH: Any clarification required there?

20 DR. SCANLON: The clarification is if it's a visit  
21 certifying or recertifying. And then we're saying that a  
22 nurse practitioner cannot be the certifier. What does that

1 mean? That means that it's got to be a visit with a  
2 physician, doesn't it?

3 MS. BEHROOZI: You need a few more words, like "in  
4 connection with certifying" or something like that.

5 DR. SCANLON: Or as I've been thinking here, if we  
6 do set up a code for this and we compensate for it,  
7 inappropriately certifying can be a false claim. We do have  
8 tools to deal with that. So the question of nurse  
9 practitioners certifying may not be as problematic as we  
10 might think. An agency and a nurse practitioner are going  
11 to be at risk for false certifications.

12 A bit part of this is how much oversight you give  
13 to this effort. And I'm thinking that in the prior  
14 authorization -- if I'm the Secretary, I'm going to have to  
15 worry about the resources to do that, though it's a good  
16 idea if we can do it. The same thing is true here. The  
17 physician or the nurse practitioner is not a great line of  
18 defense unless we have enough oversight to make sure that  
19 they're doing their job right. And we have that language in  
20 3C, and I think once we've got that language there it can be  
21 either the nurse practitioner or the physician.

22 MR. HACKBARTH: Pardon me, Bill, my mind is

1 starting to go here, starting to skip.

2 Correct me if I'm wrong, Mark, but I think the  
3 intent of deleting the "with the physician" language is to  
4 open up the possibility that the face-to-face visit will be  
5 with a non-physician practitioner like an advanced practice  
6 nurse.

7 DR. CROSSON: [off microphone] Right but the visit  
8 doesn't certify.

9 MR. HACKBARTH: Right, the certification is in the  
10 next recommendation and that needs to be done by a  
11 physician. What I heard before is that's true with hospice,  
12 the certification is done by a physician. And the ensuing  
13 recommendation would say would also be done by the physician  
14 here.

15 So we're separating who does certification from  
16 the visit.

17 DR. CROSSON: But I think the issue is if you just  
18 take out "with the physician" then it reads that the visit  
19 certifies.

20 MR. HACKBARTH: Okay.

21 DR. CROSSON: One suggestion would be a language  
22 that would say require a separately billable in-person

1 visit, leading to a certification or recertification --

2 MR. HACKBARTH: Okay.

3 DR. BERENSON: I was going to say supporting a  
4 certification or leading -- something like that. That would  
5 solve my problem, two different professionals coordinating  
6 the certification.

7 MR. HACKBARTH: Okay. Read that again, and then  
8 we can ask for clarifications.

9 DR. CROSSON: It would say Congress should require  
10 a separately billable in-person visit, leading to a  
11 certification or recertification of a patient's need for  
12 home health, et cetera.

13 DR. SCANLON: How about to assess certification or  
14 recertification?

15 MS. BEHROOZI: I like supporting.

16 DR. SCANLON: Supporting. Leading to, I'm not  
17 sure about that.

18 DR. CROSSON: Supporting, all right.

19 MR. CHRISTMAN: I think there is, if I could,  
20 maybe this language should read Congress should require a  
21 separately billable, in-person examination before certifying  
22 or recertifying. I think that captures what you're saying?

1 DR. SCANLON: I think there needs to be a  
2 connection between what's going on in the visit. It can't  
3 just precede, it has to be with the intent of working on the  
4 home health certification.

5 MR. HACKBARTH: How about a billable in-person  
6 visit --

7 DR. SCANLON: Supporting.

8 MR. HACKBARTH: -- to support certification or  
9 recertification of home health.

10 Tom, you look like you're perplexed.

11 DR. DEAN: It seems to me we're trying to describe  
12 the mechanism of how to do it but we're still not clear on  
13 what we're trying to get done. In other words, what is it  
14 that actually qualifies a person for this service?

15 They bring somebody into my office who's kind of  
16 frail and maybe in a wheelchair and maybe a little bit mixed  
17 up, and they sit there, and I've got some kind of vague  
18 history. And then I'm supposed to sign this form, do they  
19 qualify for home health?

20 Well, I don't know. And that's the position we're  
21 in frequently.

22 That's why I say we need the criteria as to what

1 it is that qualifies a person, and then we can make a  
2 judgment. But right now, at least my experience is those  
3 criteria are so vague that we make a judgment and, in a  
4 small community like mine, well, grandma wants the services  
5 and the family wants them to have the services. And if I  
6 don't sign it -- and especially as we get back to the DME  
7 thing, the providers are not above saying well, we would be  
8 glad to provide this service, but your doctor wouldn't allow  
9 us.

10 That's why I say, this is not a fun activity. So  
11 we need some criteria and I don't think this gets us there.

12 MR. HACKBARTH: So earlier Bob had made some  
13 similar comments about how we've got an educational task  
14 here. I would agree that requiring a face-to-face visit in  
15 and of itself does not solve that problem. What it may help  
16 with, though, is some of the more blatant fraudulent  
17 activity where people are being certified for home health  
18 without any visit. It's just people writing forms, signing  
19 forms, no face-to-face visit, no update on the patient's  
20 status. And to require a face-to-face visit makes that sort  
21 of inappropriate activity more difficult.

22 But it is not a total solution to the problems

1 that you've identified. It's not a solution at all to the  
2 problem you've identified.

3 DR. DEAN: And the problem is the physicians who  
4 are inclined to be a little bit loose about this are not  
5 bothered by it, and the conscientious ones are the ones that  
6 get all uptight about it and are the most frustrated. And  
7 if you talk to primary care docs, it's this kind of stuff  
8 that they find most frustrating about today's primary care.

9 DR. BERENSON: I think the problem is we don't  
10 have a long-term care benefit in Medicare and, in fact, you  
11 are caught in the middle. I mean, the patient's got to be  
12 homebound and they're supposed to need a skilled service.  
13 And the fact that they're just frail and need support  
14 doesn't qualify them for the home health benefit.

15 And I was there, too, and appreciate the dilemma,  
16 but I think it goes to the law and that there's no quick fix  
17 to just -- I mean, if we gave you great clarification, my  
18 hunch is you'd have to say no more often than you want to  
19 say.

20 DR. DEAN: Probably so, but at least then we can  
21 blame it on Medicare.

22 DR. BERENSON: Okay. That goes to my point is we

1 have some clear guidance for physicians so that they can say  
2 no.

3 DR. DEAN: [off microphone] Yes, that's exactly  
4 what I'm after.

5 MR. HACKBARTH: What I'm thinking right now is we  
6 make the modifications we've discussed in this language and  
7 we include a passage in the text that talks about the  
8 situation Tom has described that's awkward for the  
9 physician. In fact, make the point that Bob has made, is  
10 that actually there is some definition here in this benefit,  
11 that the patient requires skilled service and be homebound,  
12 and what we need is educational activity in support of  
13 physicians to apply the benefit as the law is written. And  
14 we can handle that in the text.

15 DR. CROSSON: I think there is an opening for that  
16 here in draft recommendation 3C, which asks the Secretary --  
17 it doesn't exactly, but it implies the Secretary will  
18 develop a standard form that the physicians would use in  
19 certifying the patient.

20 That form itself could be constructed in such a  
21 way as to guide the physician in terms of what the Secretary  
22 believes are the appropriate criteria for certification.

1 And we could put that in the text.

2 DR. DEAN: I agree, but we should put in there  
3 that the form should specify the criteria, because it might  
4 just specify the penalties for signing a fraudulent form and  
5 that only makes it worse.

6 DR. CROSSON: But that's what I was saying, Tom,  
7 is that in constructing the form, the form could be  
8 constructed in such a way as to guide the physician towards  
9 the correct --

10 DR. DEAN: But we need to specify that it not only  
11 specifies the responsibility and accountability, it also  
12 specifies the criteria.

13 DR. SCANLON: Okay. I am in total agreement that  
14 we have to have this educational effort here to make this  
15 work, but I guess this discussion has led me to think about  
16 3C some more and ask the question of should we be limiting  
17 it to physicians?

18 In some respects we have an inefficient process if  
19 we do. What we do is we're going to have this visit where  
20 we're gathering information --

21 MR. HACKBARTH: Just for the sake, so I'm sure I'm  
22 understanding, you're raising the question of whether it

1 ought to be a physician that has to do the certification?

2 DR. SCANLON: Right, because what we've done in  
3 the visit, 3B, is we've said that the nurse practitioner can  
4 do the visit, gather the information, make the assessment,  
5 come, and then present this to a physician who is going to  
6 make the decision.

7 There's two questions about the physician or two  
8 issues about the physician that you would want to answer in  
9 terms of why it should be the physician. One is that  
10 there's something in their medical training that makes them  
11 uniquely qualified to make this decision. We've talked  
12 about maybe it's not because a lot of this is nursing  
13 services.

14 The second potential reason why we want the  
15 physician to do it is because the integrity of physicians is  
16 higher than the integrity of the nurse practitioners. And I  
17 don't think we want to say that either.

18 For an efficient process here, to take a burden  
19 off physicians so they don't have to learn this, all of the  
20 rules here -- and that's not disputing Tom's point -- we  
21 need to clarify this. But once we've clarified it, somebody  
22 has got to learn this. This is not going to be something

1 that's intuitive. So there's got to be an educational  
2 process. If we're being efficient about, it we're thinking  
3 about trying to invest in appropriate oversight but not  
4 overspend on oversight, I think we need to simplify this  
5 process and have a trained professional, qualified  
6 professional -- physician or nurse practitioner -- do the  
7 visit, do the certification, and then whoever does it is  
8 accountable.

9 MR. HACKBARTH: So my understanding here, Evan, is  
10 that the law currently requires that a physician do the  
11 certification. So Bill is proposing that we incorporate in  
12 our recommendations a recommendation to the Congress that  
13 they modify the law to permit non-physician clinicians to  
14 not only do the in-person visit but also do the  
15 certification based on appropriate guidance from the  
16 Secretary about what is eligible for the benefit?

17 Let me see hands of people who would like to make  
18 that modification to allow non-physician clinicians --

19 DR. KANE: This is an update day, I guess. And I  
20 guess we're getting off into something that really we didn't  
21 have the background to get into. And it sounds like the  
22 more we talk, the more we feel we don't have the background

1 to decide.

2 I don't know how it's done -- you know, we need  
3 some kind of overview of how it's done now, and maybe some  
4 focus groups on how it should be done.

5 I don't feel this belongs in the update discussion  
6 at the level that we're trying to get to right -- I'm just  
7 getting very uncomfortable and trying -- I know Mark's  
8 paying everybody here to make this go longer so he wins that  
9 bet but....

10 MR. HACKBARTH: [off microphone] He's already won.

11 DR. MARK MILLER: [off microphone] So sorry I made  
12 that bet.

13 DR. KANE: I just feel the longer we talk about  
14 this, the more complicated it is, and the more I'm sitting  
15 there going I don't really think we know yet what we want.  
16 And I don't know how clear the guidelines are now.

17 This sounds like a whole chapter in itself on how  
18 do we make sure that home health is used appropriately? And  
19 how do we define this benefit better? Then how do we  
20 institute the procedures. And I don't think -- if we can't  
21 -- to me, this isn't the tail end of an update kind of  
22 discussion.

1 I'm sorry, I just had to get that off my chest.

2 MR. HACKBARTH: That's a perfectly legitimate  
3 concern. We actually did not have this December and we  
4 added these additional features in response to the December  
5 discussion. But Nancy's right, we're going deeper and  
6 deeper into detail.

7 So one approach would be for us to take -- let's  
8 see, the issues are primarily in the 3's, the 3A, 3B, and  
9 3C.

10 DR. MARK MILLER: Well, B and C.

11 MR. HACKBARTH: Yeah. Put up A for a second?

12 DR. MARK MILLER: That's the Secretary checking  
13 the pattern.

14 MR. HACKBARTH: A really is freestanding. A could  
15 go ahead on its own. But hold B and C in abeyance until we  
16 can work through the issues more carefully.

17 I see a lot of nodding heads on that. Does that  
18 make sense to people? Anybody have strong objections to  
19 that? Okay, that's good for me.

20 Did we vote on 3A already? Yes. So let's skip  
21 over B and C, and I think that means we're at the end.

22 DR. CROSSON: Should we pull the text associated

1 with B and C also?

2 MR. HACKBARTH: Actually, let us think about that,  
3 but I think it might good to raise the issues and then come  
4 back at a later point to make recommendations.

5 DR. MARK MILLER: To have it, that's what I'm  
6 thinking.

7 MR. HACKBARTH: Okay, thank you, Evan, and thank  
8 you, Nancy.

9 Okay, we are to the public comment period.

10 Seeing none, we are adjourned, and I won.

11 [Laughter.]

12 MR. HACKBARTH: We will reconvene at 9:00 a.m.  
13 tomorrow.

14 [Whereupon, at 5:19 p.m., the meeting was  
15 recessed, to reconvene at 9:00 a.m. on Friday, January 15,  
16 2010.]

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## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, January 15, 2010  
9:01 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.  
KAREN R. BORMAN, M.D.  
PETER W. BUTLER, M.H.S.A.  
RONALD D. CASTELLANOS, M.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.

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## 1 P R O C E E D I N G S

2 MR. HACKBARTH: Before we start, I wanted to  
3 juggle the schedule a bit. We're scheduled to finish at  
4 12:45, which is too late for me and I know for some other  
5 Commissioners, as well, who have to catch airplanes, and so  
6 what I propose to do is take 15 minutes off the time for  
7 each session, which would have us finishing at noon. So if  
8 the presenters can help us out and do their presentations as  
9 concisely as possible, then we'll also manage the  
10 conversation, as well, to stay within that budget.

11 So, who's leading? Anne, are you leading?

12 MS. MUTTI: In this presentation, we consider  
13 whether the efficacy of Medicare's quality infrastructure  
14 could be improved to advance the goals of high quality and  
15 efficiency in care.

16 While changing payment incentives is key to  
17 inducing change and has been much the focus of the  
18 Commission's work, Medicare has at least a couple of other  
19 levers as part of its quality infrastructure that are also  
20 intended to further these goals. They include the provision  
21 of technical assistance, which is currently offered through  
22 the Quality Improvement Organizations, QIOs, and Conditions

1 of Participation, which are the minimum, mostly structural,  
2 requirements that most providers have to meet in order to  
3 participate in Medicare.

4           We talked about technical assistance at the  
5 November meeting and raised several design questions,  
6 including what type of assistance is needed, who should the  
7 assistance be targeted to, and who should be providing the  
8 assistance. In this presentation, we're coming back to the  
9 second of these questions, that is, who should the  
10 assistance be targeted to, and we're going to explore the  
11 degree of variation in the quality of care and the  
12 implications of targeting assistance to low performers, and  
13 in particular the effect that would have on addressing  
14 racial and socio-economic disparities.

15           The second part of this presentation will focus on  
16 Conditions of Participation and explore some possible policy  
17 options for strengthening them.

18           Throughout the presentation, we are using  
19 hospitals as an example, but we do this just to simplify and  
20 focus our discussion. We are interested in other providers  
21 and would be perfectly happy to explore that further in the  
22 future.

1           MR. RICHARDSON: At the risk of stating the  
2 obvious, the first point we want to make is that the quality  
3 of care varies across the providers serving Medicare  
4 beneficiaries. This chart shows just two examples of that  
5 variation in the form of two outcome measures, risk-adjusted  
6 30-day all-cause readmission and mortality rates for  
7 Medicare patients admitted to inpatient hospitals for a  
8 heart attack between July 2005 and June 2008. The data are  
9 from the most recent available update of the Medicare  
10 Hospital Compare website.

11           Each graph shows the range between the highest-  
12 and lowest-performing hospital and the simple average for  
13 each of the rates. As you can see, there is about a ten  
14 percentage point difference between the highest and lowest  
15 performers on the readmission rate and an almost 15  
16 percentage point spread on the mortality rate.

17           The spreads for the risk-adjusted heart failure  
18 and pneumonia readmission mortality rates that are reported  
19 on Hospital Compare are not shown here, are similar.

20           It is also worth noting that even the best  
21 performer on the readmission rate measure still has a rate  
22 of about 15 percent. Our point here is not to suggest that

1 the low end of these ranges is necessarily the ideal  
2 performance benchmark for these measures, rather, simply to  
3 present a typical example of the range of variation of  
4 quality across providers, in this case, hospitals.

5           Our basic premise for this discussion is that when  
6 assessing the quality of care delivered by providers,  
7 Medicare should use a single set of risk-adjusted  
8 performance benchmarks for all of the providers being  
9 measured. An alternative approach would be to use a lower  
10 benchmark for providers that start with lower performance  
11 scores as a way to lessen the likelihood that, in the case  
12 of a readmission penalty policy, they would be financially  
13 penalized.

14           As I will discuss in a moment, our review of the  
15 literature on disparities and the quality of care for  
16 Medicare beneficiaries suggests that lower-quality  
17 performers tend to be providers who care for relatively high  
18 proportions of Medicare patients who are minorities and from  
19 lower socio-economic status. Thus, one disadvantage of a  
20 policy design setting lower performance benchmarks for  
21 initially low performers is that it, in essence, would  
22 endorse a lower standard of care for a sizeable portion of

1 poor and minority patients and could perpetuate care  
2 disparities. Instead, we start with the premise of a single  
3 performance standard for all providers.

4           And based on your discussion in November about how  
5 Medicare might improve its quality improvement  
6 infrastructure, we are honing in on the idea of targeting  
7 technical assistance to low performers and other providers  
8 facing challenges to increase the pace of their quality  
9 improvement and to reduce the performance gap between high  
10 and low performers.

11           As I noted a moment ago, research in the  
12 literature indicates that white and minority Medicare  
13 beneficiaries often receive health care services from  
14 different groups of providers and that the quality of care  
15 associated with providers used predominately by minorities  
16 and lower-income patients is worse. In terms of differences  
17 between whites and minorities and sources of care, this  
18 research has found that medical care for African American  
19 and Hispanic Medicare beneficiaries is concentrated among  
20 about 20 to 25 percent of the nation's physicians and  
21 hospitals.

22           These studies also evaluated the quality of care

1 by the providers serving predominately minority and low-  
2 income patients, and the overall findings are that these  
3 providers tend to have lower scores on process of care  
4 quality measures in the case of the hospital studies and on  
5 survey results of provider self-assessments of their ability  
6 to provide high-quality care to all of their patients in the  
7 case of physician studies. Therefore, it seems logical that  
8 targeting technical assistance to increase the quality of  
9 all low performers may also have the effect of reducing  
10 quality disparities.

11           The research we reviewed also points out the  
12 structural and financial barriers that some low-income  
13 providers may face. But we also found evidence from one  
14 experiment, where the combination of financial incentives,  
15 public reporting of results, and targeted technical  
16 assistance to initially low performers appeared to bring  
17 about dramatic changes without lowering performance  
18 standards for any of the participating providers.

19           This recent study by Dr. Ashish Jha at Harvard  
20 compared the change in quality scores for heart attack,  
21 heart failure, and pneumonia care in the set of hospitals  
22 participating in the CMS Premier Hospital Quality Incentive

1 Demonstration. After sorting the hospitals into quartiles  
2 based on a CMS index of the hospitals' relative share of  
3 low-income patients, Jha found that the hospitals that had  
4 the highest fractions of low-income patients also had the  
5 lowest quality scores at the start of the demonstration, but  
6 that these low performers were able to improve their  
7 performance over a four-year period to the point where this  
8 group of hospitals achieved the same performance level as  
9 the hospitals with the lowest shares of low-income patients  
10 that initially had significantly higher performance.

11 The chart on this slide shows the study's results  
12 for the heart attack process of care quality measures. The  
13 author found similar results for changes in quality measures  
14 for heart failure and pneumonia care.

15 We note that this study involved a group of  
16 hospitals that share characteristics that could limit the  
17 generalizability of the results. All of the participating  
18 hospitals were members of the Premier Organization, and all  
19 were motivated to volunteer to participate in the publicly-  
20 reported Medicare Hospital Quality Improvement  
21 Demonstration. The study also did not control for possible  
22 differences in the secular trends in quality improvement

1 between the different groups of hospitals. And we also  
2 noted in your mailing materials that a few studies by other  
3 authors have found smaller increases in quality scores for  
4 hospitals serving a high proportion of low-income patients  
5 when they examined changes over a similar time period,  
6 looking at measures reported on Hospital Compare. However,  
7 unlike in the Premier demonstration, those hospitals did not  
8 face any financial incentives to improve quality.

9           Nonetheless, we think that results of Jha's work  
10 suggests that hospitals serving a relatively high proportion  
11 of low-income patients can respond effectively to quality  
12 improvement expectations and incentives. It may be that one  
13 critical success factor is the kind of targeted quality  
14 improvement technical assistance that was provided by  
15 Premier to the initial low-performing hospitals.

16           Two examples of this technical assistance include  
17 provision of centralized data analysis infrastructure and  
18 ongoing technical support to increase the timeliness in  
19 targeting of internal performance tracking reports for the  
20 participating hospitals and the participation by quality  
21 improvement experts from Premier in meetings of  
22 collaborative work groups with the hospitals to identify

1 challenges and solutions to meeting the performance  
2 standards.

3 MS. NEPRASH: Since the November meeting, we have  
4 examined the correlation between hospitals with high risk-  
5 adjusted readmission rates and hospitals with large minority  
6 populations. If there is overlap between these populations,  
7 as the literature that John mentioned would suggest, a  
8 policy of directing technical assistance towards low  
9 performers to reduce their readmission rates could have the  
10 effect of simultaneously targeting facilities that serve  
11 large minority populations.

12 For this analysis, we made a comparison of  
13 hospitals with the highest readmission rates to hospitals  
14 with lower readmission rates, examining their racial and  
15 socio-economic patient mix. We identified roughly 400  
16 hospitals in the highest quintile of risk-adjusted  
17 readmission rates for 2005 through 2007 and compared them to  
18 hospitals in the remaining four quintiles. We then  
19 calculated the percentage of white and minority Medicare  
20 admissions using 2007 MedPAR data. As a proxy for the  
21 socio-economic status, we used the Medicare DSH percentage.  
22 There is no accepted source of national hospital-level data

1 on the socio-economic status of patients, but this measure  
2 has been used as a proxy in previous analyses.

3 We found that hospitals with the highest risk-  
4 adjusted readmission rates had a different racial and ethnic  
5 patient mix than their lower readmission rate counterparts.  
6 In 2007, they admitted a significantly greater percentage of  
7 minority Medicare beneficiaries. On average, minorities  
8 represented 30 percent of all admissions at these high  
9 readmission hospitals, compared with roughly 15 percent of  
10 all admissions at hospitals with lower readmission rates.  
11 Hospitals with the highest readmission rates also had, on  
12 average, a higher DSH population, suggesting that they may  
13 be serving a lower-income population than other hospitals.

14 So this analysis of patient characteristics at  
15 hospitals with the highest readmission rates indicates that  
16 a possible policy of directing technical assistance towards  
17 low performers to reduce their readmission rates could have  
18 the effect of simultaneously targeting facilities that serve  
19 large minority and socio-economically disadvantaged  
20 populations.

21 MS. MUTTI: So now we will switch gears and  
22 explore COPs to ask if they and the survey process that

1 enforces them can be better leveraged to improve quality of  
2 care.

3           Conditions of Participation are tailored to each  
4 applicable provider type, so the COPs apply to hospitals,  
5 home health agencies, SNFs, and some other 15 categories of  
6 provider types. They do not apply to physicians. Today,  
7 I'll mainly talk about COPs as they apply to hospitals, but  
8 as I said, we could consider it more broadly in the future.

9           The COPs mainly require that certain structural  
10 and physical and management structures are in place. For  
11 example, requirements for hospitals apply to such areas as  
12 the governing body, patients' rights, the medical staff,  
13 nursing services, radiology services, discharge planning,  
14 and infection control, but there are many other categories.  
15 They have been updated somewhat over time. Most notably,  
16 the quality requirements have been expanded to require that  
17 hospitals systematically measure their quality performance  
18 in certain areas of their choosing and implement specific  
19 improvement projects.

20           The COPs for transplant services reflect a  
21 somewhat different approach to COPs, one that is more  
22 proactive in ensuring quality. In addition to the

1 requirements that other hospital units have in terms of  
2 providing information about patient rights, doing quality  
3 improvement, transplant centers also have requirements on  
4 their clinical experience and patient outcomes. So, for  
5 example, lung, heart, and liver transplant centers have a  
6 requirement that they perform an average of ten transplants  
7 per year and they also have to have acceptable survival  
8 rates in order to be approved.

9           Providers must be surveyed periodically to  
10 demonstrate that they are in compliance with the Conditions  
11 of Participation. Hospitals may either be surveyed by  
12 private accreditors, mainly the Joint Commission, or State  
13 agencies, and most are accredited. Both types of entities  
14 conduct unannounced surveys, and in their surveys, they both  
15 use the "tracer methodology," which means that in addition  
16 to reviewing records and minutes from meetings and  
17 interviewing staff, they also identify a sample of patients  
18 currently hospitalized and examine the processes of care as  
19 they affected the care of these selected patients, and they  
20 have the opportunity to interview these patients and their  
21 families, as well.

22           Accreditation differs from surveys by State

1 agencies in that they tend to be more frequent, charge for  
2 their services, and require compliance with national patient  
3 safety goals, and these goals include things like making  
4 sure you are identifying the right body part that surgery is  
5 going to be performed on, you have handwashing to prevent  
6 infections, maybe better communication techniques between  
7 staff. If a facility fails the accreditation or the State  
8 survey process, it is precluded from participating in  
9 Medicare, but this happens very rarely. I'm still searching  
10 for statistics on that, but it's very rare.

11           There is mixed evidence on the efficacy of the  
12 accreditation process. Some studies suggest accredited  
13 hospitals perform better on certain quality metrics and  
14 others do not. There seems to be the sense, though, that  
15 the changes in the accreditation process in recent years,  
16 the ones I mentioned about the tracer methodology, the  
17 national patient safety goals, unannounced surveys, have all  
18 been very positive changes. But there are concerns still  
19 about the ability of accreditors or State surveyors, for  
20 that matter, to drive improvements on some more nuanced  
21 areas, like medication reconciliation or encouraging a  
22 culture of patient safety.

1           In any case, the fact that there is wide variation  
2 in quality and that there's a fairly high rate of success  
3 among those seeking accreditation -- most get it -- suggests  
4 that the accreditation process is more of an inclusive one  
5 that ideally allows for an education process between the  
6 surveyors and the hospitals and also allows opportunity for  
7 a correction in deficiencies. It's not especially punitive  
8 in that sense.

9           So with that background and given the general  
10 concern that progress on quality has been frustratingly  
11 slow, we wanted to consider options that might drive faster  
12 improvements. And the options here that we're going to talk  
13 about are very broadly sped-ed out and really intended to  
14 stimulate our thinking and to help us ask the right  
15 questions, because we recognize that we are very much at the  
16 beginning of this process and coming up on our learning  
17 curve on this issue.

18           So the options I'll present are not necessarily  
19 alternatives to one another, so you might want to think of  
20 them -- some of them could be combined with others, but this  
21 is very much for discussion. I'll briefly summarize the  
22 ones I'm going to talk about.

1           First, we'll talk about an option to make the  
2 survey findings more transparent.

3           The next two will consider whether the current  
4 COPs should be updated to reflect new evidence on what  
5 factors can improve quality of care and to introduce the  
6 idea of efficiency as something that could be included in  
7 the COPs.

8           Then there's an option to create an optional set  
9 of higher standards that can earn providers distinction  
10 among their peers, and these standards could move beyond  
11 more of the structural requirements and get into maybe more  
12 outcomes-oriented standards.

13           And lastly, we consider a couple variations on an  
14 option that would create mandatory higher standards for  
15 select services or organizations.

16           So the first option, again, is to make the survey  
17 findings more transparent to consumers and other providers,  
18 creating more motivation for providers to perform well on  
19 surveys, and it could follow the precedent established by  
20 CMS in providing information about nursing home quality. As  
21 part of the Five-Star Quality Rating System for nursing  
22 homes, CMS now provides three types of information about

1 each nursing home on its website: Details of survey  
2 findings, nursing staffing levels, and performance on  
3 quality measures.

4 In contrast, the findings on hospital surveys are  
5 not publicly available. Only the ultimate accreditation  
6 status is available, and this may be of minimal use to  
7 consumers since the vast majority of hospitals receive the  
8 same accreditation status.

9 The disadvantages of greater transparency are that  
10 consumers may be already overwhelmed by information, and  
11 also the survey results may be more complicated to explain  
12 for hospitals than for nursing homes. The range of services  
13 provided is far more diverse.

14 Another option is to update the COPs to update  
15 newer research about what dynamics lead to improved quality.  
16 For example, here, the COPs could be strengthened to improve  
17 the discharge process. For example, the COPs could require  
18 that hospital staff go over a discharge checklist with  
19 patients to increase the likelihood that patients know how  
20 to care for themselves at discharge and decrease the chances  
21 that they'll be readmitted. CMS has already developed such  
22 a checklist.

1           The COPs could also require that a list of  
2 medications be provided at discharge and require that  
3 follow-up appointments be arranged prior to discharge, two  
4 things that research tells us could reduce readmissions.  
5 These types of requirements would be in addition to some  
6 existing ones that require a hospital to do such things as  
7 prepare patients for post-hospital care and supply lists of  
8 local PAC providers.

9           Another area that might be ripe for more specific  
10 requirements concerns the role of the board of directors and  
11 its potential to drive culture change around quality. A  
12 recent study found that 66 percent of hospital boards  
13 thought their quality scores were better or much better than  
14 the typical U.S. hospital, and most notably, none of the  
15 boards of low-performing hospitals thought their quality was  
16 worse than the typical hospital. Indeed, 58 percent of them  
17 reported their performance to be better or much better. So  
18 while COPs require the board to be involved in quality  
19 improvement, obviously, the requirement is not reliably  
20 leading to meaningful engagement, so one solution may be for  
21 the COPs to be more specific and binding in that area.

22           A disadvantage of these types of changes is that

1 they're prescriptive and as such may hamper innovation or  
2 not allow for reasonable exceptions. Also, CMS has limited  
3 resources, so promulgating regulations to update them  
4 frequently is resource-consuming.

5 Another policy option is to expand the COPs to  
6 require efficiency-enhancing activities. Currently, the  
7 COPs require the hospitals to perform those quality  
8 improvement activities, and this would be a parallel type of  
9 requirement that we could consider. The activities would  
10 not necessarily be prescriptive, just like with the quality  
11 requirements. It's at the hospital's choice. But they must  
12 be able to be validated by surveyors.

13 The Institute of Healthcare Improvement, IHI, has  
14 shown that there are efficiency opportunities and has  
15 launched its own program on improving efficiency and  
16 reducing waste. IHI's vision of waste reduction calls for  
17 organizations to set waste reduction targets, like one to  
18 three percent of operating expense, and then IHI goes on to  
19 offer examples of how improvements in staffing -- in that  
20 respect, it's lower turnover, higher productivity, safer  
21 care -- can lead to greater efficiency. They also identify  
22 areas like patient flow, the supply chain, and reduction in

1 mismatched services, and here one of the examples is  
2 offering palliative care in the ICU setting. They identify  
3 pioneers out there in the field that are using these  
4 strategies and achieving their objectives.

5           Another option is to create a more rigorous set of  
6 optional COPs to allow providers the opportunity to  
7 demonstrate their higher quality and publicly distinguish  
8 themselves with a single designation, like a platinum award  
9 versus a gold award or something like that. These standards  
10 could be based on outcomes measures, adherence to evidence-  
11 based practices that are more likely to correlate with  
12 higher quality care than current standards, or  
13 implementation of practices consistent with a culture of  
14 patient safety. If providers found the designation  
15 valuable, more may be inclined to meet this higher standard  
16 of care. The current set of COPs could continue to apply to  
17 providers not opting or achieving for this higher standard.

18           There are several disadvantages to this option.  
19 First, providers may have little incentive to meet the new  
20 standards if there's no payment incentive. They may feel  
21 they can already demonstrate higher quality through some of  
22 the data that we're making public as well as other

1 accreditation or certification programs from the Joint  
2 Commission or NCQA. And also, it's possible that pay-for-  
3 performance would accomplish much of the same objective more  
4 effectively, so that's something to consider.

5           On the other hand, it is possible that having two  
6 levels of COP designation may have the advantage of  
7 simplifying the message to consumers and further motivate  
8 providers. In addition, redundancy in public policy may not  
9 be a bad thing, and some of the things that we might have in  
10 a higher set of COPs may not be captured in a P4P measure  
11 set.

12           Our last option here is to create mandatory higher  
13 standards for select services or organizations, and here, we  
14 present two variations of the option on one slide. One  
15 option would be to amend the COPs to incorporate outcomes or  
16 volume criteria for select services, and this would be much  
17 like how we do it for transplant centers, those same type of  
18 requirements. So we would restrict payment for certain  
19 services to providers that demonstrate sufficient volume and  
20 quality, and this is similar also to the Centers of  
21 Excellence concept, and it would give our beneficiaries --  
22 and help guide our beneficiaries to providers with best

1 outcomes.

2           The possible disadvantages to this option are that  
3 it requires consensus about the evidence governing the  
4 criteria. Beneficiaries might have to travel further to get  
5 their care. And such restrictions create barriers to entry  
6 for new providers and could hamper a competitive  
7 marketplace.

8           A variation would be to create higher standards  
9 for certain types of integrated organizations. For example,  
10 as providers come together to form ACOs or other types of  
11 integrated organizations, they may have -- they should have  
12 more control over the spectrum of care. Accordingly, higher  
13 standards, especially concerning care management across  
14 settings and health promotion in the community could be  
15 expected.

16           They could go further. David Cutler posits that  
17 hospital systems that account for a quarter of the market  
18 must do more to manage the care of their patients who come  
19 through their doors. He suggests these big systems must  
20 guarantee an adequate supply of primary care everywhere in  
21 the community and ensure appropriate access to emergency  
22 services.

1 Higher standards might be a helpful check in  
2 ensuring that consumers were getting greater value,  
3 particularly if a byproduct of ACOs was the ability to gain  
4 more negotiating leverage with private insurers for higher  
5 payments.

6 Among the possible disadvantages to this option is  
7 the prescriptive nature of mandatory requirements and also  
8 that the payment incentives that are part of the ACO concept  
9 may be sufficient to engender the desired attentiveness to  
10 cost and quality and that a regulatory overlay would not be  
11 necessary.

12 So to close, we are interested in all of your  
13 comments, of course, but especially on these two topics:  
14 Targeting technical assistance resources to low performers  
15 and providers with challenges. Depending on your  
16 discussion, we could bring you a draft recommendation as  
17 well as a more comprehensive discussion of the pros and cons  
18 of such a recommendation.

19 Also, with respect to policy options for  
20 strengthening Conditions of Participation, we would welcome  
21 your insight into ones we should be dropping off our list or  
22 ones that we should add on. We recognize that we are very

1 much at the outset of our thought on this.

2 MR. HACKBARTH: Okay. Thank you.

3 So this is our second discussion of this broad  
4 area. You'll recall we had a presentation in November, I  
5 believe it was. And, in essence, I think we've opened a lot  
6 of different doors that we could choose to go through, and  
7 my objective for today's conversation is to figure out  
8 which, if any, of the doors we might go through. I'm trying  
9 to organize my own thoughts about the possibilities. It  
10 seems to me that we've got a disparate set of possibilities  
11 on the table. Here are some thoughts that come to my mind.

12 A relatively narrow -- and I use "relatively" with  
13 some intention -- approach to this would be to say, look, we  
14 know that it's quite likely that there will be movement on  
15 readmissions and maybe infection rates and there will be  
16 pressure applied to hospitals in those particular areas,  
17 maybe coupled with payment incentives through the health  
18 reform legislation. And so the focus could be narrowly on  
19 that and what sort of support should Medicare be providing  
20 to institutions perhaps with a particular focus on  
21 institutions that are currently low performers and may have  
22 disproportionate numbers of low-income and minorities. So

1 that would be one type of relatively narrow focus.

2 A somewhat broader approach would be to tackle the  
3 issues of disparities more broadly and say that that's a  
4 problem for the program and that we want to assess options  
5 for addressing that.

6 Still another approach would be to say -- now this  
7 is about the QIO program in particular. We have been  
8 spending, you know, hundreds of millions of dollars for a  
9 long period of time. We need to examine whether that has  
10 been a productive investment, how it might be restructured  
11 to make that investment more effective.

12 Still another door is the whole COP thing, which  
13 seems to me to have some very different characteristics from  
14 the three previous approaches.

15 I don't offer these as the only potential paths,  
16 but these are just different planes on which you can attack  
17 this that quickly come to my mind.

18 So what I'd like to accomplish during our  
19 discussion is to get input from you on whether you think we  
20 ought to take one of these approaches or whether you sort of  
21 cut the issue differently. But I think now having devoted,  
22 at the end of this, two sessions on this, it's time for us

1 to really start to hone in on what we think the opportunity  
2 might be in this broad area.

3 Does that make sense to you folks? Mark, do you  
4 have anything on that? Jay?

5 [No response.]

6 MR. HACKBARTH: So we'll begin with our usual  
7 round one, focused simply on clarifying questions about the  
8 presentation, and then in round two I would hope we could  
9 get your input on the issues that I've raised. So let me  
10 see hands for round one clarifying questions.

11 DR. DEAN: Did you look into how these ideas would  
12 blend with what CMS is already doing on value-based  
13 purchasing and how that -- I'm not exactly sure where that  
14 stands. I was involved in some of the discussions early on  
15 about the structure of that, and I know it's moving ahead,  
16 but I don't know where it stands. But it certainly  
17 addresses some of these same issues, and whatever we'd  
18 recommend should be in concert with that.

19 MS. MUTTI: Right. At least that's one reason why  
20 I mentioned that we do have to ask ourselves whether these  
21 things fit together or whether some of the value-based  
22 purchasing achieves our objectives and we don't need to go

1 into the conditions of participation because we're going to  
2 go in through a different door and get them through P4P. So  
3 certainly one of the questions we had was understanding --  
4 that we need to understand a little better how it would  
5 either complement it or it's redundant.

6 DR. DEAN: Maybe Herb knows the answer, but that  
7 is moving ahead, isn't it? I mean, it's going to happen, I  
8 think.

9 MS. MUTTI: Yeah, John can speak to that, too.

10 MR. RICHARDSON: Yeah, the pending Senate bill,  
11 which now they're, of course, merging together with the  
12 House bill, did include a form of hospital value-based  
13 purchasing proposal, and I believe, as Anne said, you know,  
14 some of the things that we're talking about here could --  
15 for example, targeting technical assistance to low  
16 performers in there would presumably affect the way that  
17 those hospitals did on that program if it actually was  
18 enacted.

19 DR. DEAN: I thought it was actually moving ahead  
20 even before the reform proposal.

21 MR. RICHARDSON: CMS made a proposal, but it  
22 cannot be implemented unless they have legislative

1 authority.

2 DR. DEAN: I see. Okay. The one issue that came  
3 up a lot in the discussions early on was that if you only  
4 reward the people that achieve a certain level, it's the  
5 same people and you'll just -- the people that are doing  
6 well will continue to do well, and the others won't; that  
7 you need to reward both improvement and achievement, which  
8 makes the formula pretty complicated.

9 MR. RICHARDSON: And that has been the  
10 Commission's position since 2005 very explicitly.

11 MR. HACKBARTH: Right, both achievement and  
12 improvement.

13 MR. RICHARDSON: And that is in the legislative  
14 proposal, too. Excuse me. That's also in the legislative  
15 proposal.

16 DR. MARK MILLER: Just to say two things quickly  
17 about that exchange. I think some of the thinking here is  
18 you have value-based purchasing or pay-for-performance or  
19 whatever label you use to it. Then part of this discussion  
20 has been how do we help potentially low performers actually  
21 get into that game. That's part of the discussion. And  
22 then the COP discussion, the way I've always seen it, which

1 hopefully is not a complete surprise to you guys, is there  
2 is sort of a two-step process. If you're getting quality to  
3 improve, what you'd like to do is use the COPs to say, okay,  
4 now I've got a new minimum standard, and you sort of move,  
5 you know, up and kind of use the COPs to institutionalize or  
6 lock those changes in place.

7 MR. KUHN: Just before I ask my question, one  
8 observation about what Tom asked on that issue is that you  
9 raise the issue of the Premier demonstration, and it's a  
10 tournament model -- that is, there's winners and losers,  
11 what you referenced, Tom. And then when MedPAC opined on  
12 this issue, they said we really don't think a tournament  
13 model makes the best sense because you widen the gap between  
14 the winners and losers, and we ought to reward people for  
15 performance who've attained as well as improvement.

16 CMS, when they did their report to Congress on  
17 their strategic plan, at least for hospital value-based  
18 purchasing when they issued that two years ago last  
19 November, followed that same framework -- that is,  
20 improvement and attainment -- and got away from the  
21 tournament model. But, regrettably, to a degree what we're  
22 seeing in some of the legislation now is going back to the

1 tournament model, and part of that is because it scores. I  
2 mean, in order to get scoring, you have to -- if you're  
3 going to reward some people, you have to penalize others in  
4 order to take money back. And so that's the dilemma that we  
5 face, kind of going into this just so people understand kind  
6 of where that is.

7           Having said that, the one question I had on the  
8 COPs is that the COPs, when they're put together or  
9 developed, they are put out for public comment, notice and  
10 comment. Correct?

11           MS. MUTTI: Yes.

12           MR. KUHN: And then also, then following the COPS  
13 are the interpretive guidelines which may help the surveyors  
14 and everyone work through those, and those are not put out  
15 for public comment. Is that correct?

16           MS. MUTTI: No. As I understand it, it makes it a  
17 much easier process for CMS to update as a result.

18           MR. KUHN: To do. And then, finally, for a lot of  
19 the quality -- as you indicated, a lot of the quality COPS  
20 that CMS has put together, how are they doing in terms of  
21 writing the interpretive guidelines? I understand they're  
22 kind of behind on some of those and they don't have a

1 complete set of interpretive guidelines to go with the COPs.

2 Is that correct, or --

3 MS. MUTTI: Yeah, I don't know about that, and I  
4 would be happy to look into that for you.

5 MR. KUHN: Okay. Thank you.

6 MR. GEORGE MILLER: Yes. First of all, thank you.  
7 Very, very good work. I've got a couple of questions. I'll  
8 narrow them down to the technical questions.

9 On page 12, in the reading, you have a table  
10 talking about Medicare admissions unique beneficiaries by  
11 race and ethnicity. Do you propose that this should be used  
12 and make this part of a by race readmission criteria? Is  
13 that what you're suggesting that should be done? I've never  
14 seen this before, so my question is: Is this something that  
15 you're suggesting should be part of the literature going  
16 forward?

17 MS. NEPRASH: This table is just part of the  
18 analysis of --

19 MR. GEORGE MILLER: Yeah, I got as far as  
20 analysis. This is good information. But what I'm asking  
21 is: Are you going to make this a recommendation to be  
22 included for all hospitals?

1 DR. MARK MILLER: I think if I understand the  
2 question [off microphone] -- sorry.

3 MR. GEORGE MILLER: I'm trying to get --

4 DR. MARK MILLER: Yeah, I hear you, and I think if  
5 I understand your question, the question on the table to the  
6 Commission is -- and this in some ways could be linked up to  
7 what Glenn was saying as well. Let's say that one of the  
8 ways that we're going to pursue this issue is to have a hard  
9 focus on the readmission policy. You know, the Commission  
10 recommended this strategy. The Hill is clearly picking it  
11 up and pursuing it.

12 Now, the thing about the readmission policy is  
13 that some people have said the concern there is because  
14 there's a penalty. Marginal hospitals, hospitals without a  
15 lot of resources, and potentially poor-performing hospitals  
16 are going to not be able to, you know, improve and are going  
17 to be hit by the penalty, and that will make it even harder  
18 to perform.

19 So one question for the Commission -- in some ways  
20 I think why they're balking is this is a question for all of  
21 us, all of you guys, really -- is one strategy to say, okay,  
22 let's take some resources, let's pretend for a minute the

1 QIO resources, and redirect them in such a way that there's  
2 some short-term support for those types of hospitals, short  
3 term in the sense for any individual hospital but an ongoing  
4 process, to allow them to bring their performance up so that  
5 their readmission rates are not as high as they are and they  
6 aren't hit by the penalty. This is not for every hospital,  
7 but focusing in on certain hospitals.

8           The connection to, I think, the table you're  
9 talking about is, by the way, this turns out to be hospitals  
10 that see disproportionately large numbers of minorities,  
11 might have the secondary impact or, you know, complementary  
12 impact of improving care for those, those populations.

13           Does that answer your question? Or are you on a  
14 completely different angle here?

15           MR. GEORGE MILLER: Well, it does to probably  
16 about 90 percent. Obviously, the goal, at least in my mind  
17 -- let me rephrase that -- is to improve disparities across  
18 the spectrum, and this certainly illuminates a readmission  
19 threshold -- not threshold, but it identifies a segment's  
20 readmission issues for both minorities and -- I'm not sure  
21 if it also addresses socioeconomic here, but it does  
22 differentiate minorities. For example, I said before I am

1 just as concerned about Appalachian whites getting the same  
2 level of care as anyone else.

3 So the question, at least in my mind, is: Will  
4 this help by identifying and make this a requirement -- is  
5 this one of the steps that we could use to increase quality  
6 and eliminate disparities? I don't know the mechanism, but  
7 that's the question.

8 MR. HACKBARTH: In that sentence, the "this" --  
9 what is the "this" that you're referring to?

10 MR. GEORGE MILLER: Making it a requirement that  
11 readmission rates be done by minorities and socioeconomic  
12 status.

13 MR. HACKBARTH: Reporting?

14 DR. MARK MILLER: Just reporting?

15 MR. GEORGE MILLER: Reporting, yes.

16 DR. MARK MILLER: Oh, I see. Again, I think  
17 that's a question for us, but it certainly is something that  
18 can be done and can be reported. Sorry. Can be done, can  
19 be reported, for the record.

20 MR. GEORGE MILLER: Highlight and put a focus on  
21 that issue by putting this information out in the public  
22 domain.

1 DR. MARK MILLER: Absolutely.

2 MR. BERTKO: Two follow-up questions. The first  
3 is on page 18, when you talk about a voluntary higher  
4 standard, this sounds like a potentially good idea. Are  
5 there any examples of that out there today? Or is this just  
6 theoretical?

7 MS. MUTTI: I know that NCQA has in the past  
8 experimented -- has used voluntary higher standards, but I  
9 don't have the specific examples for you, but I can get  
10 that.

11 MR. BERTKO: Okay.

12 MS. MUTTI: That they have found it to be a useful  
13 way of, one, testing some new ideas and then it also can  
14 allow them over time to bring up their standards, give  
15 people kind of the heads up that's the direction they're  
16 moving and they get some progress on that.

17 MR. BERTKO: Okay. The second question refers to  
18 something you guys have prompted me to think about on  
19 accountable care organizations with the COP. I'll again  
20 identify myself as being with the Dartmouth-Brookings ACO  
21 team. We have constantly said we want to have some set of  
22 quality standards to start with. It sounds like here -- I

1 haven't thought about this in terms of a COP, but it sounds  
2 like a perfectly good way to fit this in here with an ACO  
3 being subject to COPs. I would think that, you know, if  
4 MedPAC wants to come in and say follow these standards to  
5 serve as that quality step, I think that would be good. And  
6 I'd also make the point, I think, Mark, kind of following on  
7 your lines, start with something that many or most could do  
8 and have it evolve step by step with an intentional path  
9 towards higher standards over time. So maybe we can put  
10 some work into that.

11 DR. BERENSON: This is very interesting material.  
12 I want to follow up on the characteristics of hospitals with  
13 high readmission rates. Some hospitals make the argument  
14 that they can't control readmission rates, that once the  
15 patient walks out the door, there's this ambulatory care  
16 system that sort of takes over. And I'm not terribly  
17 sympathetic to that argument, but I do wonder about  
18 particular hospitals where they might be in areas with just  
19 very underdeveloped ambulatory care sectors, that there's no  
20 one to collaborate with.

21 Do we have any -- can we or do we know anything  
22 about sort of the ambulatory care structure in the areas for

1 these hospitals that we've identified? And one specific  
2 question I would have, the data from readmission rates that  
3 show the percentage of patients who had an outpatient visit  
4 before they were readmitted, and I guess overall only about  
5 half of the people -- I mean, do we see differentials there?

6 I guess what I'm asking, do we know anything now  
7 and can we flesh out a little bit to sort of see to what  
8 extent we really can hold these hospitals wholly accountable  
9 for their readmission rates? And to what extent do we have  
10 to acknowledge that they are in underdeveloped -- they have  
11 an infrastructure around them that is different from what  
12 most other hospitals have?

13 MS. NEPRASH: I think that's an excellent point,  
14 and the answer right now is that we have not looked at the  
15 community around these hospitals in terms of access to  
16 ambulatory care. But I will look into the percentage that  
17 had an outpatient visit before the readmission and get back  
18 to you on that, and if you think of others, feel free to  
19 discuss.

20 MR. HACKBARTH: Bob's comment raises in my mind  
21 still another way that you might choose to look at this  
22 issue. So, you know, one approach would be to focus on

1 particular problems like readmissions or infection rates. A  
2 different plane on which to cut it is to say Medicare ought  
3 to be focusing its support, resources, on problems that cut  
4 across institutional lines where the infrastructure may not  
5 exist, the mechanisms may not exist to deal with a problem  
6 like readmissions to the extent that it involves, you know,  
7 poor community support on ambulatory care. And without  
8 integrated systems, providers will need some focused help to  
9 sort of knit together to deal with challenges like that. So  
10 that's still another way that this could be cut.

11 DR. MILSTEIN: Anne, a couple questions. Could  
12 you elaborate a little bit more on the chapter? Because I  
13 think your notion of building on precedent is a terrific  
14 idea as, you know, referenced in your chapter saying in some  
15 ways Medicare has already moved in this direction through,  
16 you know, how it handles transplant centers. Not all  
17 hospitals can participate in the Medicare program with  
18 respect to major organ transplants. But I wasn't sure how  
19 to interpret -- I have two questions. The first is I didn't  
20 know how to interpret these words, if a transplant center  
21 fails certain outcome tests, CMS will "not consider survival  
22 rates acceptable." Then what happens?

1 MS. MUTTI: As I understand, then that transplant  
2 center loses its approval, ability to continue to perform.

3 DR. MILSTEIN: So that if you're no longer  
4 participating, what I'll call sort of a high-risk segment of  
5 the Medicare -- okay, that's --

6 MS. MUTTI: And I did read recently that there has  
7 been precedent for that, that they found that the center was  
8 not meeting its standards and it no longer provides those  
9 services.

10 DR. MILSTEIN: Terrific.

11 MS. MUTTI: So it has been enforced.

12 DR. MILSTEIN: That's an editorial comment, not  
13 round one, but it's a nice precedent to build on because  
14 it's already established.

15 The second question I have, Anne, you know, as an  
16 aside, one of the things that I've done outside of my MedPAC  
17 life is, you know, supervise a unit that it gets called in  
18 when a hospital is under threat of losing Medicare  
19 participation. I've been doing this for about 25 years.  
20 And I will say that it's just breathtaking to sort of see  
21 what happens, you know, when a death sentence is on a  
22 hospital. I mean, the speed and rate of transformation and

1 change in management structure and investment just, you  
2 know, turns around overnight, very analogous to a death row  
3 conversion.

4 [Laughter.]

5 DR. MILSTEIN: My question is: Do you think it  
6 might be possible as part of our research to kind of, you  
7 know, look into the history there of what happens in  
8 hospitals where they sort of, you know, catch on fire with  
9 respect to -- in other words, meaning in some -- they become  
10 actually visibly frightened they're going to lose their  
11 ability to participate in the Medicare program? And what  
12 can be gleaned maybe from, you know, discussions with the  
13 OIG and others that, you know, tend to get involved at that  
14 point? Because it's a wonderful potential source of  
15 information on how to take a very bad performer and move its  
16 performance dramatically. And there may be some lessons we  
17 might extract.

18 MS. MUTTI: Definitely.

19 MR. HACKBARTH: Other round one questions?

20 DR. STUART: Both Glenn and Mark raised the issue  
21 of the QIO, and so my question is broadly focused on the  
22 extent to which you've talked to CMS about QIO activities in

1 this area, because the Eighth Scope of Work does include  
2 some very specific projects related to targeting technical  
3 assistance, including one that I'll have to say I consider  
4 really extreme, but you might be able to learn something  
5 from it. It's called the Nursing Home in Need Program where  
6 every QIO is supposed to identify three really bad nursing  
7 home providers in its region and then spend a whole year  
8 with each one of them.

9           Mathematica has been tasked to do an evaluation,  
10 kind of an assessment of both what the QIOs are doing, how  
11 others outside of the QIOs think about what they're doing,  
12 to help the agency develop the next scope of work. So  
13 that's something that you might -- if you haven't already,  
14 you might follow up with CMS in terms of what Mathematic is  
15 involved in.

16           MS. MUTTI: And that is a really good point. We  
17 mentioned it last time, but we didn't mention it in this  
18 presentation, that the targeting is quite consistent with  
19 the direction that CMS is moving in, so it would be a bit of  
20 a reiteration of that.

21           DR. STUART: I was involved in a listening session  
22 -- CMS was doing the listening -- where there were various

1 individuals that were asked to comment on this, and the  
2 comments around the table were, I guess, very much in terms  
3 of what we have around the table here in terms of real  
4 questions about what do you get when you target at the low  
5 end and do you just lower your expectations when you do  
6 that, and then how you take this information and actually,  
7 you know, bring all ships up. So there is some additional  
8 information, I think, to be had, whether it's available  
9 right now or not, but it's something that should be  
10 available fairly soon.

11 MS. MUTTI: Okay. Great.

12 MR. BUTLER: So my research by anecdote, which I'm  
13 not sure my numbers are right, but my bias would be -- and  
14 I'm going to get to a Premier question here -- that there  
15 are a series of -- these low performers on readmission and  
16 outcome, also on mortality, have other things in common.  
17 They don't do very well on the HCAHPS in terms of patient  
18 satisfaction. They're kind of nowhere on the IT  
19 development. They have high Medicare-Medicaid percentage.  
20 And there are a lot of these that are sitting in urban  
21 markets. And they're freestanding; they're not part of a  
22 system. At least there are a series of institutions like

1 that, and they're very much needed in the local communities.

2 So one side of it says, well, there are corner  
3 drug stores, and they're a model that just is not going to  
4 survive regardless. But we need a lifeline because the care  
5 is needed in those communities. That's kind of how I see  
6 this.

7 So my question related to this is, in the Premier,  
8 if you had these low performers that suddenly came up  
9 dramatically compared to others -- it's the first time I've  
10 kind of seen that -- were these -- because Premier has a lot  
11 of systems in there. Were these hospitals that were part of  
12 a system? Or can we also point to the participants in the  
13 Premier study who were freestanding and were able to achieve  
14 those kind of results without the support of a system around  
15 them?

16 MR. RICHARDSON: I don't know the answer to  
17 whether they were, say, Catholic Healthcare System or  
18 something like that. They were all, obviously, participants  
19 in the Premier family, if you want to call it that. They  
20 all worked with Premier to some level of either data  
21 analysis; they may have been participating in Premier as  
22 part of their group purchasing -

1           MR. BUTLER: I was looking at Herb because he was  
2 Mr. Premier at one point in time and may have --

3           MR. KUHN: You had a great variety of hospitals.  
4 You had those that were systems, those that were stand-  
5 alone, urban-rural, so a great variety. So some had their  
6 own infrastructure support. Some worked with the QIOs to  
7 develop those networks within their communities to put  
8 things together. You saw a number of different strategies.  
9 But I think the unifying force is that Premier itself  
10 created some collaboratives among all the institutions to  
11 help, kind of lift all boats as part of the process.

12           So individual markets vary differently, but there  
13 was this one kind of unifying thing that Premier itself put  
14 together to help them.

15           DR. MARK MILLER: What I was recalling is I  
16 thought we had a conversation. We talked about this a  
17 little bit, and we thought, you know, Premier was a good --  
18 there were lots of good things to come out of it. But we  
19 were wondering whether that was generalizable given the fact  
20 that they voluntarily did it. There was something, even if  
21 it was an individual hospital, there was something of kind  
22 of a system around this effort. And so I think your

1 question is sort of, well, what about a true stand-alone,  
2 I'm out here on my own. And I thought we had some questions  
3 about how generalizable that was because there seemed to be  
4 some infrastructure there, and in a sense, the implicit  
5 conversation we're having here is, well, should Medicare be  
6 providing some of that infrastructure for people who don't  
7 have it? Is that a fair characterization of the  
8 conversation?

9 MR. GEORGE MILLER: Yeah. And on that point,  
10 Peter brought a good question that I had in my notes to ask  
11 maybe in round two, and that is the IS question. Do these  
12 institutions have the same or credible inform systems to  
13 give them the data they need to make their improvements? Or  
14 is that something Premier provided for them? Do we know  
15 that information? Because the data collection would be  
16 critically important.

17 MR. RICHARDSON: What I've read so far is that it  
18 was a combination of both the hospitals themselves had some  
19 capabilities and then Premier gave them tools that allowed  
20 them to not only improve their own data infrastructure, but  
21 then share information across all the hospitals  
22 participating. But, Peter, I interpreted your question to

1 mean did the hospitals that had the higher percentage of  
2 minority or low-income patients, low-income, were they in a  
3 system or not, and that's what I don't know and could find  
4 out in terms of the graph I showed, the ones that had the  
5 higher proportion of low-income patients and what their  
6 characteristics were relative to --

7 MR. BUTLER: No, I was really just looking for the  
8 -- I think that may be a characteristic of the low  
9 performers, as you've already demonstrated in general in  
10 your data. It may not have been true in the Premier study.  
11 But I was really looking to see if they were really trying  
12 to say have we demonstrated that a freestanding institution  
13 given support can lift itself, or do they, in fact,  
14 ultimately have to be part of a system to get kind of the  
15 infrastructure that will really sustain themselves over  
16 time? It's a very different answer if we have the  
17 government play that role versus, say -- you know, the facts  
18 are we should encourage the development of these systems.  
19 In fact, maybe in the major metropolitan areas, you know,  
20 find ways to incentivize, or whatever, the bigger systems  
21 not to abandon those that are closing but, in fact, find  
22 ways to create community-wide looks at access in a way that

1 we really have not -- that the market by itself doesn't do.

2 MR. HACKBARTH: Okay, Jennie has the last  
3 clarifying question. Then we need to get to round two.  
4 We've got 20 minutes left, and I want to be able to give as  
5 many people who want to weigh in on how to focus this effort  
6 in the future the opportunity to do so.

7 MS. HANSEN: Yeah, this is a question for the  
8 topic of governance that you brought up for boards of  
9 directors. Was there any evidence to show that -- one, was  
10 the study about how people self-perceived their quality  
11 versus people who -- governance structures that were  
12 required to sign off on the quality? In other words, the  
13 fact that getting kind of passively reports of quality but  
14 to take some ownership, were there any studies to show any  
15 systems, whether it's Premier or others, that actually had  
16 to sign off on the fact that they read these studies,  
17 understood the implications?

18 MS. MUTTI: Right. The study that we cited did  
19 not ask that question. It did, you know, using Hospital  
20 Compare or other data, you know, we know this is their  
21 performance, and then we asked the boards, you know, what is  
22 your -- how would you answer these questions and compared it

1 and showed that they didn't line up.

2           We offer that possibility in the paper. How do we  
3 get the bindingness? Do you need to require them to sign  
4 physically that "I have read this is what my hospital  
5 performance is"? It is a very, you know, off-the-cuff kind  
6 of answer that we certainly would want to vet with other  
7 people to see if that's it. But that's the kind of notion  
8 we were thinking of. I don't know what other -- you know, a  
9 Premier initiative or HCA or some of these other systems  
10 that have put together quality improvement programs, exactly  
11 how they've engaged their boards.

12           MS. HANSEN: You know, with the Sarbanes-Oxley,  
13 other requirements, some governance kind of requirements to  
14 have some accountability, it causes people to pay attention.

15           MS. MUTTI: Yeah, and I cited this in the paper,  
16 too, but both NQF and also the HHS-OIG have put out papers  
17 in the last five years or so calling for greater board  
18 involvement, showing concern that there hasn't been enough.

19           MR. HACKBARTH: Okay. I'm going to ask Jay to  
20 kick off round two.

21           DR. CROSSON: Well, let me just first say I'm not  
22 sure what's going to come out, because I'm quite caffeine-

1 sensitive, and somebody must have switched the decaf and the  
2 regular coffee, and I feel like my head is just going to  
3 blow up.

4 [Laughter.]

5 DR. MARK MILLER: There is a lot of drama here.

6 DR. CROSSON: So I have one specific comment and a  
7 couple of general ones.

8 Just with respect to the conditions of  
9 participation -- and I think on Slide 14, you mention that  
10 one approach might be to work with the governing bodies of  
11 the hospital -- I would just hope that in that particular  
12 line of thought we also include the organized medical staff  
13 and the medical executive committee, because I think there's  
14 a lot of evidence that most quality improvement in hospitals  
15 really requires the active participation of the physician  
16 staff. And, in fact, in some states, including California,  
17 the physician staff as organized is a semi-autonomous body,  
18 and so it's not just purely about the hospital governance  
19 per se, no offense to any other Commissioners.

20 But with respect to the content, you know, after  
21 the November discussion about the QIOs, I took a look at  
22 some information about one large state and its QIO from the

1 perspective of how effective it might be, and I'm not going  
2 to really comment on that, but what really struck me was the  
3 question of how it really could be effective given the  
4 amount of resources.

5           Now, Glenn mentioned that there's hundreds of  
6 millions of dollars expended a year across the country, and  
7 that's true. But if you look at this one particular large  
8 state, the budget is actually \$12 million a year for a state  
9 that has several hundred hospitals, around 70,000  
10 physicians, and hundreds of home health agencies, SNFs, and  
11 the like.

12           MR. HACKBARTH: What state might that be?

13           [Laughter.]

14           DR. CROSSON: It's actually not California. It's  
15 not California. I have some thoughts about the process in  
16 my own state, but this is another state. There aren't many  
17 in that category, I understand.

18           MR. HACKBARTH: We're narrowing it down [off  
19 microphone].

20           DR. CROSSON: Right, we're narrowing it down. So,  
21 you know -- and some 40 employees. So, I mean, as I thought  
22 about it and the scope of both the issues of quality and the

1 issue of efficiency that you've introduced, it just seems to  
2 me hard to imagine how an organization of that size could  
3 actually do very much.

4           So I do think that the question of whether or not  
5 the QIOs as organized and as funded, whether there would  
6 need to be a separate one in every state, for example, or  
7 almost every state, for example, whether the mission that  
8 they're given, given the amount of money that they have, is  
9 actually doable are legitimate questions, and we ought to  
10 look at that. And that's not to take anything away from any  
11 of the individuals who work in those organizations, but to  
12 me the math doesn't compute very well. And so the idea of  
13 rethinking it I think is a good one.

14           With respect to the conditions of participation  
15 question, you know, Arnie -- I mean, I agree with Arnie  
16 because I've seen that sort of situation before. I worry,  
17 though, about whether that endpoint -- that is, loss of  
18 participation in Medicare -- is too sharp an endpoint to  
19 actually find its way into a systematic process of quality  
20 improvement, because it is so catastrophic for communities  
21 or for organizations that there's the risk of people backing  
22 away from it in the end.

1           So the choices seem to me either to develop some  
2 other endpoint for conditions of participation, and you've  
3 suggested some in the presentation. Other organizations  
4 like NCQA, for example, have different levels of  
5 certification or qualification, whatever you want to call  
6 it, as does the Joint Commission, so you could do that. But  
7 then you have to say, well, then, but so what impact does  
8 that actually have on the business of that entity.

9           Another choice would be -- and we haven't really  
10 brought it into play here -- is the question of expanding  
11 pay-for-performance. So as I think about the traditional  
12 breakdown of, you know, the three elements, the Donabedian  
13 elements of quality -- structure, process, and outcome -- it  
14 just seems to me that issues of structure and process fit  
15 more with the central tenets of conditions of participation.  
16 In other words, if you don't have certain elements of  
17 structure and process, then you really can't play in the  
18 game, and your job, if you don't have them, is to make sure  
19 you do have them; whereas, outcomes, you know, what you're  
20 able to produce with what you've got seems to fit more with  
21 the concept of gradated reward or punishment by CMS in the  
22 area of then expanding the idea of pay-for-performance,

1 which we've started on, and it's difficult because it's hard  
2 to find measures that work really well and the like.

3 But I think we have a potential to go a lot  
4 further with that and that that's better than trying to put,  
5 you know, relative performance or performance on outcomes  
6 into the conditions of participation framework.

7 MR. HACKBARTH: Just a quick thought here. So one  
8 set of questions is how to motivate change. Another set of  
9 questions is how to support change once you have somebody  
10 that you assume to be motivated. And, you know, I think  
11 it's useful to sort of parse those, and one of the decisions  
12 we need to make is are we doing one or the other or both of  
13 those questions.

14 Okay. Let me see other hands for comments. We'll  
15 just go down the row here.

16 DR. DEAN: I'd like to follow up. I especially  
17 concur with what Bob was talking about, the whole  
18 readmission issue as a measure, but also as you said, Glenn,  
19 I think it's a very good measure because it does cut across  
20 different parts of the system. It's true that it's not  
21 really fair -- I mean, I think hospital people will say it's  
22 not really fair to put all that burden on me because a lot

1 of that I can't control. On the other hand, somebody has to  
2 take some responsibility to begin to build the systems that  
3 will give us that kind of care, and it really is a measure  
4 of quality, I think, better than many of these other more  
5 specific things that we use.

6           There was a very interesting presentation I heard  
7 a couple years ago that Dave Durenberger organized with a  
8 fellow who was the CEO of Parkland in Dallas, and he talked  
9 about how -- he was talking about mostly about emergency  
10 room use, but I suspect it would spill over into  
11 readmissions -- about how their emergency rooms were just  
12 overwhelmed -- and, of course, they're in a difficult  
13 situation, different environment -- and how they had  
14 specifically taken the responsibility to try to build up the  
15 primary care infrastructure in their neighborhood, and, in  
16 fact, where most other emergency room use was going up,  
17 theirs went down. And he wasn't talking about readmissions,  
18 but my guess is that the same would apply to that.

19           So there are examples of places where they've done  
20 this and shown that if an organization takes the  
21 responsibility to try to look beyond their walls, they  
22 really can improve the outcomes for the people they serve.

1 And I think that's the direction -- we need to take a  
2 broader view of all this and encourage us -- so I guess I'm  
3 saying that looking at readmissions I think is a measure  
4 that does cut across those areas and something that is  
5 important.

6           What it boils down to so often, I mean, resources  
7 are important, your location is important, but the key thing  
8 is local leadership, and where you've got local leadership,  
9 these things a lot of times happen, even in some very  
10 difficult situations. And if you don't have local  
11 leadership -- and it's a hard thing to produce, but I think  
12 we need to recognize that so much depends on local  
13 leadership -- although as Peter said, you know, I think  
14 being in a system mitigates some of that.

15           MR. HACKBARTH: Okay. We have just about ten  
16 minutes, a little less than ten minutes to go, so if I could  
17 ask people to keep that in mind.

18           MR. KUHN: Let me be real quick here.

19           One, let's make sure that we don't oversell the  
20 COPs because COPs really focus on minutiae and the fact that  
21 a physician doesn't put a time on a particular form means a  
22 failure of a COP. So I want to make sure that we try to

1 strike a balance here in what we put together in this  
2 chapter, that we really want people to focus resources and  
3 time and efforts on improving quality performance, not  
4 chasing hospital staff or other clinicians in order to make  
5 sure paperwork is all in order. So we need to find a  
6 balance.

7           Having said that, I do like the discussion we've  
8 had this morning about the COPs and the interpretive  
9 guidelines in the area of the transplant sector. Remember,  
10 this is an area where they were outside the COPs until about  
11 three and a half years ago. They were part of a national  
12 coverage determination by CMS. CMS did a regulation,  
13 brought them into the COPs, and this is one that they had a  
14 mulligan, they had a do-over. They could start from scratch  
15 on this one. And they got it right, and I think they did a  
16 very good job on this, and I think we need to highlight that  
17 in a text box, quite frankly, and discuss where this is  
18 really one that focuses on quality improvement, volume,  
19 outcomes, and I think that's a real good example of starting  
20 over.

21           Likewise, in that same vein, where I think a good  
22 example of where COPs could be very effective is in the area

1 we've talked about as readmissions. Right now, the current  
2 COP, if I understand it, on readmissions is that hospitals  
3 need to have the readmission work done -- or the discharge  
4 stuff within 30 days -- 30 days afterwards. You know, a  
5 much more, I think, appropriate COP would be within seven  
6 days that summaries go to the physicians and the post-acute-  
7 care providers. That makes a lot more sense, and I think  
8 this is something, again, an example where a COP is  
9 antiquated when you think about where we're trying to drive  
10 forward in terms of readmission policies.

11           And if you take it a step further, we ought to be  
12 thinking about that there ought to be HCAHPS measures that  
13 focus on this area and that we harmonize across all the  
14 areas so that everything is focused on the outcome, that is,  
15 to improve readmissions, whether it's COPs, HCAHPS, quality  
16 measures, the whole effort that's part of that process.  
17 And, again, I think that would be an area for us to think  
18 about and highlight.

19           Two more things. One on this area of creating  
20 voluntary high standards. I'm intrigued by that, but I'd  
21 like to be convinced it really does make a difference,  
22 because what I see mostly in voluntary high standards is the

1 putting up of billboards on highways about we're a Top 100  
2 facility, we're a Top 10 facility, that kind of stuff. I  
3 really want to be convinced that it makes a difference and  
4 it's just not a way to brand and drive advertising campaigns  
5 for particular providers out there, and that would be  
6 helpful to see.

7           And then, finally, on focusing on lower-performing  
8 providers, you're right, in the Ninth Scope of Work, CMS did  
9 put provisions in there for it to -- whether it's nursing  
10 homes and some of them were special focus facilities,  
11 whether it's others. But the QIO could pick 85 percent.  
12 CMS picked the other 15 percent. That way the QIO couldn't  
13 cherry-pick the ones so that they could look good in terms of  
14 the outcomes at the end of the day.

15           But if indeed when legislation goes through and we  
16 wind up with tournament-type models in terms of  
17 readmissions, all the kinds of things out there, we do  
18 really want to focus on those lower performers, I think, so  
19 the gap doesn't widen as part of the process. So I think  
20 that would be an area worth exploring.

21           MR. GEORGE MILLER: Thank you. And, Tom, you're  
22 talking about Dr. Ron Anderson who is president of Parkland,

1 and he and I currently serve on a panel dealing with  
2 disparities, and he's done a fantastic job. And so one of  
3 my recommendations, while we are going on this path, may be  
4 to bring in both those who have large populations of  
5 minority and socioeconomic, just to get a feel of those  
6 who've done things right and those who still struggle with  
7 it to see what they would think as far as a panel discussion  
8 or just to get some feedback and input.

9           But I do like the concept of strengthening the COP  
10 not for the minutiae, but where it could certainly lead to  
11 fundamentally quality change, and also holding up boards and  
12 organized medical staff in concert responsible for improving  
13 the standards.

14           I agree with Jennie that sometimes that  
15 information is reported just within an overview versus  
16 specific measures, and we could require that the board be  
17 very prescriptive in what information they must have at the  
18 board level and then hold accountability. And, again, using  
19 the organized medical staff as well.

20           I was kind of intrigued by Arnie's comments about  
21 the fire sale that they're going to lose accreditation. I  
22 served on the Joint Commission and chaired one of those

1 review panels when hospitals were about to lose their  
2 accreditation, they would come back, and they did go through  
3 just -- they got religion and they went through major  
4 changes. But trying to -- I'm not so sure, though, that's  
5 the right approach to try to improve quality, wait until  
6 they're just about on their death bed to do that, because  
7 that's all their focus. They don't do anything else.  
8 Everything else just drops. Maybe it should be, but maybe  
9 there's a better approach so they don't get to that point.  
10 That's why I like the technical assistance where it could do  
11 the most good.

12           Finally, Glenn mentioned earlier about the doors,  
13 so my question, while I think we're on the right path, have  
14 we opened all the right doors and looking at that  
15 discussion. Again, from my point of view, I would certainly  
16 like to hear from the Dr. Ron Andersons and the others who  
17 have safety net hospitals who struggle and listen to some of  
18 their challenges. I suspect that they don't have the  
19 infrastructure that Peter talked about, the data systems,  
20 and up-to-date data systems provide that information.

21           MS. BEHROOZI: This was a really interesting  
22 paper. I was not so interested so much in the COP side at

1 first, but, you know, listening to the conversation,  
2 certainly it's important to make the COPs meaningful. I  
3 still have a couple of concerns, and one of them is about  
4 access. We shouldn't be thinking, I think, about setting  
5 the bar too high too fast so that you end up, you know, with  
6 places that can't marshal the resources at the last minute  
7 to avoid dropping out. But, of course, that doesn't mean we  
8 want people to have access to low-quality places. No  
9 question about that.

10           So I really think that we -- I like the focus on  
11 the technical assistance. I like focusing on the low  
12 performers' readmission rates. The correspondence to the  
13 disparity issue reminds me of the recommendations, the  
14 distributional recommendations we made on the SNF side.  
15 You're not exactly focusing on how to make health care  
16 better for African Americans or Latinos or whatever, but you  
17 are doing a meaningful thing that produces that result, and  
18 also addresses socioeconomic disparities.

19           Also, I think the more we can encourage the  
20 application of resources to assisting those low performers,  
21 we can do things like get behind some of the issues that Bob  
22 was raising. But the way I heard what you were saying, Bob,

1 is that there are institutions in areas that don't have a  
2 robust health care infrastructure surrounding them in terms  
3 of, you know, follow-on support and that kind of thing. But  
4 there are other types of situations that providers in  
5 different areas face, like people traveling long distances  
6 or not having sufficient family support or nutritional, you  
7 know, the nutritional context, no place to buy fresh fruit  
8 or whatever, that those institutions have to deal with on an  
9 ongoing basis. It's not like you can fix them. You can't  
10 give them the technical support to help them build a network  
11 of outpatient support, whatever. There's other things that  
12 they're going to keep having to deal with, and by focusing  
13 on those institutions, not just their outcomes as a health  
14 care institution but the context within which they do it,  
15 you might learn more about what those challenges are and  
16 more of the types of technical assistance or whatever other  
17 kind of assistance you want to call it that they and their  
18 communities need going forward.

19 In terms of Jay's comment about the process and  
20 structure components of COP requirements, I don't know,  
21 maybe you need to have different process and structure  
22 measures. And I don't mean lower standards -- process and

1 structure requirements. I don't mean lower standards, but  
2 in different communities, you know, maybe in a rural  
3 community where people have to travel long distances, that  
4 institution needs to ensure transportation services, which  
5 you wouldn't have to do in an urban area, potentially.

6           And just on the issue of the support that can be  
7 provided by participation in a system, I just want to point  
8 out that we had a conversation a couple of months ago about  
9 consolidation and some of the negative unintended  
10 consequences of consolidation, and one of the other, I  
11 think, potential -- and that doesn't mean it shouldn't  
12 happen and it's a bad thing. But I think we need to, you  
13 know, think about that, but also think about whether systems  
14 then when they make their business decisions about the parts  
15 of their system to support or to shut down because they're a  
16 loser or, you know, it would require too many resources to  
17 restore them, how systems can be required to maintain access  
18 for all the different parts of the community.

19           MR. HACKBARTH: Just let me do a time check, Bill.  
20 How many people in the queue here? Seven. So we've got  
21 seven people. We've used up the allotted time, and so  
22 everything we do now has got to come out of the other two

1 sessions. So I ask people to keep that in mind.

2 DR. SCANLON: Then quickly. First of all, I think  
3 there's a link between the two things, as you said, the  
4 issue of assistance versus incentives, because you have to  
5 have incentives for people to want to accept assistance, and  
6 so we need to think about how strong the incentives are in  
7 anything that we do. And in doing that, we have to also  
8 make sure that we're fair about it, and we've had a  
9 discussion sort of at several points in this meeting about  
10 the variation, and not controlling appropriately for the  
11 variation is a real problem.

12 The other thing I'd say about the conditions of  
13 participation, I think that looking at the nursing home  
14 experience and thinking about what might apply and what  
15 might not apply would actually be good in terms of this  
16 because there's a rich experience with respect to nursing  
17 homes in conditions of participation. There's about  
18 30 GAO reports over the last 10 years sort of on this. And  
19 there's three areas, I think. One, there's setting the  
20 standards. The second one is detecting sort of whether or  
21 not somebody has been in compliance. And the third is sort  
22 of enforcement, what do you do about it.

1           You know, I agree that conditions of participation  
2 generally are minimums, and as Mark said, we may be thinking  
3 that we can get to a point where we raise the minimum. That  
4 would be good. Detection is a real issue. In nursing homes  
5 where there's been more investment probably than any other  
6 sector, there's huge variation across the states in terms of  
7 the reported deficiencies and no one believes that they  
8 reflect an accurate sort of accounting of the deficiencies.

9           In terms of enforcement, you know, Arnie's  
10 experience of side -- and maybe it's because it's sort of  
11 the idea of threatened sort of expulsion from the program is  
12 so rare in hospitals that it becomes sort of a very sort of  
13 dramatic event. But then there's this question of whether  
14 or not there's a yo-yo sort of experience, which is that  
15 after they've come into compliance, you know, do they stay  
16 there? And in nursing homes, the experience is people come  
17 back into compliance, but then they're out again very  
18 quickly.

19           We also have in nursing homes the advantage of  
20 intermediate kinds of sanctions, and I think that's the kind  
21 of thing to think about here, too, which is that a death  
22 penalty is -- there's the reluctance on the part of the

1 person in charge to impose it. And so if you have  
2 intermediate sanctions -- and reporting is actually in some  
3 respects an intermediate sanction because it creates, you  
4 know, an incentive -- that you incorporate that into it.

5           So I think I'd strongly urge you to look at sort  
6 of the nursing home sort of experience because there are, I  
7 think, things that we can learn from this if we try to go  
8 down this -- if we decide to go down this path thinking  
9 about conditions of participation as one quality improvement  
10 sort of technique.

11           MR. BERTKO: Glenn, I'm going to respond to your  
12 first statement, which is I'd suggest keeping to a narrow  
13 focus of elements, pick up some quick wins with that  
14 evolutionary pathway. QIOs might be a good place to look,  
15 but it seems like it's a long time before we would get  
16 around to fixing them.

17           Thanks.

18           DR. BERENSON: Very quickly. On the QIOs, the IOM  
19 had a report. Senate Finance had hearings. My  
20 understanding is that the Ninth Scope is in a sense a  
21 response to try to get it right. So I think QIOs are  
22 important for us to look at, but right now I think it's

1 monitoring the Ninth Scope, and the real work is after  
2 that's over, when I think a lot of people will be interested  
3 in what the impact of a new way of doing things was.

4           The second point -- and I'll be very quick on this  
5 one -- about six years ago I presented to MedPAC Commission  
6 a model of value-based purchasing in which I had pay-for-  
7 performance as only one of, like, nine levers that the  
8 agency could use. And I regret, in fact, that the term for  
9 pay-for-performance has -- I mean, that value-based  
10 purchasing has now been appropriated to describe what I  
11 think is pay-for-performance. I think there's even things  
12 that have not been presented that can be part of the quality  
13 infrastructure, and I would urge us to have a broad look.  
14 I'm skeptical that we will get very far with just the pay-  
15 for-performance approach.

16           DR. MILSTEIN: Briefly, I think in terms of  
17 simplifying what a vision for what we might be after here,  
18 if we come up with a recommendation, we ought to ask  
19 ourselves does it do briefly -- does it successfully insert  
20 what I'll call sort of modern performance management into  
21 the DNA of U.S. hospitals. Let's work back from there. And  
22 I think Glenn's taking it apart into motivation and

1 resources makes a lot of sense to me.

2           On motivation, I think the problem is performance  
3 blindness. You know, fundamentally, it's -- you look at the  
4 survey results, you know, the majority of hospitals in the  
5 bottom half of the distribution believe that they're in the  
6 top half of the distribution. There's the problem with  
7 motivation. And I think the challenge is what's been  
8 referred to as "poverty of ambition" with respect to, you  
9 know, quality management that's both provider based,  
10 purchaser based in terms of, you know, what Medicare has  
11 articulated to the community, relatively low expectations,  
12 and I think, you know -- I don't know. You know, we also  
13 have to guard against it here.

14           I mean, for example, the notion that a hospital  
15 would have to get key discharge information to the patient's  
16 treating physician within 30 days, as Herb pointed out, is  
17 insane. And then if you sort of -- we have to, I think,  
18 guard against the notion of, well, the right answer is seven  
19 days. Maybe the right answer is seven hours, if it was like  
20 one of us or our mothers or, you know, whatever. And so  
21 it's -- guarding against poverty of ambition is, I think,  
22 very important.

1           I agree with Herb and I guess myself that I think,  
2 you know, you can't -- and I think with Bill, too. You  
3 cannot -- you know, the problem with having a nuclear weapon  
4 is it's very difficult to use. I remember when I used to be  
5 a director and had to make the decision regionally as to  
6 about kicking providers out of the program. You know,  
7 really tough.

8           And so I agree with Herb's logic that maybe the  
9 best way to approach it with the precedent we already have  
10 in place, and that is right now, you know, transplants, but  
11 it really -- that fits within a broader category of high  
12 complication risk, high variation treatments, you know, that  
13 are elective. There's a chance to move patients. I think  
14 that's probably our best bet and keeps us out of the problem  
15 that Bill mentioned, which is, you know, you can't really  
16 use a nuclear weapon. But most hospitals would care about  
17 whether or not they were permitted to serve Medicare  
18 patients with respect to high-risk, high-complication, high-  
19 variation conditions. I think that's a really nice -

20           And then in terms of resources, again, I spent my  
21 early years, you know, evaluating the precedent, the prior  
22 iterations of the QIO program, and I've had a chance to

1 interact with them more recently, and I just don't think  
2 that's our likely best vehicle for inserting modern quality  
3 management into America's hospital system. I think a much  
4 better model is one that has been advocated by others,  
5 certainly not myself, I didn't think of it, but it's this  
6 notion of taking what we can determine to be our very  
7 highest performers, you know, and then paying them to help  
8 those that are off the mark, because they really understand  
9 it, and many of the QIOs, you know, are not at this point in  
10 history the repositories of our best minds in modern quality  
11 management. There's no Virginia Masons, there's no  
12 equivalent of a Virginia Mason among the QIOs.

13           Then last, but not least, I think, you know, if we  
14 sort of think about where we're going to land on this, I  
15 think, you know, this is something I'm borrowing again from  
16 the American Board of Internal Medicine, but it's the notion  
17 -- let's not come up with something, you know, wild, but  
18 let's come up with something that when we look back on it we  
19 can say this is -- if this had been in place for five years  
20 -- once this is in place for five years, whatever we  
21 recommend, assuming it gets in place, any of us, any MedPAC  
22 Commissioner would be willing to take random assignment when

1 it came to which hospital they went to in their community.  
2 It's putting ourselves, you know, into the shoes of the  
3 beneficiary, and I think that may affect the shape of our  
4 decision if we sort of think of it that way.

5 DR. KANE: Yes. It's hard to know whether to just  
6 talk fast or cut down on what you want to say, so I'll try  
7 to do a little of both.

8 But first, I want to say, I think Conditions of  
9 Participation is too much of a sledgehammer, too hard to  
10 actually, you know, to kill a place. You do a lot of damage  
11 when you do that. And I think the example that comes to  
12 mind in my experience is tax exemption, whether or not to  
13 revoke tax exemption. And eventually, even the IRS had to  
14 come up with intermediate sanctions because it was just too  
15 heavy a hammer to drop on people and nobody -- so everybody  
16 got tax exemption, no matter how egregious their charitable  
17 behavior.

18 So I would think we could do an enormous amount of  
19 good to have CMS or somebody look through all the different  
20 ways that hospitals get recognized now, some of which are  
21 pure garbage. I mean, they pay \$50,000 to get named a "best  
22 hospital" and whatever. If you look through all the

1 different ratings systems out there and all the flags  
2 blowing out in front of the hospitals saying, "We're in the  
3 top 100," I think the consumer is very confused by all of  
4 that and it would be useful to at least disclose the method  
5 by which hospitals are chosen.

6 I think just cleaning up the noise would be a huge  
7 contribution. I mean, I was shocked to find out that some  
8 hospitals are only recognized for particular performance  
9 levels by the different organizations by whether they pay  
10 the \$50,000 to get themselves recognized. So there's  
11 something wrong there with that kind of a rating system.  
12 Just cleaning up the noise, making it an honest assessment,  
13 letting people understand how these different advertisements  
14 get created, I think, would be enormously helpful.

15 And then I think CMS or higher up would be -- it  
16 would be a good idea to create a recognition system that  
17 people believe in, because I think -- you know, I stopped --  
18 I don't even listen when they say, U.S. News and World  
19 Report says blah, blah, blah. But there is clearly a need  
20 out there for some credible rating system on, I would say,  
21 major attributes of the kinds of things that Arnie was  
22 talking about.

1           And finally, I guess I'd like to say, because I  
2 looked at safety net hospitals now for this grant we're  
3 doing with the Commonwealth Fund, that DSH is not a  
4 particularly good way to find these hospitals. One of the  
5 biggest problems with the hospitals that serve the most  
6 disadvantaged is Medicare patients don't go there. So using  
7 the window of Medicare to find them isn't a particularly  
8 efficient way to do that.

9           So one thing I think we need to talk about is how  
10 much responsibility for the experience of non-Medicare  
11 patients do we want to take sitting on MedPAC. For  
12 instance, there's a lot of county hospitals out there who --  
13 I mean, Medicare patients only get carried to them if  
14 they're unconscious and half-dead because they would  
15 otherwise say, "No, I don't want to go there." But these  
16 are the places that really need help and, frankly, serve a  
17 lot of minority and low-income people. So maybe DSH is not  
18 the best. I can give you more information on that, on the  
19 research that we've been doing. But I would say we need to  
20 clarify how much responsibility do we really want to take  
21 for true safety net hospitals, and if we do want to do that,  
22 we have to expand beyond just the Medicare population

1 because the Medicare population has freedom of choice to go  
2 someplace else.

3           And then lastly, thinking about hospitals and  
4 their span of control, I have seen some amazing examples of  
5 hospitals fixing what's missing in their community through a  
6 variety -- you know, expanding primary care, actually  
7 literally knocking on doors and signing people up for  
8 programs that will help them with their dementia or their  
9 depression or their various reasons. They actually evaluate  
10 their emergency room use and figure out why people are  
11 hitting it and go out and try to create programs to prevent  
12 the need to use the emergency room inappropriately. So  
13 there's all kinds of ways hospitals can try to target their  
14 populations if they're interested.

15           One tool to kind of look through, maybe get some  
16 ideas from, are the Community Benefit Statements that the  
17 IRS is now requiring hospitals to report, kind of getting a  
18 sense of what some hospitals are doing and try to get them  
19 in to talk about, here is how I address the fact that my  
20 local community doesn't have everything I ever needed. So  
21 that's just another resource to go to.

22           And finally, maybe we should ask some of the gurus

1 of hospital consulting who do help hospitals improve  
2 performance to come in and be a panel. There's a bunch of  
3 them. So have them come in and talk about what it takes to  
4 -- because I've been on those boards and I've tried to do  
5 it. It's not something I can see a QIO or even a government  
6 agency doing. Maybe we just need to create the incentives  
7 and maybe some standards of what kinds of things we'd like  
8 to see improved. But I really can't see that type of  
9 technical assistance being provided by certainly not a QIO,  
10 and probably not by CMS.

11 MR. BUTLER: How is your head doing over there,  
12 Jay?

13 [Laughter.]

14 MR. BUTLER: I thought I was going to be  
15 brilliant, because I had Donobedian in graduate school. I  
16 still have his book and I was going to use the structure  
17 process outcome framework, which you did articulate very  
18 well.

19 Both the Joint Commission and the Conditions have  
20 kind of had their roots in the structure, have slowly worked  
21 into the process area through things like tracer  
22 methodology, and still really is not in the outcome sphere.

1 I still think the core competencies of Conditions of  
2 Participation rest in the structure and maybe a little bit  
3 in the process, and contrary to some of the comments, having  
4 been on the receiving end of a termination letter on  
5 Conditions of Participation, knowing we're not really going  
6 to close, it was fairly effective. The basic look at  
7 facilities in some of these things, they do a good job on  
8 that and they bring some good people in when they do it.

9 Now, so my bottom line, though, the outcome side  
10 is we are, as Bob said, we're way underutilizing still the  
11 payment mechanism as the mechanism for outcomes. With the  
12 exception of the transplant and some of those areas, that is  
13 the vehicle. Think about what we've done in the past in  
14 Medicare. Think about what length of stay would be today  
15 without DRGs being inserted in the early to mid-1980s.  
16 Think about where core measures would be if we didn't start  
17 reporting them. And think about what readmissions will be  
18 as a result of -- and it's just one little piece.

19 Ultimately, we'll follow the dollars and it will  
20 be -- now take on top of it the stimulus dollars for IT,  
21 which are addressing, by the way, a lot of this same thing  
22 in the out years. You're going to have to perform to get --

1 you're not going to have just the systems, but you should  
2 have to perform, as well. Those dollars, I think, will have  
3 the largest impact on the outcome piece of what we're doing.

4           So actually, I view strengthening the Conditions  
5 of Participation on the structure side, perhaps on the  
6 process, but don't try to dip into -- the government is not  
7 the partners for process improvement and they're not where  
8 we're going to look to for expertise in general. We're  
9 going to partner best in class in our organizations,  
10 consultants, other areas, to try to match the payment system  
11 that is coming down the line.

12           DR. BORMAN: In watching all this, I've been going  
13 back to where we started this conversation. I'm struck by  
14 the traction that the whole notion of readmission rates got  
15 for us and got us to move in this area, and I think we have  
16 to ask, what is it about that that we liked and that plays  
17 backwards toward how we continue to get at those -- identify  
18 those kinds of things and how we attack them as opposed to  
19 saying, what should the process structure or whatever be and  
20 build outward.

21           It seems to me that what we like is that it seems  
22 to be an easily understood concept both on the policy and

1 regulatory side, but also to the consumer. My neighbors  
2 understand what is a hospital readmission. And maybe we  
3 understand it in a slightly different way, but it's easily  
4 understood.

5           It's relatively easily measured. We can quibble  
6 about who gets tagged with a particular readmission or  
7 whatever and the boundaries around what is for a related  
8 condition and what isn't, but again, it's something that's  
9 relatively easily measured.

10           A lot of people like it because it appears to be a  
11 system or a composite measure and that it is somewhat  
12 sensitive to how well some care is integrated, and so we  
13 like that piece of it very much. And we like the part that  
14 it moves money. It's tied, as best we can measure, to a  
15 fair amount of money that doesn't seem to be being  
16 productively and best invested of our health care dollars.

17           And so it seems to me that probably we need to  
18 look for several other things that feature those  
19 characteristics and then say, okay, out of those, if you  
20 want to fix something about it, how do you fix it? And  
21 there may be a few things that trickle out to the very basic  
22 structural part of COP and things like it. I don't know.

1           But COP, to me, in addition to being a structure  
2 thing, is it's not too dynamic. You can't just change the  
3 COP every year to reflect best thinking, new practice,  
4 whatever. So the COP and things like it, to me, are  
5 something that's the more static part of it that is moved  
6 only with a fairly major focus or reason, body of  
7 literature, or period of time behind it.

8           On the other hand, we need a dynamic piece to deal  
9 with the part we want to get at, which is changing on a  
10 relatively rapid basis, targeting the help to the folks who  
11 need it, whatever. Perhaps we try and transform the QIO  
12 system into that dynamic piece. I'm not sure we can, but  
13 maybe that's another way to think about it, is what out of  
14 all these other entities out there provide us a dynamic  
15 mechanism to deal with it, because COP, to me, seems pretty  
16 static.

17           MR. HACKBARTH: Okay. This has been a rich  
18 discussion but one that's a little hard to quickly analyze  
19 and organize. A couple quick thoughts. I want to go back  
20 through the transcript and talk to Mark and our presenters,  
21 but some thoughts that I have is that it might make sense  
22 for us to talk about a particular quality problem as opposed

1 to quality abstractly and sort of focus our exploration on  
2 readmissions or some particular problems as a way of giving  
3 it some concreteness.

4           We shouldn't quickly skip over the step of how to  
5 motivate improvement. One of the themes in this discussion  
6 is actually there are a lot of potential tools that might be  
7 used, and as opposed to just thinking about pay-for-  
8 performance or Conditions of Participation, it may actually  
9 be useful to think about how you would line up all of the  
10 available tools to attack a particular problem like  
11 readmissions.

12           There seems to be some general agreement that a  
13 particular challenge is how to elevate the poorest  
14 performers in a system and what can be done to support them  
15 in the improvement effort.

16           And then there are a bunch of questions about how  
17 to provide support. If, in fact, you want to help those  
18 institutions, the poorest performers, get better, there are  
19 a variety of different potential types of support that have  
20 been discussed here and some systematic analysis of what  
21 those options might be, you know, ranging from restructured,  
22 better financed, more focused QIO program to somebody

1 mentioned partnering institutions, high performers with low  
2 performers. We have talked previously about moving away  
3 from the QIO model to providing resources to institutions to  
4 buy consulting services of their choice. There are a lot of  
5 different potential tools there.

6           So I'm not sure that we have a narrow, very  
7 specific focus about where to go from here, but I think it's  
8 starting to take a little shape in my mind and I think will  
9 take more shape after we review the transcript.

10           Thank you for the guidance and leadership on this,  
11 and now we will move on to Part D. This presentation on  
12 Part D is informational, primarily, an update, and so it's  
13 important information I know people are interested in, but  
14 what I propose we do here is limit the questions to simply  
15 the round one very focused clarifying questions -- what did  
16 this piece of data mean, or I don't understand that chart --  
17 as opposed to a more broad-ranging policy discussion.

18           With that, I'll turn it over to Joan.

19           DR. SOKOLOVSKY: It's my pleasure to introduce  
20 once again Jack Hoadley from Georgetown University and  
21 Elizabeth Hargrave from NORC at the University of Chicago.  
22 Jack is going to bring you up to date on Part D formularies

1 and benefit design in 2010.

2 But first, I wanted to look back at drug price  
3 trends under Part D, an issue that we have talked about a  
4 few times previously. Last year, we talked about price  
5 trends for 2006 to 2007. Now we have an additional year of  
6 data. First, I want to remind you of what we mean by  
7 prices.

8 Drug prices result from two sets of negotiations.  
9 Plans negotiate with manufacturers, generally for rebates,  
10 and they negotiate with pharmacies to be in their network,  
11 paying them an ingredient fee and a dispensing fee. This is  
12 a very simplified diagram of how the money flows.  
13 Pharmacies purchase drugs from wholesalers who, in turn,  
14 purchase them from manufacturers. Plans have a lot of  
15 leverage negotiating with pharmacies and they have limited  
16 dispensing fees over the course of Part D. But plans must  
17 pay enough to cover the prices pharmacies have to pay to buy  
18 drugs. And pharmacies have little negotiating power when  
19 buying brand drugs. The prices negotiated between the plan  
20 and the pharmacy determine beneficiaries' out-of-pocket  
21 costs, particularly when they reach the coverage gap, and  
22 how much they have to pay for each script.

1           Plans don't generally buy drugs directly from  
2 manufacturers. They negotiate, again, for retrospective  
3 rebates. Plans' ability to get these rebates depends upon  
4 the availability of therapeutic substitutes. If a plan can  
5 put a drug on a formulary in a preferred position and not  
6 its alternatives, the plan can get significant rebates from  
7 the manufacturers. These rebates are provided  
8 retrospectively and do not affect the price beneficiaries or  
9 Medicare pays at the retail counter. Plans can use these  
10 rebates to lower premiums, and remember, that also affects  
11 Medicare costs since Medicare subsidizes those premiums.

12           The trend for retail drug prices, that is, the  
13 prices plans pay to pharmacies, present a mixed picture.  
14 Overall, Part D drug prices based on individual drug  
15 products -- and that's the top red line you see up there --  
16 rose 11 percent from January 2006 to December 2008.  
17 However, when you take generic substitution into account,  
18 and that's the bottom yellow line you see there, prices  
19 actually fell three percent over this period. Here, the  
20 shift in volume from branded drugs to their generic  
21 equivalents results in dramatic differences, and, in fact,  
22 it looks like a price decrease.

1           For the year 2008 alone -- and here, this is new  
2 data for you -- drug prices increased five percent, compared  
3 to six percent the previous year. When generic substitution  
4 is taken into account just for 2008, prices remain mostly  
5 stable in 2008, suggesting that there were fewer  
6 opportunities for generic substitution in 2008 compared to  
7 the previous years.

8           Last year, when we looked at biological products  
9 under Part D, we found prices increasing at a faster rate  
10 than other drugs, 14 percent for the first two years of the  
11 program. We thought that these prices occurred because  
12 there were no generic biologics and purchasers had little  
13 negotiating power to get lower prices from manufacturers.

14           This year, we looked at drugs in the six classes  
15 identified as of particular clinical concern. In these six  
16 classes, plans have to cover all or substantially all of the  
17 drugs in each class, although they can put the drugs on  
18 different tiers and use other forms of utilization  
19 management. Together, drugs in these classes account for 11  
20 percent of claims and 22 percent of costs.

21           We thought that prices for drugs in these classes  
22 might increase more rapidly than drug prices in other

1 classes because, again, plans would have to cover them and  
2 might have less negotiating power. But, in fact, we found  
3 that the overall prices for the drugs in these six classes  
4 increased 12 percent from 2006 to 2008, only one percentage  
5 point higher than Part D drugs in our price index.

6           Then we decomposed the index into the six separate  
7 classes, and here, we found that antidepressants, and that's  
8 that blue line at the bottom there, which make up about 50  
9 percent of the volume in these classes and which are now  
10 mostly generic, fell 11 percent over the period. You can  
11 actually see it really dramatically if you see that sharp  
12 cliff over there. That's one very popular antidepressant  
13 going generic and almost an immediate reaction there. Plans  
14 were very successful in getting beneficiaries to switch to  
15 generic versions of these drugs.

16           On the other hand, and now you see the white line  
17 on the top, prices for classes where there is little generic  
18 competition increased more rapidly. For example, for  
19 antineoplastics, which are oral drugs used to treat cancer,  
20 prices rose 31 percent during the period. Prices for  
21 antipsychotics rose 25 percent. And prices for AIDS drugs -  
22 - and these are not on the chart -- prices for AIDS drugs

1 rose 16 percent.

2 In the future, we may want to look at policy  
3 options that address cost growth in classes without  
4 competition.

5 But now, I'm going to turn this over to Jack  
6 Hoadley, who's going to discuss his findings on formularies  
7 in 2010.

8 DR. HOADLEY: Thank you. Thank you, Joan. This  
9 is the fifth year of the Part D drug benefit. This is also  
10 the fifth year we've been analyzing and reporting on  
11 formularies for you. The only thing I'm going to say about  
12 the notes is that we're presenting mostly enrollment-  
13 weighted results.

14 So first, looking at tier structures, what we see,  
15 as we have seen in past years, is that the standard benefit  
16 design that was built into the law, the 25 percent  
17 coinsurance, is really not used very often. It's gone down  
18 over the life of the program from about 22 percent of all  
19 enrollees seeing that kind of tier structure to seven  
20 percent in 2010. The most common tier structure is a  
21 structure that involves a generic tier, two brand tiers, one  
22 for preferred drugs, one for non-preferred drugs, and a

1 specialty tier for high-priced drugs, especially  
2 biologicals, and that tier structure now represents about 80  
3 percent of all enrollees face.

4           What we are seeing more recently is some  
5 variations on that tier structure where plans are either  
6 introducing a second generic tier, a third brand tier, and  
7 some plans continue to have a second specialty tier for non-  
8 specialty injectables.

9           The other thing we've looked at is the cost  
10 sharing, and this graphic shows you that cost sharing has  
11 tended to go up, again, mostly because plans are not using  
12 the standard benefit. They're using flat copayments most  
13 commonly, although there's some trend towards more use of  
14 coinsurance in these tiers. But what you see here is a  
15 continued upward trend in each of the separate tiers, but  
16 especially the brand tiers. What's not shown in this slide  
17 is the specialty tier that is a percentage of coinsurance.  
18 That also continues to be higher, although actually for the  
19 PDPs, the median dropped back to 30 percent this year.

20           Now, we want to turn to the size of plan  
21 formularies, and I would note that there was a change this  
22 year in how CMS defined the universe of drugs that turned

1 out to have a little effect on our analysis. What we  
2 continue to show you is the formularies based on whether  
3 plans cover a particular entity. So we don't care if they  
4 cover only the generic and not the brand version. That  
5 still counts as covering that particular generic entity. We  
6 don't get into breaking up whether they cover all the  
7 different forms and strengths of the drug for this analysis.

8           And on average, it's been very constant over time.  
9 It continues to be the case that 2010, about the median  
10 plan, and weighted by enrollment, for PDPs cover about 88  
11 percent of all chemical entities, for MA-PDs cover about 90  
12 percent. And this graph shows you, however, that there is  
13 some range of variation across the plans. Plans have  
14 formularies that cover as few as about 65 percent of drugs  
15 and some cover 100 percent of all drugs. And it skews a  
16 little bit higher for the Medicare Advantage plans, although  
17 it's not a big difference here.

18           Next, we look at the question of whether low-  
19 income subsidized beneficiaries are in plans that look  
20 different than the plans that other beneficiaries are in,  
21 and there's two reasons we might think that could happen.  
22 One is that the cheaper plans that tend to be the ones where

1 low-income beneficiaries enroll might simply have smaller  
2 formularies is one of the reasons that they're charging  
3 lower premiums. It also may be that because low-income  
4 beneficiaries are not mostly facing the cost sharing  
5 differentials that the plans that tend to serve them may  
6 manage their formularies more tightly.

7           We see a small trend in that direction. It's not  
8 large. If you look at the overall median for benchmark  
9 plans versus non-benchmark plans, the average benchmark plan  
10 covers about 90 percent of drugs. The average non-benchmark  
11 plan covers about 83 percent of drugs. And this shows where  
12 beneficiaries are located regardless of whether they enroll  
13 in the benchmark plans or as some of them do if they enroll  
14 in non-benchmark plans. But again, you see a skew here  
15 where the dashed blue line is the non-LIS beneficiaries who  
16 are a little more likely to be in plans with more drugs  
17 covered.

18           The other important part of this analysis, it's  
19 not just a matter of whether the drugs are covered, it's  
20 whether there are restrictions on the use of the drug. So a  
21 drug can be listed on formulary but have a restriction on it  
22 and that may ultimately mean the beneficiary doesn't get the

1 drug or gets it only by going through some additional hoops.

2           And so we look at, again, whether utilization  
3 management measures are applied. There are three separate  
4 utilization management measures that CMS tracks. Prior  
5 authorization, which says whether -- that a beneficiary has  
6 to get the plans okayed before that drug is dispensed. Step  
7 therapy says that the beneficiary has to try a cheaper drug  
8 before getting the okay for a higher-cost option. And  
9 quantity limit, where the plan will restrict how many pills  
10 or how often the prescription is refilled.

11           And what we see here is that there's been a pretty  
12 steady upward trend over the years towards a higher share of  
13 formulary drugs having utilization management applied, where  
14 it's approaching one-third of all of the formulary drugs  
15 have some utilization management measure. Most common are  
16 quantity limits, but we're also seeing a significant  
17 increase in the use of prior authorization and step therapy.

18           I'm going to skip over this one, but it just  
19 identifies some of the individual drugs, and go on to the  
20 next on one the plans.

21           So you get some insight into the variation on  
22 formulary size and the amount of restrictiveness by looking

1 at these, which are the PDPs and the MA-PDs that have the  
2 highest enrollment in this past year and presumably will  
3 probably have the highest enrollment in the new year, the  
4 PDPs on the top and the MA-PDs on the bottom. And the two  
5 parts of the bar here, the lighter section of the bar shows  
6 the share of all chemical entities that are available to a  
7 beneficiary without restrictions. And here, restrictions  
8 means either utilization management restrictions or being  
9 placed on a non-preferred or a specialty tier.

10 Go to the next one. So you see here that among  
11 the PDPs, you can contrast an AARP Preferred, which has all  
12 chemical entities on formulary, with Silverscript Value  
13 Plan, which has considerably fewer drugs on formulary but  
14 actually has more drugs that are available on an  
15 unrestricted basis. So plans are taking on different  
16 strategies of how they treat their formulary.

17 And again, you see among the MA plans, Kaiser  
18 Permanente in some ways represents an extreme case of this.  
19 They have among these plans the smallest overall formulary,  
20 but actually one of the largest in terms of drugs that are  
21 available unrestricted, and this is consistent with the  
22 model of an integrated delivery system that tends to have a

1 tighter formulary but then have their doctors actually  
2 prescribe from it rather than enforce it at the pharmacy.

3 We did a whole series of checks on different  
4 comparisons of different kinds of plans. There's a few  
5 identified on this slide. I'm just going to mention one  
6 this morning. And that is that, curiously, the PDPs that  
7 offer enhanced benefits and charge higher premiums on the  
8 basis of those enhanced benefits actually have slightly  
9 smaller formularies than the basic benefit PDPs. Now, it  
10 may be true that they offer some non-Part D drugs, but it's  
11 kind of counterintuitive that they actually have smaller  
12 formularies.

13 And then finally, I want to talk just briefly  
14 about -- take a look at some of the individual drug classes,  
15 and here I show you the cholesterol drugs, where you have  
16 three generic drugs there on the top. And what the bars are  
17 showing you is the share of enrollees who face drugs in  
18 different tiers. So the blue tier here is the generic tier.  
19 The generic drugs are obviously mostly covered on a generic  
20 tier.

21 When you start looking at the brand drugs, you see  
22 the variations, where some drugs are less likely to be

1 listed on formulary and some drugs, like Lescol, when they  
2 are listed, are often listed on a non-preferred tier,  
3 compared to Lipitor, which is listed more often and far more  
4 likely to be listed on a preferred tier.

5           You can go to the next class, the antidepressants,  
6 which, as Joan mentioned, is one of the protected classes.  
7 Here, you see, as Joan referred to, most of the drugs are  
8 available generically, but nearly all drugs have to be  
9 covered. The only exceptions here are Lexapro, which has a  
10 special trade-off against Celexa. Most plans go ahead and  
11 cover it. And the other one I think here that's interesting  
12 is down near the bottom, not only the combo drug, which is  
13 not required to be covered, but Pristiq, which is the newest  
14 of the antidepressants, which even though it has to be  
15 covered by all plans and is, is a lot more likely to be  
16 covered only on a non-preferred tier.

17           And finally, just to mention briefly what happens  
18 with some of the specialty drugs, these are higher-priced,  
19 expensive drugs that are regularly taken by Medicare  
20 beneficiaries, and what's interesting is that although for  
21 many of them, they're consistently covered on a specialty  
22 tier, there are some, like Procrit and Aranesp, that are

1 less commonly covered on specialty tier and more commonly  
2 covered on preferred or non-preferred tier, and actually  
3 quite a difference between those two. And you see some of  
4 the other examples on here, as well.

5 So it gives you a sense, as you start to break  
6 down to individual drug classes, that you can actually see  
7 some very interesting comparisons of how individual drugs  
8 are treated, and with that, I'll stop.

9 MR. HACKBARTH: Okay. Let's start on this side.  
10 Any clarifying questions? Arnie?

11 DR. MILSTEIN: What is standard again? What does  
12 that mean, standard?

13 DR. HOADLEY: The standard plans? Oh, that's the  
14 25 percent of coinsurance that's used by the plans that  
15 stick with the statutory -- in other words, they don't use  
16 tiers.

17 DR. MILSTEIN: Ah.

18 DR. HOADLEY: They're just covered at 25 percent  
19 coinsurance.

20 DR. MILSTEIN: Thank you.

21 DR. HOADLEY: So it's just that fixed seven  
22 percent of plans that do that, or seven percent of enrollees

1 that are in plans that do that.

2 DR. CROSSON: Just a brief clarifying comment,  
3 really, on Slide 9, Jack. Since you did bring up Kaiser  
4 Permanente and on the slide they have the smallest  
5 formulary, it would probably be worth a minute just to say  
6 how that is with respect to our plan, because we tend to use  
7 the term formulary in Kaiser Permanente a little differently  
8 than many managed care plans do.

9 So our formulary is constructed by physicians  
10 largely and is designed to guide physicians in their  
11 prescribing pattern. However, for individual patients, our  
12 physicians can write non-formulary drugs without  
13 preauthorization in most cases for most drugs. So actually,  
14 the effect of formulary is larger than that.

15 The irony of that is by doing it that way, it  
16 makes it easier to construct a, quote, formulary or a guide  
17 for the physicians because there's less concern about, well,  
18 what about if I have one patient one year who requires this  
19 other drug? Doesn't that need to be on the formulary?

20 CMS doesn't have a way to account for that model  
21 as they construct this sort of information. So I just  
22 wanted -- the actual availability on a beneficiary basis for

1 an individual beneficiary who requires a particular drug  
2 that is not on the formulary is much easier than this would  
3 depict.

4 DR. HOADLEY: Yes. That's certainly consistent  
5 with things we've heard in various interviews we've done.  
6 You know, every plan, in theory, any drug that's considered  
7 not on the formulary is available through an exceptions  
8 process. But I think it's true that in Kaiser Permanente,  
9 as you suggest, that's something that often the physicians  
10 can simply do on their own accord whereas in other cases,  
11 the physician provides the prescription, the beneficiary  
12 goes to the pharmacy, it's rejected at the pharmacy, and  
13 then there's a whole lot of processes that have to happen  
14 before the person can achieve that exception.

15 MR. BERTKO: Jack, Slide 4, please. This here, I  
16 believe, shows the change in cost sharing over the several  
17 years. I guess I want to see whether you'd agree with this.  
18 My interpretation of this is that while this probably comes  
19 from the bulk of plans, the 80 or 90 percent that have  
20 copays now, it also directly comes as a result of all the  
21 different initial coverage limits, the CCL -- those are the  
22 amounts at which the standard benefit plan changes being

1 ratcheted upward on an index as part of the direct part of  
2 the Part D benefit. And I'm just making sure you would  
3 agree with that statement that the copays tend to move up  
4 because those initial coverage limit and catastrophic  
5 coverage limits will move up with time.

6 DR. HOADLEY: Well, and anytime a plan is using  
7 flat copayments, obviously, they have to, if they are a  
8 basic benefit plan, they have to be actuarially equivalent  
9 to the 25 percent coinsurance within that initial coverage  
10 limit. And so you're right that as the overall cost of  
11 drugs increases, that the copays do have to go up to  
12 maintain that actuarial equivalent. So that is certainly  
13 part of what is driving.

14 I think what's interesting is that we see,  
15 relatively speaking, more increases on the brand drugs and  
16 to some extent on the non-preferred drugs than on the  
17 generic drugs, again, an attempt to continue to drive people  
18 towards using the generics.

19 MR. BERTKO: Let me be even more precise, then.  
20 Because the Part D standard benefit has cost sharing limits  
21 that move up with the drug index, that is, the average cost  
22 increase, that that's almost automatically to be expected in

1 there, and it does move up with the cost of brand drugs  
2 moving up, but it's also built into the formula for Part D  
3 and that should be recognized as part of the underlying  
4 driver for the upward tilt on that graph.

5 DR. HOADLEY: Yes, that's fair.

6 MS. HANSEN: Jack, this isn't part of your  
7 presentation, but it comes from the beneficiary  
8 perspective, especially when we have some of the biologics  
9 that hit that 31 percent increase. Do you have kind of the  
10 estimates of people who end up falling into the coverage gap  
11 changes over this period of time?

12 DR. HOADLEY: We're actually doing a project later  
13 this year, and for the Kaiser Family Foundation, we did an  
14 analysis for them in 2007 on the share of people who hit the  
15 coverage gap and some other characteristics of that and  
16 we're going to replicate that for 2009 data. But otherwise,  
17 I don't think anybody has yet reported on changes in how  
18 many people reach the coverage gap, other than between 2006  
19 and 2007, and 2006 was an atypical year because a lot of  
20 people hadn't signed up at the beginning of the year. So  
21 that's a question we hope to be able to answer soon, but not  
22 yet.

1           MR. HACKBARTH: Okay. Thank you very much. Good  
2 to see you again, Jack.

3           DR. HOADLEY: Okay.

4           MR. HACKBARTH: Okay. So, the last session for  
5 today is Services Provided Under the In-Office Ancillary  
6 Exception to the Self Referral Law.

7           MR. WINTER: Good morning. Before I get started,  
8 I want to first thank Hannah Miller and Kevin Hayes for  
9 their help with this work.

10           At the October meeting, we discussed the in-office  
11 ancillary exception to the Stark Law and explored some ideas  
12 for modifying the exception. In today's session, we'll  
13 briefly review the exception, present results from an  
14 analysis of how frequently ancillary services are provided  
15 on the same day as an office visit, and present options to  
16 address self referral based on your comments from the  
17 October meeting.

18           The self referral law prohibits physicians from  
19 referring Medicare or Medicaid patients for certain  
20 designated health services to a provider with which the  
21 physician has a financial relationship. However, the law  
22 generally allows physicians to provide most of these

1 services, such as lab tests, physical therapy, and radiation  
2 therapy, and imaging in their offices. This is known as the  
3 in-office ancillary exception.

4 This slide highlights the key potential benefits  
5 and concerns about physicians providing ancillary services  
6 in their offices. The primary benefit is that it enables  
7 physicians to make rapid diagnoses and initiate treatment  
8 during a patient's visit. This could improve patient  
9 convenience as well as adherence to treatment  
10 recommendations.

11 However, additional capacity for services like  
12 imaging could lead to higher volume. In addition,  
13 physicians who invest in ancillary services for their  
14 offices have a financial incentive to order additional  
15 services. Several studies, including work done by the  
16 Commission, provide evidence of a relationship between self  
17 referral and higher volume.

18 The in-office exception has had a major impact on  
19 how physician practices are organized and in how ancillary  
20 services are delivered. Over the last several years,  
21 there's been an increase in imaging, lab tests, and physical  
22 therapy provided in physician offices.

1           In a proposed rule issued in 2007, CMS noted the  
2 migration of ancillary services into physician offices, and  
3 asked for comment on whether certain services should no  
4 longer qualify for the exception, so, services not needed at  
5 the time of an office visit to help with diagnosis or plan  
6 of treatment.

7           To examine one of the key arguments in favor of  
8 the in-office exception, we analyze the frequency with which  
9 ancillary services are provided on the same day as a related  
10 office visit. We used Medicare claims data to determine  
11 whether each outpatient therapy service, lab test, or  
12 diagnostic imaging study could be linked to an office visit.

13           We then examined whether the ancillary service was  
14 performed on the same day as a visit, up to 7 days after a  
15 visit, or up to 14 days after a visit.

16           Our sample includes services provided in both self  
17 referral an non-self referral situations.

18           This chart shows the results of our analysis for  
19 services provided on the same day as an office visit, the  
20 paper describes our findings for 7 and 14 days after a  
21 visit.

22           The first finding I want to highlight here is that

1 only standard imaging, in other words, plain x-rays, are  
2 provided at least 50 percent of the time on the same day as  
3 the visit. The second finding I want to highlight is that  
4 the less complex services, the lab tests and plain x-rays,  
5 are more likely to be provided on the same day as a visit.

6 More complex services, advanced imaging and  
7 outpatient therapy, are less likely to be performed on the  
8 same day as a visit.

9 The finding on outpatient therapy isn't  
10 surprising. Beneficiaries tend to receive multiple sessions  
11 of therapy within an episode, and the physician does not  
12 have to provide an office visit with each therapy service.

13 I want to drill down to some of our key findings  
14 regarding imaging.

15 First, the share of imaging studies performed on  
16 the same day as an office visit declined from 2007 to 2008,  
17 which is interesting given that overall imaging volume  
18 increased over this time frame.

19 And second, we found wide variation in how  
20 frequently advanced imaging was performed on the same day as  
21 a visit, ranging from 8 percent for nuclear medicine and MRI  
22 up to 25 percent for CT of the head.

1           And third, physicians who own imaging machines who  
2 can also order the studies are more likely to perform  
3 imaging on the same day as a visit.

4           In light of these findings, and in light of your  
5 discussion in October, here are some strategies that you may  
6 want to consider. We have classified these options into  
7 three main categories: excluding certain services from the  
8 in-office exception, developing payment tools to mitigate  
9 incentives to increase volume, and adopting a prior  
10 authorization program for physicians who self refer for  
11 advanced imaging.

12           In the interest of time, I'm going to briefly  
13 explain the rationale for each option in the following  
14 slides, but not dwell on the pros and cons; we can come back  
15 to those in the discussion, if you wish.

16           The first option is to exclude outpatient therapy  
17 and radiation therapy from the in-office exception, and by  
18 "outpatient therapy," we refer to physical therapy,  
19 occupational therapy, and speech language pathology  
20 services.

21           At the October meeting, several Commissioners  
22 expressed a concern that physician investment in therapeutic

1 services could skew clinical decisions about the treatment  
2 of patients.

3 In addition, one of the primary rationales for the  
4 in-office exception that enables physicians to rapidly  
5 diagnose and treat patients during an office visit does not  
6 seem to apply to these services.

7 Under the approach described in this slide,  
8 diagnostic tests that are generally not provided on the same  
9 day as an office visit would be excluded from the in-office  
10 exception. The rationale for this option is that certain  
11 tests are rarely used by physicians to make a rapid  
12 diagnosis at the time of a patient's office visit. Among  
13 imaging services, for example, we saw a wide variation in  
14 how frequently different types of imaging are furnished on  
15 the same day as a visit.

16 On this slide and the next slide we talk about  
17 payment tools that could be used to mitigate financial  
18 incentives to increase -- related to self referral. The  
19 approach described here is to reduce Medicare payment rates  
20 for diagnostic test performed by self referring physicians  
21 to offset the additional Medicare spending related to self  
22 referral. Arnie suggested this idea at the October meeting.

1 Studies by the Commission and other researchers have found  
2 that physicians who furnish imaging services in their  
3 offices refer patients for more imaging than other  
4 physicians, and other studies have found a similar effect  
5 with regards to clinical lab tests.

6 Under this option, on the option on this slide,  
7 Medicare would combine multiple services into a single  
8 payment through packaging or bundling, and packaging refers  
9 to combining multiple services provided during a single  
10 encounter by a single provider, whereas bundling refers to  
11 combining payment for services that are provided during  
12 multiple encounters potentially by multiple providers, and  
13 bundling or packaging both could create incentives to use  
14 ancillary services more efficiently.

15 Under the approach described here, Medicare would  
16 require self-referring physicians to participate in a prior  
17 authorization program for advanced imaging services, in  
18 other words, MRI, CT, and nuclear medicine studies. The  
19 notion would be to either focus on self-referring physicians  
20 who order many more advanced imaging services than there  
21 appears for a given condition or those who tend to order  
22 services that are not provided on the same day as an office

1 visit. Many private plans have been using prior  
2 authorization programs to control the growth of high-cost  
3 imaging services and to ensure their appropriate use.

4           So, to sum up, we've described our analysis of how  
5 frequently ancillary services are provided on the same day  
6 as an office visit, and we've presented some options to  
7 address concerns related to self referral. We'd like to get  
8 your feedback on whether you'd like to see additional  
9 analyses or data, which of these strategies, if any, we  
10 should pursue, or whether we should examine additional  
11 options.

12           MR. HACKBARTH: Thank you, Ariel.

13           MR. GEORGE MILLER: Just one quick one.

14           I believe I read, and I think you said, but I just  
15 want to be clear, that the additional tests did not improve  
16 outcomes.

17           MR. WINTER: We don't have data on whether they do  
18 or not. We don't have data on their impact.

19           MR. GEORGE MILLER: You do not. Okay.

20           MS. BEHROOZI: This is a question about the  
21 requirements, the legal requirements, for a service to fit  
22 under the exception.

1           In the paper, you cite the congressional record  
2 saying that the exceptions were expected to apply to tests  
3 where there's a need for a quick turnaround time on crucial  
4 tests, but then the three criteria, the three requirements,  
5 none of them refers to time. None of them say that the  
6 service has to be provided within a certain amount of time  
7 from the visit.

8           Do you know whether there was a particular reason  
9 for that?

10           MR. WINTER: The justification was in the  
11 congressional record. I think it was mentioned by Mr. Stark  
12 as rationale, but in the end, Congress did not -- only  
13 excluded a couple of services from the in-office exception,  
14 primarily DME services. So, the other ones they implicitly  
15 included and there is some discussion about whether CMS has  
16 administrative discretion to exclude additional services  
17 that were not specifically excluded by Congress, but what  
18 CMS was trying to do, I think, was to make sure there was a  
19 nexus between the physicians office and the service that was  
20 provided, which was why there were requirements for the  
21 service being provided in the same site where the physician  
22 treats patients or in a centralized location, that the

1 service be supervised -- provided or supervised by a  
2 physician in the practice or someone employed by the  
3 practice, and so forth.

4           So, I think it was not something that was  
5 considered by CMS when they developed the criteria, but  
6 there was some sort of hint that this came up -- this  
7 entered their thinking later on when they put out the rule  
8 in 2007 asking for comment about the in-office exception and  
9 they went back to the original -- what they viewed as one of  
10 the justification, which is that these are meant to cover  
11 services provided when the patient is in the office getting  
12 diagnosis and treatment. And so, they didn't specifically  
13 ask for comment on whether services that don't meet this  
14 criteria should continue to be covered, but they have not  
15 issued a final rule on that, or a specific proposal.

16           MR. BERTKO: Ariel, on slide 14, I know you were  
17 being brief in the interests of time here, but the last  
18 bullet there says, "represents many challenges." You  
19 correctly identified, saying earlier on that many private  
20 payers do this. I would say probably most at this stage.  
21 And after initial physician push back, these plans tend to  
22 run fairly smoothly at this point. So, are there challenges

1 that are specific to Medicare being able to do this or are  
2 you -- are there some other things involved?

3 MR. WINTER: So, I think there are some general  
4 challenges as well as some that could apply specifically to  
5 the program.

6 So, in terms of general challenges, these programs  
7 do have administrative costs, and they are generally higher  
8 for Medicare Advantage plans because there's a lot more  
9 volume involved, and they're also -- providers allege there  
10 are very high administrative costs on them to go through the  
11 criteria either to call up the program or to go through a  
12 Web-based application and then have to deal with appeals if  
13 they are initially denied.

14 There is still push back, we here from the  
15 provider community, that this undermines physicians'  
16 autonomy and that there are negative impacts on patients,  
17 that it makes them wait longer to get the service and it  
18 throws up an additional administrative barrier.

19 In terms of -- and there are also questions about  
20 whether -- about the soundness of the evidence on which  
21 these criteria are based. Providers allege that these are  
22 "black box" programs, that the criteria are not transparent,

1 they're not clinically based, those kinds of things.

2           In terms of challenges for the program, when GAO  
3 recommended in its report a couple of years ago that CMS  
4 consider front end approaches to managing, imaging, such as  
5 prior authorization and the administrator wrote a letter --  
6 the Secretary wrote a letter back to GAO and they talked  
7 about things like how this would -- how the proprietary  
8 nature of the programs used by these vendors would interact  
9 with the public nature of Medicare; that's one issue.  
10 Another issue they raised is how denials would fit into the  
11 appeals process that the program has to maintain, and they  
12 also raised the administrative burden on the program, which  
13 we all talked about how it is faced with many challenges.

14           Another issue that I just want to raise is that  
15 the long-term impact of these programs on spending, it is  
16 still a bit unclear. We talk to plans, they have said their  
17 experience in the first year or two was quite good in terms  
18 of reducing volume, but then the prior trends tend to creep  
19 back upwards, and there is some evidence of this from a  
20 study that was published in a journal by Jean Mitchell about  
21 a year ago.

22           So, there are still a lot of questions both that -

1 - general questions as well as questions that are specific  
2 to the program.

3 DR. MILSTEIN: One question and one clarification.

4 Has MedPAC ever had a chance to hear from staff on  
5 whether or not there is or is not evidence -- reasonably  
6 robust scientific evidence as to whether or not radiology  
7 benefit management vendors do or do not, relative to a  
8 plausible control group, reduce -- moderate this problem?  
9 That's question one.

10 MR. WINTER: There have not been studies of the  
11 impact of these programs with a control group. The one  
12 published study I referred to by Jean Mitchell and Medical  
13 Care, Research, and Review looked at the experience pre- and  
14 post- to the programs. They found, for three plans, there  
15 was a decline in volume for MRI, CT, nuclear medicine in the  
16 first year. For two of the plans, volume went back up the  
17 second year, but was still a level below where it was before  
18 the program was implemented.

19 DR. MILSTEIN: You might want -- go ahead.

20 DR. MARK MILLER: In addition to that, I just want  
21 you and the other Commissioners to know we've had several  
22 meetings and conversations with the types of people who do

1 this, and they come in and sometimes more less, depending on  
2 the specific meeting, present the data that they can bring  
3 to bear, and they always have astounding evidence, but it's  
4 always exactly measured against what? So, it is the rigor  
5 of the evidence that is still, I think, a bit in flux.

6 I'm sorry.

7 MR. WINTER: Yes, and I think you want to have --  
8 ideally, you'd want a control group, but it is difficult to  
9 select one that is equivalent in many ways to the population  
10 where the intervention is being applied.

11 And the other complicating factor that these  
12 things are widely prevalent in the private sector now. So,  
13 it is hard to find a population that is really not -- where  
14 this is not being tested, except Medicare fee-for-service  
15 population.

16 DR. MILSTEIN: My clarification simply -- thanks  
17 for remembering what I had recommended before, but I just  
18 want to clarify, it wasn't not recommending that CMS  
19 unilaterally reduce fees for physicians that have in-office  
20 ancillaries, rather, that CMS consider reducing fees for  
21 physicians who have in-office ancillaries, A; B, are not  
22 part of a care organization; and C, for which there is

1 evidence of higher use than their non-self referring peers  
2 after some reasonable risk adjustment. I had more of a  
3 scalpel solution in mind than a meat axe.

4 DR. CASTELLANOS: Ariel, first of all, this is  
5 good work and this is something that we really need to look  
6 at.

7 In your text that you sent out, you mentioned  
8 that, in the same day, studies that you excluded services  
9 that were provided as an inpatient but, more important,  
10 outpatient hospital setting, and I think it is terribly  
11 important to include that for a couple of reasons.

12 One, the hospitals are now employing a tremendous  
13 amount of physicians depending on what -- and we order --  
14 that may be the group that Arnie is looking at that we can  
15 compare that group to groups of physicians that own the  
16 equipment, and I think that would be important to see if  
17 their practice pattern is different or maybe the same. So,  
18 I think you need to look at in-hospital -- not in-hospital,  
19 but outpatient, and for another reason, too, because there's  
20 a certain group of doctors out there that don't have  
21 equipment in their office and have to order it in a  
22 hospital, and we want to see if it's possible -- is there a

1 delay in getting it done in a hospital setting?

2

3 I hear rumors from the physician community that there is.

4 So, I think you need -- I'd like to clarify why  
5 you're not including that data.

6 MR. WINTER: So, the question we were trying to  
7 address is, for those ancillary services that are provided  
8 at physician offices, what percent were actually done on the  
9 same day as the visit, because that's one of the  
10 justifications for the in-office exception.

11 If we had included outpatient services -- I'll  
12 leave that aside. But that was the question we were trying  
13 to address, and that's why we excluded services provided in  
14 outpatient departments, was, of those services that are  
15 provided in physician offices, what percentage are done in  
16 the same day as the visit, because that's what relates to  
17 the -- that's what the in-office exception is trying to  
18 allow, or does allow. The decision is to provide these  
19 things in their office.

20 DR. CASTELLANOS: I agree with that and I think it  
21 needs to be looked at, but you need the compare group that  
22 Arnie just talked about, is what happens to the other

1 physicians that don't have this in their office? Is this a  
2 practice pattern? Is it a community standard? Is it  
3 society rules?

4 I think you need to grab that data from hospital-  
5 based physicians, and you also have to grab that data from  
6 doctors that don't have this equipment and how do they  
7 provide this treatment to the patient, and whether there is  
8 a delay. So, I think that data is important.

9 MR. BUTLER: Two questions.

10 I think back to yesterday, Glenn, when you responded to  
11 Ron's question about the 1 percent on the physician payment  
12 and that the Part B spending in total was going up rapidly  
13 because of things like this facilitating utilization to  
14 increase overall compensation.

15 Now, I know you've shown in the past, for example,  
16 the percentage of income for cardiologists, 30 percent or  
17 something. I don't remember whether we've done it by  
18 specialty, but that would be an interesting thing to look  
19 at. What percentage of income now is based on tests and x-  
20 rays and their -- and it's a better sense of the  
21 compensation picture and the impact of this if it is not too  
22 hard to pull together, particularly in the primary care

1 areas where we're trying to find ways to make sure we have  
2 access and presence.

3 The second question relates to the therapy side,  
4 and I understand the distinction. We say, well, over  
5 utilizing diagnostic tools is not really all the harmful,  
6 necessarily, except in things like CT, but maybe therapy is.  
7 Now, I think that radiation therapy in my mind is a very  
8 different kind of error to make overutilization on versus  
9 the other outpatient therapies.

10 So, my question is, do you have any sense that the  
11 dollar is tied up -- if we were to make a recommendation  
12 around just the radiation be an exception versus the other  
13 therapies, what are the dollars in each of those two  
14 buckets, because that might change my answer to that  
15 significantly?

16 MR. WINTER: So, we've not been able to quantify  
17 what percent of radiation therapy provided outside of  
18 hospitals is in itself provided in a self referral situation  
19 or not. Most of it, undoubtedly is not, because radiation  
20 oncologists, when they order radiation therapy, it's not  
21 considered a referral as long as they got the patient  
22 referred to them from another physician. And so, therefore,

1 it's not considered a referral, it's not covered by the in-  
2 office exception. They can do this without any restrictions  
3 under the Stark Law. So, what we're talking here are  
4 physicians -- not radiation oncologists -- who order these  
5 services for their patients and benefit financially from  
6 them. So, that's -- it's a difficult question to try to  
7 quantify, but we can look into that. Physical therapy, it's  
8 also difficult to quantify between -- quantify arrangements  
9 that are self referral versus not, and that's because when a  
10 physical therapist in private practice, they can be  
11 independently -- they can be set up independently or they  
12 can be employed by the physician, but in either case, the  
13 claim comes from them, and so we can't tell whether there is  
14 this employment relationship or not. So, it is impossible  
15 to quantify -- to distinguish in that situation. What we  
16 can do is look at therapy services that are built into a  
17 physician service, and that is probably a self referral  
18 arrangement, and so we can look into that and get you those  
19 numbers.

20 DR. BORMAN: One of the times when this practice  
21 becomes important or has met a repetitive thing for me is in  
22 dealing with patients who live at a distance, and I think

1 there is an incentive to get as much done for them in a  
2 single visit. And just in terms of bringing them back --  
3 and I realize you've broken this into same day and other  
4 days, but if I'm going to continue to treat them, generally  
5 speaking, I will vest more validity in the results if it is  
6 done in a system that I know the structure of, the quality  
7 of, whatever, particularly the more complex the test and the  
8 more interpretive piece to it, like advanced imaging.

9           So, I wonder if there's any way, even if just on  
10 some sort of representative subset of beneficiaries to look  
11 by ZIP Code or something about their home ZIP Code versus  
12 this particular piece or trying to figure out some way to  
13 tease out what is this group that is seeking care at a  
14 distance, because I think that would be a group that  
15 probably we would not want to disadvantage in some way,  
16 because if you're going to have to travel, let's get as much  
17 done as we can at that particular visit.

18           So, I just would ask if there is any way to do  
19 that that's not just 20 data steps for long-run -- for a  
20 short slide, that we consider doing that.

21           MR. WINTER: We could look into that.

22           One thing to point out is that there is a broad

1 exception just struck for rural providers, that's for rural  
2 beneficiaries. So, what we're talking about would not even  
3 apply -- any changes we're talking about to Start would not  
4 even apply to those providers.

5 DR. BORMAN: But I'm talking about a rural  
6 beneficiary and an urban provider, okay?

7 MR. WINTER: Okay.

8 DR. BORMAN: Because, just to give you a statistic  
9 from one of my own former practice locations, two-thirds of  
10 the patients that I operated on were from well outside the  
11 metro area that was our normal catchment area.

12 And so, for them to get a sono or CT or something,  
13 150 miles away by people I don't know, the interpretive  
14 quality -- it just changes things a little bit.

15 And then, the second thing -- I guess maybe it's a  
16 little more of a comment, and maybe it relates to your  
17 final bullet there, but I think all the graphs we look at  
18 all the time about different kinds of services, volume,  
19 trajectory, I think comes back to this whole notion of, do  
20 we have accurate pricing in MedPAC speak, because maybe this  
21 is a subset of that issue and coming at this without some  
22 bigger problem, look at it, and solution to it, I think this

1 risks some ill will and hurting some subgroups that may in  
2 fact benefit when what we're trying to do is come at a much  
3 larger issue.

4 MR. HACKBARTH: So, this is our second, I think,  
5 session on this issue, isn't it, Ariel?

6 And so, as in the case of the earlier session  
7 today, I think we need to decide whether and how to proceed  
8 on this. From earlier conversations, it seems to me that  
9 there is fairly broad if not unanimous agreement that there  
10 is a problem here, that we've got rapidly growing  
11 utilization of some of these services. When I say "we have  
12 a problem here," I think the causes are multiple, as Karen  
13 is pointing out. The growth may be aggravated by self  
14 referral, but there are problems in the pricing. It is  
15 attractive because there are significant opportunities to  
16 make profit. There is the inherent incentives in fee-for-  
17 service and rewards for doing more. So, my sense is that  
18 there's agreement that we've got a problem.

19 Where I'm less sure is whether we have agreement  
20 that tackling the self referral rules is the best way to go  
21 after the problem, and I confessed ongoing ambivalence on  
22 that myself.

1           As you folks know, my own experience in healthcare  
2 delivery is in organized systems, where you bring services  
3 together and there is self referral, and so, the idea of  
4 saying, well the way to attack this problem is with  
5 organizational rules that prevent aggregation has always  
6 been something that troubles me a little bit. I think the  
7 problem is not organization, the problem is the incentives.  
8 The problem is in the payment system, the problem is in the  
9 pricing. If we had the payment systems that didn't reward  
10 excess volume, we wouldn't worry about organization.

11           So, it seems to me the Start approach has always  
12 been a second-best approach for grappling with the issue  
13 when you can't fix the underlying incentives, or you don't  
14 wish to fix the underlying incentives.

15           My own preference is always to do the incentives,  
16 but that comes with an important caveat, also. They are not  
17 going to be fixed overnight.

18           Ariel talked about -- we have some options for  
19 packaging, then we have the broader options for more  
20 fundamental reform, which I put under the "bundling"  
21 heading. As much as I like those paths, realistically I  
22 have to admit that they are difficult paths, and we're

1 talking years for them to be broad in their effect.

2 So, in that context, even if you believe as I do  
3 that payment reform is the best approach, do we need to do  
4 something on self referral rules as a stopgap? So, I think  
5 that's the question for us.

6 So, as we go around this next time, I'd like  
7 people to react to, yes, this is something that is worth  
8 investing our time and resources in or not. I'd like  
9 everybody to react to that.

10 And then, if you believe the answer is yes, Ariel  
11 laid out some different paths that we might take, and if you  
12 could identify your preference among the paths that Ariel  
13 suggested or if you have a new one to add, please feel free  
14 to do that, as well.

15 So, are those questions clear to guide round two?

16 Who wants to go first? We'll start on this side.  
17 I see some hands.

18 MR. BUTLER: You're not saying -- the problem is  
19 do we want to spend time on it. The answer was yes, unless  
20 you say what do we have to give up to make room for this.  
21 But I think we need to keep this in front of us. I think  
22 that even if it was a chapter without recommendations and

1 had more, some of these philosophies and ways you might  
2 think about it, I think it would be helpful. So I'm for  
3 doing that.

4           With respect to the specific tools, as I kind of  
5 already tipped my hand, I think there are some that can be  
6 excluded, and I would put radiation therapy, for example, on  
7 that list. You know, I'm not an expert clinically on all  
8 these, but I think there are some that we could articulate  
9 that should be excluded.

10           I think the payment tools, I'm less clear about  
11 how to apply those, and we get into a very technical kind of  
12 thing that we may not be well equipped from a staff  
13 perspective to really finally do that, but the concept is, I  
14 think, a good one.

15           I think one way to address maybe the pre-  
16 authorization is to do something along the lines we talked  
17 about yesterday in home health and so forth, and maybe that  
18 there is a screening that you could do that would flag some  
19 of the utilization patterns that are just way out of the  
20 norm. And you could potentially use that as a mechanism to  
21 then, if you are outside this norm, it could merit then, you  
22 know, the requirement for pre-authorization. I'm not sure

1 that's exactly the right concept, but you get the theme, so  
2 that we begin to at least shine light on the outliers and  
3 learn more about what is happening, which in turn could  
4 inform payment tools and how they might be developed.

5 DR. CASTELLANOS: Glenn, I agree with your  
6 comments. We have a problem here. There's no question.  
7 There's a definite relationship between ownership and  
8 increased volume.

9 Now, there are a lot of reasons for that, and, you  
10 know, we don't want to just pick one thing. We have to pick  
11 all of them. And one of the questions I asked you yesterday  
12 and you elucidated very nicely is that the reason we're  
13 getting a 1-percent update is because of perhaps something  
14 like this. And there's no question -- and I've made the  
15 comments before -- that if I'm not in business today, I  
16 can't take care of today's patients or tomorrow's. And some  
17 of this behavior that we see in the physician community is a  
18 reflection of the reimbursement rate issues.

19 Now, Glenn, you and I have had a lot of talks  
20 about that, and I think we need to appropriately pay for  
21 outcomes and quality. And we both agree on that.

22 Now, what kind of things do we have already in

1 line? Well, we do have some feedback, and that's just  
2 started last year where we're going to individually feed  
3 back -- or CMS is supposed to be able to feed back to each  
4 physician, especially the outliers. And I think that may  
5 help.

6           You know, whether the physician community likes it  
7 or not, the DRA has been successful in some respects for  
8 decreasing volume use in radiation therapy. So what Karen  
9 said is to pay appropriately, and I think that's really --  
10 it's pricing, and we need to look at that.

11           What we want to do is not hurt the beneficiary.  
12 We want to make sure the beneficiary has access. We want to  
13 make sure that we don't increase cost to the Medicare  
14 system. And what we want to do is not throw out the baby  
15 with the bath, but try to see how we can better improve what  
16 we're doing now to pay more appropriately, continue the  
17 access, and continue the quality that I personally believe  
18 in-office exceptions provide to the patient.

19           DR. KANE: I support trying to explore where we  
20 might most effectively use either payment systems or prior  
21 authorizations to curb excessive use, and I'm wondering if  
22 there isn't some way to do an all-payer database on some

1 place, because some payers already do prior authorization or  
2 have employed physicians so they don't personally gain when  
3 they order up these things and perhaps create community-  
4 based profiles of appropriate use for high-cost or high-  
5 volume potentially inappropriate use technologies and  
6 ancillaries. And, frankly, one of the ancillaries that I've  
7 heard is abused is radiation therapy, but maybe I'm missing  
8 something. But the cyber knives, for instance, are  
9 apparently being used -- when a physician buys one, it costs  
10 a million bucks, and so they really want to use it a lot to  
11 get the return on it. So I don't know. There's a huge  
12 controversy -- I think I told Ron about this -- about cyber  
13 knives being used for prostate cancer.

14           So I don't know. Maybe you just need to look for  
15 potentially inappropriate usage in radiation therapy for,  
16 you know, being used for cancers that had better, more  
17 proven technologies in the past, and try to pick that up in  
18 even in claims edits or something. But I think it would be  
19 useful to have an all-payer subset, all-payer data set so  
20 that we can actually look at where physicians, even  
21 individual physicians, who may be constrained by one payer  
22 but aren't constrained by the other, what their self-

1 referral pattern looks like, and just get a sense of where  
2 it is and who we should target and for what types of  
3 services. Then maybe that could even be built into claims  
4 data to do either prior authorization or refuse to pay for  
5 the service altogether.

6 DR. MILSTEIN: Let me make a comment. I do think  
7 we should recommend specific solutions. I think there are a  
8 variety that make sense to me that have been proposed by  
9 others. And one of the reasons I think we ought to move on  
10 it is that in some ways it's instrumental to our overall  
11 vision of, you know, why in the world would any hospital and  
12 physician that is doing extremely well under fee-for-service  
13 ever want to take, you know, longitudinal -- you know,  
14 financial and clinical outcome risk like we want the  
15 accountable care organizations to do if the living is too --  
16 if it's too easy to make a fortune, you know, under the  
17 current fee-for-service payment system, and I think, you  
18 know, there is a sense -- maybe in some cases not of a  
19 fortune, but of at least a very substantial opportunity for  
20 what I've heard some physicians refer to as "easy pickings."  
21 I'm talking about some of the cardiologists who have shared  
22 with me privately -- and I don't mean to pick on them

1 because it applies across the board -- that, you know,  
2 they've gone from a world in which they were primarily  
3 trying to survive on E&M codes and interventional cardiology  
4 to a world in which, you know, half of their revenue is  
5 coming from all the bells and whistles and toys that they've  
6 got in their offices. You know, it's one of these sort of  
7 egregious changes, and there's no reason why those parallel  
8 changes would not happen in many other sectors.

9           But the challenge, I think, as we've talked about,  
10 is as we make -- as John has suggested, make the survival  
11 conditions in fee-for-service less pleasant, I think, you  
12 know, my earlier comment stands, sort of doing it in a way  
13 that we don't inadvertently, you know, punish the good,  
14 really home in on those that really, you know, appear to be  
15 engaging in the adverse behaviors.

16           So, anyway, really two different suggestions.

17           DR. BERENSON: Well, Arnie just gave my number  
18 one, which is we only get to changing incentives when we  
19 create a political environment in which people don't want to  
20 preserve the existing, and so I think we have to address  
21 this topic.

22           The second point is that I was impressed by the

1 research that I think is just the beginning of what we need  
2 to do on the diagnostic tests that are usually not provided.  
3 I think it has some potential for providing us a marker.  
4 I'd like to have more granularity. I mean, that may be CPT  
5 level and for more services. I'd like to know -- I mean,  
6 there's an MRI and there's an MRI. It may well be that in  
7 some situations it is commonly done at the same time, and in  
8 others it's not. I assume you could do that analysis at the  
9 CPT level. So I think with more granularity we might have -  
10 - and I'd be happy to talk to you about some other services  
11 I'd be interested in looking at also.

12           Then I think the final piece on the prior  
13 authorization, don't we have a position that calls for  
14 having radiology benefit management not just for self-  
15 referral for advanced imaging? We haven't gone that far in  
16 the past? Because I don't think this issue is just for  
17 advanced imaging. It's just an issue of self-referral. We  
18 have lots of referral going on, and so I think we should  
19 look at it here in the context of both self and outside  
20 referral in advanced imaging. I think private plans see the  
21 problem in both categories.

22           To me, though, an important part of this would be

1 -- and it picks up what Peter said, and others have said --  
2 is our ability in Medicare to do what I guess is called gold  
3 carding by private plans. Some of them can do it, and some  
4 of them claim administratively they can't do it, which is  
5 getting a profile of a practitioner of a practice and say  
6 they never get overturned, and why are we spending all this  
7 effort hassling them and their patients when they have met  
8 the test, and so to concentrate the administrative oversight  
9 where it would be much more efficient. And then so, Karen,  
10 for your patients who are coming from a rural area and  
11 you've got a good track record, you get to order that CT or  
12 that MRI or whatever it is at the same sitting, and it may  
13 well be some other physician doesn't get to do that, and  
14 that if that's a form of recognition of different  
15 physicians' performance, then great.

16           So I would like us to be much more tactical about  
17 how we, if we went this direction in Medicare, could do it  
18 and, in fact, have physicians be supporting this thing,  
19 because we're not going to sort of review everything that  
20 they're all doing. We're really going to target.

21           DR. CROSSON: Yeah, I mean, my comments are very  
22 similar to Arnie's and Bob's. You know, I think if we look

1 at the area of excluding services, there probably are some  
2 areas we could get to there. But my suspicion is that we're  
3 going to have to be very granular and very focused because  
4 there's a lot of clinical complexity to this. In the area  
5 of outpatient therapy and advanced imaging, I think there  
6 probably are some things that can be excluded. I think,  
7 though, for example, if we get into laboratory testing, it  
8 gets a little trickier. We might find, for example, if we  
9 looked at, to get very granular, the performance of serum  
10 potassiums, that the majority of those to monitor patients  
11 with hypertensive therapy are done on different days than an  
12 office visit. But that wouldn't mean necessarily we would  
13 want to exclude the ability of a physician to do an acute  
14 serum potassium because there's a value to having those  
15 tests done by the same laboratory over time.

16 So, I mean, this is not a major cost area, but I'm  
17 just saying that if we're going to think about excluding,  
18 we're going to have to get pretty specific and in some cases  
19 rather clinical, and I think it's going to make it  
20 complicated.

21 I think, as Glenn does, that the issue of payment  
22 seems to be the most productive area, and I agree also with

1 Arnie and with Bob that if, in fact, the payment rate for  
2 these services was appropriate and there was not an  
3 extraordinary profit margin, then some of this problem would  
4 go away. People ought to be able to perform these tests and  
5 have their costs covered with perhaps some added payment to  
6 make up for the need to replace equipment over time and the  
7 like. But it should not be something that transforms an  
8 entire specialty, you know, over a period of five to six  
9 years. So it would seem to me that that is a natural area  
10 to go, and then when we can, to move to more advanced  
11 payment techniques like bundling and packaging or  
12 incorporating this into more prospective processes.

13 And my last point is that, you know, the issue of  
14 prior authorization, as everybody well knows, is not my  
15 favorite.

16 [Laughter.]

17 MR. BERTKO: Just a quick couple follow-up  
18 comments here. On the payment reform stuff, it strikes me  
19 that any amount of payment reform we do might be running in  
20 a parallel sequence with medical homes, with bundling, with  
21 ACOs. So maybe we wait for those things to get there. In  
22 the meantime, making a statement, I like Bob's comment, gold

1 carding rewards good behavior, and then what Ariel has shown  
2 with the lack of same-day type of stuff, it might make sense  
3 to make that statement, that things that are not same-day  
4 performed should now fall under some expanded Stark rule on  
5 this to at least, you know, put a stake in the ground that  
6 says don't -- or do less of that in the same point.

7 MS. BEHROOZI: Are you and I the only lawyers left  
8 here?

9 MR. HACKBARTH: I think so.

10 MS. BEHROOZI: Okay. So I'm going to trot out the  
11 lawyer hat here. Keep me honest.

12 So there's a law that says that there shouldn't  
13 be, you know, profits made off of -- or there was a concern,  
14 I guess, about profits made off of self-referral. And then  
15 there's an exception to it that seems to have kind of  
16 swallowed the rule. And you have demonstrated there are  
17 some, you know, consequences that would seem to have been  
18 exactly why the law was enacted in the first place.

19 CMS asked whether they should reconsider the  
20 exceptions and maybe look more at things like the time of  
21 the service provision, which seems to me exactly what was  
22 originally intended in the law. Go back to the original

1 justifications of the urgent need for diagnosis, for  
2 compliance, which, you know, has to do with distances that  
3 people travel and things like that, really be very concrete  
4 about what those justifications are, and then create rules  
5 that will enforce those exceptions. Those are exceptions  
6 that are needed to the law. The law was needed. Exceptions  
7 are needed. But the way it is now, this business of being  
8 in the same building and, you know, billed by the physician  
9 doesn't seem to me to have anything to do -- I don't see  
10 why, you know, occupational therapy should be an exception  
11 to the law as it's written.

12 I'm not saying that it's a bad thing -- you know,  
13 it's my judgment it's a bad thing that occupational therapy  
14 shouldn't be provided by somebody who is employed by an  
15 entity, an integrated entity that a physician has an owner  
16 in. But then they have to change the law or come up with a  
17 different rationale than this in-office ancillary exception  
18 that seems to have, you know, really outgrown it.

19 And then I think you will have some presumptive  
20 things, whether it is same-day or whatever, and I think the  
21 physician would have to certify why that thing was necessary  
22 that same day so you don't have a proliferation of office

1 visit billing, which you kind of flagged in the paper, to  
2 justify the provision of the therapy or whatever on that  
3 day. And then you would also have certain -- so then if you  
4 had a prior authorization requirement for everything else or  
5 for a certain range of things, then you could have  
6 exemptions, presumptive permission for people who've  
7 demonstrated not only that they're good actors, but that  
8 their need to do these things fulfills the purpose of the  
9 exception, the original underlying rationale.

10 DR. DEAN: I'd just echo many of the things said,  
11 especially what Mitra just said. It seems to me that the  
12 quickest way to get to this would be to narrow the range of  
13 things that are included, because it's pretty hard to  
14 understand how physical therapy or radiation therapy would  
15 have to be done on that day in order to deal with a  
16 particular condition.

17 I think limiting it to diagnostic interventions  
18 certainly would make sense. I'm a little uncomfortable with  
19 the idea of using the test that whether or not it is usually  
20 done on a different day, because I think as Jay said, there  
21 are some tests that may commonly be done not necessarily at  
22 the same time, but there certainly are times -- and the

1 potassium is a good example -- where it really is necessary  
2 to do it on that day if you're going to give reliable care.  
3 So the one-day test does both me a little bit. But I would  
4 think the first step is to narrow the range of things that  
5 are included to really involve things that you can really  
6 justify are needed to make a diagnosis, and then -- but  
7 that's only a start, and obviously the payment issues are  
8 probably much more important but also a lot harder to do.

9 MR. HACKBARTH: Okay. Thank you, Ariel.

10 Obviously, we will be coming back to this.

11 We'll now have a brief public comment period, and  
12 I'd ask those who wish to comment to first identify  
13 themselves and their organization, and limit your comments  
14 to no more than two minutes. When this red light comes back  
15 on, that's the end of your two minutes.

16 MS. TRUJILLO: My name is Sylvia Trujillo. I work  
17 for the AMA as a Legislative Counsel and a Senior Attorney.  
18 I work on fraud issues. But I'm actually here today to talk  
19 about my personal experience and what it means when a frail  
20 beneficiary does not have access to the type of accepted  
21 services in a physician's office.

22 My mother is a Medicare beneficiary with a number

1 of chronic conditions. Last year, she was diagnosed with  
2 two very rare conditions. Left undiagnosed and untreated,  
3 these would have been fatal. She remains medically fragile  
4 and continues under the care of specialists and requires  
5 monthly lab work. She is essentially the poster child of  
6 what Medicare is dealing with, individuals with multiple  
7 chronic conditions and declining health.

8           Last summer, her condition began to rapidly  
9 deteriorate. Because of her extreme fatigue and  
10 disorientation, simply making it to her physician's office  
11 was a challenge. After running into many brick walls in my  
12 efforts to help my mom, a coworker found me in my office  
13 literally in tears because I could not physically transport  
14 her to her physician's appointments and to have her lab work  
15 done in a separate location, as ordered. She suggested I  
16 hire a care provider. I did, an LPN. She was tasked with  
17 taking my mom not only to her physician appointments, but to  
18 the various lab locations she needed to go. Instead of  
19 simply managing the names and locations of her physicians,  
20 we had to also keep track of the lab work and the locations.  
21 This was enormously time consuming and exceedingly  
22 expensive. In addition, the LPN was responsible for

1 ensuring that the lab results were delivered to the treating  
2 physicians' offices before her follow-up visits because they  
3 weren't arriving on time or weren't done correctly.

4           During one of my mom's hospitalizations, she was  
5 prescribed Heparin and her blood platelet count dropped.  
6 Subsequently, after her discharge, a hematologist ordered  
7 labs to be run to see if she had Heparin-induced TP.  
8 Despite going to an independent lab no less than twice for  
9 draws in order to determine whether or not she had this  
10 condition, we showed up at the physician's office and the  
11 labs had not been delivered and had, in fact, not been run.  
12 We ultimately went to a third laboratory and the physician  
13 had to give us the results over the phone.

14           My mother continues to be transported to different  
15 locations for her lab work and her physician visits. She  
16 has 17 different medications which we have to update every  
17 time she makes a lab visit.

18           The in-office exception is commonly defended as a  
19 convenience for patients. It is not about convenience at  
20 all. It is about coordination and access to care and  
21 outcomes. When these services are not available in your  
22 physician's office, it means you are shuttled to multiple

1 locations and dealing with many strangers, all of whom  
2 require detailed information about you and your care. When  
3 you are ill, facing these extra hurdles can be the  
4 difference between receiving the care you need or not  
5 receiving it.

6 This was true in my mother's case. She did not  
7 receive the care or diagnosis that would save her life until  
8 my family and I stepped in and spent thousands of dollars  
9 and innumerable hours trying to ensure basic care --

10 MR. HACKBARTH: I need to interrupt.

11 MS. TRUJILLO: Okay. Thank you.

12 MR. HACKBARTH: I feel bad about doing that. It's  
13 an important story, but we -

14 MS. TRUJILLO: So in short, the answer is --

15 MR. HACKBARTH: The "in short" first and --

16 MS. TRUJILLO: Right. In short, the answer to  
17 this question, I think, is that it's very complicated and  
18 that simply narrowing the exception means that you are  
19 narrowing access to care to many vulnerable and underserved  
20 beneficiaries.

21 MR. HACKBARTH: Okay. Thank you.

22 DR. MARK MILLER: [Off microphone.]

1           MR. HACKBARTH: Let me just remind people, I know  
2 it's frustrating that this is a limited opportunity, but I'm  
3 really going to have to limit it to now five minutes,  
4 because we have got people who have to catch airplanes.  
5 This is not your only opportunity to communicate with the  
6 Commission. The staff are the best way to do that. You can  
7 also go to our website, and we have a place on our website  
8 where you can make comments and include anecdotes, if you  
9 wish.

10           MR. KAZON: Thank you. I'll try to be brief. My  
11 name --

12           MR. HACKBARTH: Excuse me, you will be brief. Two  
13 minutes, I'm cutting you off.

14           MR. KAZON: Absolutely. I will succeed in being  
15 brief. My name is Peter Kazon with the Law Firm of Alston  
16 and Bird. I'm here on behalf of the American Clinical  
17 Laboratory Association today. ACLA is a not-for-profit  
18 organization that represents clinical laboratories  
19 throughout the country.

20           We appreciate the Commission's recent attention to  
21 the in-office ancillary services exception, and laboratories  
22 are very concerned about this exception, and in particular

1 with regard to anatomic pathology services, which as the  
2 Commission knows are the analysis of tissues that are for  
3 cancer and for other services.

4           In recent years, there's been a growing trend by  
5 which physicians capitalize on the in-office ancillary  
6 service exception by purchasing or contracting for the  
7 professional and the technical components of anatomic  
8 pathology services or by setting up an in-office laboratory  
9 to provide those services. In each case, the physician  
10 group obtains the pathology services, then is able to bill  
11 for the full professional component or the technical  
12 component to Medicare.

13           This results in a profit to the ordering physician  
14 on each service ordered and such arrangements lead to  
15 increased utilization and higher costs. These types of  
16 arrangements are generally made possible by the in-office  
17 ancillary services exception.

18           To follow up on the discussion that's been  
19 happening here today, while other sorts of services  
20 frequently are performed in the physician's office and are  
21 performed while the patient is present in the office,  
22 anatomic pathology services are never performed while the

1 patient is in the office. Because of the fact that they are  
2 done on a biopsy, there's a technical and a professional  
3 component, they have to be done at a minimum overnight and  
4 they may take several days. Therefore, the rationale for  
5 the in-office ancillary services in other situations does  
6 not apply to anatomic pathology services because those are  
7 never done while the patient is present in the office.

8 We encourage the Commission to continue to look at  
9 this issue and we thank you for your attention.

10 MR. HACKBARTH: Okay. Thank you.

11 MR. LEVIN: My name is David Levin. I'm a retired  
12 academic radiologist. I'm a member of the American College  
13 of Radiology, but I'm not necessarily representing their  
14 viewpoint.

15 I'd like to speak to the issue of self-referral  
16 and advanced imaging, and by advanced imaging, I mean MRI,  
17 CT scanning, PET scanning, and other nuclear medicine types  
18 of scanning.

19 When the Stark Law -- my understanding is that the  
20 official title of that exception is the in-office ancillary  
21 services exception. Now, if you think about it, things like  
22 MRI, CT, PET scanning, and other nuclear medicine studies

1 are really almost never ancillary to an office visit. These  
2 are things that are usually done on an elective basis and  
3 they can be referred to a hospital radiology facility or an  
4 imaging center or what have you.

5           The original intent behind the in-office ancillary  
6 services exception was, let's say, for example, a patient  
7 comes in having fallen down and twisted her ankle and she's  
8 got pain and swelling. The question is, is this a sprain or  
9 is this a fracture? So if the physician has an X-ray  
10 machine in his office, that X-ray of the ankle is ancillary  
11 to the office visit. I think having X-ray equipment in the  
12 office and perhaps ultrasound equipment in the office is  
13 legitimate. But I don't think that things like MR, CT, PET,  
14 and nuclear medicine are truly ancillary to that office  
15 visit.

16           So my recommendation to the Commission would be to  
17 exclude those kinds of services from the exception. Thank  
18 you.

19           MR. ADLER: Thank you. My name is Dave Adler.  
20 I'm the Assistant Director of Government Relations with the  
21 American Society for Radiation Oncology, ASRO. I'll be very  
22 brief. I just wanted to thank you for your continued

1 examination of the in-office ancillary services exception.  
2 We agree with many that have voiced it around the table that  
3 radiation therapy should not be part of the exception. I  
4 won't go into all of the reasons why. You all have, I  
5 think, articulated it very well.

6 I do want to address one point, Chairman  
7 Hackbarth, that you raised regarding the organized systems.  
8 While we would like to see radiation therapy removed from  
9 the exception, I think within ASRO, our concern is with the  
10 arrangements that are designed around profit, frankly. The  
11 systems you referenced, the Mayos, the Billings of the  
12 world, we don't believe those are designed around profit.  
13 Those are designed around better care. Perhaps if you make  
14 recommendations in this regard, it would be appropriate to  
15 address those important situations. Thank you.

16 MR. HACKBARTH: [Off microphone.] This will be  
17 the last comment.

18 MS. RAU: Thank you. I'm B.J. Rau [phonetic].  
19 I'm an academic radiologist. And again, I'm a member of the  
20 American College of Radiology but do not necessarily  
21 represent their opinion. This is my opinion and from the  
22 work that we have done.

1           When you think about it, most M.D.s do not own  
2 their equipment. It's a minority of the non-radiologist  
3 physicians who see patients and self-refer and have their  
4 own high-end imaging equipment, i.e., MRI, CT, or PET. And  
5 we also know the data shows that they utilize imaging at a  
6 much higher rate. And knowing that that's adding to higher  
7 utilization, that there's only a limited pot of money, as  
8 there's more spending being done on imaging, it takes away  
9 money from other physician services, such as E&M, et cetera.

10           And when it comes to access, it's really a  
11 minority of the physicians that own their equipment, and we  
12 are talking about access for those Medicare beneficiaries.  
13 So the vast majority actually don't have that convenience  
14 factor to start with. Thank you.

15           MR. HACKBARTH: Thank you very much, everybody.

16           We're adjourned and I'll see you all in March.

17           MR. BERTKO: If everyone could please remember to  
18 give me their blue sheets, if you're interested in reviewing  
19 a chapter.

20           [Whereupon, at 12:01 p.m., the meeting was  
21 adjourned.]

22