MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

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COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
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DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

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AGENDA PAGE

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P R O C E E D I N G S

MR. HACKBARTH: Good morning, everybody. Welcome to those of you in the audience. This is the last meeting in this annual cycle of MedPAC. Much of the material that is presented and discussed today will appear in the June report, but not all of it.

In keeping with how we've handled June reports in the past, or at least most of them, much of the material in the June report is educational in nature, some of it foreshadows future MedPAC discussions and recommendations. There will be only one chapter in the June report that actually includes recommendations and that is one on long-term care hospitals, and there will be commissioner votes on that.

DR. SOKOLOVSKY: What I'm going to present for you today is what will be the second half of a June chapter that focuses on implementation of the Medicare drug benefit. This is about the processes that have to be gone through when people change drug plans or drug plans enter or exit markets.

Whether Medicare beneficiaries choose drug coverage through Medicare Advantage plans or stand-alone drug plans, their drug plan is very likely to be managed through a pharmacy benefit manager or PBM. PBMs currently

manage drug benefits for about 200 million Americans, processing 70 percent of all prescriptions dispensed annually.

The form of this chapter is to look at what happens when a transition takes place, what are the processes that have to be gone through, what are the problems that arise, and what are the implications for implementation of the Medicare drug benefit. To maximize efficiency and cost savings, the Medicare drug benefit depends upon competition among plans. The challenge for the program is to provide opportunities for continued competition while minimizing instability and disruption for beneficiaries.

There are two kinds of changes that we're dealing with here. One where a plan exits a market and all of its enrollees must change drug plans. And the second, when individuals change plans during the annual open seasons. Although some of the issues are different in both cases, whether plans enter and exit the market, or beneficiaries enroll and switch plans, plan sponsors and the Medicare program will have to ensure that the transition from management of the drug benefit by one PBM to another PBM is as seamless as possible.

The process of making drug plan transitions is

one that there's virtually no research on but a great deal of anecdotal reports of the difficulties involved. Our study tried to provide some research on it. We focused on the experiences of plan sponsors that changed PBMs to see what issues they encountered and what were some of the best practices that minimized problems. Our goal was to see what policy lessons could be learned.

It was a three-part study that began with structured interviews with experts who had experience with drug benefit management. Our interviewees included representatives from PBMs, pharmacists, consultants with experience managing these kinds of transitions, representatives from health plans, and other large organizations that have recently changed PBMs. These experts not only gave us their experience but also recommended sites for us to visit. In the second part of a study we conducted two site visits, one at a large public organization and one large private organization that had both recently changed PBMs. At these sites we met with benefit managers and other executives that were involved in the decision to change PBMs. We met with physicians and pharmacists, union officials, and external consultants employed by the organization to help manage the transition process. Finally, at each site we

conducted two focus groups, one with active employees and one with retirees where they gave us the sense of what their experience was during the transition.

So first I'd like to give you some idea of the process. The first question you would ask is, why does an organization make the change? The most frequent answer was cost. They thought that they could get better cost savings from another PBM. They weren't satisfied with the cost savings they were getting from their current PBM. Some of our interviewees also mentioned service problems.

It was a very hard decision to make to change PBMs because everybody agreed that it was a very time-consuming and resource-consuming process. Universally we heard that to do it well it takes at least six months. One plan we heard from did it in 90 days but had continuing and what they considered very major problems.

Once they make the decision to change they tend to issue an RFP asking for proposals from PBMs about how much they would charge and what they would do, et cetera. At this point, if the benefit is going to change, and by change it usually means higher copays, stricter formularies or some change that enrollees might not like, some plans would begin the communication process at that time trying to explain why they're going to have to make

this change.

Once the new plan is chosen, this is when the data transfers have to take place. There are two kinds of data transfers. One is the data from one PBM to another. This would include who's enrolled, all the enrollment information. It includes if people are on maintenance medications and they have open refills where the physician has written a prescription for say a hypertension drug that can be continually renewed before the person has a come back to the physician, that open refill information has been transferred from one PBM to another.

This information and also the new benefit structure, what copays will be charged, what is the current formulary, what is the deductible, all have to be electronically available at the pharmacies on the day that the new plan takes over, usually January 1st.

The new plan has to issue cards that the enrollee can take to the pharmacy on that day to process a prescription. And all of the plans emphasized that it's important to have this data in advance so you can test the data transfers and whatever bugs are in the system they can be fixed.

Lastly, you have to provide notice to enrollees, but also to pharmacists, and if possible

physicians. They say that the earlier you can do it, the better.

When we look at the problems there is one piece of very good news that comes out on top which is that in general transfers of the big data sets from one PBM to another are much easier now than they used to be, much more streamlined because plans are using standardized code systems. But that doesn't mean that problems don't occur, and when they occur, for example, if enrollment data isn't transferred or the new cards are not received by the enrollee before the date of the transfer when they go to the pharmacy they cannot get their medication. This is particularly a problem if the open refills, those maintenance medication prescriptions are not transferred because in that case, even if the beneficiary is willing to pay cash out of pocket, the pharmacist cannot legally dispense the medication because there's no prescription.

Sometimes incorrect copayment amounts are transferred, but the biggest problem that we heard from virtually all of our interviewees was the issue of prior authorizations. Prior authorization is when a plan asks the physician to get approval in advance for dispensing a particular medication. It could be because it's a very expensive medications like one of those new self-

injectable biotech drugs that can be very, very expensive. It could be for a drug that's subject to overuse like some of the painkillers that people may become addicted to. It also can be a situation where a drug is not on the formulary but the patient has already gotten an exception because the drug that's on the formulary doesn't work for them.

In all of these cases plans had a great deal of trouble getting that information transferred from one plan to another.

When it doesn't work it frequently entails extra physician visits. Sometimes if it's a whole plan and people are using the same physicians -- we had one case where physicians had to rewrite every prescription for every kind of open refill and every prior authorization that they had issued.

One example where it did work was one plan that thought about this very carefully in advance and actually sent to every enrollee a separate list with other drugs that would require prior authorization. They were the only plan that never reported any problems on this issue.

Even with the best communication strategies we found that many times the first time that enrollees and physicians were aware that the formulary had changed with

the new benefit was when the patient arrived at the pharmacy counter. This is something we'll talk about a bit later.

Another problem that we heard about were changes in mail-order procedures. This was a case where a plan would use a different mail order system than the previous plan, the drugs would look different and the beneficiaries would get drugs, usually generic drugs. The old ones might have been blue. This is a different company; it's red, and they're not sure that they're getting the right medication anymore.

It's clear that some of these problems are easily and quickly dealt with them. Some of that seem to take much longer.

So what are the implications for the Medicare drug benefit? I'm sure it's going to come as a surprise to nobody to say that an effective communication strategy is critical. Everybody said, you've got to tell people lots of times, you've got to tell them simply, and you've got to tell them in different ways. Send them a letter, send them e-mail, have advertisements, do a lot of different things because no one thing will reach everybody.

Second thing was time. Again this was something

that came up everywhere. You need time to test the data transfers and prepare targeted mailings to people who are going to be affected. For Medicare there's a tension between giving plans enough time to develop their bids and negotiate with CMS and making sure that there's enough time for beneficiaries to learn about their choices, and on the other hand, giving plans the time to transfer the required information.

Data transfers will be much more complicated for Medicare because the plan will have to have systems in place at the pharmacy where they can track copay levels by income, and also the level of out-of-pocket spending. Plans right now -- PBMs have told us that right now they don't systems in place that can track the level of individual spending at the pharmacy counter, although some of them can do it through their own mail-order systems.

There also, we think, should be contract requirements that plans have procedures in place not only how are they going to get the data from the old PBM when they get new enrollees, but also what are the requirements for handling data when enrollees leave the plans. We found that there were situations where the old PBM, not many, but a couple where the old PBM left on a bad note and transferred no information. We think that Medicare --

that it would be important to put in the contract, make sure that doesn't happen.

Lastly, we think it's important to provide information in advance to pharmacists and physicians. It seems that no matter how good the communication strategy is many people will first learn about the changes from the pharmacist or their physician. Making sure that they have this information well in advance is important because they will be doing much of the problem-solving and education anyway.

It may be hard, on the other hand, to notify physicians because it won't be clear necessarily to the new plan who would be the relevant physician to notify.

As I said before, this study, along with what you heard in the March meeting on formularies will be part of a June chapter on implementation of the drug benefit. Jack Hoadley, who is sitting next to me here, is the head of a team of researchers at Georgetown University and NORC at the University of Chicago and they've been working with us on a set of implementation issues. Jack is going to present to you now our preliminary results from a study on state roles in implementing the low-income drug benefit. This won't be part of the June report but will be a later study. We will continue monitoring and looking at

implementation issues of the drug benefit.

Now I want to turn it over to Jack.

DR. HOADLEY: Thank you. Appreciate this opportunity to talk about the results of our work. Want to first just review quickly the low-income provisions that we're talking about when we talk to state folks and some other people in this project. We really talked to them both about the discount card program and the eventual Part D benefit. As you certainly know, the discount card is very much in real time right now, so as we did our interviews we really were seeing a moving target as we talked to people. Card sponsors were selected in March. Beneficiary enrollment will start in a few weeks and the cards will generally be effective in June.

As you know, beneficiaries can select one Medicare-sponsored card which normally would have an enrollment fee of no more than $30, but in the case of the low-income beneficiaries or at least those whose incomes are below 135 percent of poverty and are not in Medicaid or some other drug coverage, they'll be eligible for transitional assistance of $600 for each of the two years of this program as well as waiving that enrollment fee.

we turn to the Part D benefit in January 2006, low-income beneficiaries -- all beneficiaries that want to

participate in the benefit will need to select a Part D plan, and that includes the beneficiaries who are currently on Medicaid. So again, that's one of the areas where the states are affected by this. Low-income beneficiaries, as I'm sure you know, are subsidized. While the details of the subsidy are complicated, generally those up to 150 percent of poverty or Medicaid enrolled get some portion of a subsidy. And then states can supplement coverage for any beneficiaries but can't get federal match for that supplementation. So these are some of the context items that affect the folks that were talking to us.

Basically we're mostly dealing with the topics of education and outreach and there really are three goals that need to occur. One is the need to explain the changes in prescription drug coverage to beneficiaries. Another is finding and enrolling individuals who are eligible, particularly for the low-income benefits, the transitional assistance for the discount cards or low-income subsidies for the Part D benefit. Finally, the potential to provide help to Medicare beneficiaries in assessing their options and choosing among the different discount cards right now or the prescription drug plans later.

So our project was to interview a number of experts in this area, particularly state officials and others knowledgeable about the issues facing the states and their interactions with low-income beneficiaries to find out how states are perceiving their role, what are they doing now and what do they plan to do as they look forward to 2006, and what are some of the challenges they face. We conducted a total of 19 telephone interviews with mostly current and former state officials, a few other policy experts and advocates for low-income beneficiaries. We covered a total of 13 states amongst our various interviews, and as you see, we covered different kinds of programs within the states.

I put the dates very precisely here. We conducted our interviews between March 10th and April 14, so we really were straddling a number of the key events, particularly the announcement of the discount card sponsors and some of the other things relating to that. So our messages to some degree changed as it went along.

So first I'll talk about the discount card portion. What is it that states perceive as their roles and responsibilities? In many cases the first thing they told us is that they perceive this to be a federal responsibility and not really a state issue. One of the

quotes was, when it's a federal program we think the feds will do the communication. These are Medicare folks, why should we have to do anything?

Now obviously their message became more nuanced and different as we went along but there really was often the first message we heard is, why has this become our problem? We didn't pass this new program and it's a lot of new work for us. Some of that's about funding, but a lot of it is about really trying to figure out and learn about a program that the federal government is operating and they're only trying to keep up and learn what's going on.

States also vary a lot in their capacity and their interest and their enthusiasm for dealing with these issues. For example, the SHIP programs, the health insurance counseling programs vary a lot across states. Some have are very active, very effective programs that really give them a big base to build on. Other states have much smaller programs, ones that don't have nearly the kind of experience and capacity to do the kind of work that's potentially here to be done.

States also varying incentives, and one particular important area for that is the state pharmacy assistance programs. Those states that have pharmacy

assistance programs, particularly now when we're talking about the discount card, they have a very strong incentive because if their enrollees are eligible for and can enrollee in the transitional assistance, that's $600 that the federal government will pick up of the drug cost that the state funds don't have to pay for. So they have a strong incentive and we'll come back to that point in a minute.

Just to elaborate on that, I think again people are probably familiar with the state pharmacy assistance programs, but there are 19 or 20 operating programs around the states, another six or eight that are authorized but not operating. Most of these are fully state funded although some are operating with federal dollars under waivers. The programs vary a lot. There's a handful of large, long-established programs like New York, New Jersey, Pennsylvania, Illinois. Other states they're smaller just because they're small states but still are long-running active programs, and then some others that are relatively small and/or relatively new. So depending on the different situations in those states again what we heard from them was often different.

So what is it states are doing about the discount cards? A few of them by the time to talked to

them had begun to do some kind of outreach. In some cases though they said, this is still early. One told us, we're still trying to figure out what this piece of legislation is, understand all its elements so we can coordinate within the apartment. That's kind of where everybody is at this point. But things are starting to move and we really actually saw the pace pick up across the month or so of our interviews. We heard about one SHIP program that was already holding sessions during the month of April to tell beneficiaries in their state what to expect, even though they couldn't yet counsel them specifically about how to go about picking one card versus another.

We saw the state action more so in the states that had either active SHIP programs or active pharmacy assistance programs, again where the incentives greater. We saw a lot less when we talked to Medicaid folks. Generally because Medicaid beneficiaries are not eligible for the discount cards the Medicaid folks said this really isn't our issue for this part. We'll be involved in the drug benefit in a year or so, but not right now.

The planning really is going on very vigorously on the discount card program and that's something if I'd talked to you after our first handful of interviews I wouldn't have said. But as we moved we could really see

that pace picking up. Yet at the same time they're also waiting to see what CMS is going to tell them about the various issues and what about the federal money that's going to come through to assist the counseling.

So what is a typical state plan for outreach? In many cases they rely on Medicare. They've been told that Medicare will send a letter to all beneficiaries, that the Social Security Administration will send a targeted letter to all low-income beneficiaries who might be eligible for transitional assistance. Card sponsors will soon be reaching out as well. Then what the states figures that they can do, at least the ones who seem to be more interested and active in doing this, is to provide follow up messages, to have letters that follow the federal letters and give them more information specific to the situation to might apply in that state.

In particular, again, that has to do with the states with strong SHIP programs who are training volunteers and preparing to do one-on-one counseling, which is one of the strengths of the SHIP programs. They're really expecting to sit down with those beneficiaries who come to them and try to help them figure out whether to get a card and if so what card. But also the states with pharmacy assistance programs are really

gearing up. Some have issued RFPs to designate a particular card sponsor. Some have already sent out letters to begin to tell people what to do. In some cases the first message is, don't get a card until you hear more from us. Then they'll have another mailing or other communication going out to say, here's the way we think you can take advantage of this program.

States are also beginning, and just this week CMS, or at the end of last week, CMS announced some options for auto-enrollment and standardized enrollment forms that states could use, and the states are really, at least the more active ones, are really prepared to start doing that. Again, Medicaid agencies, they're just really not seeing this as a big part of what they're doing.

What are some of the communication strategies? Again, mailings are part of it. But they did point out to us that mailings can sometimes raise more problems because they raised questions, and they've got to be geared up to be able to have a hotline or a phone line to follow up on the questions that come up in the mailings. They've had that experience with some of the mailings that went out on the Medicare savings program in previous years and if they weren't geared up and ready for the onslaught of calls that followed then it actually became a burden to them.

They're also looking where they have existing mailings going out to beneficiaries where they can add a message about the discount card. One state told us that they were interested in trying to communicate with providers, to physicians, to pharmacists and would use the periodic letters that go out through Medicaid or through the state pharmacy assistance programs to add messages about the discount card. Also do the same thing on the web sites that they use to communicate with providers. So you really get this variety of strategies.

What are some of the challenges that states will face? Administrative capacity is certainly one. The challenges of coordinating efforts across the different state agencies that are involved, coordinating between Medicaid and an aging department, coordinating within the subagencies of an aging department. We heard a lot about, especially when you're operating in a short timeframe, how hard it is to bring all the relevant parties together and get them all on the same message. There's the potential for competing messages coming from CMS, from the states, from the card sponsors and they're all trying to work hard to try to make sure that doesn't happen. But when you're working on this short timeframe, it's difficult.

Also challenges around reaching some of the most

vulnerable populations, the disabled, the institutionalized, the frail elderly at home or in assisted living. Most states acknowledge that those are hard audiences to reach and at this point and this fast pace they don't really have magic bullet strategies to how to reach out, although some have tried to, in the past, develop particular targeted communication approaches for those.

Let's turn then to the drug benefit that goes into effect in 2006. As we asked people about that our first message was usually, again, a federal responsibility. It's not our problem but we'll somehow deal with it. But they really also gave us an equal message that they did understand that this was a population, particularly the ones who were enrolled in the state programs like Medicaid and pharmacy assistance that they felt a responsibility to. They understood that they were part of the partnership that needed to make this work. But that came after they first complained, we've got this new job to do and it's not of our making.

What is it that states are doing relative to Part D benefit in 2006? One person basically said, it's still too early. That respondent told us that 2006 is a millennium away in state time. We're just not there yet.

Somebody else said, there's nothing for anyone to do right now. It's too soon. There's much that we're trying to resolve with CMS. Until we have more information from the federal government about what they are telling beneficiaries, only then will we have a sense of how we want to communicate and what the messages are we want to communicate. So again their real message was, it's early to figure what to do.

It's also that the circumstances are very different. Again, Part D versus the discount card is a different set of messages, and they're having to work hard to absorb the messages for the discount card and it's going to be different. So for example, you tell a Medicaid beneficiary, right now the discount cards aren't relevant to you. You have coverage through Medicaid. You don't need the discount card. Next year they've got to turn around and tell those same beneficiaries, now it's Medicare Part D. You do have to be worried about this. You need to enroll in Part D and need to select a plan. So they're just beginning to learn really the split of the messages that has to happen.

Same with the state pharmacy assistance programs. Right now they're thinking about those that are eligible for transitional assistance or ones we want to

get enrolled in that. They've got to also be now thinking about how to create a wraparound, or if they want to create a wraparound Medicare to decide what to do. So outreach and education will only come after these policy issues.

We even had one respondent say, I don't want to get too far ahead because for all I know the federal government will change the program again before 2006, and it will look different by the time we're implementing it, for whatever that's worth.

So what outreaches, again, will the states face in 2006? It's really very similar to what they faced for the discount card but it's more intensified because there's a lot more to do. As I said, the messages will be different. The messages need to go to all beneficiaries, not just a smaller number that may find the discount card relevant to their situation. But again there's a lot of policy options. We don't know yet what the geographic regions will look like, what there will be that focuses on nursing home residents. A lot of the specific policy issues that will effect how the states formulate messages to do outreach and communication haven't been determined yet.

Nursing home is a particularly interesting

question because obviously many, many nursing home residents are Medicaid beneficiaries and the pharmacy situation is different there. But it's really something that we were told both by states and by, in one case, a representative of the nursing home industry, it's just something that's just early. We don't know yet how that's going to work out but we know it's important and we know we need to worry about it. Again, a challenge is going to continue to be how to communicate with the various kinds of vulnerable beneficiaries that states need to deal with.

Some what were our conclusions? First, that outreach is critical in any kind of program where participation is voluntary. States recognize that. They know that they have a role in it, even if it is the federal government's program and the feds started them down this road. They know that they play an important role to try to protect their states' residents.

They also tell us that the federal outreach is tremendously important and that's where it's got to start. And they know that if beneficiaries get messages from a trusted source like Medicare or like the Social Security Administration, that's something that is the starting point for their understanding of the program.

States do understand that they can be important

partners in implementing the benefit and have, as we said, on the discount card really started to take actions to be partners and to be involved in helping on that. 2006 is a millennium away for them and they just don't know yet what they're going to need to do but they know they will do something.

They also pointed out the role of not just the SHIP programs that depend on volunteers from the community but some of the community-based organizations that they typically work in partnership with, whether it's advocacy organizations, or senior centers, or other kinds of senior and aging organizations. They know those groups are going to be important as well as, and I didn't put it on this slide, but the physicians and the pharmacists that people turn to. That's one of the common points between the findings that Joan was talking about and what we found here.

Finally, anytime you talk about the states, we know that the states' levels of investment, effective, enthusiasm are going to vary considerably and it's going to be affected by some of the differences that we've talked about like whether or not they have a state pharmacy assistance program, and the type of enrollment and program that they had under their Medicaid.

So that's the end of my comments.

DR. NEWHOUSE: Thank you both for a set of interesting and useful talks. I wondered, Joan, if there was anything to be gained by looking at the experience of changing fiscal intermediaries or carriers in terms of handoff from one carrier to another? I don't know that you need more material, but since you kept saying there isn't really a lot of relevant information here I wondered if there was anything there.

The second point I wanted to make is just a more conceptual point, that some of the issues you are raising would be alleviated if we had followed a path that was more like the commercial model and one had a single plan for a geographic area for a limited period of time and then periodically re-bid it. That, it seemed to me would not eliminate transitions or changes in formularies but it probably would reduce some of the noise here.

DR. SOKOLOVSKY: As far as the fiscal intermediaries and carriers, that's a wonderful idea and I have to admit that never even occurred to me. I don't think it could be part of the June chapter but it's definitely something to look at.

MR. HACKBARTH: Isn't a more analogous situation a transitional among private plans under Medicare

Advantage? Because part of the challenge here is that if you're the new plan your new enrollee could come from any number of different sources, each of which had different formularies, different rules, as opposed to an employer transition, the commercial model where everybody operated under one set of rules and you've got to educate them about a new set of rules. There are just more permutations that you have to deal with under this structure. The private plan situation under Medicare seems like the most analogous situation to me.

DR. SOKOLOVSKY: Absolutely. On our formulary project we did talk to a lot of plans that offer Medicare Advantage and heard many of the same issues but because of payment changes, generally speaking the drug benefit in the past couple of years has been diminished enough that these issues were much less.

MR. SMITH: Thank you, both. This was useful if sobering. Joan, I was struck in the mailing materials by two references, one is on page 12, one is on page 18. They're not specifically important but they both suggested that beneficiaries' price sensitivity led them not to take drugs at all rather than to move to something in a lower copay tier. That's striking and troubling and gets to a lot of the questions that both of you raised about what

does the information look like, how do we communicate people both about formulary structure but also about price tiers in order to help people figure out where they ought to go.

But it also raises the question of how will people respond -- will people respond to closed formularies that in some way limit their ability to take the drug that their doc tells them to? Will they respond the same way that the research suggests that they do on the basis of higher tiered drugs that are prescribed? That really does suggest that we need a mechanism to tailor the communication almost one-on-one, which just seems unbelievably daunting for a lot of the reasons, Jack, that you identified. But there isn't some way to do this on a broad basis, particularly if individuals respond in the way that the research you cite suggests they do, by not taking the drugs at all.

DR. SOKOLOVSKY: I don't know exactly what to say. The research doesn't say that everybody will respond that way, but there is a significant minority of people who do respond that way, and I don't know the answer to that problem.

DR. MILLER: Could I just say one thing about this? I think there's two different issues here. One is

getting down to the retail level of dealing the patient. I think when Joan was talking about how to communicate, be sure that you're communicating with the pharmacist and the physician, because some of that can happen there.

But then there's the second question of how people respond to tiers, and there are some things recently in the literature that raise the point that you're making.

DR. REISCHAUER: Thank you, both, for interesting presentations. Joan, I found your material particularly interesting as someone who is considering shifting the PBM of the organization that I run and its affected my thinking about it.

I really wondered how much of this was relevant to the Medicare situation. What you're talking about, the employer market, is group and it's mandatory. I make a decision that the Urban Institute employers are going to go from one to another. This is individual and voluntary. By voluntary what I mean is, somebody is in a plan -- we're talking about after the thing is up and running and some of what you have is relevant to the getting it up and running but not to the ongoing it strikes me.

So I'm an individual and I'm dissatisfied with my current provider so immediately I've made some

decisions, I'm thinking about things, I'm looking at the drugs that are covered here and aren't covered there and how they're covered, or my daughter is doing it for me. This is a very different kind of the situation from suddenly I send all my staff a new little white card that they have no idea really what has happened, and I've sent them memos during the previous three months which they have thrown in the wastebasket without reading or taken it home and said to their spouse, you read this and he or she has thrown it away. It's a very different kind of situation.

Then secondly, I would assume, maybe incorrectly, that CMS in going to specify a bunch of handoff procedures. A minimum dataset that has to be transferred from one company to another in a standardized form and during open enrollment period there will be a very routinized way of handling off this stuff. It's going to be a problem, it strikes me, in two instances. One is where in the middle of the year I move from Boston to Arizona and I have to shift plans. My guess even there is that, that judging from the discount card, that all of these are going to be national plans, unless I'm in a Medicare Advantage plan. These are going to offer services everywhere.

The other possibility -- I see people shaking their heads, but the other possibility is that a plan that I signed up for leaves an area and therefore there's a big group of people who have to -- but this is during open enrollment -- shift. We can worry about that but I really don't think these are going to be quite the same kinds of problems that arise in the employer-sponsored environment.

Will there be dropped balls here and there? Yes, but horrendous, I don't think.

DR. SOKOLOVSKY: I think what I want to say is, yes, the model is different and I did try to reflect that in the writing that some of these problems won't be the same problems, won't occur. But I think that some of the things we learned are, in some ways, exactly what you mentioned. For example, one of the things we would like to make sure when CMS comes out with its regulations is that the handoffs are specified in the contracts, both for old PBMs and for new PBMs.

The second thing we learned is that some of the things are not routinized. Every plan has prior authorizations. They don't have a way of transferring smoothly that kind of data.

DR. REISCHAUER: But right now these are

cooperative relationships among private enterprises which don't have to cooperate and one is snatching the other guy's business. This is providing a service that's paid for largely through government funds and I would presume that the federal government is going to specify the handoff of prior authorizations and existing prescriptions. I would hope so.

DR. MILLER: I think that's the point, is we wanted to point out the edges on the current system and I think you've just put your finger on a couple places, the open scripts, the pre-auth where under the current rules those are handled on a retail basis. In this population they may be a much bigger issue. You're right, it may be that people at CMS will look at this and say, we've already thought of this. But we wanted to make sure that we walked through with the current state-of-the-art and said, these are the places where things get rough.

I also think Joan's point about getting to the physician and the pharmacist is something to emphasize in the terms of the communication strategy, because I think a lot of it will get hit there.

DR. REISCHAUER: Can't we be even stronger than -- we're saying, in the private world these are problems, and go the next step and say, in this new world

regulations and the way we write contracts can reduce them.

DR. MILLER: I think that's the intention.

DR. REISCHAUER: Be stronger.

DR. SOKOLOVSKY: That is exactly where we were going. I guess the other point to make is that in general for individuals it may not be a problem but if drug plans, as the years go on, enter and exit markets in the same kind of history then you could see some more problems that could be more similar to the employer problem where you have a lot of people all at once. Again, it won't be as simple where they all move to one other plan but you can still have these large numbers of people who suddenly have to make changes.

DR. HOADLEY: Can I just add a comment from interviews that we did in conjunction with the transitions project, that one of the points that a number of the people mentioned when we got beyond just asking them about their experiences in the private-sector transitions was to ask them a little bit to reflect on what the differences may be in the Medicare world. Obviously many of them are familiar with what is coming. One of the big points that they made is the difference between having an employer who's watching over that process and making sure some of

these happen in group, who's the person that's going to look over that process in an individual, one-to-one kind of relationship?

Obviously part of that is what you were just talking about in terms of CMS and I think you've got a good point when you say that people are at least making an active choice in many of these situations to change so they're not just passive recipients, here's a card and a memo. I didn't pay attention to it; now I'm in trouble, so that will certainly help as well.

But there was certainly a lot of concern among the folks that we interviewed that without the employer benefits officer shepherding this process that it potentially could be difficult and some of these steps would be needed.

DR. NELSON: This is very good work and I want to highlight just a couple of the aspects with respect to access and quality, which after all remain a lot of our concern in addition to the structural configuration and exchange of information so forth that we've been discussing. Every patient that has to change their medication that has been successfully managing a chronic problem like diabetes or heart disease, whatever, has the potential both for hassle and harm. They've been doing

well; thank you very much, and now because of formulary changes they have to have their medication program changed and maybe it either doesn't work as well, or they have side effects, or they believe that they have side effects because of some of coincidental event. But in either event it involves discomfort for the patient and hassle for the physician, because you know who they are going to talk to, their physician or their pharmacist.

You discussed grandfathering as a means of minimizing that and I think that's an important concept to show up in our recommendation, at least for certain therapeutic classes or at least for certain periods of time, understanding that some grandfathering may not be in everybody's best interest, but certainly there has to be the provision in order to minimize that problem.

The requirements for refills and prior authorization should be made as a simple and hassle-free as possible. Here again I'm concerned about access, and for physicians, if this turns out to me an enormous increase in the amount of hassle because of unrealistic requirements for writing refills, getting prior authorization, it would be one more incentive to not take any new Medicare patients.

The formularies should be made available through

searchable electronic databases, either in a diskette or that they can download from the Internet. Not all physician office by any means have that kind of electronic capability, but it's increasing and can be extremely important assistance in keeping their knowledge of the formulary up-to-date.

Some appeals process needs to be incorporated in this, I believe. At least should be required of the PBMs for uncommon but important drugs may not be on the formulary just because they're used so uncommonly but are important; some orphan drugs and that kind of thing. There should be an appeals mechanism because it seems to me that a Medicare patient's need for a certain drug ought not to be ignored just because it's rare.

Finally, medical organizations and pharmaceutical organizations, other professional organizations, nursing and so forth, should be used in the communication process. They all have communication vehicles with their members. They probably will read their journal more readily than they read their mail when it's got government letterhead, so that opportunity ought not to be missed. The same goes with AARP and the other consumer groups with respect to the notification process. Certainly we could consider having in our text some

acknowledgment of those opportunities.

MR. DURENBERGER: I found the chapter challenging and very helpful to read. I sit here and listen to people talk about Mary's mom and smile because I am Mary's mom. I'm waiting for the influx of helpful information, because I don't have an employer other than the Federal Employee Health Benefit Plan to help me make these decisions.

So my comments, like Glenn's and Bob's, are directed to the chapter and the way the chapter is constructed. And I really do believe that because the chapter heading is so promising -- just look at that, Implementation of the Medicare Drug Benefit. What follows after that from our standpoint is really critically important.

So laying it out right away in some longer range context so we're really looking ahead to 2010 or whatever the future may be, through a series of analytical steps that we plan to take in order to advise the Congress on the implementation of the program, to me would be a very helpful way to construct the chapter and all of the information that is contained in this chapter, which is just like chapter one probably of a series of works that we will be doing. And to keep in mind the importance to

whom this chapter is directed. Right now it ought to be to 435 people who are the board of directors of the Medicare program who are out there trying to defend whatever they did without the benefit of anything like we have, against the noise someone spoke of which comes basically from two sources.

There are conflicting sources. Part of the noise is simply coming from drug pricing itself. In my part of the world -- and I've spoken to thousands of seniors in the last few months in groups. In my part of the world the pricing issue is way past the benefit issue in terms of what is really important to them. It is really obscuring the benefit issue. The only thing the benefit decisionmaking, whether it's the discount card or something else has going for it right now is the fear that if you don't sign up now or you don't sign up appropriately then you lose or you get a penalty or something like that.

But the two areas I would suggest that our trusted sources, one less than the other, the first is whoever is out there selling it from the board of directors better know what they're selling, and they had better know where to refer people for information.

The second one is, the trusted source so far is

nobody that I have seen. It certainly is not SSA and it's not Medicare and its not anything like that. It's the doctor and the pharmacist, and I don't see a lot of investment anywhere in informing -- and it's expensive to do it -- to informing that part of the world that all of us are going to rely on.

MR. MULLER: Both the chapter and your presentations do a very good job, as the other commissioners have mentioned, in laying out the challenges of implementing it so it may be premature to think about where one creates a safety net when some of the problems arise. But my analogy, I think about the plans entering and then exiting M+C and Medicare Advantage, the safety net we've had over the last few years is in fact the doctor and hospital network that keeps serving people even when plans exit. I'd like to ask you to speculate a little bit with us as to where those counterparts may be in this program as plans come and go.

As the chapter that you presented to us as well on information technology pointed out, probably the part of the health care sphere that is most sophisticated in its computerization is the pharmaceutical medical sector, so probably instant eligibility determinations can be made much more quickly in this arena than it can in other

benefit parts of the Medicare program. So the lack of eligibility could be almost instantly ascertained when plans exit as opposed to poster going on for a month or two.

So what are your thoughts about where some safety net might be as plans come and go? I know it's somewhere down the line, but thinking about that safety net I think is an appropriate thing for us to consider.

DR. SOKOLOVSKY: Are you talking about the safety net for information or a safety net to provide drugs?

MR. MULLER: A safety net for the beneficiary if the old plan has pulled out and the new plan hasn't yet made the successful communication, and contact, and sign up, et cetera, with them. As you pointed out, going forth now with 18 months of planning, which based on what you said and what Nancy-Ann says, an incredibly tight timetable, when people have to start doing it in 24 hours or 24 days it gets even more difficult.

DR. SOKOLOVSKY: When those kinds of problems happen it is going to be at the pharmacy that people are going to find out that they have a problem, and it is going to be the pharmacist who is likely to be the one who is going to be trying to manage that. The pharmacist, who

cannot write prescriptions, is going to have to be in contact with the physician, and that is in fact what happens when there are problems in these private-sector transitions now as well. There's a lot of additional work for the pharmacist and for the physician.

MR. MULLER: But they're also pretty efficient in saying, I can't help.

DR. SOKOLOVSKY: The ones that we spoke to spoke about the kinds of works they did to help.

DR. NEWHOUSE: Ralph's scenario raises the question about what happens if a plan pulls out and the beneficiary hasn't signed up for a new plan, or finds that out when they get to the pharmacy. Presumably they're not covered. But then what happens next?

DR. SOKOLOVSKY: That's a really interesting point. If a plan pulls out and the beneficiary doesn't sign with someone else, it seems to me that's a whole separate issue that really has to be explored, and I don't know the answer offhand.

DR. NEWHOUSE: That's surely going to happen.

MR. FEEZOR: Joe, I wonder -- that actually was going to be a part of my comment. First off, good chapters. Joan, I found myself nodding. Everything that you had in this chapter were things we confronted in

moving 400,000 lives in our self-funded program at CalPERS.

Two points though. I think on the safety net that Ralph is raising and the people who are lost, there's not that employed. Okay, maybe the Secretary maybe could be, but the reality is there's not that employer that has that force. I wonder if the PBMs might not want to look at the model that's used in some of the auto insurance industry, the compulsory pools. Or maybe a better analogy would be within the old days when every state had it's own Blue Cross plan. They had an interplan bank, or a plan would run that so if there was a lost soul, I show up and my pharmacist says, wait a minute, I don't have you being with Medco, and I say this is lifesaving. And the pharmacy says, wait a minute, and there might be an authority, if you will, as there are in some other insurance, that that sort of account is marked against and the losses in the administration of those lost individuals then in fact gets borne by the entire participating industry.

So I would suggest that we might explore that a bit more in some of our subsequent evaluation.

The one other thing, it was in the chapter but not as explicit as I thought on the lessons we learned.

If we learned anything in the last few years in MedicareChoice was the constant changing of benefits really began to cause people a lack of faith and their willingness to participate. Here you probably can do some tinkering on the benefits. And even more pernicious I think can be the formulary changes that I can do every month I guess. If I really am going to be suspect I could probably even do some not so subtle risk and financial impact play by what I'd do with that.

It is brought out in the chapter but I would underscore it, I think you don't want to preclude formulary changes but you want them to be done in a predictable fashion with, as the chapter was excellent in pointing out, with advanced notice to all parties. And it might be that they're done -- if there are changes, they're done at the beginning of a quarter or something like that. I would even say once a year but maybe that's too restrictive -- simply so that people get used to, wait a minute, there may be some changes that affect me and I know where to go to look to find it on the web site or whatever.

DR. ROWE: Just a couple points. There's been a lot of discussion about this. Very interesting stuff. I do think there are already effective communications out

there. I visited my mother on Sunday. She's 94 and she showed me a letter she got from Medicare describing the discount drug program, the discount drug card. I thought it was very well done. Now maybe I'm not the average Medicare beneficiary, but she seemed to understand it and it was very clear. So things are starting to happen there. So we should give CMS some credit because we're always beating on them. Obviously they are moving very quickly here.

I wondered whether it was worth hearing a word about what's going to happen to people in long-term care facilities. I was thinking about Bob's comment about this is an individual rather than a group. But the fact is people who are in long-term care facilities get their medications hand-poured by staff and they're purchased right now probably by the nursing home or nursing home chain or whatever through some wholesaler. Then the individuals are probably charged some retail price per pill I guess it varies.

Anyway here we are now, there's a nursing home with 120 people and they're probably all Medicare eligible, and the six different cards are being held. What's going to happen and how are they going to get the drugs? Or is the nursing home going to contract with one

company? These are not necessarily the beneficiaries that the companies are going to be marketing to necessarily, depending upon where the profit is. If it's a percent of the total cost then they might be. So what's going to happen there? I haven't heard much about that.

DR. SOKOLOVSKY: That was an issue that we were particularly interested in and certainly it was part of Jack's project to try to ask exactly those questions. From states we heard very little information to begin with. But there's some things in the law that we know. One is the law says no copayments for beneficiaries in nursing homes, and that was very important. It also says that whoever offers a drug plan has to have a way of coordinating with the pharmacies that provide drug benefits within nursing homes. Exactly what that means is not yet specified, but it is, as you said, an extremely important issue.

DR. HOADLEY: I was just going to add, we did try to explore that question with a couple of our respondents. One of the respondents we had in our project was somebody who formerly had worked in a state program and now was working in a nursing home, company and then others with some of the state people who interact a lot. One of the things I was struck by again was this notion

that it really is early in the process. He said, in terms of his own nursing home company that he is involved with, they just haven't begun to think through that.

But what I did get a little speculation on was the notion that one possibility is that a nursing home, especially one whose residents are mostly on Medicaid, that might be important, that might not be depending on the circumstances. But one possibility is that they would either ask the authorized representatives of these residents or strongly recommended to them that they sign up with a particular drug plan that has agreed to work with nursing home pharmacy, because most of these nursing homes as you're pointing out do have special relationships with a particular pharmacy that orients itself and works with nursing homes.

So I think what we'll probably end up seeing, although quite how we get there is not so clear, is some kind of situation where all the residents of a particular nursing home end up getting signed up with a plan that agrees to coordinate and work smoothly with that nursing home. But of course you have got to do that in a way that preserves the choice, the option of beneficiaries to make their choice. It is a voluntary and it's voluntary what plan you pick. It is early but I think it's a really

important area to pay attention to.

DR. ROWE: It's more like a group. If you think about a nursing home change, maybe a big one, a national one, then that's a big group. I'm a little concerned that there are going to be some opportunities here that are not going to be particularly advantageous to the Medicare beneficiaries. I think that maybe half of the Medicare beneficiaries in long-term care facilities have cognitive impairment. We've got an enriched population that's vulnerable because they're going to do what the nursing home people suggest. Not that they would suggest a wrong thing, but they're not quite as autonomous because of their living situation and their cognitive status and health care literacy. So we need a little bit of extra attention to how that gets implemented.

MS. BURKE: Just in follow up to that, and I apologize if you discussed this while I was out of the room. What if any knowledge will we gain from the discount card in answering some of these issues? That is, how one either informs people or essentially gets that information and also gets participation. Will we have gained experienced or will that be transferable in any sense in terms of our knowledge of what -- in the context of nursing home patients but generally?

DR. SOKOLOVSKY: Funny you should ask that question because as it happens, in this series of work that we're doing with Georgetown and NORC the next project is, what are the lessons that we're learning from the discount card that will be applicable to Part D benefits, and it's exactly those questions that we are looking at.

MS. BURKE: I'd like then, as Jack suggested, a further discussion as we go along in terms of what we hear in that context would be helpful.

DR. HOADLEY: One important thing to remember in terms of particularly the nursing home population is for those nursing home beneficiaries who on Medicaid, for the most part the discount card isn't relevant. They won't be involved with that. I think where we will get some things to learn is that not all nursing home residents are on Medicaid, so for those who are private pay or paid by some other kind of long-term care insurance they may find the discount card relevant and the whole process how that part of it works certainly will be opportunities to learn.

DR. REISCHAUER: Just one comment on what I was talking about before. My guess is that the transaction costs for an individual for shifting from one drug plan to another are going to be very high and people are going to end up being very, very sticky. That's just how much of

this is going to go on.

But when you read the law lots of stuff isn't specified, and as analysts you can sit down and think, think of the loopholes, think if there's some evil force here that really wants to turn a buck what they could do to the elderly and what they could do to the industry and all of that.

But if I had to predict three years out, I would be very surprised if we saw a lot of pernicious activity. My guess is that the folks who are going to be offering stand-alone drug plans by and large are going to be associated with large PBMs or insurers that have reputations to maintain, that are providing a benefit that is national not local. That there's going to be not a lot of these things, maybe a dozen or so. The competition is going to be pretty fierce. It's going to be hard to appeal to this group and not to that group when the ads are being put on the back of buses to participate. That should the worst happen and there be no offering or somebody withdrawing from a region, which I don't think will occur, there always is the fallback plan. When that's not the case there is the fact that the others will try to be scarfing up that business.

So what we should do is try and direct CMS and

attention to providing the protections that will ensure that all of this way does turn out this way, but not pursue the nightmare of the analysts and assume that this is going to take place.

MR. HACKBARTH: Let me sound my agreement with that, and in particular I think it's important for the people in the audience to understand that just the nature of these things, we're exploring something new and different and there's a tendency, a natural tendency I think to try to identify potential problems. Certainly there's a lot of complexity and a lot of opportunity for things to go amiss. But keep it in context.

We're not rendering judgments, but trying to learn, understand, anticipate, and help other people anticipate. Certainly as Jack pointed out, a lot of work is being done to make it go well, and we need to from time to time acknowledge that and recognize that.

So think you, Jack and Joan, for excellent work on this and we need to move on to our next topic which is defining long-term care hospitals.

DR. KAPLAN: Good morning. In this presentation I'll briefly review the research findings presented at the March meeting and also present two additional analyses designed to answer questions you raised at the March

meeting. Then Carol will present some examples of criteria we've developed that Medicare can use to better define long-term care hospitals and appropriate patients for them. At the end of the presentation we'll ask you to discuss the draft recommendations and the draft chapter.

As we've told you before, growth in the number of long-term care hospitals has been rapid at 12 percent per year from 1993 to 2003. Recently growth has accelerated. During fiscal year 2003 22 long-term care hospitals opened. That same number opened in the first six months of fiscal year 2004. From 1993 to 2001 Medicare spending quintupled from $398 million to $1.9 billion. The number of long-term care hospital cases increased 24 percent from 2001 to 2002. As the number of long-term care hospitals continue to grow they may find it more difficult to fill their beds with appropriate patients.

Long-term care hospitals have very high payment rates. On the screen is a comparison of 2004 per-discharge rates by setting for five diagnoses common in long-term care hospitals. Like any prospective payment system, financial incentives encourage these facilities to admit patients with the least costly needs within a case-mix group.

At the last meeting you questioned why long-term care hospitals are located where they are. Using multivariate analyses we found no relationship between the presence of a long-term care hospital and the share of the sickest patients. We found a negative relationship with certificate of need. In previous research we found a relationship of teaching hospitals to the presence of a long-term care hospital, and the empirical analysis confirmed that. The empirical analysis also confirmed the strong presence of long-term care hospitals in the southern parts of the nation.

Now I'm going to briefly review the findings I presented last month. As you will recall, we had two qualitative components to this research and a quantitative component. For the quantitative work we used episodes of care. In the full dataset we had 4.3 million episodes and we created two subsamples to examine if the results differ for patients who are more likely to be admitted to long-term care hospitals.

To be as conservative as possible in our research this year we did several things to control for severity of illness. First we used every clinical variable available from the administrative data. In addition, we used statistical methods to control for

severity of illness, including an instrumental variable approach to control for unmeasured severity.

As you remember, we found that the role long-term care hospitals play is to provide post-acute care to a small number of medically complex patients, less than 1 percent of patients discharged from acute hospitals. These patients are more stable than ICU patients but generally do not have all their underlying problems resolved at admission to the long-term care hospital. A diagnosis of tracheostomy with ventilator support is the single strongest predictor of long-term care hospital use. But patients with tracheostomies represent only 3 percent of long-term care hospital cases. As severity level increases, the probability of long-term care hospital increases.

Supply of long-term care hospitals matters, especially when they are hospitals within hospitals.

We found that acute hospitals and SNFs are the principal alternates to long-term care hospitals. We found that long-term care hospitals users have shorter lengths of stay in the acute hospitals than non-LTCH users. Shorter lengths of stay suggest that acute hospitals and long-term care hospitals are substitutes.

We also found that freestanding SNFs are a

principal alternative to long-term care hospitals in areas with and without long-term care hospitals.

On average, long-term care hospitals users are more costly Medicare compared to clinically similar patients who use alternative settings. For patients with the highest probability of using a long-term care hospital we found a positive but statistically insignificant difference in Medicare spending for the episode.

Regardless of the method we used, we found that long-term care hospital users had lower readmission rates than simpler patients treated in alternative settings. This is what we would have expected because long-term care hospitals have to have the capacity to treat hospital-level patients. Our results for death in 120 days are inconclusive.

Last month you expressed concern about whether to reduced probability of readmissions among long-term care hospital users would affect our results on total spending for episodes. We did two analyses to ask you question.

First we examined total episode spending for the 80 percent of patients who aren't readmitted. Second, we roughly estimated the effect of the lower probability of readmissions on total spending among long-term care

hospital patients. With both analyses we found that when long-term care hospital admissions are not targeted their patients cost Medicare more. When long-term care hospital care is targeted to the patients most likely to use long-term care hospitals the difference in spending for those patients and patients who use alternative settings are not statistically significant. In other words, a much shorter way to say it is, the story did not change.

The main conclusions from our study are that when admissions to long-term care hospitals are not targeted to the sickest patients, long-term care hospital patients tend to cost Medicare more than patients treated in alternative settings. Based on our analysis, we conclude that long-term care hospital care needs to be targeted to medically-complex patients that generally cannot be treated in less costly settings.

Now Carol will talk about criteria to better target long-term care hospital care.

MS. CARTER: We had several goals in mind in developing examples of criteria for long-term care hospitals. First and foremost, we wanted to clearly distinguish this level of care from other settings, most notably SNFs. We wanted the criteria to be feasible to administer, both for CMS and for the hospitals. The

criteria should establish clear expectations and hold providers accountable for their actions, and reinforce the provision of high-quality care. We wanted the criteria to be consistent with the payment policies of other PPSs. In the longer-term, the criteria should facilitate the adoption of a common patient assessment tool and classification system across post-acute care settings.

During our site visits and numerous interviews we were consistently told about the features of long-term care hospitals that distinguished these facilities from other settings, most notably SNFs and rehab facilities. This is what they told us. They treat sicker patients and that the majority of their patients are likely to improve. They frequently use admission criteria to screen patients.

Many told us about the daily physician involvement that their physicians have with their patients. The level of care that they provided was fairly intensive, ranging from six to 10 hours of licensed nursing care hours per day. They had respiratory therapists available 24 hours a day. They hired physical, occupational, speech and respiratory therapists and had them of staff. And they had multidisciplinary teams preparing and carrying out treatment plans.

Based on these examples we developed example criteria that could be used to ensure that long-term care hospitals treat medically-complex patients. On the next slide you see examples of facility-level criteria.

First, each hospital would establish a patient review process that screens patients prior to admission and periodically throughout their stay and assesses the available options when patients no longer meet continued stay criteria. The purpose is to have each facility have a clear and uniform process that is used to assess each patient.

A standard assessment tool would eventually be used by all long-term care hospitals. This tool needs to provide reliable and valid clinical assessments of patients. Many facilities already use patient assessment tools such as the Apache 3 system. We think all facilities should use the same tool as a way to ensure consistency across facilities in how patients are assessed.

Strong physician presence and active involvement with the planning and provision of patient care was a key feature distinguishing long-term care hospitals from SNFs. One criterion that could establish expectations regarding the types of activities that physicians would be involved

in and their availability.

We think consulting specialists should be on call and able to be at a patient's bedside within the hour.

We think the current average length-of-stay requirements should be retained in the near term as yet one more way to ensure that patients require a high level of resources. Over time as the patient criteria clearly delineate the patients appropriately treated in this setting we would reevaluated the need for this criterion.

Multidisciplinary teams would plan and carry out treatment plans. Given the diversity of patients we expect the staff to have a mix of specialized expertise including wound care experts, respiratory therapists capable of rescuing patients, PT, OT, and speech therapists, and staffs capable of providing end-of-life counseling.

Examples of patient criteria are on the next slide. They would ensure patients admitted to long-term care facilities require an intensive level of resources, have good chance of improvement, and cannot generally be treated in other less costly settings. National admission and discharge criteria would be developed for each major category of patients, such as

medically complex and respiratory patients. The criteria would specify clinical characteristics such as blood pressure, respiratory insufficiency, or open wounds, depending on the type of patient. And the criteria would delineate the need for specific types of treatment such as IV medications, pulmonary monitoring, ventilator support, and GE suctioning, again depending on the type of patient. Patients who do not meet the admission criteria would be expected to be admitted to a different level of care.

Discharge criteria could be specific to the discharge destination. For example, discharge criteria for a patient headed to a SNF could be different from those headed home.

To distinguish the types of patients treated in this setting from patients treated in other settings a high share of patients, for example, 85 percent, would be classified into broad categories such as complex medical, complex respiratory, cardiovascular, ventilator weaning, and extensive wound care.

To ensure that long-term care hospitals treat the most severely ill one criterion could be that a high percentage of patients need to be assessed at admission at high severity levels. For example, 85 percent of patients would be assessed at the APR-DRG levels three or four.

Patients who are less sick can be treated in less costly settings. We appreciate that when the criteria are first implemented it will take time for the industry to adjust to them. Therefore at first this criterion could start at a lower share. Over time we would expect the share required to increase to compensate for changes in coding that are likely to occur.

Admitting patients who require a certain amount of skilled care is another way up to ensure that patients are appropriate to this level of care. For example, a criterion could state that patients required 6.5 hours per day of licensed nurse, respiratory therapist or physical therapist time.

Now Sally would like to walk you though a draft recommendation.

DR. KAPLAN: On this slide you see the first part of the first draft recommendation. There are actually two slides for this.

It reads, the Congress and the Secretary should collaborate to define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex, have a good chance of improvement, and generally cannot be treated in other settings. It goes on, facility-level criteria should

characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria should identify specific clinical characteristics and treatment modalities.

We estimate that the beneficiary and provider implications are that the adoption of criteria would expand access for patients who actually need long-term care hospital level care. Medicare spending implications are that stringent criteria will result in reduced spending.

The second recommendation is that the Secretary should require the quality improvement organizations to review long-term care hospital admissions for medical necessity and monitor that these facilities are in compliance with defining criteria.

The beneficiary and provider implications are that enforcement of the criteria would expand access to patients appropriate for LTCH level care. Medicare spending would increase for QIOs.

Before you begin discussing the recommendations we want to note that ensuring the appropriate use of long-term care hospitals requires a two-pronged approach. First, criteria such as the ones we've outlined well help

ensure that long-term care hospitals already in operation treat patients who require this level of care. But we recognize that in the longer-term refinements to the pre-existing PPSs for acute hospitals and SNFs are needed to make sure that the development of long-term care hospitals is not simply the byproduct of shortcomings in these other payment systems.

On the inpatient PPS side there are three policies that we think warrant further study. First, a classification system that reflects the severity of patients may improve the matching of payments to patient costs and could make acute hospitals financially neutral to treating the complex cases that are currently transferred to long-term care hospitals. This would also likely lower the number of outlier cases that routinely get transferred to long-term care hospitals.

Second, the current outlier policy we believe needs to be studied. The threshold and cost-sharing requirements may contribute to acute hospitals unbundling care to long-term care hospitals, and modifying these policies could make acute hospitals less prone to transfer cases who they could treat themselves.

Third, clear rules regarding hospitals within hospitals will ensure that hospitals do not discharge

patients prematurely for financial gain. CMS has expressed their concern about hospitals within hospitals a number of times and we look forward to seeing what they do.

On the SNF PPS side, we and others have noted the shortcomings in the current RUGs classification system. Refinements that better target patients to medically-complex patients and away from being driven by the provision of therapy services may encourage more SNFs to admit certain types of patients that could be appropriately treated in this lower cost setting.

That ends our presentation.

DR. MILLER: On the implications from provider, beneficiary and on the spending, really I think what we're saying at this point is, we don't know. We're talking about draft criteria. We don't know what would be adopted. There could be some increased access for some sets of patients. There could be some effect on the current spending curve but I don't think we really know. When we get to putting this in the chapter I think this is going to be hard to draft and it's probably going to say in fancy words, we're not real sure. I think that's what we're trying to get across here.

MR. DeBUSK: I think this is an excellent

chapter. There's a lot of time, lot of work gone into this. That's quite evident. I want to back up to page 13, examples of facility-level criteria. The standard patient assessment tools, could you expand on that a little bit? What's out there at present?

MS. CARTER: There are a number of different patient assessment tools. The one that we looked at and talked the vendor about was the Apache system. We're not recommending it but it is one out there, but there are many others. Many of the hospitals and sites that Sally visited were using admission criteria screening. InterQual is another one.

MS. DePARLE: I agree that we've really done a lot of work in the last 18 months on this and it's excellent. I just want to raise one thing. In the discussion of the conclusions we said when admissions to LTCHs are not targeted their patients tend to cost Medicare more than patients in alternative settings. We discussed last time the readmissions and you did obviously a lot more work to discover that it still cost more. Remind me what we know? We cannot, I take it, draw any conclusions but the quality or the outcomes being better or worse?

DR. KAPLAN: No, we can't. The only outcome

measure that we have is the readmissions. There is no patient assessment instrument in these facilities and that's one thing they would hope to -- we did have a discussion of quality in the chapter, that that's one of the things we would hope to see that would come out of these criteria.

MS. DePARLE: Is that implicit in our recommendation about criteria, that there be a patient assessment? Because it seems to me, down the road we're going to want to be able to look at these various settings. If we got better results I'd be willing to pay more I think.

DR. KAPLAN: The recommendations basically say we need criteria and generally describe what we expect the criteria to accomplish, and then in the chapter we discuss the examples of criteria we think would be useful in greater detail. The patient assessment instrument and the quality measurement are discussed there.

MS. DePARLE: I guess that leads me to the other question I had. We talked about this a little bit the last time. I'm still not clear on what CMS could do on its own now, understanding that CMS has a lot of other things to do. But if they wanted to do, for example, a patient assessment instrument and asked the LTCHs to use

that, as well as other settings, as you point out in the chapter do use patient assessment instruments, could they do that? We use this language about collaborating with Congress. Is that because we're not clear how far CMS can go on its own?

DR. MILLER: I think there's a couple answers. We think that there are lots of things that we're talking about within this criteria that probably can be done administratively. Then what really falls between the Secretary and the Congress I think we are a little bit unclear on. So for the purposes of this discussion we've cast it as both actors being involved in this. There's some murkiness there.

MS. RAPHAEL: I think it's important somehow to put a little broader frame around this chapter which I think has really come a very, very long way. I think what we're saying based on this chapter is that the long-term care hospitals are part of the post-acute care spectrum. They have a role to play for a certain set of patients, and based on a certain set of criteria that we would like to see come into play. So I think it's important to set that there because I think where we're headed is trying to have a more rational post-acute care system, hopefully where patients who will likely have better outcomes in

certain settings somehow are more likely to go there.

The other things I was going to ask you, I think Mark answered a question I had which was the impact. If all of this were to come to pass what would it all amount to. I understand that it's hard to capture that. But several other questions that I had based on the letter that we received, one was about the role of rehab in these settings, because rehab expenditures seem to be particularly costly when compared to SNF for these settings. I was wondering if you could comment on the role of rehab. When is it appropriate for rehab patients to go to LTCHs versus rehab facilities? I wasn't entirely clear.

Secondly, could you clarify the issue around staffing? Because a point that's made in the letter is that in SNFs the nursing staffing component encompassed actually unlicensed aide time. I guess I'd like to have that cleared up in terms of what we mean.

Lastly, maybe it's not for today's session but I would like to learn a little more about the QIOs. They don't do any of this now. How well equipped are they to take on this role in the future?

DR. KAPLAN: I'm going to go in reverse order to your questions. QIOs currently have in their scope of

work that they review 116 randomly selected cases from long-term care hospitals of month. That just began in January. So they are becoming extremely familiar with long-term care hospitals and the cases. Some of them already use some of the criteria that we looked at in considering what type admission criteria and discharge criteria you might want to use or might need, and some of the QIOs are already using that criteria for long-term care hospitals.

So I think that they may not be all that familiar with them now but they are becoming much more familiar.

DR. NELSON: Sally, do they make site visits or do they just do a record check?

DR. KAPLAN: That I don't know.

DR. MILLER: I think our impression is that what they're doing is claims analysis and medical records review like they've done in other kinds of settings. I don't think they're going to the facilities and doing conditions of participation type inspections if that's what you're referring to. I'm pretty sure they don't do that kind of stuff.

DR. KAPLAN: I think this is retrospective. It's not they see the patient when the patient is in the

facility.

DR. NELSON: That's what I wondered, if it was concurrent or retrospective. Thank you.

DR. KAPLAN: Staffing, aides and SNFs. One of the big points that the long-term care hospitals that we visited on our site visits made was what distinguished them from SNFs were many things, but one of the biggest points was, first of all, daily active intervention of physicians, and staffing. That they provided professional staffing. They did not have a lot of aide care in the long-term care hospital. That is what we are trying to accomplish, to make sure that these are not SNFs and that they aren't souped-up SNFs. So that is why we have put the staffing.

The 6.5 hours actually comes from InterQual criteria. My understanding is this is the level that step downs from ICU units have that level of staffing, which is also what we were told the long-term care hospitals told us, that they're step downs from ICU units.

DR. MILLER: The other part of her question had to do with aides, which we did talk to several people about in the industry. Our criteria says very carefully, licensed. The issue that they brought to us is, can we reach this criteria by using somebody other than nurses?

Can we respiratory therapists, wound specialists, that kind of thing. In contemplating this work we see that that wouldn't be an issue. We do not see them reaching this level through aides, however. I thought that was part of your question.

DR. KAPLAN: Now let me go to your last question which was the rehab and the long-term care hospitals. I think one of our concerns is that there are -- the payments in long-term care hospitals for the very same patients that are in rehab are very attractive. I used the major joint replacement as a good example, $67,000 a case in the long-term care hospital versus $17,000. That is for a person with the most ADL impairment and the most comorbidities in the rehab facilities. So that's the most you could get for a major joint replacement in a rehab facility.

Our concern is that long-term care hospitals do not become very highly paid rehab hospitals. So this is not to say that patients in long-term care hospitals wouldn't receive rehab. This is not to say that a patient who may have been a major joint replacement but had lots of comorbidities and really couldn't be taken care of in a rehab hospital couldn't go to a long-term care hospital. This is really to try and build a line between rehab

hospitals and long-term care hospitals.

DR. MILLER: And the line is focused on the severity of the patient.

DR. KAPLAN: Yes, on the severity of the patient.

DR. ROWE: I have two points. This is very nice work; congratulations.

One is, you mentioned on page 14 and one of your recommendations that the average length of stay should be greater than 25 days, and I had two thoughts about that. One is I wonder whether that's average live discharges. These are very, very complex patients. A patient gets admitted, dies after three days, is that counted as a three-day length of stay as we're calculating it?

The second is, would we be better off using the median than the mean? Because there are some patients in these facilities who are there for like two years and then you can have a whole bunch of patients there for five days and you have an average length of stay greater than 25, and that's not really the spirit here.

So I would just ask you to think a little bit about whether that is really the right -- if we're going to have some new recommendations -- I don't know what the distributions are. I haven't seen them. I'm just

thinking about that that maybe we could improve that if we looked at some data.

The second point I think is more important and it goes to Carol's comment about the rehab and the business you just said, Sally, about trying to divide rehab hospitals from long-term care hospitals. The first rule is primum non nocare here; above all, do no harm. I think it's great to divide these institutions as long as we're not cutting any babies in half here. I think some of these institutions have evolved along a pathway where they're basically 50 percent rehab hospitals where they're probably getting overpaid for those patients, but they have to keep them in 25 days which is really not what they want do if they're really a rehab hospital, and 50 percent long-term care hospitals. They don't want to be a hospital in a hospital because then they'd have to have different CFOs and medical directors and governances, et cetera.

So going forward I think these are a terrific set of recommendations. Looking backward I would hope that our work reflects the possibility that there are some institutions, and we could have very strict criteria, that perhaps by virtue of the way they have evolved and the role they play we might consider approaching differently.

I'll leave it at that.

DR. REISCHAUER: Of course your first recommendation might be cutting some of these babies in half.

DR. ROWE: I understand. I'd like to see what the data look like, and if you did both things then maybe would be okay. I understand. If you just did the first thing it might make it worse, not better.

MR. HACKBARTH: We're trying to put together here a conceptual framework defining how this fairly expensive resource is used, and as we do that there may be some unique circumstances that arise out of historical factors that make this less than the perfect fit for particular institutions. I think we ought to acknowledge that explicitly in the text. Having said that, I don't think this is the appropriate forum to try to deal with those circumstances but we ought to acknowledge that they may exist.

DR. NEWHOUSE: In that paragraph I'd like to suggest that we say something about we don't envision that there would be any entry under these criteria. That is to say, or I envision saying something like, the original criterion for defining a long-term hospital was solely that you had an average length-of-stay of more than 25

days. That encompassed a variety of institutions notable for their heterogeneity and that, as Jack said, some circumstances may dictate that we would treat some of these people that qualified initially differently but that we explicitly say something about entry. Because if there's anything we've seen about the long-term hospital industry it's entry. We don't want to set up exceptions that encourage entry into those exceptions.

MR. HACKBARTH: I think that's an excellent addition. Thanks.

MR. SMITH: Thank you very much. This has been good work over the last year. Most of what I wanted to say has been said so I won't repeat it. Looking at recommendation A, we say that these folks generally can't be treated in other settings. A big part of the argument of the chapter is that they are routinely treated in other settings. I think we need to be careful here. Figuring out what the patient criteria are seems to me to be the critical part of both the argument in the chapter and of the recommendations.

We have a suspicion that there are some people who would be better off treated with the more complex apparatus available in the long-term care hospital but really don't say that. Instead we hint at it. On the

other hand, our current practice is that they are routinely treated in acute-care hospitals and SNFs and in some cases, rehab facilities. If we really believe the line we used at the end of the first paragraph of recommendation A, that's what we ought to turn our attention and we ought to underscore that in the text of the chapter.

MR. MULLER: My thanks as well for really elaborating our understanding of this. If I can take us back to the slide on page three and the question of the classification of patients. As Carol said, if we have the appropriate care in these hospitals vis-a-vis alternative settings then this is a good place for them in the continuum of care.

But in looking at that table, I must say if indeed the acute hospital is a low cost provider we should gold plate this slide as the first time we've ever shown that. But what are we showing here in terms of the mix of patients, because that would truly be a pleasant surprise to some of us who always defend the alternative? So what are we seeing here in terms of classification of patients? Because they truly are comparable patients and we know from what you said earlier, the LTCHs are not in all parts of the country and you've shown the predominance of them

in four states or so. What are we really measuring here across these patient populations in terms of comparability?

DR. KAPLAN: For instance, the stroke is DRG-14, as an example. That is the per-case payment, a standardized amount that an acute hospital received for each stroke patient. That is the standardized amount that a long-term care hospital receives for each person that has a stroke, that has DRG-14. It's a little bit more complex.

MR. MULLER: So there's obviously differences in acuity --

DR. KAPLAN: Yes.

MR. MULLER: -- because otherwise you would say, everybody should just stay in an acute-care hospital then and not go to these --

DR. KAPLAN: If we could get them to stay in acute-care hospitals that might be our choice, but that hasn't been what we've got -- we haven't been able to make that happen. That's one of our solutions was that we need to look at the acute-care hospital payment system to see if there are ways that we could provide incentives for acute-care hospitals to keep more of these patients.

DR. REISCHAUER: I was wondering whether if you

adjusted the acute-care hospital stroke for similar severity level and then look at outlier payments associated with that as well what would the number be? You don't mislead us in any way in your description of this, but that could be the logical comparison really.

DR. KAPLAN: I don't think I can do that for the June report. If you would like that next year maybe, but not this year.

MR. HACKBARTH: Even accepting that you can't do that specific calculation, it might be good to add some additional text that explains that this is not necessarily and apples to apples comparison of similar patients.

DR. ROWE: Why don't you take the acute hospital data out? That's not really what we need anyway. Really it's the long-term care versus the inpatient rehab versus the SNF.

MR. MULLER: In many parts of the country where there aren't the long-term care that in fact is -- so probably in terms of the incidence of cases it's where -- that's where the care is. So I think Bob's point about what's the real underlying payment when you look at the whole payment. But still, outliers aren't that good they can go from six to 31 or from eight to 44.

MR. SMITH: But the first, third and fourth

columns up there are subsequent to the second column. In that sense this really isn't apples to apples. It's $6,000 plus $31,000. It's $6,000 plus $34,000. So we should really take that column out of here.

DR. KAPLAN: I think that's a good suggestion, We can also put in the text too that we aren't measuring by severity level on this.

MR. MULLER: I don't agree with David's conclusion because if they don't go to a long-term care hospital or a rehab hospital then that's it.

MR. SMITH: Right, but the comparison is when they go.

MR. MULLER: No, the comparison is, what does it take to take care of a patient? And if the patient can only be in an acute hospital because there's no alternative, that's what it takes. So the patient is the comparative point, not -- then you look at the patient across different settings.

MR. SMITH: That's right. But then it would be additive in many and in some cases, most cases, right? The episode of care is not always longer than the acute stay, but often is.

MR. MULLER: Yes, but then oftentimes it's in hospice or some other kind of nursing home. Not in a

rehab. Probably then the nursing home is more likely. Probably in terms of the incidence of care around the country I would guess the most common is the acute hospital followed by the nursing home in terms of where the bulk of the cases are. Then in settings where there are rehab hospitals and long-term care you have this payment pattern that's described here. But if you just look at flat out incidents, my guess is, the way you said it, it's column two and four, not a combination of -- just in certain cases about the country.

MS. BURKE: At the risk of being positioned as being opposed to long-term care hospitals I will make the following comment. Let me first ask a question. In the context of the growth of long-term care hospitals note is made in the chapter about the particular increase in the in-house or the hospital related long-term care hospital activities. I wondered what we knew about the proximity of that growth, those particular institutions, to other freestanding? And to what extent we can infer that there's a certain amount of defensive action that has taken place; i.e., are we seeing the growth in the in-house hospital-based long-term care units in close proximity to freestanding long-term care?

Is this a market-driven kind of issue? Are they

essentially trying to compete for patients? Are you seeing, for example, inpatient facilities developing in areas where there are no long-term care freestandings, or do they tend to be in the same markets? That would be my first question. What do we know about that? So to what extent is this a defensive mechanism?

Secondly, I have a question as to whether there is any inherent difference between those two types of facilities. You note that on average those that are located within hospitals tend to be smaller, that their referral patterns tend to be slightly different, neither of which is terribly surprising. Are there any other aspects of those facilities, either the patients they see, the costs that are reported, the nature of the services, the lengths of stay, the mix of specialists or staffing patterns that are different between those two kinds of facilities? I would be interested in that as well.

Going back to David's point, and he said it far better than I did, and I think also touching on Carol's. I am fundamentally concerned about a statement which suggests that these are patients that because of the nature of the acuity of their condition requires what is now provided in these facilities when in fact the majority of these patients are being seen in other kinds of

facilities around the country. So I think you're very wise to have suggested that part of what must happen is to re-look at the payment system for other facilities that are in fact taking care of the majority of the patients that present themselves in exactly these situation, because it presumes that people that don't have these in their neighborhoods are somehow disadvantaged. So I think your point to make that part of our recommendation ought to be highlighted, that the bulk of these patients really are being cared for arguably in other settings. And let us not assume that the only answer is to develop one of these in your neighborhood. But rather let's find something to do about the payment system that effectively deals with the patient irrespective of where the patient is located. Unless there's something fundamental that we ultimately want to say about other facilities never fundamentally being able to take care of these patients, that a hospital will never be able to take care of a step-down sub-acute patient, which I find somewhat hard to believe. That somehow someone who's been discharged from a unit can't be taken care of in a hospital. It concerns me about hospitals.

So I think that point ought to be, perhaps, emphasized even more strongly, that we really need to look

at where patients are being treated, make sure that the payment system reflects the needs of the particular patient. But I would also in future work like to understand the nature of this sort of what has occurred in the growth of these particular facilities in hospitals and what is that suggesting to us about those particular hospitals and the way they're structured and what they're responding to?

MR. HACKBARTH: Could I address the last point? I think the point that Dave made about the language in draft recommendation, that generally cannot be treated in other settings, is exactly right, and I think it is at odds with an important made in the chapter.

Moreover, I strongly agree, Sheila, that the recommendations related to the acute hospital, severity and outliers and also looking at the SNF payment system, I think they are critical parts of this chapter. So when we get to the draft recommendation what I was going to propose is to delete that last phrase about generally cannot be treated in other settings.

DR. KAPLAN: Let me just briefly try and answer your question about hospitals-within-hospitals. A lot of what you're asking I can't answer. I can't tell you but difference in staffing or difference in cost structure

because we don't have PPS costs. I think to look at it in the pre-PPS world is fishy at this point.

We did make an attempt to see if we could find differences using our multivariate models and the instrumental variable approach, to find the differences between the hospital-within-hospital patients or episodes and the freestanding episodes, and we really were not able to get stable parameters. So we have to conclude at this time that there isn't a difference. I want to make that real tentative because it's really because we couldn't get the stable parameters.

Now if we do re-do this work post-PPS we might find a difference.

MS. BURKE: Should I assume, because it doesn't suggest otherwise, that the growth in these particular, the hospital-based, are following the same geographic pattern, or are they more distributed?

DR. KAPLAN: I think they're more distributed. First of all, almost all of the latest growth is hospital-within-hospital. They now represent 50 percent of the long-term care hospitals. CMS makes the point that every long-term care hospital that has opened up since the PPS went into effect is a hospital-within-hospital.

There is some that have opened up in markets

where long-term care hospitals already existed. For instance, the 35, 36 long-term care hospitals that are down in Louisiana, there are a couple freestanding ones down there. But most of those are hospitals-within-hospitals. I would say that the new trend is almost all to hospital-within-hospital. So anything that's opening up since 2001 --

MS. BURKE: But is it largely staying in the same general geographic area?

DR. KAPLAN: No, they're spreading out more.

MS. BURKE: So they're going north, they're going west, they're going central.

DR. KAPLAN: Right. I'll give you an example. For instance, in St. Louis there was a long-term care hospital, a Kindred long-term care hospital, the old Vencor chain that's been here since, I want to say the early '90s. Now in the last few months there's been a hospital-within-hospital that's opening, one or more in St. Louis. So it's kind of hard to tell what I think you're trying to get, is it market or is it because competition that the hospitals are opening them up?

MS. BURKE: Right, or whether -- part of this is my trying to understand how much of this is really driven by the need for these services and by patient needs that

aren't being met by other capacity, and whether or not we are seeing in fact the spread across the country or whether they are staying largely in certain areas where there's been a history and where the market might suggest that there's an opportunity to compete for patients where there's already been a pre-established presumption that these are a better alternative. I'm just trying to understand how widespread this has become as we look at this going forward.

DR. REISCHAUER: Can I just add a footnote on to that? Early in the chapter you mentioned that 80 percent of the revenue of long-term care hospitals comes from Medicare. We know there are some older ones and some different types of ones. If we just looked at the new ones and the hospitals-within-hospitals is this like 95 percent Medicare, so one would presumptively come to the conclusion that it is an artifact of the Medicare payment system that has created the growth that we're seeing?

DR. KAPLAN: I can only answer based on our site visits, because we don't have cost report -- the share of how much Medicare pays comes from the cost reports. We don't have cost report since the PPS. Some of the anecdotes we heard when we were out at site visits was that more than 80 percent is coming from Medicare in some

of these facilities.

DR. WAKEFIELD: Just a couple of questions. On the data that you have that show the long-term care hospitals users have fewer admissions, will you remind me what the categories of comparison were there? Lower than just SNF or lower than readmitted back into the hospital, rehab facilities, et cetera. So which category was that comparison to?

Also related to that, would it be inappropriate to suggest that after these criteria were put in place and we started to say, because we're basically incenting that patients be taken care of in different settings -- would it be inappropriate to suggest that there be some tracking of any changes in readmission rates after the accommodation of these criteria? Would there be some reason why we wouldn't want to do that, to make that kind of a suggestion? I'm not suggesting it as part of a recommendation but would that be a piece of information to be looking at after the implementation, because we're suggesting that there's some subset of patients that are best treated in non-long-term care facilities, or treated at least equally well. Would that be worth continuing to take a look at?

Then unrelated to those two points, the

criterion that speaks staffing and the use of just licensed personnel, that application of that criterion, it sounds like you were suggesting that basically all long-term care hospitals already staff maybe with just licensed personnel or at least we're suggesting that they all should, rather than using aides. Am I misunderstanding that?

DR. KAPLAN: We're not suggesting that they not staff with aides. What we're saying is for the staffing level that we're talking about that aides would not count towards that. Only licensed people would count towards that.

DR. WAKEFIELD: Part of the reason why I was asking that was because acute-care hospital staff by and large, or many of them that I'm familiar with, staff with nurse aides as part of that mix of staffing. But I take your point, it's the counting of that level of staffing.

Then will you come back to my first point for me?

DR. KAPLAN: Yes, I was going to answer your first question. You were asking me whether the readmission analysis, who the comparison was. If you think of it, what we're comparing is people of equal severity level. And we're comparing those that use long-

term care hospitals versus those that don't. So we aren't comparing against any particular setting. We are comparing those who used other settings.

DR. MILLER: Who use post-acute care.

DR. KAPLAN: Yes, it would be. It's an apple to apple comparison.

DR. WAKEFIELD: So based on the work you've done would you find value in continuing to take a look at those readmission rates between those that use long-term care hospitals and all others over time after these criteria were applied and the patients start to shift out differently in terms of where they're actually getting services? Would that help tell us something about what might have been triggered or not by the application of these criteria?

DR. KAPLAN: I don't think it would hurt to track it. I guess the point that I come to on the readmissions is it's one of the few things that we have -- I actually think it's a fairly weak outcome measure -- for facilities that have to be licensed as a hospital. They should be able to handle almost everything, so we would expect those readmissions. But I think readmissions are always an important issue to track in every setting, because Karen and the other quality people presented

readmissions for avoidable conditions are a huge quality indicator.

So yes, I think we should. But at the same time I don't think we want to bank on that one. I think we need a lot more than that.

MR. HACKBARTH: Two more comments then we need to turn to the vote.

DR. NEWHOUSE: I'd like to follow on where Sheila and Bob were and go maybe a few steps further and actually propose another recommendation, which is that we suggest a moratorium on new hospitals-within-hospitals. I see the hospital-within-hospital fundamentally is a threat to the integrity of the prospective payment system, if you can shift your long-stay patients off to another floor of the hospital and get separately reimbursed.

As a second order and speculative point at this point, but it may well be that those patients are actually different than the patients in the freestanding long-term hospitals, and we get into a kind of freestanding -- like we have freestanding versus hospital-based SNFs and these are really two different groups of patients and this system doesn't fit the other one any way, although I'd lay emphasis on the first point, that if we have a per-case system for the acute hospital it seems to fundamentally

threaten that to set up a hospital-within-a-hospital where you can shift your long-stay patients.

MR. SMITH: Very quickly. Ralph is surely right that my suggestion of eliminating column two on page three of that chart doesn't solve the apples to giraffes problem, but leaving it there doesn't either. I wondered whether or not we can get some episode data where it's acute-care facility plus post-acute, or in those cases where it is simply a stay in an acute hospital? So that we really are looking at the episode here rather than the current misleading use of the acute-care number in cases where there's a discharge to a post-acute setting.

Second, Glenn, I think you're right about changing recommendation A, but I think part of what you said in doing that suggests yet another new recommendation . Building on Sheila's observation, we're not going to fix this simply on the long-term care hospitals side. We've got to address both the SNF and acute-care PPS in order to get them working together. I think that's where Joe was headed, get them working together rather than being payment-driven substitutes for each other.

Some maybe we can translate the observation that Sally and Carol make at the end of the recommendations into a third recommendation which urges the reforms that

they outlined in both the acute and SNF PPS as part of getting this one right.

DR. KAPLAN: The only thing I want to say is we've made the recommendation on SNFs three years in a row now. I just want to point that out, that it has been three years.

MR. SMITH: Just take advantage of the opportunity to underscore our previous recommendation.

DR. KAPLAN: But I think we need more study of the acute-care hospital before we can really -- I personally feel strongly that we do need -- we might fix things for long-term care hospitals, but we might be messing things up for other sectors. I think it's a bigger issue than just for the 100,000 discharges in long-term care hospitals. That's my concern, is that we -- I think it is important and I think it's work that we should do, but I just don't know that we should make a recommendation that CMS run off and fix something that we haven't studied, especially if you consider the competing demands on their time now with MMA. I think we want to give them a little better direction than -- fix it how?

MR. HACKBARTH: Help me out. The something in that sentence, fix something, was what?

DR. KAPLAN: Fix the acute hospital PPS. We've

already told them we want them to fix the SNF PPS.

MR. HACKBARTH: What I thought we were saying is that -- we can reiterate the specific recommendation on SNFs, and what I thought we were saying with regard to the acute hospital is that we think these are areas that require further study, as opposed to I don't think we've got the foundation for saying we're recommending a severity adjustment for inpatient PPS. We may well do that in the future, but we don't have the foundation for that established right now.

DR. KAPLAN: I'm sorry, I misunderstood what David was saying. So you want to reiterate the SNF PPS -

MR. SMITH: We ought to do the SNF recommendation and we ought to underscore the need to lay the groundwork to --

MR. HACKBARTH: Exactly.

DR. ROWE: I don't want to prolong this. We've gone a long time and I know you want to end this, but Joe just suggested an additional recommendation about a moratorium. I think if we we're going to do that we're going to have to suggest until when? Usually moratoria have -- until what happens? When is the end of a moratorium? What are we trying to do, just call time-out? Is it some kind of study or is it some kind of

clarification, or are we calling for a cessation?

MR. HACKBARTH: Here's my view of it. Over the course of the last two meetings at least Joe and Bob and Sheila and maybe some others as well have expressed concern about the hospital-within-hospital phenomenon. Personally I find the way they presented it pretty compelling. I'm convinced that it's something to watch and look at.

Personally though, I feel it's a bit premature to go to the step of recommending a moratorium. I would like to see more evidence, more data of the sort that Sheila was asking for, comparing the hospital-within-hospital to the freestanding, so that we have a foundation, an analytic foundation for saying this looks more, pardon the expression, like a PPS-unbundling tool than an institution that is like the freestanding. I don't think we have that factual foundation established yet.

Now I know the counter-argument would be, don't let them proliferate rapidly while you're getting the data.

DR. REISCHAUER: You're increasing the sample size.

[Laughter.]

MR. HACKBARTH: Personally I would prefer to do the analysis first. A moratorium in the context of the Medicare program is a pretty significant step and I don't like to take steps without more analysis. My take on it. Welcome any reactions to that.

MS. BURKE: I wouldn't disagree with you, nor would I necessarily disagree with Joe. I think it is a question of timing and making sure that we are fully informed. I agree with you that we ought not today contained make that decision without being fully informed. I think there are a series of questions around the nature of the patient they are serving, what it says more fundamentally about the hospital and about the structure of the payment system. It raises issues about transfers. There are a whole series -- all these issues are wrapped up with one another.

I think I would support your suggestion that we give more thought and analysis to the nature of these patients and the potential impact. I don't want to either disadvantage the hospital, nor do I want to create an incentive for more fracturing. So I would support your desire to get more information and make a decision, but for what it's worth, simply say that there is concern. That we are trying to understand it, and let folks know

that what we don't want to see is this unbundling. And we're going to be looking very closely at exactly who these patients are, what it is that's being done, what is the problem they're trying to solve and is the right way to solve it.

DR. NEWHOUSE: I don't see how it could fail to be anything but unbundling, because they've been an acute-care hospital. If it hadn't been for the LTCH they would have used some other --

MS. BURKE: Of course that's the question which I'm trying to understand, which is what is the problem that they are trying to solve? Is it a function of the payment system that does not adequately acknowledge that there are patients of an acuity level and require resources that we don't currently acknowledge or support? I don't know. LTCHs developed for some reason. They developed in three towns or whatever, and what we now see is this proliferation.

I don't want it simply to be taking advantage of a payment system but I want to understand -- the argument that many people that have gone and spent time there suggest that these are really qualitatively different patients that require qualitatively different services. I want to understand how that reality exists, knowing that

most of these patients are not treated in LTCHs but in fact are treated in our current hospital structure or nursing home structure. What is it that we need to do going forward that fundamentally takes care of the patient? What is it that we need to do?

DR. NEWHOUSE: Which, of course, could be true.

MS. BURKE: Absolutely. I'm not assuming that it isn't. But fundamentally what it ought to be is a payment system that takes care of the patient, irrespective of where the patient resides. My concern is I'm not sure I fully understand the difference and whether or not what we've allowed to have happen is in fact to the advantage of the patient. Maybe it is, in which case we ought to do it differently.

MR. HACKBARTH: I think you're making important points and they apply both to the freestanding and the hospital-within-hospital, and the gist of what we're doing here is saying that we believe that there ought to be patient and facility criteria to help assure that this expensive mode of care is applied only to a much smaller subset of patients. That would apply in both instances as well.

DR. NEWHOUSE: I was going to respond to Jack but I think it's also a response you, because it's clear

that the Commission doesn't want to go to a formal recommendation here, but that we should in any event initiate a study here of who is using the hospital-within-the-hospital and whether in fact this reimbursement system fits that group, as opposed to all users of LTCHs.

MR. HACKBARTH: Okay, we are well behind schedule so let us turn to the vote. So we have --

DR. REISCHAUER: Can I just ask a point of clarification on recommendation A? You used an interesting term, which is Congress and the Secretary should collaborate. Is this something that does not require legislative change?

DR. KAPLAN: I don't think we're clear as to exactly what CMS can do without legislative change and what it can't.

DR. MILLER: Some of it may. Most of it is probably is administrative, but some of it may and that's what we're trying to do.

MR. HACKBARTH: We still may want to just delete the collaborate and just say, the Congress and Secretary should define --

DR. KAPLAN: That would be great. We can do that. We've taken the last phrase -- unfortunately I'm not able to revise it right here, but we've taken the last

phrase off of here and put an and between medically complex, so that the recommendation would read --

MR. DURENBERGER: Can I ask about that? I'm reading this first part as a preamble and the other part as the important part, the criteria and so forth. I'm looking at recommendation A with this third line in it which is, and generally cannot be treated in other settings.

MS. RAPHAEL: We took that out.

MR. DURENBERGER: Not yet.

MR. HACKBARTH: That's the proposal, to take that out.

MR. DURENBERGER: My question is whether we should take it out or if there's an alternate.

If it stays as cannot be treated in other settings then it draws a very bright line. But as a preamble to getting into the criteria and some of the other problems, it seems to me that if the reality is -- and I'm reflecting on my own community where we've had one for 15 years, it's non-profit, it's part of a large health system and everybody refers to it -- are not likely to be -- these are people who are not likely to be treated in other settings who are going into an LTCH.

MR. HACKBARTH: The problem is that in large

swaths of the U.S., including my part of the country, these institutions don't exist, either variety, freestanding or hospital-within-hospital. So it literally is not true to say that they cannot or should not or primarily not, and that's one of the basic findings of our work.

MR. DURENBERGER: I understand that, but I'm back at Sheila's very last point which is the patient. I'm not saying that in your part of the country patients are always getting, these very complex patients are always getting all of the care that they need in one of your regular acute-care hospitals. I'm reflecting only on my own experience which says, a lot of hospitals in my community would prefer to have a long-term care acute hospital, staffed as they are, for certain very complex cases, so they've created one in our community.

So I'm trying to express a concern for the patient and the implication that in many places where the long-term acute-care hospital it is because other hospitals and other people in that community have decided it would be better for patients to have this kind of a specialty mix service. I simply want to make that point. Maybe we can't make it without -- I don't have the language to alter that either.

MR. SMITH: Dave, isn't the recommendation as modified perfectly consistent with what you just said? Which is really the first point.

MR. DURENBERGER: And I might not even be making if we weren't taking it out.

DR. KAPLAN: Are you comfortable with getting rid of the collaborate to and have it read, the Congress and the Secretary should define long-term care hospitals by facility and patient criteria that ensure that patients admitted to these facilities are medically complex and have a good chance of improvement. Then go on to, facility-level criteria should characterize this level of care by features such as staffing, patient evaluation and review processes, and mix of patients. Patient-level criteria should identify specific clinical characteristics and treatment modalities.

MR. MULLER: On complex, complex can mean many things, so not too much wordsmithing. Are we meaning more complex or do we -- is that the implication here, based on what we're finding, especially going back to this comparison of, at least the way I read table three was these are far more complex patients, otherwise they wouldn't have payment rates at the outlier point, five, six times of the acute rate. So are we saying these have

to be more complex than what would be seen in the acute settings or just complex?

MR. HACKBARTH: It is a complication. I prefer to leave it the way it is here. If you add the word more then the reader anticipates that we're going to describe the relative, relative to what, in the ensuing paragraph, and we don't have the basis for doing that. So I understand your point but I think it would complicate matters to add more.

So draft recommendation A, all opposed?

All in favor?

Abstentions?

Okay, draft recommendation B. I think we can forgo the re-reading of it. All opposed?

All in favor?

Abstentions?

Okay, we are done.

Okay, we have a brief public comment period, and since we are well behind schedule and have a lengthy agenda for this afternoon, as always I want you to keep your comments brief and please avoid repeating a prior speaker's comments. I'm also going to ask that we limit comments to the two topics that we discussed this morning, namely the drug implementation issues and long-term care

hospitals. Thank you.

MR. KALMAN: Hello, my name is Ed Kalman. I'm general counsel for the National Association of Long-term Care Hospitals and I have two comments I would like to make. With regard to slide three which was a comparison of Medicare expenditures to different sites of care, acute hospitals and other post-acute levels of care I'd like to note that the long-term care hospital PPS system has a short-stay policy. That is the standardized is not applicable to all patients. CMS has stated in the preamble to its update rules that that's approximately 50 percent of the patients.

So therefore, in setting forth Medicare payments to these providers I would think it would be important that the entire payment system be referenced. For acute hospitals payment equals the standardized times the weight and certain other adjustments. For long-term care hospitals that's not the case. It's the standardized amount times the weight and a short-stay policy. So I would hope that you would consider that.

My second comment goes to the discussion on rehabilitation which I thought was quite constructive. It is the case that there are long-term care hospitals that are community resources, and this is mostly freestanding

long-term care hospitals, that serve rehabilitation patients, both sick rehabilitation patients and comprehensive rehabilitation patients. Disrupting them in their communities could have significant adverse effect on patterns of care. I want to underscore to you so you understand that. That means patterns of care as to crossover patients, because these institutions take care of long-stay patients many times that are on the juncture between Medicare and Medicaid, which is not a very hospitable place to patients. You're going to be discussing that this afternoon.

I do think, however, that the notion that these patient should be paid the appropriate rate is extremely important. When you discuss that in that portion of the chapter I would hope you would have some consideration to allowing these facilities to continue and to be paid for these patients and an IRF PPS rate in rehabilitation units within their hospitals, for which there is a need for congressional authority.

Otherwise, I'd like to state our association's complete agreement with the notion that there should be clearly-defined criteria. We're very happy that the staff has chosen to reference the QIOs as a vehicle and note that they can get up and running very soon.

Thank you very much.

MR. LAUGHLIN: Good afternoon, I'm Rod Laughlin. I'm president of Regency Hospital Company in Atlanta, Georgia. We operate 11 hospital-in-hospital LTCH hospitals around the country. I want to address the issue that these patients are routinely treated in the short-term acute-care hospitals.

It really gets back to your definition of treatment. I can look, and I do routinely every day when I decide where to look for an opportunity to build a new LTCH hospital, I pull the MedPAR data and I look at all the discharges for Medicare and commercial and everything else, and I look by length of stay and by DRG. There are about 175 different DRGs that an LTCH would typically treat so I can routinely access that data for people who stayed 15 days or more, 20 days or more, and what have you.

What I find that's proven true in looking at hundreds of hospitals across America is that 2 percent to 3 percent of their med-surg discharges will fall into the 175 DRGs that an LTCH could treat, and if you look at 15 to 20 days or longer, that group of people will have an average length of stay of between 24 and 26 days. It happens so often using those parameters that it's just

amazing.

What that means is that depending on the size of the hospital that we're dealing with, there are routinely 200 or 300 patients in that hospital that could benefit, apparently, by being in an LTCH, because they have some medical condition, often just simply multisystem failure which is very difficult to treat, that means they don't respond in the short-term hospital.

What we have found in the LTCH that makes a difference in the outcome -- and by the way, I'm getting an average of 55 percent to 65 percent of these patients home, I'm sending another 25 percent to SNF or rehab as quickly as they're medically strong enough to go. We are losing 11 percent to 12 percent, which is substantially better than the industry average of about 30 percent, and we're getting those people home because of the nursing hours and the respiratory therapy hours and the multidisciplinary program we're applying.

I am delivering, and Mutual will verify the fact that we have the highest case-mix index of the patients in the country. I have hospitals routinely just under the new PPS system treating a 1.4 to a 1.65 case-mix index, which is very, very high. We're selecting the sickest patients we can find from the post-hospital and anybody

else who refers in that community, and we're getting a substantial group home. But it's because I deliver eight to 12 nursing hours per patient day. And that's not aides. That's all licensed people -- based on the acuity of the individual patient. I also deliver five hours of respiratory therapy per respiratory day and two hours at PT/OT and speech across the total patient days. We run this program seven days a week. It doesn't slack off on the weekend. We're selecting very, very sick people and we're getting great results.

I believe that these criteria are the right direction to go because they will eliminate some abuses that I know very well, being in this industry, in certain LTCH hospitals. The PPS system is also going to eliminate some abuses and change behavior over time in the future.

What I would say to you today is, I don't know how you can make these decisions without getting the data on outcomes. Commissioner DeParle said, I would be willing to pay more for better quality. When I started in the LTCH business in 1992, obviously I saw that it was about saving short-term hospitals some money for patients that don't fit their mission, that require things they're not set up to provide. But what I have come to understand is that a properly-run clinical program in an LTCH can get

great outcomes for people and give them their lives back.

If you just throw money at the short-term acute PPS without requiring a change in the way those hospitals treat these patients, you won't get a difference in the outcome for people. I am in the LTCH business and I'm passionate about it because I've seen people get their lives back that were not responding even though they were in some of the best tertiary care hospitals in America. It's that 2 percent to 3 percent that we need to look at differently and I applaud you for going through the studies to get this information.

Thank you.

MR. HACKBARTH: Okay, we'll reconvene at 1:30.

[Whereupon, at 12:45 p.m., the meeting was recessed, to reconvene at 1:30 p.m., this same day.]

AFTERNOON SESSION [1:39 p.m.]

MR. HACKBARTH: We are currently running about 20 minutes behind schedule so we need to pick up the pace just a little bit. Several of the presentations we have this afternoon are basically informational in nature and I hope that we can move through them relatively quickly. I hope the presenters will not interpret that as a lack of interest in what they are presenting but rather just the practicalities of getting done on time.

First up this afternoon is a presentation on beneficiary financial resources and financial liability.

DR. ZABINSKI: We know that a primary goal of the Medicare program is to improve beneficiaries' access to care and we also know that financial burden due to out-of-pocket spending on health care plays a key role in beneficiaries' ability to access their care. So today I'm going to discuss the current state of beneficiaries' burden due to out-of-pocket spending and also look at whether that burden has been increasing or decreasing, and think about how that burden might change in the future.

Before getting into the results of my analysis I think it's important to cover some important points of my method. First of all, throughout my analysis I will define out-of-pocket spending as the sum of out-of-pocket

spending on four components: the cost-sharing from Medicare-covered services, the services that are not covered by Medicare, the Medicare Part B premium, and any out-of-pocket premiums on any supplemental insurance that a beneficiary has.

Of these four components, non-covered services have the largest share of out-of-pocket, accounting for about 50 percent of the total on average, followed by supplemental insurance premiums which are about 31 percent of the total out-of-pocket spending.

I'd like to say a little bit about the data I used. Generally I used two databases in my analysis, the MCBS cost and use file and the consumer expenditure survey, both from 2001. Both are annual databases using beneficiary's out-of-pocket spending over one year. The bulk of my, analysis uses the MCBS, but I did use the consumer expenditure survey, or the CES, for a small part of it.

The MCBS is an individual file whereas the CES is a household file. Because of this difference in the two files the results sometimes look a little bit different between the two files so I just thought I'd tell you about that ahead of time.

When I used the MCBS I excluded two groups of

beneficiaries. First of all, I excluded the institutionalized who are primarily people in nursing homes, and I also excluded beneficiaries who are in Medicare Advantage plans or other managed-care plans in the Medicare program. I excluded the institutionalized because they have no data on supplemental insurance premiums for supplemental insurance that they have, and their expenditure data on prescription drugs in somewhat unreliable.

I also excluded beneficiaries in the Medicare Advantage program, or at that time since I was using 2001 it was Medicare+Choice. But I excluded them because their health care expenditures tend to be under-reported relative to beneficiaries in the traditional Medicare program.

One other thing about the MCBS is it has a general problem of under-reporting of prescription drugs expenditures. But a using a method that I obtained from researchers at CMS I attempted to adjust for this under-reporting.

Now a little bit about my analysis when I used the CES. Now that analysis also excludes the institutionalized but that's because the institutionalized are not part of that survey in any way. I did not exclude

people who are in Medicare Advantage or any other managed care plans from the CES analysis because, first of all, you can't identify them on that survey. Also I don't think their under-reporting is as much of a problem on the CES as it is in the MCBS.

Finally, none of the results I'm going to present today reflect the impact of the recently passed MMA. The data that I have, as I said, were from 2001 and that was well before the MMA was even in existence.

Let's turn to my results. First let's look at the current state of burden from out-of-pocket spending for beneficiaries. This uses the MCBS. The most common measure of beneficiary's burden from out-of-pocket spending is beneficiary's annual out-of-pocket spending as a percentage of their income. Using the MCBS I found that the out-of-pocket spending as a percent of income has a mean of 20 percent and that's illustrated by the leftmost bar in this diagram.

I think at this point it's important to emphasize two facts. First of all, Medicare pays for over half of beneficiaries' health care cost so beneficiaries' out-of-pocket spending as a percent of income would probably be much higher if Medicare did not exist. Second of all, the mean value of 20 percent I really want to

emphasize is only one a number it hides substantial variation in this measure among beneficiaries. For example, we know that 10 percent of beneficiaries spent less than 2 percent of their income on health care, and that's illustrated by the bar for the 10th percentile in the diagram. At the same time, another 10 percent of beneficiaries spend more than 30 percent of income on health care and that's illustrated by the 90th percentile bar on the diagram to the very right.

Another issue regarding the mean of 20 percent is that it may be a little bit misleading measure of the burden for what you might call the typical beneficiary. For example, in this diagram we show a value of about 10 percent at the median or the 50th percentile. What that tells us is that half the beneficiaries actually less than 10 percent of their income on health care despite the average being 20 percent.

A relationship that has been frequently analyzed by researchers is the correlation between beneficiary's income and their burden from out-of-pocket spending. On this figure we show that as beneficiary's income increases in relation to the poverty line their out-of-pocket spending as a percentage of income tends to decline. For example, out-of-pocket spending as percentage of income

has an average of 45 percent among beneficiaries who are below the poverty line but an average of only 7 percent among beneficiaries with income greater than 400 percent of the poverty line. Now I'd like to turn to the concept of whether burden from out-of-pocket spending has increased among beneficiaries. This analysis consisted of looking at elderly households from the 1981, 1991, and 2001 consumer expenditure survey where I define an elderly household as a household has at least one member age 65 or older. The analysis excludes the disabled under-65 beneficiaries because you can't identify such beneficiaries on the consumer expenditure survey and that's why I only worked with the elderly.

The results of my analysis are kind indefinitive. I definitely can't determine whether the burden of out-of-pocket spending has increased or decreased. The answer depends on how you measure burden. For example, if we again use the measure of burden from the previous two slides, that being out-of-pocket spending as a percent of income, it appears that burden has increased substantially over the timeframe we're looking at, 1981 to 2001. Basically I found that the mean of this measure increased from 15 percent in 1981 to 26 percent in 2001 among the elderly households.

But using an alternative measure of burden in household income net of out-of-pocket spending I get a very different result. What this measure indicates is household income that is available to pay for goods and services after the household has paid for their health care. I found this measure stayed nearly constant in real terms from 1981 to 2001 lying in the $22,000 to $23,000 range in 2001 dollars. What this suggests is that burden from out-of-pocket spending has changed very little over this timeframe.

The reason we have these seemingly conflicting results from the previous slide versus this slide is that on the previous slide it reflects the fact that income increased by a slower rate or a smaller percentage than did out-of-pocket spending, while in this slide we reflect the fact that income increased by a greater magnitude than out-of-pocket spending even though income increased at a slower rate.

Next I'd like to consider how the burden from out-of-pocket spending may change in the future. I've identified two key factors that would likely affect beneficiaries' burden from out-of-pocket spending in the coming years. One is a decline in the prevalence, or at least the potential decline in the prevalence of employer-

sponsored insurance or ESI as a source of coverage to supplement Medicare. Such a decline will likely increase the overall out-of-pocket spending because ESI tends to be a relatively generous form of supplemental insurance.

The other factor is the prescription drug benefit in the MMA which should decrease out-of-pocket spending in the aggregate.

First let's look at the decline in the prevalence of employer-sponsored insurance. On the MCBS it shows that typically the decline in the availability of employer-sponsored insurance actually has been quite small amongst current beneficiaries. In this case I emphasize I'm talking about current beneficiaries. For example, the prevalence of ESI has dropped the most among beneficiaries age 65 to 74, yet the percentage in that age group with ESI decreased by only three points from 39 percent in 1993 to 36 percent in 2001.

However, other data show that a decline in the availability of ESI is likely to be a much larger problem among future retirees or people who have yet to enter Medicare. A survey by the Kaiser Family Foundation indicates that in 2003 10 percent of large firms that are defined as firms with at least 1,000 employees dropped coverage for future retirees. Moreover, 20 percent of

those large firms said they are least somewhat likely to drop coverage for future retirees over the next three years.

In addition, the percentage of people working in large firms is declining as well. That's an important fact because large firms are much for likely to offer ESI to retirees than are small firms so this trend will also reduce the number of beneficiaries with employer-sponsored insurance as a form of supplemental coverage.

Now you may be wondering what's so important about this decline or this potential decline in ESI. The issue is that ESI is, on average, the most generous and the most common form of supplemental insurance with 33 percent of beneficiaries having that type of supplementation. However, if the survey from the Kaiser Family Foundation is any indication it may no longer be the most common form of supplemental coverage in the future.

Now alternatives to having ESI as a form of supplementation include purchasing a Medigap plan, which is currently the option chosen by 28 percent of beneficiaries, or one can enroll in a Medicare Advantage or other managed-care option which at the time of the data that I have 16 percent of beneficiaries held, or a

beneficiary could go without supplemental coverage which is the status of 9 percent of beneficiaries. The key point is that having some of these options in lieu of ESI will likely result in higher out-of-pocket spending and could potentially affect their access to care.

Now let's consider the drug benefit under the MMA that will begin at 2006. The drug benefit will increase out-of-pocket spending for some beneficiaries but decrease it for others and on net should reduce beneficiaries' out-of-pocket spending in the aggregate. To get a strong understanding of how the drug benefit could affect out-of-pocket spending we should get an understanding of the cost sharing for which the beneficiary is responsible under the standard benefit.

On this slide I think it's easiest to work from the bottom up here. At the very bottom we have the annual premium of $420 in 2006 as estimated by CBO. Working up the diagram, the drug benefit has a deductible of $250. Then if a beneficiary's drug expenditures go above $250 the drug benefit bill pay 75 percent of the expenditures with a beneficiary facing a coinsurance of 25 percent. This lasts until the total expenditures on drugs reach a coverage limit of $2,250. Then if combined drug spending by a beneficiary in a program exceeds $2,250, the

beneficiary is then solely responsible for the next $2,850 in drug spending until reaching a catastrophic limit of $5,100. At that point the beneficiary would have $3,600 in out-of-pocket spending on drugs plus $420 for the premium. Finally, for drug expenditures beyond a catastrophic limit the program pays 95 percent of cost with the beneficiary paying the remainder.

Then to end my presentation I'd like to summarize result of my analysis of the impact that demographic characteristics can have on beneficiary's burden due to out-of-pocket spending. A motivation for this part of the analysis was that we were asked to examine the impact that demographics can have on out-of-pocket spending. The analysis consisted of comparing the burden of out-of-pocket spending for groups of beneficiaries who have the same characteristics with one key characteristic being different. For example, I compared men age 65 to 69 who have ESI or employer-sponsored insurance to women who are age 65 to 69 who also have ESI. This comparison allows us to get at least a sense of the impact that gender can have on the burden of out-of-pocket spending. Using similar analyses I also examined the impact that supplemental coverage, marital status, and age can have on burden. For each comparison I

made I measured burden with two variables that I used in this discussion. One is the out-of-pocket spending as a percentage of income, and the other is income net of out-of-pocket spending.

The results of my analysis revealed greater burden from out-of-pocket spending if a beneficiary is unmarried rather than marries, is a woman rather than a man, is older rather than younger, and has Medigap rather than ESI. In general the results were driven more by differences in income rather than differences in out-of-pocket spending. That is, characteristics that reflect relatively high burdens of out-of-pocket also tend to reflect relatively low incomes.

To close I'd like to say that this work is intended as an appendix to the June report. The purpose of the work is to compile a database that will allow MedPAC staff the capability to quickly examine the impacts of things like policy changes and to perform other analyses similar to this one.

MS. ROSENBLATT: I thought this was excellent. There's one thing, if it's possible to add to the chapter for the June report, the figure B-2 that you showed, out-of-pocket spending varying with the mean of 20 percent and then in the 90th, the highest people spending about 35

percent. You have a very interesting paragraph in there. You say, the average may not even provide a meaningful representation of the typical beneficiary. The average of 20 percent is twice as large as the median value of 10 percent.

Using the Jack Rowe rule that most people look only at the graphs, would it be possible to have a graph that takes out the extreme and looks at it from that perspective? I'm just thinking that because the mean is so different than the median, people who just look at the graphs are going to get walk away it's a 20 percent number. If we can avoid that I think that would be beneficial.

DR. ROWE: With respect to the emphasis on employee-sponsored insurance, which I think is appropriate, I have a sense that you may -- some of these data may exaggerate the number of Medicare beneficiaries who are retired who actually have ESI. You might want to consider the distinction between an employer offering insurance to retirees and an employer who just offers access to the network discounts that are in the plan for their active employees because does not subsidize the payment at all.

So that what happens is an employer might have a

full policy for their retirees and their retirees might pay some portion of the premium and the costs are covered. Then the employer says, I can't afford that anymore so here's what I'm going to do. I'm not going to give you insurance anymore, but we are going to give the lower rates that we get that Aetna, who is our insurer, or Wellpoint who's our insurer, has negotiated with the network, with the physicians and the hospitals or the pharmacy for that matter for the cost of the medicine. So you get to buy at the discounted rate but you have to pay the whole thing yourself.

Those people don't have insurance. You say that they have employer-sponsored insurance, ESI. They are not insured. They are paying everything out of their own pocket, but they have a discount. If you look at what's happening I believe a large proportion of employers are going to route.

DR. ZABINSKI: I think that's correct, yes.

DR. ROWE: When you call them and you say, do you have a retirement health benefit, their answer would be yes. But they really are not insuring their retirees and they're not paying anything out of the company.

So that definition, it might be worth going back to Kaiser and asking them if they differentiated, or

making some statement about that.

DR. ZABINSKI: Just about that, the information I have about who's got employer-sponsored insurance, that's from the MCBS. As far as whether there in a circumstance that you describe where the beneficiary is paying the entire premium you can't really tease it out fully. But the Kaiser Family Foundation study that I cited in a little bit different context also talks about this trend towards having a beneficiary pay the entire premium and I think we can mention that. I think that would be a real good idea.

MR. SMITH: Just very briefly. I wonder if we know anything about expenditures that don't get made. The next step here it would seem to me is, given the burden and whether it's growing or not -- I understand we don't know, but the distribution of the burden particularly as it affects particularly low-income beneficiaries would suggest or at least cause one to wonder whether or not there are expenditures that aren't being made. Part of looking at financial liability and the adequacy of the system in terms of what it tosses onto beneficiaries is trying to get a handle on foregone expenditures, expenditures that don't happen that should.

DR. ZABINSKI: Basically saying people that

should get care but don't?

MR. SMITH: Right. One of the things that Joan old us this morning thinking about getting ready for the drug benefit is, in some circumstances, confronted with a higher tier copay associated with a drug, the expenditure doesn't get made at all. That's an important piece of this puzzle. I'm sure we can't do it by the June report but it would be important in terms of understanding this burden to get an understanding of what the burden for medically-appropriate expenditures looks like and then figure out how much of that gets made.

DR. REISCHAUER: If we had that, we would have the answer to a lot of other questions.

MR. SMITH: It's not a trivial question or an easy one.

DR. NEWHOUSE: I have a suggestion for another chart or analysis that you may or may not be able to do in time for the June report. You followed the customary tradition of measuring annual out-of-pocket spending relative to annual income. That seems to me to be reasonably useful for someone who is cash-flow constrained, which would be not atypical in this population. But for a burden calculation it seems to me something on a longer-term basis is better because large

out-of-pocket medical doesn't necessarily happen every year. I think the MCBS has some kind of rotating panel, right?

DR. ZABINSKI: Right, basically one-third of the panel is new every year. People are in three years.

DR. NEWHOUSE: So I wonder if you could do a three-year analysis with what you're showing as percentage of spending as a percentage of income and so on for a three-year period instead of a one-year period to see how much of the skewness flattened out.

DR. ZABINSKI: Just a few thoughts on that. I really like the idea of doing multiple years is something that I think is a great idea. I have one concern about sample size. If you work with three years of data you'll end up with a sample of about 3,000 which for the entire group is fine. But if you start cutting into groups, I worry a little bit, like eight women 65 to 69 who have employer-sponsored insurance.

DR. NEWHOUSE: Either give it to me for the whole 3,000 or pool a couple years, pool a couple three-year samples.

DR. ZABINSKI: All right. I see what you mean. My other concern, maybe I'm confused about it right now and it's not as difficult as I think, but how to handle

people who switch categories. People age and they start in the 65 to 69 group in the first year, but then they turn 70 halfway through your three-year cycle, how does one classify them?

DR. NEWHOUSE: Adopt some convention, starting age or middle year age or something.

DR. ZABINSKI: I like the idea though.

DR. REISCHAUER: Dan, you mentioned at the beginning that the data here is not particularly good. Remind me what fraction of income is actually reported, 60 percent, 50 percent?

DR. ZABINSKI: I worked with somebody at CBO who shall remain nameless, but by his estimate it looks to be more like -- at least when he compared it to the current population survey, using that as a benchmark it's 12 percent, 13 percent too low.

DR. REISCHAUER: But the CPS is low too.

DR. ZABINSKI: Probably.

DR. REISCHAUER: I'm not criticizing it, it's just I would make a little bit more out of that.

Another thing I was really surprised about, and I look forward to aging here, in the sense that you said the CIP discovered that 9 percent of people in the CIP had assets over $1 million.

DR. ZABINSKI: So you think that's a lot? My take was that's not very many.

DR. REISCHAUER: It depends on what we're counting. If we're counting pension assets, particularly in a defined benefit, a capitalized value of a defined benefit plan it probably isn't.

DR. ZABINSKI: No, my understanding is that's not in there. Let me tell you why I think it's low, or my initial take was that it's low is that all these experts on retirement say you should have $1 million in assets when you retire to retire comfortably, and if only 9 percent of people are there, we're all in trouble.

DR. REISCHAUER: But those same experts say, most of you are going to be miserable. Should and are are two different things.

The other question I had is, on some of these what we do about dividing income and assets among the spouses? Because the medical expenditures you clearly can associate with an individual. The resources that that family unit has you can't. When you go to some of these later tables where you were looking at ESI versus Medigap I was wondering whether what I was looking at was pure or the ESI applied to a couple, some individuals and some couples mixed together. Whereas, the Medigap we know

applies only to an individual.

DR. ZABINSKI: If I follow what you're talking about, first of all, at the beginning I talk about assets, just talk about beneficiary's asset situation. But throughout the analysis I strictly rely on out-of-pocket spending relative to income.

DR. REISCHAUER: How do we do the income for a couple?

DR. ZABINSKI: What I did was, on the MCBS spending is recorded at the individual level. Now if somebody lives alone their income is also at an individual level. Now if they're married they report joint income with the spouse. What I did in that case is I divided the income by 1.26. You're asking, where did he come up with that?

DR. REISCHAUER: No, that's fine.

DR. ZABINSKI: I'll stop there then.

MS. RAPHAEL: I have a question on form. What determines if something goes into the appendix or becomes a full-fledged chapter in our June report?

DR. MILLER: On this one, there's actually a couple things that you've seen in the last year. We did a set of charts on a question that had come up on PLI -- I can't remember -- and we came through and had a set of

pictures to try and answer that question. There is some push to do some more of that. Instead of long dispositive chapters, that kind of thing, when you have an issue that lends itself to data, trying to do some of that.

That coupled with the fact that we're just breaking ground on this, we're not really talking about what we're doing. We're just painting a picture in then it's really building a database to go forward, pushed us to an appendix on this.

MR. HACKBARTH: This seems different in character. It's strictly descriptive. Most of our chapters, if they don't make policy recommendations, they go more into the policy issues. Here it's really strictly descriptive data.

DR. WOLTER: This is a little different line of question and it's not the intent of this chapter and perhaps it's already been done, but it would be interesting just to the see a summary of how policy affects this in terms of the percentage of out-of-pocket against the total charge; rural-urban, geographic variation, inpatient care, outpatient care, physician care. Because it seems to me from the data we've looked at over the last year or two that, for example, out-of-pocket spending in hospital outpatient I believe, as a

percentage, is higher than inpatient. I may not be remembering that right. But it would just be interesting to put a little package of that together. It might influence how one thinks about policy and out-of-pocket spending in the different sectors.

MR. HACKBARTH: Okay, thank you very much, Dan.

Next is dual eligible beneficiaries.

MS. MUTTI: This presentation will focus on several new analyses that we've done on dual eligibles. This complements the work that we've done earlier and will be part of a chapter, a draft of which you've received. We're adding these new analyses. One will be more detailed findings on the composition of the dual population and their spending patterns. Another one that Susanne will present on is how long have duals been duals. And a third one is our analysis of dual beneficiaries' access to care. While Dan is not initially presenting any information here he is available to answer questions because he did much of the work on the spending and composition of the dual population. In the future we hope to follow up on this work, looking particularly at the quality of care for dual beneficiaries. I know that was an interest of at least one member of the commission. We'd also like to look at policy options to improve their

access and quality and cost-effectiveness of their care. At the end of the presentation we look forward to hearing your comments not only on this material which we plan to incorporate in the chapter but also the whole chapter altogether.

As we discussed last month the dual population is not demographically homogenous, nor is it all equally costly to the Medicare program. As with non-dual spending, it's concentrated in a minority of beneficiaries. To get an understanding of the composition and the spending patterns of the population we divided the population into six subgroups, three under disabled and the same three categories under aged. We also aggregated the three categories for disabled as well as aged so you actually see eight lines of data there. Let me give credit, this work builds on stuff that Chris Hogan and Sandy Foot has done with respect to the disabled population.

A couple words about our method. First we pulled MCBS data over two sets of three years. This was to allow a sufficient sample for us to cut it as finely as this analysis required. Then we aside the beneficiaries to categories using a hierarchy. So that if people had mental or cognitive problems they were assigned to the

mental and cognitive subgroups regardless of whether they had difficulties with ADLs. So some of those people in the mental and cognitive category definitely have problems with activities of daily living. For those people assigned to the other categories, they do not have mental or cognitive problems as we measured it.

We identified people with mental and cognitive problems through a combination of survey responses, diagnosis information on claims, and prescription drug use. We sought to count only those who have serious mental illness including dementia and mental retardation. We did not try to capture people with depression only in this analysis. When assigning beneficiaries to a category based on limitations in activities of daily living we used survey results only.

As with our earlier analysis we found that just over one-third of the duals are disabled and under 65; about two-thirds are aged. Of the disabled, about half have mental or cognitive problems. Of the aged, about one-third have mental and cognitive problems. Perhaps surprisingly, just less than half of the aged duals have difficulty with less than two ADLs. The composition of duals has changed somewhat over the last few years. The proportion of duals under 65 and disabled has increased

from 28 percent to 34 percent. This appears roughly commensurate with the increase in the population of disabled overall in the Medicare population. There's also been a small increase in the portion of duals, aged and disabled combined, that are mentally and cognitively disabled.

By looking at aged and disabled dual beneficiaries together we can summarize our findings in another way; 39 percent have mental or cognitive limitations, 20 percent have difficult with two or more ADLs but do not have cognitive or mental problems, and over 40 percent have difficulty with less than two ADLs, but again, don't have mental or cognitive problems.

On this slide we look at Medicare spending levels by subgroup and compare them to non-duals with the same characters in the 1999-2001 time period. It is important to focus on the fact that here we're just presenting the Medicare spending totals, not total spending for the beneficiaries which would also include Medicaid spending and out-of-pocket spending. We find that the most costly group of duals here is the aged with mental and cognitive limitations, and then next comes the age with difficulties with two or more ADLs. The disabled overall are less costly to Medicare than the aged. And

certainly the least costly groups are those with difficulties with less than two ADLs.

When comparing Medicare spending for duals to non-duals, the disabled are statistically significantly different than their non-dual counterparts. However, Medicare spending on aged duals is not statistically significantly different than spending for non-duals in any of those subgroups, and the asterisks indicate the statistical significance on the slide there.

The similarity in Medicare spending for aged duals and non-duals should not mask the differences in total cost between the two populations however because the aged duals are more likely to be in nursing homes than aged non-duals, much of their spending is reflected in Medicaid spending and that's just not shown here.

We also took a look at how Medicare spending is distributed by service for duals compared to non-duals. For this analysis we just looked at those living in the community. On this chart the numbers reflect the percent of Medicare spending on each of the selected service. As you can see, the bulk of spending for both duals and non-duals is for hospital inpatient and physician care. I don't think that's very surprising. But we do see a few statistically significant differences between the two

groups, as indicated by the asterisks.

First, a greater proportionate of Medicare spending is devoted to home health care for duals than non-duals. And second, a great portion of spending is devoted to both physician and SNF care for non-duals as compared to duals.

This chart builds on the last one by adding two columns with data from the 1993 to 1995 period. This comparison allows assess us to see if there's been a change in spending patterns, and if there has been, is it consistent across both duals and non-duals, or does it just apply to one group. The asterisks here indicate statistically significant differences across the time period. So we can see for non-duals, the portion devoted to each service category changed. The portion spent on hospital and home health care declined, while the portion spent on physician, OPD, and SNF care went up.

Just to be sure you're following me here, for example, on hospital care in the '93 to '95 period, the non-duals hospital care had a portion of about 52.2 percent of their total Medicare spending. By '99 to '01 it declined to 49.1 percent. Spending for duals changed also. As with non-duals, there was a decline in the portion spent on home health and in increase in the

portion spent on physician and OPD care. There was no statistically significant change in the portion spent on SNF or inpatient care.

With that, let me turn it over to Susanne.

DR. SEAGRAVE: In response to a question from the Commission we analyzed the length of time dual eligible beneficiaries tend to remain on Medicaid. It is important for policymakers to understand the length of time beneficiaries remain on Medicaid because it affects whether, and if so how, they might want to consider tailoring policies such as policies that encourage care management to this particular population. A couple of caveats to note about this data. First, the data likely under-represents the medically needy dual eligibles as these beneficiaries are much more difficult to identify in administrative data. The other thing to note is that we included beneficiaries who had gaps in their Medicaid coverage in this, because the question that we were interested in looking at was how long in total people tended to remain on care. But the people who had gaps were in the minority in this data.

We found that dually eligible beneficiaries tended to remain on Medicaid for relatively long periods of time. This chart include Medicare beneficiaries who

first became eligible for Medicaid in 1994, 1995 or 1996, and we have data on these people through 2002. The total height of the first bar represents those people on Medicaid for less than or equal to one year. The second bar represents those on Medicaid for between one and two years and so on. The yellow sections on the top of the bars indicates the percentage of these beneficiaries who died in each of the time periods.

As you can see from the bar on the far right, a full 47 percent of these beneficiaries stayed on Medicaid for six to nine years, or through the end of 2002. I should note that some of these beneficiaries could have kept going on Medicaid past the period we were able to observe.

Conversely, only about 14 percent of these beneficiaries are in the bar on the far left, indicating that they were on Medicaid for one year or less. Of this 14 percent, about 40 percent of those died in the first year.

This analysis suggests that policymakers should keep in mind that dual eligibles tend to stay on Medicaid for relatively long periods of time, when designing policies targeted to this population. For example, these results may make care management options more meaningful

for this population.

Sarah Lowery will now discuss our findings regarding duals' access to care.

MS. LOWERY: Are dual eligibles able to access to health care they need? This question is particularly relevant for this population because, one, they exhibit characteristics associated with needing care, like they have limitations in activity of daily living, as well as they rate their health status poorly. And two, they often have characteristics that may hinder their ability to obtain care; for example, they are often poor and poorly educated.

One way to measure beneficiaries' access to care is by asking beneficiaries themselves to rate their access to care. Two surveys that do this are the CAHPS, the Consumer Assessment of Health Plan Survey, and the MCBS, both of which are administered by CMS. Results from these surveys in 2001 show that most duals report good access to health care. Of the questions that we analyzed, between 75 percent and 93 percent of dual eligible beneficiaries highly rate their access to care.

Medicare beneficiaries with other sources of supplemental coverage, such as employer-sponsored coverage or Medigap, rate their access to care more highly than

duals however. The exception to this is beneficiaries with other sources of public supplemental insurance, such as that from the Department of Veterans Affairs. These beneficiaries do not rate their care as statistically different than duals.

Beneficiaries without supplemental insurance, those with just Medicare. defined as Medicare-only beneficiaries, may or may not report better access to care than dual eligibles. Results depend on the access of care that is measured.

Now we'll look at these measures.

When asked if they had a usual source of care like a particular clinic, doctor, or nurse duals respond yes more often than Medicare-only beneficiaries. Duals access to personal doctors, nurses, or facilities appears to be good. Duals also report that they delay care due to cost less often than Medicare-only beneficiaries. Intuitively, this make sense since duals have little out-of-pocket liability. The majority have Medicaid coverage for services that Medicare does not cover and for cost-sharing associated with Medicare-covered benefits.

In response to questions asking how often they got immediate care when needed or got a prompt routine health care appointment, Medicare-only beneficiaries

responded usually or always more often than duals. This suggests that duals may have slightly more problems accessing both immediate and routine care than do beneficiaries with only Medicare. These differences are statistically significant but are not very great, as you can see from the slide.

When asked the broad, overarching question of whether the beneficiary had any problem getting necessary care we find conflicting results. This question to asked on both surveys and on the MCBS we find no difference between duals and Medicare-only beneficiaries responses. However, on CAHPS duals report that they have slightly more problems getting necessary health care than Medicare-only beneficiaries. Both duals and Medicare-only beneficiaries appear able to see a specialist when needed and both groups appear satisfied with their personal doctor, specialist and overall health care.

So overall when compared with Medicare-only beneficiaries duals have a slightly more difficult time accessing immediate and regular care, but they are more likely to have a usual source of care and less likely to delay care due to cost. Again, these differences are statistically significant but are generally small. Both groups rate their health care and providers highly.

It's important to keep in mind that both MCBS and CAHPS are beneficiary satisfaction surveys, which can be biased and influenced by factors such as socioeconomic status and education levels. For example, one bias that can affect survey responses is the tendency of respondents to answer in a way that they perceive to be consistent with societal norms rather than based on their own personal experience. Studies have shown that survey participants with lower income or education levels exhibit biases such as this, and therefore these demographic groups satisfaction with their access to health care may be overestimated. It is important to keep this in mind for duals in particular because they are poorer by definition and may often have lower education levels.

Another limitation of only analyzing survey data to determine whether beneficiaries have good access to health care is that these datasets are unable to describe whether beneficiaries received appropriate health care. We plan to look into this further, together with our work on quality.

Now we welcome your comments on this presentation and the draft chapter.

MR. HACKBARTH: Any questions or comments?

DR. REISCHAUER: The first few pages where you

are trying to lay out who's eligible for what I thought I understood until I read this. It's even more complicated than I thought, and I think you made it even more complicated than I now think it is, in the sense that what most people are interested in is the what, and then the who. By the what, they're the full dual eligibles, and there are a required budget and then there's an optional bunch. I don't know if the people between 73 percent and 100 percent of poverty which at state option can receive full dual, whether the state without a waiver can offer a more limited benefit package for those folks than to others. I don't think so. I know the medically needy they can, but I don't think they can for them.

But you make it sound like these guys are really QMBs that some states are deciding to give something else to, whereas, there's the required dual eligible folks, 73 percent of poverty and below, states have the option to expand that up to 100 percent of poverty and a number of states have. Then there's the QMBs, which federal law requires everybody below 100 percent to get it, and the SLIMBs, et cetera. I have a suggestion for maybe how to arrange the chart, if you think it makes sense.

I then had a question about the mental health payment rates. This is on page 24. In scenario A, is it

true that if the Medicaid rate is $50, Medicaid has to pay $12.50, but if the Medicaid payment rate is $49.99 it pays zero? Because I thought Medicaid didn't have to pay anything over it's own payment rate.

MS. MUTTI: Actually let me spend a moment thinking about that and I'll clarify that.

DR. WAKEFIELD: Is the PACE program just for dual eligibles or were you just taking about it when it's applied to dual eligibles? I couldn't tell. It's discussed on page 32.

MS. THOMAS: In order to participate in PACE you have to be Medicare or Medicaid. You don't have to be both but most people are, and there are processes to get capitation payments from each program. But if you're only Medicare, of course there's only a Medicare. If you're only Medicaid, there's only Medicaid. But typically, 95 percent of the folks in PACE are dual.

DR. REISCHAUER: In that complex chart, table two, under the ADLs the dual thing doesn't add to 100.

MS. MUTTI: I caught today too. It's supposed to be 45 percent on the first one.

DR. REISCHAUER: Then I would, the first time you mention the word Medicaid I would put parentheses or a comma, means-tested program. It isn't till about page

seven that you say that, and I think it brings more understanding to some of the things you're saying about income levels and other things early on.

MR. HACKBARTH: Thanks.

Next is purchasing strategies.

MS. MUTTI: Last month we presented our work plan and summary findings for our draft purchasing strategies chapter. As you may recall, the purpose of this effort is to explore the range of strategies that private purchasers and other governmental purchasers may be sing to improve the efficiency of health care delivery. Our thought here is that this experience may provide ideas for the management of the Medicare fee-for-service program.

Since the last meeting we have revised our findings, incorporating your comments as well as additional research. We have also added to the chapter a discussion focusing on the strategies used by the private sector to address concerns about the appropriateness and quality of imaging services. This includes a brief assessment of the extent to which the federal government is using similar strategies. Kevin will provide further detail on that in a moment.

Our final new part of the draft raises several

of the fundamental issues that must be addressed if these strategies are considered for fee-for-service Medicare, and Jill say that a bit about this. First, let me just turn it over to Kevin though and say that we look forward to getting your comments on the chapter as a whole at the conclusion.

DR. HAYES: We'll talk now about the imaging section of the chapter. One way to think about it is as a kind of case study. It gave us an opportunity focus in on a particular type of service, provide some additional detail on private insurers' purchasing strategies. The other thing it allowed us to do was to look for parallels or similarities between the strategies of private insurers and current activities of the federal government, either on the part of CMS or in the case of, as we'll get to in a minute, mammography facilities of the Food and Drug Administration.

So why imaging services otherwise? First off, we have the matter of last year's June report. Recall that we had a chapter there on growth and variation in the use of physician services. One type of service we paid particular attention to was imaging. It was a case where we found quite a bit of variation geographically in use of the services, and it raised questions, as other research

has done, about whether there is some overuse of these services.

The other reason to consider imaging services from a purchasing strategies standpoint has to do with the panel that we had at last month's meeting. From a staff standpoint our perception was that the panel generated a fair amount of discussion among commissioners and was overall well-received, so we wanted to try to summarize what the panelists said and then, as I say, link that to current federal policy.

So the next part of our plan here for this chapter is to just to summarize what we heard from the panelists. In general we can see that they talked about a number of different strategies. It's useful I think to categorize them into two groups. We have the first three strategies profiling, preauthorization, beneficiary education. These were strategies that we heard about otherwise in interviews with health plan executives. One way to perceive what the panelists said was that it wasn't anything particularly unique about imaging services with respect to these strategies.

On the other hand, the last three, the safety standards, privileging, and coding edits did come across as having been honed a fair amount to focus in on

particular issues surrounding imaging services. They really were intended to address half a dozen or so different problems that the private insurers had identified in the market areas where they are operating. They include such things as proliferation of imaging equipment, lack of familiarity with new imaging modalities on the part of some physicians, concerns about self-referral, direct-to-consumer marketing of imaging services, repetition of imaging studies, and poor quality of imaging equipment, or just in general concerns about the technical quality of imaging services.

What I'd like to do now is just briefly summarize what we said about those latter three strategies for the chapter. Turning first to the matter of safety standards and inspections, we heard about a study which showed that failure rates on inspections of imaging facilities approached 50 percent, depending upon the type of practitioner operating the facility. Different kinds of problems were identified, a couple of them had to do first off with the age of equipment; just use of old equipment, used equipment, that kind of thing. The other was incorrect equipment, wrong equipment for the job. We had the vivid example of dental equipment used for x-rays of toes.

So what we have here is a strategy that is essentially in two parts. We have, one, the development of standards, and the second has to do with the field work of actually inspecting the facilities. When we look at current activities of the federal government we see a couple of parallels here. The first has to do with the work of the Food and Drug Administration in inspecting on a regular basis some 9,000 or so outpatient imaging facilities. They do so under authority of the Mammography Quality Standards Act that was passed in 1992.

The other area where we see some similarities has to do with the rather extensive program of survey and certification that is administered by CMS. The standards involved here go by a couple of different names, one, conditions of participation, the other, conditions of coverage kind of depends on the type of the service and setting. But in any case, what we're talking here about is a set of standards primarily for institutional services, hospitals, SNFs, that kind of thing, some Part B coverage having to do with renal dialysis facilities. But the notable exception here is physician services that are not subject to survey and certification at all with the exception of the last item that's listed here which has to do with clinical laboratory services. Under authority of

the Clinical Laboratory Improvement Amendments passed in 1988 CMS is doing survey and certification of clinical labs, many of which are in physician offices. So that's the story with respect to this first strategy, standards and inspections.

Then we can turn to another strategy, privileging, which can be defined as a policy of restricting payment to certain physicians based on things like specialty, qualifications or other criteria. This strategy too is responding to concerns about technical quality as are the safety standards, but also concerns about proliferation of equipment and self-referral.

CMS has some experience with this kind of a strategy. The obvious example here has to do with the policy having to do with coverage for services provided by chiropractors. There is essentially one service covered here and that's manipulation of the spine. Other examples have the do with a recent policy adopted with power-operated vehicles, also known as scooters. Here because of some concerns about fraud and abuse and rapid acceleration and growth in use of these devices CMS has established some criteria saying that only selected physicians can order these things. This would be physicians specializing in rheumatology, physical

medicine, orthopedic surgery, or neurology.

The other thing that we could do here is to link the idea of privileging with limits on self-referral. As you know, under the Stark laws there are restrictions on self-referral. Physicians cannot referred Medicare or Medicaid patients to entities which they or members of their family have a financial interest. These entities covered by the law include radiology services, but other things too like laboratory services, physical therapy, home health, and durable medical equipment.

The topic of self-referral admittedly is a very complex one, one that we'll take on in the context of work on a report concerning specialty hospitals, a report that you'll hear about tomorrow. But suffice it to say for now that we have a contractor working on this with some legal expertise in the area. But for now let me just say that one way to think about what the panelists said last month in the context of self-referral is that they view their privileging policies as a way to fill a gap that's not addressed by Stark. That would be that if we think about Stark as covering things like referral to the lab down the street, the imaging center down the street, that leaves then the other form of self-referral, which is referral of patients to in-office equipment; the orthopedic surgeon

who has an MRI machine in the office. So we could view the privileging strategies of private insurers as a way to address that form of self-referral not addressed by Stark.

That then brings us to the third strategy here which is coding edits. This one from our perception seems to be the one that's most similar to current Medicare policy. Recall that these coding edits are rules that are invoked during claims processing to make decisions about whether or how much to pay for billed services. Medicare has a system, a mechanism in place for developing these edits called the correct coding initiative, a transparent process that allows for input from the physician community. The result is a set of edits that are in the public domain, and it turns out that private insurers often use those edits. They then add to them in a couple of different ways.

For example, they might have edits that compare billed services to practice guidelines. They might also make some payment adjustments when multiple services are billed on a single claim. A good example of this would be computed tomography services where they would pay a full payment for -- imagine a patient comes in for two CT services, one of the abdomen, another of the pelvis. They would pay the full rate for one of the procedures, but a

discounted rate on the second one.

Medicare has a similar policy like that now for surgical services, but nothing for anything other than that and certainly not for imaging services.

So just to wrap things up here, we have heard from a panel. We've heard about a number of ideas, see some parallels between what private insurers are doing and Medicare policy. The question now is, should we go further in learning more about ways to perhaps adapt these policies for the Medicare program?

Next steps in doing so would include things like looking more closing at what private insurers are doing, comparing that to Medicare and existing policy, and understanding better what the feasibility is of actually importing some of these strategies.

The other thing to learn about would be just effectiveness, and what kinds of savings experience the private insurers have had with these strategies, what the implications are for quality and that kind of thing.

Jill now is going to talk about the idea of next steps from a broader perspective on purchasing strategies overall.

DR. BERNSTEIN: Looking ahead to where we go from here, the chapter ends with a very brief overview of

some broad evaluation issues. The first have to do with the current structure of the Medicare program and the chapter includes a brief overview of some issues related to law and regulation and to Medicare's purchasing authority. The other issue look more closely at the specific issues surrounding individual purchasing strategies and what they might mean in fee-for-service Medicare.

A basic question is, how would different purchasing strategies affect Medicare beneficiaries? We would also want to know how a purchasing strategy might affect the delivery system that serves beneficiaries and therefore might affect their access to care. And finally, could the Medicare program administer a particular strategy effectively?

We look forward to your comments on this and the rest of the chapter.

MR. HACKBARTH: Questions or comments?

DR. NEWHOUSE: There was a suggestion made at one point in this chapter on the availability of CMS claims data to other carriers for purposes of profiling, and since in many markets many carriers have very small market shares it's not really feasible for them to profile. I was wondering if we should make a

recommendation to the Congress that they authorize that, since my understanding is that CMS is worried that that's beyond their pay grade to do.

MR. HACKBARTH: Any reaction to that?

MS. MUTTI: We definitely heard that from a number of people that we interviewed, that they would be anxious to get that data, and we understood that CMS was unclear whether they had the legal authority to do that. There was privacy issues raised, concern about people being able to identify beneficiaries. But the advocates of having access to that information pointed out that they thought that it could be done in a way so that beneficiaries' identification was suppressed. But I think some people are concerned about the physician identification being so available.

MR. FEEZOR: That was mentioned at the top of page 10, that gets into what she just said and would be a place if we want to insert that.

MR. HACKBARTH: Other questions, comments?

MR. FEEZOR: Mine dealt more with -- Kevin, first off thank you for your view on the imaging. We somehow need to really drive home just the growth of that even more than perhaps we do.

My comment that struck me most and I felt we

were maybe shortchanging our readers a bit was in the reference to the health resource accounts. We talk about conceptually what they're used for, but we don't mention the fact in terms of the pretax, post-tax. We don't get into any discussion on that, and I think that would be very helpful to have that spelled out a little bit more. And then particularly the ability to do any rollover on that, and whether or not we are talking about active versus passive income, since the latter is more applicable to retirees.

Then one other observation, and if didn't come out in your analysis or discussion with other third-party payers, but all on the centers of emphasis, centers of excellence I noticed that geographic distance was not listed as an issue that had to be dealt with. I know in a couple of programs that we looked at when I was on the payers' side, that was a very real thing, the ability to move large amounts of that specialty to areas that were more than 70 or 100 miles away frequently; was a big issue. One of the ways we dealt with that was basically coming up with an accompaniment benefit where you actually pay for families hotel for a brief period a time. If that was not found or any of the folks that you interviewed that was not an issue, then not. But otherwise, it seems

to me that's one of the things, real barriers to using the centers of excellence, centers of emphasis.

DR. WOLTER: I'd just underscore, think the self-referral issue is a very important issue and we do have areas that are well-defined where it's clearly identified as a conflict of interest, and then we have other areas where it remains not very well-defined. It is complicated but I think it's an important issue which is driving lots of investment in various parts of the health care sector today. So I'll be quite interested to see what your contractor comes up with and how we might approach defining that even more.

I think the other thing I would just mention in terms of approaches to the rapidly growing cost in imaging -- and I certainly don't have my hospital or physician or rural hat on right now -- but it is one of the highest margin activities in health care. I think that doesn't mean that people are necessarily doing a lot of inappropriate things. There's lots of reasons why imaging has grown and people need the service, but it is very high margin, so I think payment rates are certainly part of the issue.

DR. MILLER: Kevin said this but I'd just like to draw it out for people, and you've touched on it again

so I just want to say it. I think there's one path that we will pursue and plan to pursue where we're going to look at self-referral and talk about how it got where it is and how the rules apply. This gets particularly complicated because we're talking about in-office types of activities where self-referral gets incredibly complicated.

The point I just want people to track on is, what Kevin was reminding us that the panel said is, they go at that issue differently. So they may, instead of going through a self-referral exercise, go through a privileging exercise. I realize for Medicare that's a very complicated policy area. But I just wanted to draw that point for you, that for the private sector, some of these people go at that issue a little bit differently, which is not to say that we won't be taking that issue on. I just wanted to make sure that that point caught people's attention.

MR. HACKBARTH: Others?

Like Allen Feezor, I thought that maybe we could elaborate a little bit more on why we elected to include imaging as an example within this. I think we just cross-reference some previous Medicare work, but I think it might be helpful just to elaborate on the growth and the

like without prejudging in any way what policy measures, if any, ought to be taken.

But I do feel like this is a good area for us to explore next year and do intend to come back. Maybe we'll decide it is a fruitful area; maybe not. I don't know. But I think there are a number of reasons, not least of which is what we heard from the panel last time, that we ought to take a close look at this.

DR. NELSON: Somewhere see if you can insert a sentence about the role that direct-to-consumer advertising of these capabilities is playing, because I don't know how it is in other markets but there's sure a lot of stuff on the air about open CTs, and it's not unheard of for patients now to go into their physicians and say, my knee hurts, I want a CAT scan on it. The demand management piece of this is something that at least needs to be acknowledged.

DR. STOWERS: I just read an article again the other day about the increase in x-ray use and that kind of thing is connected to the PLI crisis in the country, and there's a lot more -- we've always had trouble measuring defensive medicine and all of that, but there are some things coming out about that particular crisis going across the country now, increasing the amount of images

and ordering them quickly than we did five or six years ago when that person asked for the knee or the abdominal pain or whatever. We're a lot quicker to get the higher-priced scanning and that kind of thing than we were a few years ago. That's definitely true in our emergency rooms.

MR. HACKBARTH: Anything else?

Okay, thank you.

Next is another descriptive piece on the characteristics of independent diagnostic testing facilities and ambulatory surgical centers.

MR. WINTER: Thank you. As Glenn said, I'll be talking about two types of facilities that focus on different kinds of outpatient services. One you've heard about before and that's ASCs. The other type we'll be discussing for the first time and that's independent diagnostic testing facilities or IDTFs. We'll be looking at IDTFs because they're a growing provider of imaging services and are an example of how CMS has attempted to regulate the provision of these services.

So here's the overview of the presentation. First I'll explain what IDTFs are and what services they provide. We'll look at the growth of spending for IDTF services, raise some policy questions and think about next steps. Then we'll turn our attention to a couple of ASC

related issues. We'll continue our analysis of the extent to which ASCs specialize in certain services, which will be useful as we think about the development of a new ASC payment system. Finally, we'll discuss the characteristics of markets in which ASCs are located.

A facility that provides diagnostic service that is independent of a hospital and physician office must enroll with Medicare as an IDTF. Later on I'll explain the details of this definition. Medicare spent about $740 million for IDTF services in 2002. This includes both program spending and beneficiary cost-sharing. Imaging procedures accounted for about 85 percent of all IDTF spending, or $630 million. The remainder was primarily for tests, such as electrocardiograms and cardiac stress tests.

To put this in perspective, total Medicare spending for imaging services paid under the physician fee schedule was about $8 billion in 2002. So IDTFs accounted for about 8 percent of imaging spending.

This chart shows the distribution of IDTF spending by type of service. MRI was the largest category at 41 percent, followed by tests, cardiac catheterization and related imaging, other echography, which is ultrasound, and CT, or computed tomography. IDTFs are

paid under the physician fee schedule at the same rates as physician offices. Under the fee schedule, Medicare makes separate payments for the technical component and professional component of a test unless both components are furnished by the same provider. The technical component covers the cost of the equipment and non-physician staff while the professional component covers the physician work involved.

As you've heard before in other contexts, spending on imaging services paid under the physician fee schedule has been growing rapidly. It increased by 27 percent between 2000 and 2002. Spending for the portion of these services provided in IDTFs grew more than three times as fast during this period. The fastest growth in IDTF services occurred among cardiac catheterization and related imaging, CT, and nuclear medicine. We identified 2,400 IDTF entities in 2002 using 2002 Medicare claims. This represented a 35 percent increase from 2000. Each entity may have more than one location which may be fixed or mobile, such as a trailer. We identified 3,600 separate locations in 2002 which is an average of almost 1.5 per entity.

We also looked at what kind of services high-volume IDTFs provided. We wanted to learn what share of

these facilities specialize in a single type of procedure. That is, they derived at least 90 percent of their Medicare revenue from a single procedure category. We found that only 30 percent specialize in one category of services, which was mostly MRI or tests.

We also plan to look at the geographic distribution of IDTFs and the characteristics of markets in which they're located.

The rapid growth of IDTF spending raises the following questions. Why did CMS create this category and how does CMS distinguish IDTFs from physician offices? What rules does CMS apply to IDTFs, and how are they monitored? Medicare created the IDTF category for freestanding diagnostic centers in 1998. Previously these entities were largely unregulated by CMS or the states. The Office of Inspector General and CMS had found evidence of fraudulent behavior and inappropriate use of services by freestanding centers. There were also safety and quality concerns. Thus, CMS developed the IDTF category and its rules to address these problems.

To elaborate on the definition I gave you earlier, a diagnostic center is considered to be independent of a hospital and physician office and thus required to enroll as an IDTF if it is not a physician

practice that is owned by one or more physicians or a hospital, if it primarily bills for diagnostic tests rather than other physician services such as evaluation and management, and if it provides diagnostic tests primarily to patients whose conditions are not treated by physicians in the practice. In other words, it's sole purpose is to provide diagnostic tests, services to patients who conditions are treated elsewhere.

A radiology practice is different in nature than other physician practices because it primarily performs and interprets radiological tests but does not treat patients' underlying conditions. Thus, CMS applies different criteria when deciding whether a radiology practice is a physician office. The radiology practice is exempt from enrolling as an IDTF if the practice is owned by a radiologist or hospital, the radiologists provide test interpretations at the location where the diagnostic tests are performed, and the practice primarily provides professional services of the radiologist.

Some diagnostic services are exempt from the IDTF rules. These are mammography, which is regulated by the FDA, certain tests furnished by audiologists, physical therapists, and clinical psychologists which do not require physician supervision, and clinical laboratory

tests which are regulated by the Clinical Laboratory Improvement Amendments.

IDTFs are subject to the following rules which do not apply to physician offices that furnish diagnostic tests. They're required to go through an enrollment process with the carrier in their your area. They must have at least one supervising physician who oversees the quality of the testing, the operation and calibration of the equipment, and the qualifications of the non-physician staff. The non-physician staff must be licensed by the state or certified by a national credentialing body. All procedures performed by an IDTF must be ordered in writing by the beneficiary's treating physician. And finally, the list of procedures they wish to provide must be approved by their carriers.

Before enrolling IDTFs in Medicare, the carriers must verify through document review and a site visit that the IDTF actually exists, that it meets the requirements that we mentioned on the previous slide, that the equipment it uses is properly maintained and calibrated. However, CMS does not specify the standards carriers should use in evaluating the equipment.

IDTFs are not subject to ongoing monitoring such as repeat site visits except under certain circumstances.

The OIG plans to review whether services provided by IDTFs are medically necessary, there is adequate physician supervision, and non-physician are properly licensed or certified. The IG's concern underscores why we're interested in how these facilities are monitored.

So where do we go next, both with regards to IDTFs and on the broader topic of imaging services? Presumably our overarching goal is to control growth in the cost and use of these services while at the same time ensuring access to appropriate high-quality care. This could be a difficult balance to achieve between these two objectives.

So what tools can we use to accomplish this goal? These could include some of the methods that CMS uses to regulate IDTFs as well as some of the private purchasing strategies we heard about earlier. We could also think about incorporating some of the methods that the federal government uses to regulate mammography and laboratory services.

Then finally, in what settings should we apply these tools? Should they be limited to freestanding facilities like IDTFs, or also apply to physician offices? At the end of the presentation we'd like to get your feedback on these questions.

Now I'll move on to the ASC topics. For our March report we tried to characterize ASCs by what services they provide. We used 2002 claims data to estimate the proportion of single specialty and multispecialty ASCs certified by Medicare. This is an important issue changes to the ASC payment system may affect single specialty and multispecialty facilities differently. For example, a large reduction in rates for eye procedures could have a bigger impact on an ophthalmology ASC than an ASC that performs a variety of procedures. It's also relevant because facilities that specialize in one type of procedure may be more efficient and thus have a different cost structure than a multispecialty facility.

Since the March report we started to track changes in the mix of ASCs over time and we'd like to share our results with you. I just briefly want to review our methodology. We selected high-volume ASCs, those that submitted at least 1,000 claims, so that we'd have an adequate sample size to look at, and we looked at their share of Medicare revenue related to each physician specialty. We define a single specialty ASC as one with at least 90 percent of revenue related to one physician specialty. The others we classified as multispecialty.

Using this threshold we found that about half of ASCs are single specialty, which is consistent with what an industry survey has found. In the future we may change our definition to one based on the type of procedures that ASC's provide rather than the specialty of the physician providing them. This would be more consistent with how we plan to categorize specialty hospitals as you'll hear about tomorrow.

So using 2000 data we identified 750 high-volume Medicare-certified ASCs, and we found that 56 percent were single specialty, mostly ophthalmology or gastroenterology. By 2002 the number of high-volume ASCs increased to over 1,200. While the number of single specialty ASCs increased, they declined as a share of all high-volume ASCs to 48 percent. This decline was driven by a steep drop in the share of ophthalmology ASCs from 37 to 27 percent. During the same period Medicare payments to ASCs for eye procedures did not increase as fast as payments for all procedures.

In previous MedPAC reports we've noted that ASCs tend to be concentrated in specific states. We've now started to drill down on what variables affect ASC location in specific markets. This should help us better understand the factors influencing ASC growth.

The first question is what geographic unit best approximates an ASC market area, a county, metropolitan statistical area or MSA, or a market defined by patterns of hospital use? We currently have a study underway that uses data on where an ASC's patients live to help define an ASC market area. In the meantime, we have used MSA and counties as proxies for ASC markets and looked at the characteristics of areas with different levels of ASC concentration. Our results from MSA and county analyses were similar so I'll only be presenting the MSA results.

We divided MSAs into quartiles based on the number of ASCs per 1,000 population in each area. We compared MSAs in the lowest quartile of ASC concentration to MSAs in the highest quartile. Areas with the most ASCs tended to have smaller average population size, faster population growth, lower managed-care penetration, higher poverty rate, and more hospital beds and surgeons. There was almost no difference between high and low ASC areas in terms of median income, the share of the population over 65, use of all Medicare services, and beneficiary risk scores.

Some of these results make sense. For example, it's not surprising that ASCs tend to be located in markets with faster population growth, which probably

indicates a growing market for health care services, with more surgeons who can do the surgical procedures, and lower managed-care penetration which might indicate looser provider networks.

However, some of these results are puzzling. For example, we would have expected ASCs to choose markets with higher median incomes and greater Medicare service use, which might indicate stronger demand for surgical services.

We also looked at the relationship between ASC location and the presence of state certificate of need laws that regulate ASC development. In 2002, 61 percent of ASCs were located in the 24 states without these requirements. These states accounted for 57 percent of the U.S. population and 56 percent of beneficiaries, so it doesn't appear that CON laws by themselves play a major role.

For our next steps we plan to use multivariate analyses to isolate the impact of variable while controlling for other factors. We also plan to the look at whether there are common factors that influence the location of ASCs and other specialized entities such as IDTFs and specialty hospitals.

Finally, we intend to examine whether markets

with high ASC concentration process are associated with greater overall use of surgical services. This study is part of our specialty hospital workplan which Carol and Julian will be discussing tomorrow.

This concludes my presentation and I look forward to your feedback and discussion.

DR. STOWERS: I just want to make a comment. If you level out for quality and the physician knows the facility and knows that it's going to provide essentially the same service as what is provided in the hospital, I think one thing that explains this growth and that sort of thing that I didn't see discussed in here was the fact that usually the upfront charge to the patients in these facilities is dramatically less than what it is in the hospital. So you may want to get that average charge data.

But even more than that, from the patient's perspective, the copay or amount that -- because it's Part B, or if the patient is a private pay patient or with some insurance is dramatically less. I referred to CAT scan last month that was $2,000 in the hospital, cost a total of $900 in one of these facilities. The patient's responsibility dropped from $1,000 to $1,100 down toe $390. So I just think that part of the growth I know out

in the rural community is just the fact that a lot of it is patient driven. They're convenient. They can get it at a more economical cost. As we get a broader part of our population that doesn't have that employee insurance and all the other things that they've had in the past this is becoming more and more attractive as an economical place to get their health care done.

DR. ROWE: I think while the name says diagnostic, some of the procedures that are done in the diagnostic vendors are actually therapeutic and not just diagnostic, such as getting coronary angiogram or an angioplasty. Is that the case?

MR. WINTER: I don't see any claims for angioplasties or stents. When they do cardiac catheterization it's just the angiogram. They bill for two things. They bill for placement of the catheter and the related imaging is just an angiogram. That's what's showing up in the claims.

DR. REISCHAUER: It might be interesting to do a case study of colonoscopy. Here's something that is newly covered, number one. Certainly is pretty far down on the list of the things that people want to have done, is pretty far up on the list of things that people should have done and aren't having done, are done in outpatient

settings and in ASCs, and probably, although I don't know, much more efficiently done in a non-hospital setting, I mean from the standpoint of the individual. It's less of a hurdle and all that. To look at both the amount of this that's going on in these kinds of settings versus hospitals over a period of time and see if we can ferret out something. I don't think you can argue that there's a lot of inappropriate colonoscopy going on. So we just get rid of that issue and try and look at the pure what's left in the market.

MR. HACKBARTH: So this would be a way of testing whether these new types of facilities are increasing access, and attractive?

DR. REISCHAUER: More attractive to individuals, things like that.

MR. WINTER: The last couple of times we've looked at that, at the trends in site of care for different kinds of services, colonoscopy is increasing in ASC essays relative to outpatient department and physician office, but we haven't updated that in about a year and-a-half or two years, so we could look at that again.

DR. REISCHAUER: We can look across metropolitan areas and see if an infusion of ASCs creates greater utilization.

DR. NELSON: A comment and a question. The comment, I understand why these are commingled, these two categories of facilities for the purposes of your research. But if this were to appear in the form of chapters the audiences for it would almost certainly say that ambulatory surgical centers are vastly different from than independent testing facilities. One provides therapeutic services, the other diagnostic and so forth. So after the work is done, if it sees the light of day in publication I would hope that they would be separated in some fashion.

DR. MILLER: This was completely a convenience of organizing some information for the purposes of presentation here. We had a couple things that were responding to questions, couple of things were getting off the ground. Ariel was doing both of them so we just packaged it for -- these things are headed to different homes in the long run.

DR. NELSON: I assumed that that was the case but I wanted reassurance and thank you for that.

The second is that, I wonder the degree to which these facilities has grown is a product of managed-care contracts? Where, for example, my managed-care entity when I or a member of my family needs an imaging service

we go to one of these and it's because that's whom they have a contract with, rather than selecting hospital facilities to contract with.

That may not be as much a factor in Medicare+Choice but their existence and growth may be a product of managed-care penetration. I don't know and I don't know that it's worth doing a lot of digging to find out, but if there's an easy way to correlate those two it might be interesting.

MR. WINTER: As we did with the characteristics of ASC markets we're also going to look at what are the characteristics of markets with lots of IDTFs and few IDTFs, and one of those factors we'll look at is managed-care penetration. So we can try to get at that at least broadly speaking.

MR. MULLER: My question is essentially the same. If they have these costs and convenience attributes, how are private payers incentivizing the use of them, the ASCs, the diagnostic facilities and so forth? That in a sense is a test case because they have clear financial incentives to do so, if in fact this steers patients towards a lower-cost or a higher benefit type of setting. So if there's any evidence that we have that there's clear incentives in that market to drive people in

this direction versus the hospital outpatient setting and so forth. That would be useful to see as an example of the questions we're asking.

MR. WINTER: We'll look into that.

MS. ROSENBLATT: I don't know how you get statistically at this issue but Ray and I were just having a side conversation here. There is something different about these ambulatory surgical centers in terms of the ambiance versus a hospital. I really think that -- I'll count myself in. Depending on what I'm having done, I'd rather go to an ambulatory surgical center just because there's a different environment than there is in a hospital. I have a feeling I'm not unique in that.

MR. WINTER: We've recently some site visits to ASCs in the D.C. area, two endoscopy centers and a multispecialty facility and they're very nice. My son recently had surgery at an ASC in Montgomery County and it was also a very positive experience, so I can see the attraction. Maybe not for him.

MS. ROSENBLATT: I've been to one in Beverly Hills where it looked more like a hospital spa.

DR. ROWE: I don't know much about Beverly Hills I'm just a guy from Hartford, Connecticut, but I would say a couple -- while ambulatory surgery centers are

attractive and many of them that's because they're new because of this growth. They're different in a number of ways. Often the cost is lower because the workforce is not an organized bargaining unit whereas in hospitals they ordinarily are. That's one of the other differences, not that that should guide our policy one way or the other.

Secondly, there's very little training that goes on in these facilities. There are very few residents in these facilities. Usually when the procedures occur in the hospital outpatient department, the residents are rotating there, et cetera. These are often in remote locations.

I think, thirdly, the patient population is different. Alice is a good example of a healthy, young woman who can go to an ambulatory surgery center. A frail, older Medicare beneficiary with multiple comorbidities is not as well managed always in that kind of an institution, particularly if the procedure carries greater risk of an adverse event because of the condition of the patient.

So before we get irrationally exuberant about these beautiful new spas and/or ASC, I think they play a role. It's okay that there's not much training as long as there's enough training, colonoscopies or whatever it is,

for the residents to get the training that they need to be able to take care of Medicare beneficiaries. They don't need to be there for every case. So they do play an important role, but it's part of the picture and has to be seen as part of the picture.

MR. WINTER: Just to make a note here to Jack, our research on patient mix differences between ASCs and outpatient departments supports what you're saying about the frailer and sicker patients go to outpatient departments.

MS. ROSENBLATT: If I could just make one statement in my defense here before I get connected with Beverly Hills. This is probably another issue that we need to be careful about. I was ill when I went to that Beverly Hills ambulatory surgical center. It was done under doctor's advice and if I had it to do over again I would have done the procedure in a hospital, not at the ambulatory surgical center. So I really do think patients like myself are being sent to the wrong venue at times.

MR. MULLER: Along those lines, some of the states that have more restrictions on things -- there's a reason that they do ophthalmology and those more simple procedures, is literally you have one case that goes sour in one of these settings because somebody went there and

there wasn't the appropriate backup, that usually then leads to some kind of regulatory fever to stop their explosion. So I know you don't have as much -- it's kind of hard to -- your variable is more CON and non-CON, and I'm not sure there's any good way of sorting out a variable there that has a little bit more power than just the on-off switch of whether you have CON or not. But sometimes you do see that, that the regulatory climate does change when some more complex case is done and then something happens.

MR. DeBUSK: From a device standpoint, the roles that ambulatory surgery centers play today will be completely different in the future because of the research and development and the dollars that are being spent today on devices and what have you is around the 23-hour stay in the surgery center. A great deal is going on there with that. They're even doing hips at Duke University on an outpatient basis now. So that is going to change.

MR. HACKBARTH: Anybody else?

Okay, thank you very much.

Next is hospice care.

MS. BOCCUTI: Good afternoon. In this presentation I'm going to review a few of the points that Sarah raised in the last meeting and note some growth

trends in the hospice provider community. Then I'm going to discuss some payment refinements that have been proposed, and finally, I'd like to leave plenty of time for the Commission to discuss these issues and comment on the draft chapter.

In brief, hospice is a set of palliative care benefits for terminally ill beneficiaries with a prognosis of six months or less to live if their illness runs an expected course. The services covered within the hospice benefit includes skilled nursing, therapy, home aide, homemaking, some physician services, nutrition counseling, medical social services, bereavement and pastoral care, respite care, prescription drugs, DME, and medical supplies. These services may only be provided for palliative indications because beneficiaries who elect hospice care must forego curative treatment for their terminal illness. However, Medicare continues to cover curative care for conditions unrelated to the terminal illness.

Once a beneficiary enrolls in hospice care, the agency caring for the patient is paid a fixed amount daily for that patient regardless of how often an agency staff person visits the patient. 95 percent of payments are made at the routine health care level. The remaining 5

percent of payments are higher and are made when patients are receiving inpatient care, continuous health care, or respite care.

There are two kinds of payment caps. Although most agencies do not receive them, some agencies have publicly noted in their investor reports that they've exceeded Medicare's total annual payment cap, which in 2003 was about $18,700 per served beneficiary. The hospice payment system has no outlier payments. It also has no case-mix adjustment. Under current law daily payments are automatically updated annually based on the hospital marketbasket.

Growth in the use of the hospice benefit has been substantial. Among fee-for-service beneficiaries who died hospice has grown from about 16 percent in 1998 to 25 percent in 2002. The average number of days in hospice, which is generally the number of days beneficiaries are in hospice before they die, has increased to 55 days. The median, however, has remained constant due to the steady share of beneficiaries who are in hospice less than a week.

Recalling Sarah's presentation last month, growth in hospice use has been greatest among several types of beneficiaries, those that are the oldest, those

with non-cancer diagnoses, and those who reside in nursing facilities. It seems clear that in many cases we're talking about the same patients. That is, beneficiaries who reside in nursing homes are more likely to be older and have terminal illnesses other than cancer, and with all these factors have a longer length of stay.

Finally, with more people enrolling in hospice and having longer hospice stays on average Medicare spending on hospice has increased substantially. CMS's Office of the Actuary estimates Medicare outlays to have doubled between 2000 and 2003.

So the growth in hospice can be due to several factors. First, there appears to be an increase in the demand for hospice care. It's a form of care appropriate for the dying population and beneficiaries and physicians are likely accepting and appreciating it more. Indeed it was in past years, and likely still is, underused by Medicare beneficiaries with terminal illness. CMS has also made efforts through publications to physicians to promote the use of hospice care by appropriate beneficiaries.

Second, new provider entry into the market, which I'll get to in a minute, indicates that the financial environment for providing hospice care is likely

very favorable.

This table on this slide shows the types of hospice providers in the industry. As you can see, not-for-profit programs remain the largest share of the industry but their share has dropped slightly each year. Moving down to the hospice types, we see four types: freestanding, home health, hospital and SNF-based. I want to make it clear here that the term freestanding is sometimes a bit of a misnomer. It does not necessarily indicate that it's a brick and mortar freestanding building. But rather it means that the hospice is not based on another type of provider. Also for clarity, hospital-based facilities do not necessarily provide care in a hospital. They're simply owned by a hospital and may provide services in patient homes. Freestanding facilities compose the largest share of hospice agencies as most for-profit agencies are freestanding hospices.

Just as the number of beneficiaries using hospice has increased, so has the number of hospices. As you can see in this slide, the number of for-profit facilities has grown 25 percent, significantly more than facilities with other types of ownership. Freestanding facilities have also shown considerable growth. CMS collects this kind of data on an ongoing basis and they

reported to us that growth in 2004 is continuing along these same trends. CMS stated to us that provider growth is primarily due to new facilities entering the market.

However, some investor reports and articles in the business trade press have noted acquisition of not-for-profits by for-profits. Keep in mind that because hospice benefits are usually provided in patients' homes, the hospice industry can also grow through increases in its capacity. We have found that the number of high-volume hospice agencies is increasing while the number of low-volume hospices is declining.

This final slide lists an array of policy options and considerations that have been proposed by various scholars and organizations including MedPAC in the past. First here we have case mix. Case-mix adjustments attempt a refine provider payments to reflect the costs for furnishing services to a given impatient. In doing so, case-mix adjustments can improve access to care for patients with high cost care needs. Because the hospice payment system does not have a case-mix adjustment, hospices have financial incentives to enroll patients whose costs are expected to be low and deny enrollment to those with high expected care costs.

An article that was published in last week's

Journal of the American Geriatric Society revealed that some hospices deny admission based on indicators that they may have high service costs. Specifically, 63 out of 100 California hospices surveyed in this study denied admission based on at least one reason. Reasons for denying patient admissions included their receiving total parental nutrition, or receiving tube feedings, or radiotherapy, or chemotherapy, or transfusions, or lack of a caregiver in the home. This study found that the larger the hospice, the less likely they were to deny admission based on these kinds of criteria.

Hospice representatives also told us that agencies which do not feel that they have the resources to care for a patient do sometimes deny enrollment. Indeed, some expensive services such as chemotherapy were not factored into hospice cost estimations when the benefit was first established because they were not use in a palliative way. Costs for the hospice benefit have not been recalibrated to reflect any changes in hospice care practice patterns.

Next we have length of stay. Payment adjustments related to length of stay have also been suggested. Agencies with shorter lengths of stay have higher average daily costs because the initial and the

first day are most costly. Some have suggested special payments for the first and last day of care. This could potentially be paired with payment adjustments from long hospice stays.

MedPAC analysis has found that patients in for-profit facilities have, on average, longer lengths of stay than those in not-for-profit facilities.

Next on the list, rural adjustment. Another article published last week confirms other studies which find that urban areas have higher rates of hospice use than rural areas. Rural hospices also have lower volume on average than urban hospices. This low volume may raise hospices' cost per case and some have suggested that Medicare payments should account for these differences.

Type of residence. Some observers have noted that hospice care for patients in nursing homes may be less costly than for patients who live at home. The industry has noted, for example, that a hospice can save on transportation cost when serving several patients within the same nursing home.

For dually eligible patients, hospice agencies receive payments from both Medicaid and Medicare. The hospice then contracts with the nursing facility to provide the room and board. Further research on service

costs and total payments for hospice patients in nursing facilities may inform payment refinement for this population.

Outlier payments. Outlier payments have been suggested to cover the cost of patients with unusually high service costs. Along the same lines as case-mix issue, outlier payments could assist with access to care for patients on expensive therapies such as palliative chemotherapy. Hospices are paid on a per-diem basis but there are no visit number requirements as long as the hospice follows the patient's plan of care. It might be useful for Medicare to collect more data on the number content of visits per patient as it does with home health delivery. This information would address provider accountability concerns and also help Medicare understand the cost of providing hospice care.

And then to quality. Another area which the Commission may want to explore is quality improvement and reporting. Updating Medicare's conditions of participation to include quality measurement and quality improvement activities could be helpful. Most agencies seek accreditation and in doing so meet quality improvement requirements. As in other provider settings, the results of quality measurement could be reported

publicly through a Medicare initiative. Some quality measures that some hospice providers are using include whether the patient was comfortable or had effective pain management, and whether the patient's choice of place of death were followed.

Under eligibility, some experts have noted that the six-month prognosis requirement can be a barrier to accessing appropriate hospice care. That is, people who wish to give up all curative care for their illness are unable to enter hospice if their physician feels unable to predict their death accurately. Some have suggested that hospice eligibility take acuity levels into account and diagnoses as well so that people with terminal illnesses that have less predictable diagnoses could receive the advantage of hospice care before it's too late to benefit fully.

Finally, managed care. Last month, Sarah discussed the payment issues surrounding hospice care for beneficiaries in managed care. In review, beneficiaries who elect hospice care must receive their palliative care from a hospice agency rather than from their managed care plan. Plans receive a reduced monthly payment for hospice patients but are no longer at risk for all their Medicare-covered benefits. This payment circumstance deters plans

from developing and providing palliative care and encourages a disruption in the patient's care. Some managed care plans have begun developing innovative end-of-life care programs but Medicare's payment policy does not support the use of such programs. This payment structure has also been found to increase Medicare costs and add a high level of administrative complexity to plan payments.

That concludes my presentation. I would be happy to answer any questions.

DR. WAKEFIELD: You mentioned earlier in your comments that your data show that the number of low-volume hospices is declining. Do you have a sense of where those low-volume hospices are in terms of geographic distribution? So in other words, are they in places where you already have maybe one or two or three other alternatives available in a large urban area with a higher volume of hospice services, or do you have a sense that some of those or a lot of them might be low-volume hospices that exist in rural areas, so that we might be losing access to that set of services more broadly to -- albeit sparse, but to populations nevertheless?

I was interested in your comment about the fixed overhead low volume issue. You cited some article that

have been published recently about that. Obviously we've looked at those relationships before in terms of making recommendations about refining payment policies to better align them, given those circumstances and the hospital care. So I'm interested in that point as well. But for starters, any descriptive info on the geographic distribution.

MS. BOCCUTI: I wish I could, and I'll try and look for it in other places. The place where I got the information on declining enrollment low-volume and increasing enrollment in high-volume hospices, or the number of hospices. It's not enrollment -- is from the Federal Register listing. While it's broken down urban, rural, it's not cross-tabbed that way so I can't figure that out. But I'll look in other areas. I think that the article that I brought up doesn't look across time, but I'll look at that again to see whether there's a decline.

But I bet that if I look a little harder I could come up with some of that or talk a little bit further with CMS, because they have the data and we have to figure out what to ask for and how to get it. So I can look into that. Did that answer your second question as well?

DR. WAKEFIELD: It did.

MS. BOCCUTI: It's not a situation where I can

say that it's impossible to get.

DR. WAKEFIELD: Even on the issue of low volume, you may not be able to go there either.

DR. ROWE: This was very interesting and I think we're making real progress. I have a couple points, some of which I've said before but just to reiterate.

First of all, I think the data and the information on length to stay deserves a little more analysis. You say that the length of stay went up to 55 days in 2002. The table 6.3 shows it at 52 days.

MS. BOCCUTI: It should be 55.

DR. ROWE: But even if it is up to 55 and you say the median is constant, the median is actually declining from 18 to 17 to 16, and the 25th quartiles is about the same. So really the point is here that there are an increasing number of very long stay, and that's what's going on. The 25th quartile is about the same. So I think it's worth just giving people a little bit more information about that so they don't have to connect all the dots themselves, because they headline otherwise is going to be, average length of stay increasing, and it's artificial. There are a small number of people who have very long stays, and that's a good thing I think. But it's just a little more information.

The second thing is, I don't believe we should have a cap, a monetary cap on a benefit that we all agree the greater use of it is better. There is cognitive dissonance for me when we say we want to increase the length of stay in hospice and then we have a benefit that has a financial cap. Because what you are going to do is have more and more people get up to the cap just before they die and then get kicked out of the hospice. So it just doesn't make any sense to me, if I understand that there is in fact indeed a financial cap. So I would need to understand better how that works. But to have a slide that says there is a financial cap and --

MS. BOCCUTI: Let me say a couple things about the cap. You're right, we haven't gone into a policy analysis about the use of the cap. It came with the benefit when it was first established to allay concerns about it going widely out-of-control and being a budget issue. It is not common to hit the caps, but it is happening.

DR. ROWE: I would think it's happening with that small proportion of the people with the very long stays that are bringing up the mean.

MS. BOCCUTI: It's for one agency. It's on an agency by agency basis, and it's their total number of

patients. So it's not an outlier.

DR. ROWE: I see. Maybe that was described in detail. I missed it.

MS. BOCCUTI: So what it's saying is if an agency hits the cap then their payments have exceeded the cap.

DR. ROWE: I interpreted it, and I may not be the only one, as a benefit cap on a beneficiary, so I apologize.

I would agree that the managed care situation is archaic and I think managed care companies are just going to go develop better programs with respect to care at the end of life. To whatever extent you want more Medicare beneficiaries in managed care, that will be a problem. But I would agree with that.

I do think that the last thing I'll say and we said this before, the six months requirement, which is basically asking people to walk through a door that says over it, abandon hope all ye who enter here, is not the way people think about themselves and their lives. A hundred years ago when I was practicing medicine I would say to people, you're not responding to these treatments. It doesn't mean we won't keep trying. I'm talking to my colleagues. Some other things may come up and we're going

to do everything we can, but it's time to start thinking about what if you don't respond, and there are things that you should be thinking about and talking with your family about, and there are other approaches to treatment that you might find helpful. You don't just say, sign this paper.

MS. BOCCUTI: That is a unique eligibility requirement to the Medicare hospice program. In private plans they don't often require that kind of a signature.

MR. HACKBARTH: Here again, it was a provision that was added I think strictly out of fear of the cost. Sheila will know all of this firsthand.

MS. BURKE: Let me just go back to '83 when we did this. The challenge at the time was that we really didn't understand nor fully appreciate how people would experience this benefit and how the benefit would be utilized. There was little experience in this country. Connecticut was one of the few places where it was occurring. We looked to Great Britain for essentially a lot of the stuff that was coming out of there, and there were a number of fears.

One, there were tremendous fears about drugs. There was this great issue we were going to create an entire nation of heroin addicts. There was a tremendous

fear but what we didn't know about palliative care.

Secondly, there are a concern that people would bounce. That they would choose this without acknowledging that they were making a choice about this as compared to curative care. There was a sense at the time that people had to in fact -- that you needed to encourage people to make those decisions. It was a crude way of doing that.

We also didn't really know what the timeframe was, whether it was six months, whether it was two months, whether it was a week, whether it was eight weeks. So what you've seen over the years is a growing acceptance of that as a method of care and a willingness to essentially make these transitions, although the lengths of stay are still too short. People tend to choose to late, for one of the reasons you suggest, which is people hold out hope. People want to know that there is in fact that opportunity, and making that transition, making the decision between seeking curative care and accepting and making a decision to seek supportive care is a very difficult one, so people don't make it, as you know better than anyone.

So it was at the time an attempt to get a benefit in place with little understanding of how people would use it, and trying to control the fear around what

the cost would be, what the utilization would be, who would choose it, why they would choose it. And also, that you wouldn't literally have people this week do hospice, next week decide they want to go back in traditional care. So it was trying to create an environment in which that bounding didn't take place.

We are way beyond that, and the refinements that are suggested here, and a greater appreciation and understanding clearly is what has to happen. But it was done with the best of intentions given how little we knew and our intention to do the best we could with what we knew at the time.

MS. RAPHAEL: I think there is something else that happened and it is not as prevalent today, but in the last five to six years there has been a lot of OIG reviews of the six-month requirement and a number of hospices were cited for having cases that didn't fit in because the physician had not prognosticated accurately, which is very difficult to do anyway. I think that has had a chilling effect which takes a longer time to dissipate than one would think, even though that has receded and there's been a CMS proclamation, go forth and don't be inhibited by this unduly. I still see a lot of hospices being very skittish about this particular requirement. So it's

almost become a more forceful part of the program in the last few years.

MR. HACKBARTH: Do we have sufficient information from outside the Medicare program, whether it's private payers or other countries, whatever, at this point, that we could say this requirement can be eliminated without dire consequences, financial or otherwise?

DR. ROWE: I've been looking at this recently and I don't believe so. I think that what happened for a long time is many health plans followed Medicare's policies with their eligibility requirements, as they do with respect to coverage of things. It's easy to defend and who knew to do it differently. Now people at least in our firm are starting to look at this a little differently. I don't think we've accumulated enough experience, but I think a reasonable policy recommendation would be to change the six-month requirement on the part of physicians to 12 months. Twelve months is really very different and a might relieve some of the concerns that Carol has just indicated.

I think that there could be a statement about the fact that curative care could continue to be offered but some recognition of the fact that you're in a

different stage. But this business about promising never to ever let anybody give you anything that might be interpreted as curative is just too much to ask people. I'm sure there are people in the field, and I'm not in the field, who have experience with this. But I do think these recent cases have been a problem and I think 12 months would give us a lot more room.

MS. BURKE: I think there are a number of pieces in this. One is the piece in terms of the determination that you are seeking palliative as compared to curative care and that conscious decision to sign off. The second is the cap. The third is the six-month. You could imagine modifying one of those without putting the others at risk.

For example, you could go to 12 months, leave the other pieces in place and begin to understand adjustments to that and still probably not run the risk of the program or the benefit going out of control. The question is which of those pieces to move before you move the other to see what the result would be. If that's the great inhibitor at the moment, maybe doing that to 12 without removing the requirement they make a decision or the cap, or just the cap based on some better understanding of acuity, might be the way to begin to

manipulate those pieces without great risk.

MS. RAPHAEL: There's been much more erosion of the demarcation between curative and palliative and I think we've dealt with that. I don't think the cap is a major barrier from my knowledge nationally. I think the six-month is.

And one other point that you made I think is a barrier, which is if you don't have a family member who can participate, that is a barrier. We have many Medicare beneficiaries who are widowed and don't have a family member or don't have a child living in close proximity. Anyway, I think that we should focus on the six-month because I think that remains as the major issue.

DR. NELSON: Carol, you said that there has been erosion of the demarcation between curative and palliative. Would you clarify that for me? Use congestive heart failure as a case in point, where it might be damn hard to say what was palliative in terms of medication.

MS. RAPHAEL: Congestive heart failure is a problem for many reasons because you tend to have very great difficulty in predicting what the length of lifespan will be for congestive heart failure. That and Alzheimer's patients are the most difficult to predict.

But I think in terms of using chemotherapy, it's no longer prohibited to do chemotherapy for people who are in hospice, and I think that's what I meant. So for cancer patients there's less of these barriers.

DR. ROWE: But regardless of whether or not Medicare prohibits it, you're still asking the patient to sign a document which says -- and I don't think that document has changed any in the last 20 years. So that's the barrier that we're concerned about, less than the clinical practice barrier. We need some advice about how to handle that I think.

DR. REISCHAUER: In a sense the length and the cap are redundant at some point. The longer you make it -- if you say it can be up to a year -- the more likely it is that the cap will be constraining rather than the days will be constraining. So I think in a way --

DR. NEWHOUSE: No, because you can keep going with successive periods of eligibility.

DR. REISCHAUER: But it's during a year. The cap is for a year, average payment per beneficiary over the year.

DR. NEWHOUSE: But as I understand it, the proposal was --

DR. REISCHAUER: If the average rate got up at

175 days from 55 days I think we'd hit the cap.

DR. NEWHOUSE: But as I understood it, it was just to ask the physician to certify that the patient would likely die within a year. But that doesn't necessarily mean that the average use is going to go up. It puts the physician less at risk.

DR. REISCHAUER: You don't have to worry if the doesn't. But if you're fearful that extending that time is going to lead to growth in the average time span of beneficiaries, then I'm just saying that there is a connection between these two and you shouldn't get overly worried. Just keep one. Or I'm not that worried about your proposal is what I'm basically saying.

DR. ROWE: I'm not worried about worrying you about my proposal. Because you don't want to spend the money and I want the patients to be in the hospice.

DR. REISCHAUER: But we have to remember that the latest RAND study suggests that people who participate in this cost 12 to 18 percent more than those who don't.

MS. BOCCUTI: Depending on the diagnosis.

DR. ROWE: I thought it was 4 percent.

MS. BOCCUTI: That's overall. He had a different diagnosis in mind when he was saying that.

DR. ROWE: Actually what he had in mind was that

I hadn't read the study.

[Laughter.]

DR. REISCHAUER: I thought you hadn't, and neither had I, but we could then have a conversation about it.

The other observation or question I'd like to ask you is, with the Medicare drug benefit going into effect, if we keep the payment system the same, in effect aren't we boosting the margins of these entities? Because one of the costs that they've been paying disappears or not?

MS. BOCCUTI: The per diem payment always was meant to cover the palliative care prescription drugs. Now if a patient has drug coverage it doesn't mean that they're going to go and get those drugs -- they might get them elsewhere, but the benefit still covers the drugs. So it's going to have covered it just as it did before the Medicare drug benefit.

DR. REISCHAUER: But I was thinking, if I came in and I was a member of this plan it wouldn't be paying for the drugs?

MS. BOCCUTI: No. It's my understanding that the hospice benefit would because that's always covered the drugs anyway.

The only issued to bring up relative to the drug benefit is that --

DR. REISCHAUER: So when you go into hospice then you have to stop paying your premium?

MS. BOCCUTI: Unless you want it for non-palliative care drugs.

DR. NEWHOUSE: Something else may happen to you that you can in fact curative care for.

DR. REISCHAUER: Is this going to be complicated.

MS. BURKE: The drugs in some cases are unique enough that they're unlikely to be on a formulary that you would use in the normal course. It depends on the nature of the drugs used in the hospice. If they're pain control, it would depend on what's in the formulary for the basic drug benefit. You may still need things that the hospice wouldn't in the normal course provide unrelated to your --

MS. BOCCUTI: Right, if you have gout or --

MS. BURKE: Gout or any number of those things. That would still be under the drug benefit.

MS. BOCCUTI: Maybe this is what you're saying. The drug benefit, the person probably has higher cost sharing than what's in the hospice benefit. The hospice

benefit is nil. So before the Medicare drug benefit there was obvious financial advantage if the patient had a terminal illness, there might be some incentive for them to enroll in hospice to help with covering the oral pain medications, if they didn't otherwise have drug coverage. But that still may exist, and I have no data about the demand relating to a drug benefit. But that could still exist given that even if the person does have drug coverage it's still more financially beneficial to have their drugs covered in the benefit. So that's really the only interplay between the two.

MR. HACKBARTH: Any others?

Okay.

DR. ROWE: What are we going to do, make recommendations?

MR. HACKBARTH: Not at this point, but we'll take this up next year and in our next cycle and then make recommendations.

Okay, we're going to have a quick clause while we change the mic here.

The last item today is chronic kidney disease.

MS. RAY: Good afternoon. Recall that at last month's meeting, Joan, Karen, Rachel and I discussed with you issues associated with implementing the chronic care

improvement program, Section 721 of the MMA. Also recall that we will be including this analysis in our June 2004 report. We have revised the chapter to reflect your comments from the March meeting, and please let Sarah Thomas know if you have any additional comments.

In your mailing materials this month we included in the revised chapter a case study on the potential of care coordination services to improve the quality of care for patients with chronic kidney disease. The last portion of the chapter includes the case study, and our objective for today's session is the focus in on this case study.

So let me just go ahead and set some context here. The target conditions set forth by Section 721 are diabetes, congestive heart failure, and chronic obstructive pulmonary disease. Chronic kidney disease patients will most likely be among the participants of this program, at least some of them. Diabetes is the leading cause of renal failure. About 45 percent of incident dialysis patients have diabetes, and about 30 percent have congestive heart failure.

Let me just to say here at this point that CMS's RFP to implement Section 721, however, excludes patients with end-stage renal disease. It does not exclude

patients however before they progress to end-stage, so chronic kidney disease patients again will most likely be included among the participants.

This case study discusses some of the issues surrounding chronic kidney disease that policymakers may want to consider when implementing Section 721. So one of the questions that we try to address is, does care coordination have the potential to improve the care for these patients?

The other thing I wanted to mention was, why did we choose chronic kidney disease for our case study? We clearly could have selected other chronic conditions. We selected chronic kidney disease because of the Commission's longstanding interest in improving the quality of care furnished to renal patients.

So let me define up front, what is chronic kidney disease? People generally reach end-stage renal disease as a result of chronic progressive kidney disease. the national Kidney Foundation in their recent guideline defines and divides chronic kidney disease into five stages. That definition was included in the mailing materials. Stage five is permanent renal failure, ESRD. In stage three, the National Kidney Foundation recommends evaluating and treating complications of chronic kidney

disease, and in stage four preparing patients for renal replacement therapy. As I previously said, the underlying disease that cause progressive kidney failure, diabetes and hypertension, at least diabetes is clearly a target conditions and these folks will most likely participate in the program 721.

Why the interest in the potential of care coordination for kidney disease? As the title mentions, Healthy People 2010, one of its objectives is to reduce new cases end-stage renal disease. ESRD, particularly dialysis, is costly. Most patients who are ESRD are on dialysis. There are approximately 300,000 dialysis patients. Patients are hospitalized frequently -- about twice a year -- and hospitalization and mortality rates have remained high and relatively unchanged during the past decade. ESRD patients fit the profile of groups who might benefit from care coordination as well as chronic kidney disease patients, as I will show you. And finally, ESRD has a negative impact on patients' quality of life.

Our review of the literature suggests that delaying or preventing end-stage renal disease may be possible. It may be accomplished by better care of complications of chronic kidney disease, like anemia, for example. Also, better management of comorbidities like

diabetes and hypertension and other cardiovascular conditions.

It's worth pointing out here that patients with chronic kidney disease are more likely to die of cardiovascular causes than to progressed to ESRD. It's also worth mentioning here that there are several programs that do focus on the pre-dialysis population. One in particular is a large HMO in Southern California, and another is actually an alliance, a western New York alliance of insurers and providers. Both programs attempt to identify chronic kidney disease patients when they're in stage three and four and then refer them to a renal team that's composed of nurses, physicians, dietitians and social workers. The focus of the pre-ESRD care is on complications CKD, including anemia, placing vascular, particularly AV fistulas, on proper nutrition, better management of comorbidities, and patient education.

Another reason we are interested in the potential of care coordination is to better prepare -- and this is during the pre-ESRD period -- those stage four chronic kidney disease patients who will progress to permanent renal failure. There's some evidence in the literature to suggest that morbidity and mortality of ESRD can be reduced if the comorbidities and underlying causes

are better managed.

Again, we're talking about here surgically placing an AV fistula, which takes several months to do so, and providing education about the different renal replacement therapy options, including home dialysis and kidney transplantation.

Your mailing materials reviewed some of the literature that suggests that ESRD morbidity and mortality is reduced for patients who are referred to a renal team earlier. To examine the potential of earlier intervention among chronic kidney disease patients we contracted with Direct Research LLC to follow chronic kidney disease patients in the one year prior and the one year after they first started dialysis. The goal of the study was to look at the use and services and spending based on the timing of the patient's first visit to a provider with expertise in nephrology, and Chris Hogan here will talk about the benefits that he used to do so.

DR. HOGAN: My job was to find these people in the claims and then track their costs and use of services. You have to keep in mind when you look at the results, this is a retrospective study. We started from the first date of dialysis, then we looked backward to the pre-ESRD period, and forward into the ESRD period to track service

use and costs.

Probably the most important bullet point on this whole page is the next to the last. Mostly the only people we can find are the elderly, and that's because if you qualify for Medicare services based on ESRD only, you start dialysis before you're on the Medicare program, we can't see your claims. So we ad to find people who were already Medicare enrolled and then look at their claims before and after dialysis.

To make this as clean as possible, we took Medicare's official dataset that tracks end-stage renal disease patients and matched it up against the claims to make sure that we agreed with Medicare as to the initial date of dialysis.

So Nancy asked me to look at a few indicators of service, use and quality. Mainly we wanted to see whether the patient was seen by a nephrologist before the onset of end-stage renal disease, how soon before, how long before, and then what happened prior to and after? Particularly, did they get some kidney disease related treatments prior to the onset of ESRD, and what happened to them after ESRD began.

You have to keep in mind a few things. This is sort of a rough-cut study. We looked for any mention of a

physician specialty that being a nephrologist and physician specialty in Medicare is self-reported, so it's self-reporting nephrologist. And if you had even one visit we counted you as having had a consultation with a nephrologist.

We have no way to make this population look like the average incident ESRD patient because all we can do is track the people who were already in Medicare before the onset of ESRD. Probably most importantly, we did no risk adjustment. This is how the claims shake out as you track these people before and after the onset of ESRD. So we didn't look for the comorbidities. And the numbers we show you probably will not match anybody else's numbers because it's a very unusual population in that it's very elderly for an ESRD population. That's the only population for whom we could find claims.

MS. RAY: So Chris classified our study population into four groups based on the number of months between their first visit to a nephrologist and the start of dialysis. Those four groups are, they first saw a nephrologist on or after dialysis, within 4 months before dialysis, between four and 12 months before dialysis, and more than 12 months before dialysis. So when I say late referral patients I typically mean those folks who didn't

see a nephrologist until on or after they started dialysis. And the early referral patients are typically those that saw a nephrologist more than 12 months before they started dialysis.

DR. REISCHAUER: Just a question, somebody who's 66 and has first dialysis at age 65 and six months -- you're shaking your head.

DR. HOGAN: Actually, to make it as clean as possible, I required them to have two years of Medicare entitlement prior to the onset of dialysis. So they actually had to be 67 before they started dialysis.

DR. REISCHAUER: Conceivably they could have seen a nephrologist at age 48.

DR. HOGAN: That's correct.

MS. RAY: That's right. This is just in the period before dialysis.

DR. HOGAN: It's really the two years prior to onset. And of course, if they were disabled they could have been younger.

MS. RAY: Right. So I just wanted to reiterate what Chris had said, that the results that we are going to present to you are not representative of all incident dialysis patients because of the selection methods that we used. Our study population is older on average than all

incident patients.

Second, as Chris also pointed out, these results are not adjusted for potential differences in demographic and clinical characteristics between our four groups.

So this pie chart shows you that 40 percent of all patients saw a nephrologist more than 12 months before they started dialysis. That's the good news. The not so great news is that 45 percent did not see a nephrologist until four months before dialysis onset.

Chris also looked at when a patient first had a claim for chronic kidney disease; that is, ICD-9-585, which is chronic renal failure. 51 percent had a claim with that diagnosis code more than 12 months before the start of dialysis, and 18 percent had such a claim four to 12 months before the start of dialysis, and 28 percent had a claim one day to four months before the start of dialysis.

Finally, another interesting piece of information I'd like to mention that Chris just ran out for us is the diagnosis of chronic kidney disease overall among the Medicare beneficiaries. What Chris did was he identified patients with at least two claims for that ICD-9 of 585 which we are using as a proxy for chronic kidney disease, in a given year. So that diagnosis has increased

from 0.9 percent in 1996 to 1.6 percent in 2002.

Why is it increasing? The incidence of ESRD is increasing somewhat. And it could also be due to the increased awareness of chronic kidney disease.

DR. ROWE: Is that age adjusted?

MS. RAY: No.

DR. HOGAN: But it's a relatively short time period.

MS. RAY: This is '96 to 2002.

DR. ROWE: The average age of Medicare beneficiaries --

DR. HOGAN: Crept up a bit, but not very much over that period.

MS. RAY: Some moving along to looking at the use of services and outcomes of the study population. In this table of contrasted service use and outcomes for the early referral patients, those who saw a nephrologist more than 12 months before dialysis and the late referral, those whose saw a nephrologist on or after the start of dialysis. You will stay differences in the proportion of patients who received at least one medication for chronic kidney disease complications like anemia or bone disease. This would be an injectable medication. So it would be erythropoietin, for example, for anemia.

Rates of hospitalization in the one month before dialysis are high for both groups, but yet again are less for early referral patients. Use of AV fistula at least one month before dialysis is 30 percent for the early referral versus 10 percent for the late referral patients. Finally, there was a modest difference in mortality one year after dialysis, 25 percent versus 30 percent.

Turning our thoughts to spending, we do find modest differences in spending, $32,000 for late referral patients versus $27,000, and that was spent in the year prior to dialysis. Again, there is approximately a $5,000 difference in the one-year after dialysis between these two groups. You'll note that most of the difference in the one year before dialysis stems from the inpatient spending. Again that tracks back to the previous chart on the rates of hospitalization in the one month before dialysis.

Now this is spending for our entire study population. This tracks spending on a monthly basis. So minus 12 is the twelfth month before dialysis, and plus 12 is 12 months after dialysis. The minus one is that one month before dialysis. You will see that spending peaks in that month. When you look at this same bar chart, separating out the early versus late referral patients,

the biggest difference you will see is in the month prior to dialysis, particularly the inpatient spending.

So there's no surprise here that spending goes up once they become dialysis, and we've already spoken about the spike in inpatient costs in the one month prior to them becoming end-stage renal disease. So then at issue here is the potential of care coordination programs to reduce the hospitalization rate before and even after dialysis, and the impact on spending after the program fees would be included in the analysis.

So let me make just a couple of brief conclusions. The literature suggests that earlier intervention and the better management of patients with chronic kidney disease may in some cases delay or prevent ESRD. Our results showed that -- again, our results are not representative of all incident dialysis patients -- but earlier referral of CKD patients to a nephrologist may reduce the morbidity and mortality associated with ESRD. Care coordination programs as configured under the law may provide opportunities to promote earlier intervention and improve management of stage three and stage four chronic kidney disease.

Next steps that we could think of include evaluating how well the contractors of 721 improve the

outcomes of patients with chronic kidney disease, and to examine the potential of different care approaches to improve the quality of care for these patients.

We'd be happy to take comments about this topic.

DR. REISCHAUER: This is going to sound a little gory. When we are comparing the costs, I'm wondering should you take out the cost associated with the people who died? The point is, if you looked at this over two years and you kept the panel the same then they would have zero cost in year two and that's not the way one wants to look at whether Medicare is getting a benefit or not from this. But if you think there's the last year of life problem and every Medicare beneficiary is going to face it sometime. Chris, you've probably thought about this a lot more than I have.

DR. HOGAN: I can offer some comments. One, of all the Medicare beneficiaries with high end-of-life cost, ESRD patients have the highest. They almost always die in the hospital, so end-of-life costs are very important for this population. My second thought was, the elderly ESRD patients have an astronomical mortality rate, 30 percent a year die in this population. The average for all ESRD is about 17 percent, and the younger ESRD is about 12 percent. So to have struck the elderly who died from the

cost series entirely -- once they die we don't count them in the denominator anymore, so we don't let the average cost trail off with a bunch of zeroes on the end. We do take the months post-death out of the denominator when we calculate our rates.

But it seemed like such an important component of cost that it was a judgment call to leave them in, but it seemed like a reasonable judgment call to leave them in. We could certainly rerun the numbers, exclude the decedents. You'll see a lot lower series, but I'm not sure that that's the more relevant series.

DR. ROWE: A couple questions. I think this is great that we're doing this, obviously. Why didn't you include transplant? The really elegant way to handle these patients is never to have them dialyzed but to have them go right into a transplant, if they're seen well enough ahead of time and get the work -- so I'm talking about patients who were transplanted but never dialyzed.

DR. HOGAN: Never came up.

DR. ROWE: Because that's really the way to do it. You have a family member who wants to donate. The patient's renal failure is getting worse. Dialysis is terrible, so you transplant the patient.

MS. RAY: I had considered that, and we can

certainly do that.

DR. ROWE: Good; thank you.

MS. RAY: But we did put in rates of peritoneal dialysis, and you'll notice with those rates of peritoneal dialysis how much lower they are than all incident dialysis patients, again because of the age of our population. We're dealing with folks who are much older on average than your incident population, so rates of kidney transplantation will be even lower among our study population. That was my one thought of why I did not choose to do that, but we certainly can. It's worth looking at.

DR. ROWE: If you're looking at care management, I think that whether they were seen by a nutritionist, which there should be a claim for, would be a good measure.

DR. HOGAN: That benefit only got covered recently. So it's such a long time series to pool enough people to find --

DR. ROWE: But if you an epoch of the data in which it's covered, because the thing that the nephrologist does, after confirming that you have chronic kidney disease, is send you to a nutritionist so that you can start to get on the right diet, which is really what

it's all about, and then controlling your blood pressure obviously. So that would be a nice marker.

The third is, I think one problem with the logic here, and you're very smart and I'm probably wrong here but that's okay, I'm not easily embarrassed. You noticed that 25 percent mortality in the year after dialysis started in the ones that had been seen by a nephrologist and a 30 percent in the ones that hadn't, and you come up with a statement that says there may be a benefit to mortality. But let me see if I got this right. If you see a nephrologist early then you're likely to be put on dialysis earlier. That is, if you didn't see a nephrologist until the time that you start dialysis or afterward, I bet your creatinine is higher when you're starting on dialysis than if you had seen a nephrologist a year or two ahead of time and they were watching and waiting.

If it's year after the start of dialysis and dialysis is beginning earlier, then you would expect a lower mortality rate in that first 12 months because the people aren't as far advanced and as sick. So there's something wrong with my logic and you tell me what it is.

DR. HOGAN: I'm absolutely amazed that we have numbers that show that it's much better to be referred to

a nephrologist and you're disagreeing with us.

DR. ROWE: I'm an insurance salesman. I used to be a nephrologist.

[Laughter.]

DR. HOGAN: But the logic is it is very difficult to draw a causal inference out of --

DR. ROWE: If you have the serum creatinine values, I would bet that the serum creatinine at the outset of the dialysis under people who saw a nephrologist ahead of time is lower. So I would take this statement out about the mortality. I don't think you can say anything about mortality.

DR. HOGAN: This is as another tough call methodologically because it was a retrospective study. Your point is well taken. We took a crack at finding all the CKD patients and then thinking of running -- at least to find the prevalence and running forward to see what happened to them. That would be a different study to do that.

We also took just an informal look at not risk adjustment, per se, but looking at a lot of values for the patients who saw the specialists and who didn't and it looked like the specialist was seeing the sicker patients. So perhaps we could resolve this with a little more risk

adjustment to try and figure out --

DR. ROWE: Up until you do a little more I would stay away from statement, because -- you may be right but we're really not confident that you're right until we do a little more study.

DR. NEWHOUSE: I agree with Jack. I think there's going to be a temptation to interpret it causally if it's out there.

I had a picky, technical comment and a picky, technical question. On the power cancellations, which it looks like Chris did, the picky, technical comment is we should say what the assumption is on type II error, which wasn't there.

DR. HOGAN: Yes, I believe that's correct.

DR. NEWHOUSE: The question is, you show samples that would be needed for inferences in later years, and to do that you need the intertemporal correlation, unless you're just using the actual year to year spending.

DR. HOGAN: This is such a hard question.

MR. HACKBARTH: I was going to ask you the same thing if Joe didn't.

[Laughter.]

DR. HOGAN: We can go down this path but it leads to all sorts of very difficult --

DR. NEWHOUSE: I know, but it turns out that even seemingly relatively small intertemporal correlations matter a lot for power calculations.

DR. HOGAN: Yes, the power calculation that you saw was one year at a time, period.

DR. NEWHOUSE: That's what I suspected.

DR. HOGAN: It was the simplest possible thing to do. It is not clear how the care coordination demo is going to be evaluated. The potential impact of care coordination on the mortality rate makes it a very difficult thing to evaluate, because if I've suppressed the mortality rate in year one I'm left with --

DR. NEWHOUSE: No, it's not the mortality rate. I'm willing to let you assume that the mortality rate -- maybe I shouldn't. You're saying you don't want to assume the mortality as independent of the rate of spending.

DR. HOGAN: I don't know what to assume, and I've asked a lot of people and I haven't got a good answer.

DR. NEWHOUSE: You can get a number on the intertemporal correlation. That's not hard to do. And you can put that into a power calculation. But then to make sense of it you would need some kind of Independence assumption and that's probably not there. But the number

that's here is not right either. Maybe you just don't want to do the downstream, the second year after start, third year after start, numbers.

DR. HOGAN: I'm sorry, tell me why that number is not right.

DR. NEWHOUSE: Because basically observing two people for each of one year is better than observing one person for two years because they're not independent.

DR. HOGAN: Yes, so what I --

DR. NEWHOUSE: And you're observing the same people going forward.

DR. HOGAN: Right. I completely admit to doing the simplest possible thing and to ignoring that. But I never got clear direction even from the Federal Register notice as to whether the evaluation is going to be done on were your costs in year three separate from -- I think I must be misunderstanding what you're asking.

DR. NEWHOUSE: No, I'm assuming that somebody is going to want to know the episode cost.

DR. HOGAN: The cumulative three-year cost is what you would rather have seen?

DR. NEWHOUSE: Yes.

DR. HOGAN: I would love to do that calculation. And you want to see that in the report as opposed to a

year at a time?

DR. NEWHOUSE: The one year will be the year at a time, but, yes.

DR. HOGAN: You would like to see the three years cumulative done properly.

DR. NEWHOUSE: Yes, because if you are doing one year at a time on the same people, those calculations are not independent.

DR. HOGAN: Yes. I will take that as the go-ahead and go and do that.

DR, MILLER: Can we get an estimate on how much it's going to cost to find this out?

[Laughter.]

DR. STOWERS: I may be jumping ahead here too, but when we looked at what the cost was for a year and that kind of thing, it seems like to me what we're looking at from a cost standpoint is the cost-effectiveness of chronic care management or chronic disease management. So we've got X number of dollars here, if we take that to the final step what would be the cost that was added on to Medicare if this patient had been in some type of a managed care program or management program or whatever? Because it's the net net that's going to make a difference here at to whether it was a cost effective thing for the

Medicare program to do or not.

So I think if we don't take this logic to the next step in this chapter somehow then it's not been much guidance as to whether or not this was a good program to have or not to have. Only from cost, not from quality of care or whatever. But I think we need to somehow make that last step at least in some kind of a discussion that everything you see here in savings is not savings, if in fact they've been in a new added-on expense chronic care program. So we're taking a glance at this chart like we just saved $5,000 here. But we haven't because we've incurred a new expense by contracting with these individuals or whatever company or management company or whatever.

DR. MILLER: I think I follow your point. We shouldn't be talking about this as clear savings if our hypothesis is that somebody is going to need some kind of management. There's a cost to that.

MS. RAPHAEL: I was wondering how you were going to examine the potential of different care coordination models? Because I think in a way this is a microcosm of a group for whom the now classical disease management will not apply, where you really do need some different models given the complexity of this population. We know that

it's not out there. We don't know with the CCIO to what extent we'll really get some of the models, what they're now calling case management models. So I was just wondering what your approach is going to be?

MS. RAY: That's a good question and this is clearly something for the future that we would sit down and think about. As a first step, there are a few programs out there that do focus in on the pre-ESRD population and do provide some care coordination for that population, so would clearly be a first step.

To be honest with you, in my search of the peer-reviewed literature I did not find any studies with any kind of statistical analysis on the pre-ESRD population showing the benefits of such programs. But that will definitely be a challenge.

MR. HACKBARTH: Anyone else?

Okay, thank you very much.

That concludes this afternoon's session. We'll have a very brief public comment. I'd ask you to confine your comments, if you have any, to things that we discussed this afternoon or this morning.

[No response.]

MR. HACKBARTH: Okay, hearing none, we will reconvene tomorrow at 10:00 a.m. For those of you who are

used to 9:00, it is 10:00 a.m. the public session tomorrow.

[Whereupon, at 4:30 p.m., the meeting was recessed, to reconvene at 10:00 a.m., Friday, April 23, 2004.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 23, 2004
10:13 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. DeBUSK
DAVID F. DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY E. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA PAGE

P R O C E E D I N G S

MR. HACKBARTH: I'm sure Craig is going to introduce not just the topic but the speaker, as well. but Nancy, welcome. Nancy and I knew each other a little bit in Boston and had a few occasions to talk. So it's good to have you with us.

MR. LISK: I'd like to introduce you to Nancy Kane, Professor of Management in the Department of Health Policy and Management at the Harvard School of Public Health.

Dr. Kane's research is focused on financial and managerial performance of health care organizations.

Today she is going to discuss her work on IRS form 990 as a data source for reporting on hospital investments, endowments and access to capital. This is one of two reports mandated by the MMA that are due June 1st of this year which the Commission will be discussing this morning.

After you're through with the discussion of the 990 project with Dr. Kane, David, Jeff and I will discuss the other Congressional mandated report on the need for and sources of current data to determine the solvency and financial circumstances of Medicare providers.

DR. KANE: Thank you, Craig. Thank you

Commissioners and Mr. Hackbarth.

It's a pleasure to be here this morning to talk about a subject that I probably know a lot about it and you probably don't want to know too much about. So I will try to keep it brief brief. But I guess Congress is interested in monitoring the financial health of hospitals and understanding the impact of not just Medicare but other forces on the hospitals' financial condition, and obviously is looking to the 990s as one of the major sources of information.

So what I'm going to try to do today is give you some idea of how valuable and not so valuable at times the 990s are as a source of information on these fairly critical issues, and I think becoming increasingly challenging to understand.

Just keep in mind, the 990s' purpose is an informational document required by the IRS and it's used by the IRS and some state oversight agencies like the attorney generals in charge of charitable assets in a state. It's used by donors. It's often read by the media more than anybody else. In fact, that's where a lot of the attention is paid to charitable organizations. It's often the journalists trying to learn how to read these things. I have given many sessions, in fact, teaching

journalists how to read these things.

But their main purpose is to decide whether the organization continues to meet requirements for tax exemption and that's quite a different purpose than trying to ascertain financial stability. Many of these organizations are small and oriented towards non-health-related activities. So again, a very different focus than what you might want to know about in a hospital. And that's where some of the issues come up when you try to do financial analysis. And I will be explaining those in more detail in a few minutes.

The good news about the 990s is the public disclosure has expanded a lot in recent years, since around '96 when the IRS began to require that charities put their 990s in a public domain and the GuideStar web site came into being and therefore people have access to them without having to go to the organization and stand there and beg for the form 990, which I used to have to do.

Who reports? All tax-exempt organizations with greater than $25,000 in gross receipts, excluding churches. Hospitals that are religiously affiliated do report so they're not exempt. But this means more than 220,000 public charities and 60,000 private charities file

some version of the IRS form 990. It's a lot of organizations, a lot more than the IRS can possibly audit or even review in any one year.

The types of information included on the 990s, it's a six-page form plus up to 40 or 50 pages of attachments. There are 105 items that are specified and requested in the forms, and there's 45 pages of instructions. So it's a lot of data around the revenue expenses. That would be sort of like an income statement, functional expenses. Again because of charitable purpose there's a real interest in the division of expenses between what the charity program is comparing to the management expenses and the fundraising expenses.

There is a disclosure of program service accomplishments. There's sort of a balance sheet. I'm saying sort of because my standard, by the way, is the audited financial statements that are governed by generally accepted accounting principles. So when I sort of devalue a little bit the 990, it's because it doesn't quite come up to the generally accepted accounting principles version or the audited financial statements.

It also discloses compensation because of the charitable issues involved with inurement that the IRS and others are interested in. And one of the most valuable

things the 990 does is it lists all of the affiliates and subsidiaries of the entity that's reporting. We'll come back to that, though because that actually makes it hard in other ways to understand the financial condition of the hospital.

That's sort of an overview of the 990s. Now I'm going to get into the specific question of how valuable is the 990 as a data source for reporting on investments and endowments. One of the first things you might want to know is how well do they report information you need to know about investments and endowments? Under generally accepted accounting principles, investments are broken up into these various categories that are used differently depending on where they're coming from. So there's restricted and unrestricted is the first category, where unrestricted is available for general operating purposes. Restricted it is restricted by donors.

The management of a hospital cannot use donor restricted investments for any purpose other than the donor specified purpose. So those assets are not available to meet an operating deficit or repay debt or any of the general operating purposes of the organization.

Their unrestricted assets are broken up into

operating cash, board-designated investments which are amounts of securities that the board has said should be used, usually for capital purposes. They can also undesignate them, so they are considered available for general operating purposes.

And then a third category is trustee-held investments which are investments set aside under some sort of contractual arrangements such as debt service funds or self-insurance funds.

Only the top two categories of unrestricted funds, operating cash and board-designated cash, are commonly used to create ratios that creditors would look at for the availability of cash or days cash on hand as part of assessing hospitals' financial health. So you do need to be able to segregate out these categories to do an effective analysis of hospitals' liquidity and days cash on hand.

The bad news is in the 990 none of these categories are recognized. All investments are reported on one line item on the balance sheet. So sometimes it's disclosed in the attachments but the attachments, as I say, do take a little more time and are rarely collected in any kind of automated form.

Another issue around investments, and one reason

you might be interested in investments is that they generate income. And the income generally comes in three different classifications. If you look across the top of my slide, the top row, there's dividends and interest income, there's realized gains and losses which is basically what you realize when you sell the asset for above or below cost. And then there's unrealized gains and losses which is the fluctuations in market value of investments that you continue to hold.

Under generally accepted accounting principles investment income hits the income statement or not depending on which type of investment it comes from. So if it's an unrestricted investment it hits the income statement unless it's unrealized gain and loss, in which case it does not hit the income statement.

DR. ROWE: I'd like to ask a clarification, because I just remember things as being a little different than the way you stated them, Nancy. so maybe you can clarify this for me.

I was under the impression that for a restricted gift of an endowment that, perhaps depending upon the language of the deed of gift, capital gains on the corpus can in fact be used for unrestricted purposes. And therefore, would appropriately be included by rating

agencies and others when they're looking at the financial stability of an organization.

DR. KANE: Depending on how detailed you want me to get. You're absolutely right, some donors do stipulate that their endowment is to be set aside in perpetuity. But some of the return may be used for general purposes.

But it's not all.

DR. ROWE: Some organization that gets to be most of the --

DR. KANE: That's correct.

DR. ROWE: So in a restricted category --

DR. KANE: Unfortunately, that's the general notion. There are states that allow hospitals to keep all of that in a restricted account and have all of the income accrue to a restricted net assets until management chooses to use it. So it will go back and forth. You have to be able to read the footnotes, let me put it this way, to know when the restricted asset income can be moved into unrestricted.

So in general, and I'm really trying to keep it general, depending on where the investment income is coming from it either hits the income statement or it doesn't. If it doesn't, it hits the change in equity, change in net assets. And that's an important distinction

in terms of determining, for instance, your excess revenue or your bottom line.

Unfortunately, the 990 doesn't keep that distinction clear. So there are many times when the 990 is looking at income that should have just been a change in net worth or net equity in the donor-restricted assets that it classifies as income that goes into what you would call your income statement.

And that's one of the biggest problems with the 990. If you want to know the bottom line, you've got a mixture of restricted and unrestricted revenues in there, and you need to know exactly which ones should go on the bottom line.

I've compared these to audits and it's often off. In fact, I'll give you an example of that.

MR. HACKBARTH: Thanks, Jack, for the question.

Just one reminder before Nancy proceeds. Because of the statutory deadline for this report, which is June 1 of this year, this is going to be the only time that we discuss these matters. So it's even more important than usual that if you have questions or you have concerns, this is going to be your opportunity to get them clarified in we're fortunate to have Nancy here to help us do that.

DR. KANE: So I won't be counted against going over my time?

I think just to show you how important investment income is and understanding where it's coming from and how much it is, this is a charge of a state that I generated from their audited financial statements, not the 990s. And what this shows you is the excess revenue for all the hospitals in this state for the period '98 through 2002 from their audited financials.

What I want you to notice is how much of a difference investment income makes in the level of excess revenue, which is the numerator by the way of your total margin figure, which I know you'll be talking about again in a little bit.

So one of the things you might notice from this chart is that investment income was driving the excess revenue right up through 2000. And then suddenly, you know right when the stock market doesn't do too well. 2001, 20002 investment income practically disappears.

In that sense, the total margin would make these hospitals look worse over this period. However, the green is their operating income which is the result, basically, of their patient service mission. And you see it rising over this same period.

So if you're just looking at total margin, you'll think oh, they're doing worse over this period. But if you're concerned with how the third-party payment system is operating or how the patient care mission is doing, you get the exact opposite impression.

So again, this is just to explain how important it is to be able to pull out investment income and understand its impact on the bottom line.

I'm going to take this year 2002 --

MS. ROSENBLATT: Nancy, I'm sorry.

When you're using the term investment income, are you only counting what's coming in? Or is it net of what might be going out? Interest expense.

DR. KANE: It's before interest expense, which is actually an operating expense. There may be some other nets against it that relate to the cost of managing the investment fund but it's not counting interest expense that you use to service your debt.

Let's look at 2002 for a minute. You'll notice that investment income has practically disappeared and that other non-operating revenue is negative. I just want to give you a sense of the magnitude of what's underneath those numbers, and to help you to see why it's important to be able to pull out investment income and its various

categories.

This is that 2002 of that state. And you can see that contributions are positive but investments and other entities, they're losing cumulatively about $5 million that year. Interest and dividends generated $31.8 million but that was almost entirely offset by realized and unrealized losses. That's basically the effect of the stock market drop in 2002. So they end up having negative non-operating revenue.

But again, if you're trying to assess the performance of an organization, it really does help to understand where the negativity is coming from. And here you can see very much it's related to the drop in market value of investments.

The next issue I wanted to talk about is capital access. And these are measures of capital access by financial stability. This is the same state that I've been showing you all along. And as of 2000 we had roughly seven years of data on these hospitals. What I've done is pull out seven of the key ratios that one would look at to determine capital access.

What I've also done is categorized these hospitals based on seven years of data as to whether they were distressed, whether they had red flags, which meant

they had some bad things in their performance that you would worry about as an analyst, whether it looked like they had barely sustainable performance or whether they looked advantaged, like they were had very strong financial performance and it gave them a competitive advantage.

This is one state. This is not, by the way, a typical state necessarily. I don't know what a typical state looks like because we don't have a national dataset that does this this way. But it gives you a sense, by categories the hospitals this way, how these seven ratios differentiate across varying degrees of financial distress. And it helps you understand why these ratios are quite useful to have if you're going to assess access to capital.

What you see, very clearly, total margin pretty much correlated with the financial stability or instability, operating margin also very much correlated. Days in accounts receivable which is, by the way, one of the ratios that you can get from the 990 pretty cleanly, does not differentiate much across these four categories in this particular state. This is really how fast are you collecting your revenue. It doesn't look like the financial instability in this state is caused by slow

payment.

Days cash on hand, very closely related to financial status. Again, you can't calculate that, as I mentioned before, because of the poor categorizations on the 990 of investments.

Equity financing, which is a proportion of your total assets financed by equity, pretty much correlated and you can get that from a 990 reasonably well. It's actually close to the audited.

Debt service coverage you cannot get from the 990 but it's a key ratio used by creditors and you can see again it's highly correlated with financial status.

Average age of plant, you can get from the 990 and it does show a relationship with the financial status categories.

DR. ROWE: Nancy, I'm a little concerned if a table like this is going to appear in the MedPAC document because it indicates that MedPAC feels that an operating margin of 1 percent is sustainable, makes an institution sustainable.

These are not-for-profits, so there's no tax and presumably not many hospitals pay payments in lieu of taxes. But there are capital expenditures that are required. I just don't see 1 percent as being

sustainable, maybe necessarily. We get into a lot of arguments about what the margin should be when we try to figure out what the payment adjustments should be.

If we're going to publish this, I don't want it out there for people to reference as MedPAC's definition of a sustainable hospital.

DR. KANE: That's really up to you how you want to categorize it. I will say a 5 percent total margin does help and so does an eight-year-old plant, which is right about the national median.

DR. ROWE: But the operating margin on the slide is 1 percent. And I don't think it's sustainable. You can't sustain an institution and make any capital investments over time at 1 percent in my mind, in my experience.

DR. KANE: Well, these places have actually survived and are still doing very well in 2002.

DR. REISCHAUER: Why can't you? They have a lot of investment income and they choose to use that for good purposes.

MR. MULLER: But Nancy said, we don't know what is a representative sample, and so forth.

DR. ROWE: They don't have a lot of investment income. Most of their endowment is restricted.

DR. REISCHAUER: I'm saying they may or they may not. And I don't think we really know.

DR. ROWE: You can't tell from that, but there are hospitals, and Ralph's may or may not be one of them, that would find a 1 percent operating margin to be the only source they had of capital for IT improvements or other kinds of changes in a market that demands those kinds of changes.

It just seems like a definition that maybe it's the right definition. But I'm not sure we've discussed it here at MedPAC.

DR. NEWHOUSE: But isn't that a question of how we just labeled the columns?

DR. ROWE: Absolutely. Maybe you want to call it stable.

DR. NEWHOUSE: Should there be some indication of the range or variability within each of the columns?

DR. KANE: That's fine. I can do that.

DR. ROWE: For the purpose of this analysis, but it could be used for a different purpose. That's all.

MR. HACKBARTH: I'm not sure whether there is an intent or not to include this particular table in a MedPAC report. The way I understand it is Nancy's using this to try to illustrate to us what's available on the form and

how well it correlates with different levels of financial performance. And what label you attach to them, we don't need to focus on right now.

Your point is well taken though. I hear you.

DR. KANE: Any other questions about these ratios and what they mean? And the fact that only three out of the seven are available in a reasonable way out of a 990.

I wanted to give you an example of, a comparison actually, of a 990 versus the audited financials. And for good measure we threw in the Schedule G from the Medicare Cost Report, which you may or may not want to talk about today.

What you see here on the income statement of this very large teaching hospital is the net patient service revenue across the audit, the 990 are close. The Medicare Cost Report, for some reason, has a lower net patient service revenue. And that can be for a lot of reasons that I won't go into today, but I did write a whole article about that, if you want to read it some day.

But where the 990 has real discrepancies with the audit is under other operating revenue. And that's the problem of the mixing of restricted and unrestricted revenues where it's putting into the income statement

revenues that the audits say do not belong there. They belong as a change in net assets in a restricted account.

What that does, if you scroll on down to the operating income, it throws the operating income off by about $20 million and makes it look better in the 990 than it is in the audit.

Now some of you who are looking at the Medicare Cost Report column are probably saying wow, look how close the Medicare Cost Report is on the operating income. And that's great and once in a while that happens.

But then if you keep on going down below the operating income, here's where the Medicare Cost Report gives you trouble. It doesn't properly classify the investment income. It calls it a donation, a contribution.

And then if you get to the bottom bottom line, excess revenue over expense, the 990 continues to be off by $20 million because it's got restricted revenues mixed in there. But the Medicare Cost Report had this other unfortunate area called other expense in which they put in capital donations and other changes to net assets that don't run through an income statement. But they ran through the income statement on the Medicare Cost Report. So you end up about $25 million off on the Medicare Cost

Report in the bottom line.

Okay, these are little numbers on a percentage basis. The audit gives you an operating margin of minus 1.4 percent and a total margin of minus .1 percent, both of which are below that state's median operating and total margin. The 990 does not look a heck of a lot better except that it raises this hospital into the top half of performers in their state. And the Medicare Cost Report, it depends on which number you want to pick, where they land relative to the state median.

So these are small numbers. People say so what, it all comes out in the end. But actually, if you're really trying to do financial analysis and compare it to their peers or their state or national data, even these small numbers that are operating income and total margin make a difference. Therefore, it is better to have something accurate in trying to understand your bottom line, your total margin and your operating margin.

Another hospital that is much smaller shows that small classifications can make a huge impact. This is a critical access hospital. Obviously people are concerned about their operating performance and how well they're doing. They've been deemed an essential community hospital. If you look at operating income on the audit

they make $800,000. If you look at it on the 990, they lose $39,000 as it relates to how they've classified their expenses. And they are obviously not the same classification, whatever reason. It turns out they have the same total margin but a very different operating margin.

So if you look at the operating margin under the audit it's 5.8 percent. One would conclude -- I think even maybe Dr. Rowe would conclude -- that's probably sustainable. But if you look at the 990, you go that's not sustainable. It's minus .3 percent.

So again, the classifications of your expenses and your income really need to follow generally accepted accounting principles to get a comparable and sustainable read on what's going on.

There are other issues around 990s that are important to appreciate. One is that they don't report any faster than the Medicare Cost Report in terms of coming out. They are allowed to report five months after the close of the fiscal year and many of them request extensions and so you don't get them until eight or nine months after the fiscal year. If you're relying on GuideStar it's usually a two-year lag.

So in 2004, right now, I'm able to get most of

the 2002s when I go in and look for a particular hospital. So not an improvement over the Medicare Cost Report.

In terms of reporting inconsistencies, there's a lot of variability in the completeness and the accuracy, although the GuideStar disclosure has helped enormously because now they know someone can actually get access to these things and read them. But the problem is the IRS really can't enforce any kind of reporting consistency. Their audit staff reviews .43 percent or less 1 percent of charitable 990 filings and it's pretty impossible. And they're mostly looking for whether they're compliant with charitable requirements, not whether they're financially stable or have accurately reported their income statement and balance sheet elements.

In terms of electronic availability, the GuideStar is great but it's one by one by one, with again the 40 to 80 pages at the end of the six-page form. Those of you who have used them have probably gotten a computer headache by going through, if you don't download those onto paper.

There are some electronic datasets but they do not pick up most of the elements that you would need to do financial hospital analysis. For instance, the NCCS, the Urban Institute collects these pieces of a 990 on a gig

core dataset. If you look at the balance sheet items they pick up, the only one they pick up is total assets. So you don't have any breakdown of anything that would be useful to you for doing any of those capital asset ratios or understanding investment categories.

And I guess the last part that's really critical to understand is the issue of affiliated organizations. The 990 and the Medicare Cost Reports and the audits and have this problem, except that it's easiest to figure out from an audit whose reporting and what that means, in terms of what you're seeing and what you're not seeing.

So the next chart shows you, all these entities are in one stage but it's a multi-hospital system and it's in 2002. What you see is a parent company, a system A, a corporation B, a major teaching system, and then seven more affiliates.

The Medicare Cost Report pulls out all the yellow boxes here, the hospital, two physician practice companies, and a real-estate company. The Schedule G on the Medicare Cost Report reports on all those entities.

The 990 reports on just the entity that's outlined in pink, which is just the major teaching hospital.

And the audited financial statements give you a

consolidated view of all of these entities as well as consolidating breakdowns on each one. So when you want to look at financial status, it might help to know what the hospital is embedded in, how the hospital is doing on its own, and then how it's doing in the context of its larger organizational affiliations.

And the next slide gives you some sense of what that means. I did do the ratios off the audit. On the pink column the hospital only, the yellow column the single system with the Medicare Cost Reports picking up, and then the green column the consolidated health system. And what you see for our ratios, our capital access ratios, is that the hospital is actually doing quite well, a 3.2 percent operating margin, 6 percent total margin, collecting receivables fine, 195 days cash on hand, almost five times debt service coverage, six-year-old plant, pretty darned good.

The single hospital system does less well. particularly on the operating margin, a little less cash.

But the consolidated system, when you throw in all of the entities, all the companies, all the different affiliations, the system as a whole only a .2 percent operating margin and a 2 percent total margin. And there I am happy to agree that these guys don't look good. And

I wouldn't classify the consolidated as a sustainable margin over all. Although they still have pretty decent cash on hand and average age of plant.

In general when you see these complex organizations, if you have a healthy hospital, it is not uncommon for that hospital to be what we call from my MBA days the cash cow for the system where the cash is leaving the hospital and supporting all of these different entities in varies ways, some of which are quite strategic and some of which I don't understand fully but perhaps someone else can figure that out.

DR. ROWE: I think the reason it's not easily understood is because you can't understand it from these numbers because there are missions beyond the bottom line, the community mission or the educational mission, which drive a lot of those other investments so that they may not look good from this point of view but it's still important to the institution or the board.

DR. KANE: And I think one of the things that you as a group may want to talk about at some point is when you're thinking about how effective is a third-party payment system, which mission are you trying to cover financially? And that's something I guess you all can work on in your spare time.

Another affiliate model that's actually a problem, from both the audit perspective and the 990 prospective and the Medicare Cost Report perspective, is what I'm going to call the foundation model. That's probably not generalizable, but this is an example of a foundation model in which both the Medicare Cost Report and the 990 are trying to give you information about the hospital entity but there's no balance sheet. It basically has most of the assets in the hospital entity are what is called intercompany receivable or something meaningless. Of this $177 million in assets, $105 million is a receivable. So you don't really know anything about plants or debt or any of these. There's no data because the data is all consolidated and the hospital system has not created an audited separate entity statement for any of the other entities.

So you have a foundation with $608 million in assets, $350 million in investments, $167 million in tax-exempt debt. But you can't find that from the Medicare Cost Report or the 990 because it's all up there in that foundation. What they say in hospital's 990 is we can't do it. This foundation hospital is related to other organizations, the financial statements are only available on a consolidated basis so we can't give you a balance

sheet. They do give you sort of an income statement.

And that creates obviously a lot of problems because a lot of hospitals do follow this model where you can't pull it out of the embedded whole.

To summarize and maybe add a few more points, there are some benefits and there are some drawbacks to the 990. The good news is all private non-profit hospitals do seem to be reporting on the 990 forms. The bad news is publicly-owned hospitals and investor-owned hospitals do not report a form 990 because they do not fall under the charitable classification.

The balance sheet does provide some useful ratios although the bad news is you often have to use the attachments so it's labor intensive. It's not an automated type of exercise.

With some changes, which various organizations that monitor these 990s have suggested, the income statement could be made more useful.

Also very helpful, when you're looking at an audit, is to have the 990 to give you hospital level detail when you can't get it from the audit. But they're not filed electronically and the hospital entity data is not audited. This is self-reported data and it doesn't always correspond to the audit.

If one wants to do a large national sample of 990 data and to tell you what's going on with the hospital industry nationally, it requires an analyst to spend a lot of time because you don't have footnotes, you don't have the right classifications of revenues or assets, there's no cash flow statement which is one of the key measures I use for understanding financial health, and the attachments are not uniformly provided.

So again, six pages of forms, 40 pages of attachments. An analyst would need a lot of time. I've timed myself a couple times. It takes anywhere from one-and-a-half to two days to do five years off a 990, to get them standardized in any way that you think you have some idea of what's going on, although you still don't know for the income statement what's operating and what's not operating, what's restricted and unrestricted.

And you cannot do any of this as a clerk. You have to have a financial accounting background. You need somebody who's fairly well trained to do it.

DR. MILLER: That was two days for one entity, right?

DR. KANE: One entity, yes. That was me.

DR. ROWE: And that was you.

DR. KANE: Which means when my husband does it

it's three days.

[Laughter.]

DR. KANE: Findings, the 990s are a useful alternative to the Medicare Cost Report when audited financial statements are not available at the hospital entity level. It's very helpful as a supplement but it does require a lot of analytic effort and training.

The Medicare Cost Report is in electronic form, which is helpful, if they could make Schedule G a better schedule. And I think the staff will be talking about that later.

And regardless of reporting source, there really needs to be some kind of effort to decide what entities are you interested in. I think you should be interested in both the hospital and the whole and be concerned about what's going on across the hospital and it's whole and what kind of financial implications the whole has.

But the reporting for that has not really followed that. So for public policy purposes it is quite hard to get a complete picture of the hospital's financial condition.

I think it that point I should stop. Any more questions?

MR. MULLER: Thank you for that very useful

presentation, Nancy, again.

I think, as you said right from the start in your first slide, the report was created for another purpose. And when you have a report created for another purpose it's very hard then to meet other objectives with it. So I think in many ways it's somewhat dispositive of how one can use this. I look forward to obviously your comments, and the staff, on how to better use the cost report.

But I think your summary pretty much started from the first slide, which said this is not what it was created for.

Thank you.

MR. HACKBARTH: Other questions, comments?

DR. WOLTER: Is there interest or is anybody looking, other than ourselves, at the 990 and suggesting that it be changed so that it would be more useful? Is the IRS looking at this at all?

DR. KANE: I think the IRS is not looking at it as a tool of financial analysis. Again, they're going back to their purposes. The Urban Institute's National Center for Charitable statistics, NCCS, is looking at the 990. I just read something that was about five pages of suggestions, some of which would make it more useful.

They do pick up on the restricted/unrestricted problems. They do pick up on the consolidation problems.

But again they are very much focused on the charitable issues. They really want more disclosure on compensation and loans to insiders. So they're never going to get, because they're looking at such a wide range of organizations, they're never probably going to get to the level that you need to get with a hospital, which is a huge entity. They're looking at these little tiny organizations, many of them, compared to hospitals.

So I don't see that upgrading to the level that someone whose organization is totally focused on a hospital would get to, like the Schedule G would be focused on hospitals, could put in requirements around the way hospitals report data and be consonant with the audit requirements. I don't think the 990 will ever achieve that level of compliance or disclosure.

DR. REISCHAUER: Nancy, I thought that was a summary of where we are and where we can't go. The fact of the matter is that there's no way on god's green earth that the IRS is going to move in a direction that would make this useful for what we want because its mission is different and is limited to that mission.

There will be electronic filing of the 990s

slowly taking place. So as Nancy says, it will be easier to get the stuff off the basic form. But much of what you want is in the appendices so it's not clear at all. And that won't be electronically useful, I don't think. And to the extent that we, at the Urban Institute, do delve into this area it really is to examine the evolution of the non-profit sector broadly defined.

So I don't think there's a lot of hope in that direction either.

MR. HACKBARTH: Any others?

Scheduled next is the staff presentation and I think the general drift of the conversation here is that the 990, per se, probably is not the tool to depend on. I think Nancy mentioned, at least in passing, that another direction to go is the Schedule G in the existing cost report and improving that in certain ways. I think that's, in part, what the staff are going to discuss with us.

So I'd like to have that. I hope, Nancy, you can stay and the ensuing conversation may come back to some of issues that you've raised in your presentation.

Before you go, could I just ask you a broader question? Obviously we, in MedPAC, have focused not on the total overall margin for providers. It's been our

policy to look specifically at the Medicare margin for hospitals base our recommendations on that.

These Congressional requests are, of course, requests we need to meet but they are sort of a different thrust looking at the overall financial performance of hospitals.

Looking however at the Medicare-only financial status of hospitals, what we have seen recently is declining Medicare margins for hospitals. And when we do that calculation, incidentally, we look not just at the inpatient but also if the hospital has outpatient department, home health, SNF. We look at all of them aggregated.

And when we get back in the fall to looking at Medicare financial performance of hospitals and moving towards an update recommendation again frankly, I'm a little concerned about what we're going to find given the recent trend of significantly declining Medicare margins.

You're looking at the hospital sector from a very different vantage point, looking more at the overall financial performance of hospitals. I'd be interested just in hearing your impressions of what's happening, the financial status of hospitals overall based on the work that you do?

DR. KANE: Well, as you know, I don't have a national sample. I do look at different states, often the whole state, but they're not representative. And I do look at some of the indices that are in the public domain such as the hospital almanac and some of the data that's out there.

And I think hospitals, which you see often is a peak going up to around 1997 and then they start to come down to around 2000, and then they start to move back up again. That really goes along with perhaps it's the third-party payment system paying better as the premiums have been allowed to rise.

But that's very general. There are big winners and there are big losers still out there. So as an industry it's got a huge range in performance.

So I think generalizing about the industry is very hard. Some of the bigger, wealthier, competitively advantaged organizations are doing very well, particularly if they have basically a monopoly stranglehold on a market. Whereas some of the smaller hospitals, maybe number two or three or four in the marketplace, don't do so well, often again related to the negotiation process in the private sector.

So Medicare is not the only driver, obviously.

So I think it's very hard to generalize. I'd say they're doing better as a whole because of the pulling away of some of the constraints on the private sector.

MR. HACKBARTH: Why don't we proceed then to the staff presentation? Craig, are you leading the way on that?

MR. LISK: David's actually going to introduce this.

MR. GLASS: Nancy's going to stay right here.

Good morning. This one is the second of the two reports Craig referred to. We call it the data needs report is the short title for this.

In Section 735 of the MMA, Congress required that MedPAC report, as the slide shows, on sources of current data to determine solvency and financial circumstances of Medicare providers. Not just hospitals, other Medicare providers as well. And although we're talking about Medicare providers, as Glenn pointed out, this is talking about total financial performance and it's all payers and all costs. It shouldn't be confused with what we generally look at, which is financial performance under Medicare, whether Medicare payments cover the cost of an efficient provider.

So this is looking at a different question and

this is what Congress wanted us to look at.

Nancy Kane's discussion just reflected the benefits and costs of using the IRS form 990 as a possible source of data and we're now going to discuss some other sources of data and some measures you might want to use of financial performance that might be useful for assessing financial circumstances, as they asked us.

Both reports are due June first of this year which is a little over a month.

The key questions we're going to talk about in this briefing are first, what measures used as indicators of their profitability and solvency. Jeff's going to talk about that. And then Craig is going to talk about what sources of data can be used to construct the measures and how we can improve our data sources. And then I'll sum up when we get to the end.

DR. STENSLAND: To evaluate the total profitability and solvency of providers we've convened two expert panels. The first was a panel of analysts from government. The second was a panel of private sector and academic experts in financial analysis.

The two panels thought that a provider's total profit margin is a useful indicator of total financial performance. But as Nancy Kane discussed earlier, the

total margins can be dominated by non-operating losses such as investment gains. And so to avoid this problem some analysts focus on operating margins. However, our panel believes that operating margins can be inconsistent due to the inconsistency in distinguishing between operating and non-operating expenses.

Due to this inconsistency of reporting the operating margins, the panel suggested focusing on total margins in conjunction with the cash flow measure when calculating margins for a large number of providers. Both the total margin and a cash flow measure, such as free cash flow from operations, reflect the return to the owners of the health care facility.

The panel also discussed looking at the total return to all investors in the facility. So if we wanted to look at the investment return to both stockholders and bondholders, we may look at the return on investment which is the average return to those two types of investors and is an indicator of the overall attractiveness of the industry to private investors.

So far on the first slide I talk a little bit about profitability. Now if we switch to looking at solvency, some panels suggested we examine a cash flow measure called EBITDAR, which is earnings before interest,

taxes, depreciation, amortization and rent. A provider might be moving toward bankruptcy when its cash flow as measured by EBITDAR is lowered that its required debt service payments.

However, I want to stress that bankruptcy does not always lead to closure. For example, as we remember from a few years ago, a large number of SNFs filed bankruptcy. Following that they restructured their debt and they continued to service patients.

While providers with a low but positive EBITDAR may be able to restructure their debts, it will be very difficult for a provider with negative EBITDAR to restructure its debts. These providers with negative EBITDAR are not generating cash flow that can be used to pay their interest and rent expenses. So these negative EBITDAR providers, we expect them to move toward closure unless they can obtain transfers from related entities.

The transfers may come from related entities such as foundations or parent corporations. As Nancy Kane discussed, these transfers are often not reported on the income statement. And they are not included when computing the profit margins.

They are reported on the statement of changes in net assets. Therefore, when evaluating solvency it's

important to examine both the changes in net assets and to calculate a cash flow measure such as EBITDAR using a cash flow statement.

So far I've talked about measures of profitability and we discussed measures of cash flow relative to debt service requirements. But when evaluating solvency, analysts also calculate days cash on hand which is a measure of the size of the provider's cash reserves. In addition, analysts often examine financial leverage on the balance sheet using measures such as the debt-to-asset ratio.

To calculate the measures of profitability and solvency discussed above, analysts would need to obtain the following four standard types of financial statements: an income statement, a cash flow statement, changes in net asset and a balance sheet. Now Craig can discuss with you how we can obtain this information in a timely and accurate fashion.

MR. LISK: We will now review five possible sources of data to create the measures that Jeff and Nancy described.

We've already discussed the IRS form 990 so I won't go into that because we've discuss the pros and cons of use of that form.

Audited financial statements are another source of data that Nancy discussed and they are prepared by independent auditing firms according to generally accepted accounting principles. They include all the forms that Jeff just mentioned and are available for providers with publicly traded bonds and for providers in some states where states require the filing of these, at least for hospitals and some other providers.

They are, however, not compiled on an organized and consistent database that may reflect the consolidated entity and they may reflect the consolidated entity and not the specific provider, although again from looking at those forms you can potentially get a lot of the information on the individual providers within the statements.

SEC form 10-Ks are a type of audited financial statement filed with the SEC by publicly traded for-profit corporations. They reflect the corporate entity and not the individual provider. Thus SEC 10-Ks are filed for, let's say HCR Manor Care Nursing Home, Gentiva Corporations but not the individual hospital, SNF, home health agency or dialysis facility.

Surveys are another source of data that can be used. The AHA annual survey provides data on the

hospitals but is no more timely than the Medicare Cost Reports. It does contain some other type of information on total performance but some of that information is not publicly available. It's only available to the AHA members.

The NHIS, National Hospital Indicator Survey, is something that we have used that provides quarterly data on hospitals' total financial performance in terms of limited data in terms of total revenues and total expenses. But only for a sample of hospitals, not for other providers. And it can't be used for judging performance of an individual provider. It's only for the industry as a whole. Medicare Cost Reports is what we come down to next, which cover all Medicare providers of services. It's an electronic database. It includes not just data on Medicare cost and payments but the schedule G, as we've talked about. And all providers who file cost reports have this Schedule G. Now, it may not be identified as Schedule G for home health, for instance, but they do file a similar thing to what hospital's file what's called Schedule G. So we're going to refer it as Schedule G here.

So this contains data on a provider's total all payer operations.

Since the cost reports are one source of data filed by all providers and available electronically, it's worth spending a little time discussing some of the data issues on the cost reports and in particular Schedule G. These include the timeliness and accuracy of the information included, the consistency in the reporting entity that's included on the provider, and the completeness of the data. In other words, do the cost reports contain all the information needed to conduct a thorough financial analysis. Nancy Kane has covered a lot of that issue in her discussion, as well.

Let's move to timeliness. This chart shows the most common cost reporting periods for hospitals. This coming October fiscal year 2003 data should be available for most providers. It's important to understand some of the facts about the timing of Medicare Cost Report data.

Cost reports, at their earliest, are available seven to eight months after the end of a provider's fiscal year. Providers have five months to complete the cost reports and then electronically submit them to the fiscal intermediaries. Then the fiscal intermediaries have 30 days to approve those cost reports, make sure they have completed them properly, and then another 30 days to put the approved cost reports into the data system for

transmission to CMS.

CMS then has access to the data within 24 hours at that point in time. This is the data that is used for making the cost report files the analysts use for analysis.

Now CMS can produce special runs so the data can be available more timely after this point in time. But generally, in terms of the general community, CMS produces quarterly cost report files that are available about 45 days after the close of the quarter. But data can be available a little bit more timely if special requests are made.

So what are the prospects of having 2004 data, let's say in the fall? Well providers that begin their fiscal year in July, the top line, they still have two months to file their cost report with a fiscal intermediary at that point in time. For providers who file their cost report periods beginning in October, their fiscal year just ended so there's not likely going to be any data for them in terms of speeding up the process. And for providers who file their cost reports in January, they are still in their fiscal year.

So in terms of the timing, that's one of the problems in terms of length of the fiscal year and the

length of the reporting.

The first cost report data containing substantial 2004 data, in terms of for the people who report who have July's fiscal year start dates, would generally not be available until March of 2005.

I next want to talk about the accuracy of the cost report data and there are two issues consider here. First I'm going to talk about the auditing and cost allocation. Only a small proportion of providers' cost reports are audited. While there is a statutory requirement that dialysis facilities be audited at least every three years, there is no audit requirement for other facilities. On average, about 15 percent of providers receive some form of audit every year.

The audits are also focused on items that affect payment or I should say basically only focused on items that affect payment. For hospitals, audits may focus on DSH and IME adjustments, the direct GME payments, Medicare bad debts and cost-reimbursed items like organ acquisition costs. For SNFs, audits usually focus on Medicare bad debt payments unless the audit picks up something else that they want to look at.

Items on Schedule G for the cost reports are generally not audited since they do not affect payment,

although some FIs may do some checking in the desk review process to see if Schedule G information ties to audited financial statements, there is no requirement that the FIs do so.

Now one interesting aspect in our look here is hospitals and other providers are required to submit with their cost reports a form 339 which is a survey information that's filed with the cost reports. And with that they are required to include a copy of their audited financial statements to providers to the FIs.

These audited financial statements, though, are not subject to FOIA requirements so they are not publicly available but they are used by the intermediaries for doing some checking if they find issues with the cost reports.

Hospitals and other providers that don't have audited financials for the specific provider still have to submit financial reports that are used to compile what might be the audited financial for the corporate entity because they still have those pieces that go there. So there is that information that is filed that I thought was important for you to understand that it is filed actually with the cost reports.

Cost allocation issues primarily affect the

accuracy of cost estimates by department, inpatient versus outpatient for instance, or between payers, Medicare versus private payers. It does not affect the data used to examine total all-payer financial picture of the provider.

Cost allocation is an important issue for the Commission and accurately measuring Medicare cost and is the focus of another study that we are in the process of conducting, particularly for this sector costs for inpatient versus outpatient for instance.

Next there is no consistency in what providers report as a reporting entity on Schedule G of the cost report. It could be a system with affiliates, such as a hospital-owned physician practice and real estate company that Nancy had showed you. It could be just the core provider. There is no consistency in what is actually reported here.

So when we're looking at particular hospitals, we are comparing potential apples to oranges. We're not consistent here in what is gathered.

As Nancy Kane just reported to you, how the entity is defined can have substantial impact on providers' financial circumstances.

Finally, as Jeff mentioned, some of the base

information required to develop some of the financial ratios Jeff and Nancy discussed are not available on Schedule G of the cost report, particularly the lack of a cash flow statement, from our panel, was considered a major shortcoming of the Schedule G of the cost reports.

Finally, I want to discuss the options for overcoming some of the limitations on Schedule G of the cost reports. To increase the timeliness of the data you could supplement with survey data, something similar to the National Hospital Indicator Survey, which has some of its own shortcomings but have similar surveys for other types of providers. Such survey data could provide more timely data on cost and revenue trends for a particular sector but cannot be used to judge what might be happening for an individual provider.

Alternatively, you could require providers to submit quarterly data on financial circumstances, something similar to the NHIS, but just as a requirement for Medicare reimbursement, for instance, data similar to what's reported on NHIS.

Another option is you could require providers to file a Schedule G separate from the cost reports, breaking it off from the cost reports because it's a separate document in some sense but it's not what the basis of the

Medicare cost determinations are. And it could be separated. And our panel thought that was actually a good idea.

And it could be filed about at the same time that audited financials are required to be filed, about three months after the reporting period.

To improve the accuracy of the data, you could require random audits of providers on Schedule G data. Audits, though, could be expensive depending on the number and extent of the audits.

One of the issues you have in terms of the accuracy is providers don't have an incentive to necessarily report this data accurately since there is no checking.

So alternatively, you could have the FIs just do a check at the desk audit process for checking with consistent with the audited financials. And if providers realized that was happening, they may be more careful in what they're doing on Schedule G.

The reporting entity, including the Schedule G, is not consistent across providers and our panel thought it would be most useful to have Schedule G reflect data for basically the smallest corporate entity that contains a provider. This allows for a more apples-to-apples

comparisons and gets the core facility's financial performance in terms of how, for instance, hospitals or SNFs are doing on their core business rather than what other things are happening with the other related entities, for instance.

But our expert panel also thought it was important to have what's happening with the broader organization, as well. So the consolidated reporting would also be important.

So at a minimum, a complete transaction report would be helpful to have in terms of transactions between organizations and the affiliated organizations related to the hospital and other providers or a consolidated financial statement. So essentially, two Schedule Gs in other words.

Finally, Schedule G as completed in particular does not include a cash flow statement. Our panel of experts thought that the additional of a cash flow statement would make Schedule G and the cost reports much more useful. And finally, it would be helpful though to have Schedule G also revised to use a standard financial statement form and to conform to GAAP accounting standards. It currently does not. And standardize revenue categories such as operating and non-operating

revenue, which are not currently available.

So what that, I'll turn it over to David.

MR. GLASS: I will just sum it up.

Basically, what we are saying is in summary, if Congress wants to understand the total financial performance of Medicare providers, the most direct route is probably refining Schedule G to report clearly defined complete financial information aligned with audited financials. And you could also report it separately so you could get it a little earlier.

As Ralph talked about in the last discussion, Schedule G was designed a long time ago and probably for a different purpose and it has some funny things on it like vending machine revenue and that sort of thing. It really hasn't caught up with the current state-of-the-art or generally accepted accounting principles. So it's kind of due for a redesign.

This would give us the data to compute, or give Congress the data to compute the multiple measures necessary to assess financial circumstances. These are the measures that Jeff talked about. So Congress would then want to compute those multiple measures, look at total margins, look at cash flow, look at changes in net assets. That would enable us to evaluate profitability

and solvency.

And finally, we would want to look at trends over time so we can see what direction the industry is going in and to compute some of these measures as meaningful averages. For example, capital costs and investment performance. That might have a lot of year-to-year fluctuations so you'd want to look at it over several years. So if there are any questions or comments on the general organization or tenor of the report, we'd be happy to hear those.

DR. ROWE: For me, I think the question is if we had had these data before, and this updated Schedule G as you propose, looking back over the last four to five years can we identify things we would have done differently? Have we make mistakes because of the gaps and the lack of specificity in the information that would have really made a difference because changes like this are not simple and they take a while to do, et cetera, et cetera.

So are there specific years that we could say gee, you know, if we had realized this was happening in the hospital sooner we would have not done what we did or we would have done something differently? I think for Congress or somebody, that would be a question that I think would be useful to point to if there are such

instances.

MR. HACKBARTH: This is where the difference between the question that Congress has asked and the one that we have focused on becomes a bit confusing and disorienting. For reasons that I've discussed ad nauseam, I believe that when making Medicare payment decisions the right thing to look at is the Medicare margin.

I don't see that as something you do by default because we don't have accurate total margin information. I think that's the right thing to do as a matter of principle. Now having said that, there are still lots of issues around timeliness of the information and the difficulty of making projections and the like.

DR. ROWE: [off microphone.] In the policy this could not be important. That's my question. Would we have done anything different?

MR. HACKBARTH: Having said what I just said, Congress did ask for how to best get information on total margins and we're trying to answer that request.

So I don't think there's anything we would have done differently. Now whether they would've done anything differently, that's a question for Congress to answer.

DR. NEWHOUSE: I agree with this general route of bulking up Schedule G. I think, Jack, although I agree

that it would be helpful to cite instances where things might have been done differently, that would be presumably pretty speculative.

I think there's a kind of legitimacy or face validity problem to just making policy with data that are a couple of years old, that just on the face of it it's better to have -- I think in the grand scheme of things this seems like reasonably small potato kinds of changes to me, that we're talking about.

I have a couple of suggestions. As I understood it, Craig, this is in respect to the timeliness. Without going to quarterly data, which I actually don't favor because I think there's more noise there because of where you recognize revenue expenses and so forth.

MR. LISK: That's a good point.

DR. NEWHOUSE: I think it's possible to analytically look at each quarter's cohort or month cohort if you want to go that far. So for example, the hospitals whose fiscal year end date is the calendar year, you analyze them. You analyze then the next quarter's cohort. You can do an analysis each quarter if you chose to. You don't have to. You can develop both a weighting factor to say how each quarter's cohort brings you up to the full sample or the universe. And you can, in principle, if you

want to go back and develop an estimate of the universe, you could put together a kind of weighted average over the quarters where the weights declined as you went further back in time, reflecting the fact that those were more uncertain estimates as a predictor of the future. So that's one suggestion.

And the other suggestion is that, and I just wasn't clear on what if anything we were saying here. It may be useful, and I'll bring this up again in the specialty hospital discussion, if we had costs reported both with and without allocations. Because for some purposes one would, I think, want to know the costs of something before any allocated costs. And I don't see that that would be any great burden.

MR. LISK: There was at the panel -- I'm trying to remember the name -- it was the direct contribution margin, for instance if you're looking at a specific service, for instance, with how you would treat the allocated costs. The indirect costs would not be included in that margin estimate. So you're seeing whether the service itself is profitable or it's actual variable cost items.

DR. NEWHOUSE: Were you planning to include that as a suggestion?

MR. LISK: I guess that's a question of what we cover and going back to what we cover in terms of improvements that are for the Medicare data versus the total data. And yes, on the Medicare data we had mentioned that's something -- and I think it's something the Commission might want to discuss about what we could be using ourselves in terms of how we could be looking at the sector margins, for instance, if we're interested in that.

DR. NEWHOUSE: I would think both we and the Congress in terms of -- I'm actually thinking of making separate update recommendations. We might want to know costs before allocations.

MR. LISK: Sure.

DR. NEWHOUSE: And then for particular policy issues like specialty hospitals one may want to know that.

MR. LISK: Yes.

MR. HACKBARTH: On the first part of it, I'm not sure I totally understand all of the timeliness suggestions that you made.

DR. NEWHOUSE: As I heard the presentation, it was kind of wait until all of the hospitals are in for that fiscal year which means that since we're reporting quarter by quarter, for the early reporters we're waiting

a long time. We're way back in time for their cost reports.

I was saying at a point in time you can either look at just the cohort of the most recent reporters and try to extrapolate from there. Or what would be better would be to go back in time but down weight the further ago reporters because you're more uncertain that their picture further back is a predictor of the future.

MR. HACKBARTH: I'm not sure what the solution is our whether in fact there is a solution on the timeliness issue. When I read the draft text, I was a little concerned that it read in a way that sort of downplayed the timeliness problem. It says one of the limitations in using cost report data is timeliness. On average cost report data are about one year in arrears.

And I understand what you mean by that, but when in fact we get to trying to make a recommendation for fiscal year 2006, we will be using fiscal year 2003 cost report data.

So it feels like a lot bigger difference than one year in arrears.

MR. LISK: That's right and that's part of the interpretation. And what you realize is at that point in time that the Commission is working, fiscal year 2004 just

ended and the only cost reports really that potentially could be available are those July reporters. But because of the current timing, having five months to file, they haven't even filed their cost reports yet. And there were issues that were raised by our panel in terms of in the past, I think prior to '97, there was actually a three month requirement for filing for the cost reports. They changed it to five.

But providers were asking for and granted extensions frequently because they couldn't do it in three months. And our panel really thought that they needed the full five months to compile that information.

And there are other pieces of information that they don't necessarily get and won't have complete to having their data absolutely complete at that point in time for the Medicare part of the cost reports.

MR. HACKBARTH: The reason I wanted to leap into the queue here is that's an issue that's come up repeatedly within the Commission. Here's a vehicle for us to, if we have any ideas, make the recommendations here. So as we go around and have our discussion, now is the time.

DR. REISCHAUER: I'd like to ask a question on this, sort of a modification of what Joe is suggesting.

What we should be interested in is the change from one year to the next. And presumably, if you did this quarterly the sample of hospitals that report at the end of July or the end of June fiscal year is the same from year-to-year. And if we look at the changes, in a sense quarter to quarter -- not it's year over year but you're sort of one group here and then the next it's another group.

If there were big trends going on, you would be picking them up and it would be, in a sense, equivalent to contemporaneous -- as contemporaneous as you could get.

MR. SMITH: I have no reason to think there's any systematic distribution. We'd have to check and make sure.

MR. MULLER: That's what I'm saying, we can certainly look at this idea.

DR. NEWHOUSE: There are actually some differences in what the hospitals are reporting but they're stable. You can adjust for that.

DR. REISCHAUER: And if you weren't looking at levels but percentage of changes...

MR. GLASS: So as I understand what you want us to do is check each of these courts, not a sample of them but everyone reporting at the end of that cohort, and do

those.

MS. ROSENBLATT: It was my turn. I'm going to jump into this because I come down much harder. As somebody that spends most of my work life working on financials for the health plan industry, quarterly filings to the SEC, I just don't get this. This makes no sense to me.

Medicare is spending what, $400 billion a year on hospital payments or something like this? I would require quarterly data submission. I would require it within 45 days of the end of the quarter. I would tie reimbursement to it. You don't submit within 45 days, you don't get paid. Or late charges or whatever. But I agree with David. Changes are long overdue. This is insanity.

And I agree with a lot of your what I would call lower-level recommendations. I would add the cash flow. I would add standard formats. I would add consolidation rules. I would require conformity with GAAP. I would create standards for what is operating and what is non-operating. And I would just try to totally reform these things and get to financial soundness.

As a country, we are focused right now on financial soundness. We have, for the last two years, seen scandal after scandal. It's time to totally change

this thing.

[Applause.]

DR. ROWE: Let me make a comment relevant to what Alice said. Our company is maybe not as big as Alice's company, but it's a big company.

[Laughter.]

DR. ROWE: We close our quarter and I certify to the SEC, under oath I think, within 10 working days of the end of the quarter. And we sign those things and certify.

And so five months, and we need an extension, is just...

DR. REISCHAUER: But you guys are big for-profit entities that are doing this anyway for market purposes. What about the 40-bed hospital in Montana?

DR. ROWE: Of it's only 40 beds it shouldn't take that long.

[Laughter.]

MR. MULLER: We might even get paid by that time.

DR. ROWE: They should be done in three or four days.

DR. STENSLAND: Maybe a question of clarification from Alice of what you're looking for.

There's two bits of financial information and it gets confusing sometimes. The one is the information on total financial performance, and that's like the Schedule G information. And these hospitals are generating that already. That's the kind that you're going to see on the SEC form 10-Ks or 10-Qs.

But then there's also the cost reporting information which is what we generate the Medicare margins off of. And they aren't doing that on a quarterly basis. So then we would have to require them to do some sort of quarterly cost accounting if we wanted the cost accounting data and a Medicare margin. If we just wanted a total margin, it's much easier because we can just say give us what you already have.

MS. ROSENBLATT: But the total margin for SEC is only the for-profits, right? All you have are these 990 things that, from Nancy's thing, aren't very good. So you need something like an SEC on a quarterly basis.

But I go along with Medicare is paying a lot of money. So I would require quarterly reporting so that Medicare has the tools that it needs to do its monitoring.

I would actually require both, but as a stopgap measure at least Medicare, as this is huge payer, should require some kind of reporting on a quarterly basis. And

at a minimum within 45 days. Because I agree with Jack. We're doing it a lot sooner than that and it's possible.

Even the 40-bed hospital probably has one or two PCs and it can be done.

MS. BURKE: I think back to your original question, Glenn, and that is that we have -- at least as long as I've been involved in the discussions here at the Commission, but for years even at the committee level, there has been a hue and cry about how antiquated the date is upon which we make decisions, which is Glenn's point.

And that is there is a sense of being unable to be equitable or make wise decisions because we don't have the data in front of us. And each year the staff struggles to try and accomplish what cannot be done because the data is literally not there.

I think Alice's point is exactly right, as is Jack's. And that is I think there is an accounting that has to be done finally. And that is that to the extent that we want this system to in fact be fair and be viewed as fair and be viewed as being based on wise decisions, we have to begin to get that data.

And a quarterly requirement for the information, in both cases, I think is not an unreasonable thing to request.

Now that also recognizes that the systems are antiquated and many of the issues that have existed in the past have been as a result of the government and what it has asked for and how it's asked for it and how it changes its rules along the road.

But I think there ought to be an agreed-upon set of minimum criteria. I think the standardization issue is also a critical one, so that we can in fact begin to see this information in a way that is understandable, irrespective of how the organization is organized and can be compared unit to unit.

So I have to say I absolutely agree. I think we've gone beyond the point where we can argue going forward that we can begin to answer what are increasingly complicated questions without having this information.

And irrespective of the size of the organization, whether it's a home health organization or a SNF or a 40-bed hospital or a 20-bed hospital, we have to expect these people to be accountable. And that data is the only thing that's going to hold them accountable. So I think we have to get there.

MR. MULLER: I think all of us, over the years, have expressed a desire for more timely data in terms of making the right policy decisions. I think it's also

important to not so quickly go from thinking that the Medicare Cost Report is that easy to file compared to the standard financial statements. Most entities do have their financial statements available on a monthly basis within several weeks. That's different than filing a Medicare Cost Report. So I think Alice's enthusiasm, in one way, I'm sure a lot of entities could file their standard financial reports quite timely. That's different from filing the Medicare Cost Reports and all of the kind of changes that that requires.

So I think the theme here of how we revise the Medicare Cost Report is a very important theme for us to be pursuing. And I think the kind of discussion we've had today is in the right direction.

But if you just basically want everybody to file the financial report that they file for their own purposes, whether it's hospitals -- most people are talking about hospitals today -- but whether it's hospices or imaging centers and so forth, I think the reality is that people do have financially reports that come out much more timely than five months after a year. I mean, people do file monthly reports.

So I think we should decide do we want those kind of reports? Do we want them on a sampling basis, and

so forth, compared to filling out the Medicare Cost Report? There's obviously a lot of desire to have standard information that one can compare. And whether one can truly filed a Medicare Cost Report within five days after the end of quarter, I think is something I'd like to have the panel speak to, because you, in fact, did talk to experts in the field. That's point one. So I don't think it's an exact comparison, Alice, to say that these providers don't have financial reports. They may not have the Medicare Cost Report available that quickly.

A second point, we've had a lot discussion today -- and this may be more appropriately focused to Nancy than to this panel, but I'll throw it to you.

We've had a lot of conversation today about how one treats income, especially investment income, in these reports. I'd like to ask a little bit about how we treat costs, because one of the ongoing themes is whether there are costs that are not allowable and to what extent there's a systemic bias in the reporting of costs that understates cost or overstates cost.

So whether Nancy or anybody else wants to speak to that, you've given us some of your considerations on how to think about the reporting of income. But I'd like to get a sense from you whether there's any kind of

systemic under reporting of costs that also could go back to Jack's question that might have changed how we analyze some of these kind of issues.

Maybe I'll ask for some comments on the second question first, about how report costs and how we understand them. And then perhaps if you help us understand the difference between the -- and to go back to the kind of fervor we have for quick reporting -- what's the fastest one really could file a cost report if it were more simplified? That would be my second question.

DR. KANE: Medicare Cost Reporting is not my expertise. Years ago I did actually have to do desk audits of cost reports at the state level and I do know they can get pretty byzantine and I think there is some issue when you're trying to allocate costs by payer that there is a lot of issues that create bias one way or the other.

I used to teach students how to do that to maximize revenue, just to help them understand the payment system.

So there's no question, as you try to take the cost of the whole operating entity and divvy it up, artificially somewhat, into payers or even product lines, there is some biases that get introduced depending on the

incentives and who's going to use the data. So there are biases.

Now when you're looking at financial statements there's less opportunity to under- or over-report, although where you classified it on the statement there is some opportunity, non-operating versus operating

So I would say on a cost report there are issues of bias and I think everybody has known about them for years, in terms of how you allocate them across product lines or payers. But I think in the financial statements it's not as much of a problem.

MR. LISK: To the second question, on the timing, in terms of our panel discussion. Some of those who are actually filing cost reports really said that they thought they needed the full five months to have everything that they needed. So of it was information that they needed. That's on the Medicare reporting in terms of the current structure of the cost reports.

In terms of other ideas, in terms of reform of the cost reports, in terms of potentially simplifying, you potentially then get issues if you're trying to get more accurate estimates of costs in terms of dealing with cost allocation issues. You potentially make it less accurate when you do some of those simplifications, for instance.

So that tends to go the other direction, potentially requiring more time.

They did, though, feel that the Schedule G type of information could be reported earlier and separated from the cost reports and thought, in fact, that it probably should be separated. So that type of total financial performance information could be -- and we said one of the options was some sort of mandated correlated report like we have for NHIS or something like that. It could be much more complete, in terms of ideas. We haven't scoped that out. But those are the types of ideas that could be pursued if you wanted to get more timely data.

Now more timely data like that, depending upon what information is collected, could get you not necessarily on Medicare but could get you what the current trends are in changes in costs per case or costs per some unit of service, for instance, that we currently just rely on from NHIS, for instance, potentially is some indicator that we sometimes use.

But that data has some serious limitations because of the sample size and other things like that. So a broader reporting would potentially be beneficial. We know providers can do it. There is reporting into

Databank for some of this information that many states require.

MR. MULLER: There's obviously an enormous difference, like a 14 month difference between five months after end of a fiscal year and 10 months after a quarter. So we are talking such different time frames that I'd like to reconcile kind of our fervor for getting it 10 days after a quarter end and then your sense of -- now I understand the difference you're drawing between the Schedule G and the cost report. But that seems to be such an enormous difference in time, 14 months, that it would be useful for us to speak to what can be done on a more timely basis.

And if it's Schedule G, we should perhaps make some estimates as to what a reasonable amount of time is to be able to secure that on a sample that's sufficient to be able to make any kind of policy judgments of it.

MR. HACKBARTH: We're already overtime substantially and since this is Friday I fear we're getting to the point if we run over time we're going to start losing people for our final segment.

I do want to give Nick and Pete the opportunity to come or ask questions, they've been in line for quite a while. But then we're going to have to cut it off and

move forward.

DR. WOLTER: I would share Alice's enthusiasm for moving ahead. I think it is disconcerting that with the level of expenditure that we don't tighten up reporting.

I am still, though, a little bit kicking around whether quarterly makes a lot of sense in this sector. There really are other reasons for it in the publicly traded sector. So that might be one that we need to think through. But certainly an annual reporting that is linked back to audited statements makes it off a lot of sense, and revising Schedule G makes a lot of sense to me.

I would hope that would be done along the lines though of looking at the cost report for other areas that might be simplified in addition to just adding new requirements. Because I think that cost report does need a look and it needs some changes.

On a more specific issue, I would hope we would look at reporting of both operating and non-operating margins because although there is variability in how organizations put things into the operating side, for example, that is tightening up over time. And I think they tell us each something that is useful. And then maybe over time it becomes more consistent.

And as Glenn pointed out, we have kind of gotten into two sets of issues in this conversation. One is Congress's desire to understand overall financial health in the health care sector.

The second is what's going to help us? Whether it's quarterly or annual reporting of this data, that still doesn't get us to some of the issues we're facing in terms of how is Medicare covering costs, particularly in the individual sector areas like inpatient versus outpatient. And I think we still have some very significant issues there.

I certainly agree with our chapter that overall Medicare margin is something that we should really use as our linchpin.

But underneath that, we're still struggling with systems of payment that are different for inpatient and outpatient. And as we do updates, it's very, very hard to know how to update those separately. And I think that then leads to providers having different incentives in those sectors in terms of how they do their business planning.

Those issues are not solved by whatever direction we take on this particular data reporting.

MR. DeBUSK: Of course, for the last four years

I guess I've been most vocal about old data and I totally agree with Alice and Sheila.

But you know, the whole cost reporting system came out of a time where we were on a cost-plus basis, the old TEFRA system. Perhaps we should look at it in a different way. Maybe we should take the GAAP system and look at modifying what is needed on the cost report for Medicare to the GAAP system and try to standardize some of this. Because it's everywhere.

We need to break the old plate and start over.

MR. HACKBARTH: Okay. I know there's more that could be said but I'm afraid we really do need to move on. We've got commissioners that need to catch airplanes. And the next subject, although it's just a plan for work, is equally interesting and controversial, namely the work plan for specialty hospitals, the specialty hospital study.

MS. CARTER: The MMA asked us to examine specialty hospitals. And what was defined in the law was for us to look at cardiac, orthopedic and surgery hospitals.

The context for this study is the following: specialty hospitals, practically physician-owned hospitals, represent a small but growing share of the

hospital industry. GAO reported last year that the number of specialty hospitals had tripled and now number 100. And there were 20 additional ones under development.

Another piece of context is the Stark anti-self-referral law. This law prohibits physicians from referring Medicare patients for certain services to facilities in which they have a financial interest. Hospitals are excluded from this ban. The idea being that an individual physician gains very little from the range of services provided by a hospital.

Lawmakers may have different views and concerns about specialty hospitals. In the MMA, Congress imposed an 18-month moratorium on excluding new hospitals from the Stark self-referral ban. As a result, hospitals are subject to the ban, effectively freezing the development of specialty hospitals.

Congress also requested two studies. HHS was asked to look at referrals and the differences between specialty and community hospitals in the amount of uncompensated care and the quality of care that they provide.

We were asked to look at five areas, hospital costs by DRG and to compare physician-owned and community hospitals costs for the different types of specialty

hospitals. We were asked to look as patient selection within a broad category such as heart cases and to compare the mix of cases at specialty and community hospitals. We were asked to look at payer mix and the financial impact of specialty hospitals on community hospitals. And finally, we were asked to determine how the inpatient PPS might be refined to better reflect hospital costs.

Our report is due in February of next year.

In the last several months, we've met with various representatives of specialty and committee hospitals and these are the themes that we've heard. Supporters told us that the development of specialty hospitals is often physician driven. Some physicians want to improve the efficiency of the services and have become frustrated by the barriers they face in making improvements at the hospitals where they practice.

Supporters contend that specialty hospitals focus on the types of cases that they do well and that this concentration has many benefits. For example, they have improved facility designs, staff experienced in treating a specific type of patient and standardized care processes that produce services more efficiently. These features also result in quality of care that is comparable or higher than the care provided at other hospitals. And

these same features also result in higher patient and physician satisfaction.

Some specialty hospitals acknowledge that they do select certain types of patients but contend that this is responsible practice because specialty hospitals have fewer services such as backup capability and consulting physicians on staff. Patients who are likely to need these services are referred elsewhere so that they are not exposed to unnecessary risk by having been admitted to a hospital that cannot handle their complex medical condition.

Supporters noted that some specialty hospitals avoid entering small markets where community hospitals are week. In such situations the community hospital might fail and it would leave the specialty hospital to provide services that they are not ready to take on.

This is what the specialty hospital critics told us. They maintain that the development of specialty hospitals is driven by physicians' desire to raise their incomes. To this end they argue that specialty hospitals select profitable DRGs and within those the uncomplicated lower cost of cases, leaving community hospitals to treat the unprofitable patients.

Critics also note that specialty hospitals are

less likely to offer certain services like emergency room and uncompensated care. And because profitable cases were selected and treated at specialty hospitals, community hospitals have diminished financial ability to furnish these services or to afford the kinds of improvements that would make them more like specialty hospitals.

This brings us to our study. Our first task is to define a specialty hospital. Based on the mandate language, we will focus our study on physician-owned hospitals. We will examine cardiac, orthopedic and surgical hospitals. We will base our definition on specialty hospitals on the degree of concentration, that is the share of a hospital's discharges in a single clinical area. Though our definition will be based on looking at the distributions of shares across hospitals, it cannot avoid being somewhat arbitrary.

For comparison hospital groups, as requested in the mandate, we will compare physician-owned specialty hospitals with all community hospitals in their markets. But because this community hospital group is very heterogeneous, we plan to compare physician-owned hospitals with two other groups of hospitals. First, community hospitals that are equally concentrated but not physician-owned. This will allow us to examine equally

concentrated hospitals but different in terms of their ownership.

A second group, particularly to examine the impact of specialty hospitals on competitors in their markets, will look at community hospitals in the same market that provide comparable services. These are the hospitals that specialty hospitals most directly compete with.

In different analysis, we plan to look at different comparison groups and, for example, in looking at quality of care and maybe competition we might focus on specific types of services within even the specialty hospital range of services.

Now Julian will summarize the studies that we have planned.

MR. PETTENGILL: As we described in the mailing, we have analyses planned in six areas identified on this slide. In addition to that, we plan to make site visits to several markets where physician-owned specialty hospitals are located. This site visits will give us the opportunity to interview people in the specialty hospitals and in local community hospitals to better understand the motivations and the dynamics of this phenomenon.

Now what I'd like to do is briefly walk you

through the six analytic areas identified here.

Once we have a working definition of a physician-owned specialty hospitals and the comparison groups of community hospitals, we will begin with some descriptive analyses of the characteristics of the specialty hospitals and the markets in which they are located. Hospital characteristics would include things like the number of hospitals, their locations, size, services offered and that sort of thing. We will also have some information on their ownership arrangements and their Medicare and market shares. For the markets we plan to contrast markets with and without specialty hospitals and will be able to assess whether they are rural or urban in character, population characteristics of the people living in the area, and some other features of the market and regulatory environment.

The next topic is patient selection. This part of the study will examine differences in DRG case-mix and severity of illness within DRGs between physician-owned specialty hospitals and the community comparison groups. Most of this analysis will focus on Medicare data, Medicare case-mix and illness severity using claims from the 2002 MedPAR file.

For a few states we may also examine case-mix

and severity differences between specialty and community hospitals for the population covered by private payers.

In a third part of the study we will be looking at differences in profitability across DRGs under Medicare's inpatient prospective payment system and we'll also look at whether private payers payment rates appear to follow a similar pattern across DRGs.

For the Medicare inpatient prospective payment system we will use data from the claims and the hospital's cost reports to estimate payments costs and profitability across and within DRGs. For the private payers analysis we will be using the pattern of payments per case in private insurance claims and will compare that with the pattern under Medicare.

If we find substantial differences in profitability in the PPS we will then examine potential refinements to the DRG definitions and to the way the weights are calculated that might make profitability more uniform across DRGs and thereby reducing payment incentives for favorable selection and specialization.

The next part of the study will address the quality of care. And here we'll be looking, to the extent possible, at differences in the quality of care between physician-owned specialty hospitals and our comparison

group of our community hospitals. We will use many of the same mortality and patient safety indicators that the Commission used in its quality chapter of the March report this year. Our ability to find quality differences in this analysis will be limited you understand, of course, because we're likely to have relatively few physician-owned specialty hospitals and correspondingly small number of cases to work with here in which we're trying to find relatively rare events. Kind of a bad combination.

We will also look at differences in length of stay, transfer rates and discharge disposition of patients.

And then, as we were asked to do, we will also examine the effects that specialty hospitals have when they enter the market on beneficiary service use, program spending and, of course, the community hospitals' financial outcomes. Again, our ability to find much here to answer these questions will be limited because most specialty hospitals haven't been around for more than a few years. Consequently, we don't have very much information to work with in terms of cost report data and so forth.

We may be able to take a case study kind of approach in a few markets where specialty hospitals have

been around for four or five years and we may have to be satisfied with that because there's simply no other data available.

Another way to get some sense about some of the potential outcomes, at least regarding substitution across sites of service and impact on program spending, is to look at what's happened with the entry of ASCs into markets. The advantage there is that ASCs have been growing rapidly for a long time. They have been around a lot longer and we have much more data to look at. And of course, they are of interest in their own right. That's the one study that Ariel talked about yesterday. So we'll be doing that.

And then finally the last area, we weren't asked specifically to do this, this is something that HHS was asked to do. But it's awful hard to talk about this topic without going into the origins and evolution of the self-referral policy. It's a very important part of the context. It's also one area of policy in which modifications might be made to address the underlying issue of whether specialization of this kind is appropriate and how one might limit it. So we will have an analysis of the origins and evolution of the policy.

We will also have some analysis of other

strategies that some of the states have been considering. This would include things like requiring all hospitals to have a staffed emergency room and other restrictive policies that sort of raise the barrier to entry.

Now we'd be happy to take any questions or comments or suggestions.

DR. NEWHOUSE: I have a couple of suggestions. One is in the analysis of cost. It wasn't clear in the draft you circulated but I think you should use costs in the acute care hospital before allocation. That is conceptually you want to know what costs would have been incurred in the acute care hospital but for the care moving out. So you do not want fixed costs in that comparison.

And my guess is that the unallocated costs are a better approximation of that than the allocated costs. But you should use your judgment. --

MS. CARTER: So you're talking about the allocation of overhead, not the allocation to Medicare?

DR. NEWHOUSE: Correct.

My second suggestion is on the control group. There was a discussion and, in fact, you alluded to it in your presentation, of using a control group of community hospitals where specialty hospitals are located. I

actually think you want two comparison groups. You'd like to look at community hospitals where there's more and where there's fewer specialty hospitals to look at an impact.

MR. MULLER: I think you did an excellent job of laying out the study design.

Going by analogy back to some of our concerns seven or eight years ago about whether we have the right risk adjustment in the managed care plans and whether there's a lot of opportunities by careful case selection to profit handsomely from the Medicare program. I think we should also look at to what extent the specialty hospitals can undermine the whole PPS system because obviously you get it in some part here.

But in a system based on averages the extent to which one can ride below the averages and take off cases that do not -- take cases and aggregate them in a way, as you point out in your analysis, by having this just in three specialties, many of them not having a wider range of services, not having emergency rooms and so forth, a lot of the complexity that goes into a more general setting is obviously not witnessed -- I mean, I shouldn't presume it but it may not be witnessed there. The GAO study showed that as well.

So I'd you to consider commenting on the study as to what extent this moment can, in fact, undermine the whole integrity of the PPS system.

MS. BURKE: I won't repeat it but I, in fact, was going to make the same point that Ralph was going to make. I do want to understand that sort of fundamental question about whether this really does undermine the whole thought as to how we built the PPS system.

But at the risk of repeating yesterday's arguments, I wonder whether there is anything that we will learn here or that we could learn here that would inform us as well on the issues relating to the LTCHs.

There are similar kinds of questions about market analysis, about impact on the community hospitals. And I wondered if there isn't, as we look at both of these issues and build an understanding of the markets in the community hospitals and what has happened in terms of service mix, whether there isn't some benefit sort of both sides looking for some of these issues together and perhaps looking to what extent there are similarities or answers that might be gleaned from either study that would help the other.

MR. PETTENGILL: I think some of the analysis of DRG profitability and case selection within DRGs and that

sort of thing would be very relevant to the long term care hospital problem. By having said that, that's probably the only part where there's sort of a direct parallel. The rest of it, the study population we have to look at here in terms of markets and hospitals, the database in effect, is very different.

DR. WOLTER: I think this was very well put together and certainly it's ambitious when you look at looking at DRGs and the self-referral issues and all of these things.

I think though, that if we get some good information back that this could be very, very helpful. And as you know, I'm very interested in the DRG profitability issue because I think, even aside from the specialty hospital issue within the not-for-profit hospital sector itself lots of decisions around business strategy get made on that basis which are not always driven by what's in the best interest of the services needed by the beneficiary. So I think that could take us in a number of directions.

And then that I would just underscore, I think the whole issue of self-referral is so important and it is a very difficult issue, an emotional issue. We have rules about it in some areas but not in others. But when is it

a conflict of interest to be referring to yourself and when is it not? And there are gray areas here. But I think that discussion can be quite valuable.

DR. WAKEFIELD: No rush. Go-ahead.

MR. DURENBERGER: We're on the same plane, go ahead.

DR. WAKEFIELD: You're right, we are on the same plane, it's true. You're not leaving without me, Dave.

You mentioned in the text that you provided us that proponents of specialty hospitals suggest that patient satisfaction is perhaps higher for patients treated in those facilities.

Is there anything that you could access that would give us a sense from national datasets in comparing these hospitals to non-specialty hospitals about the patient satisfaction? Any read that we could get on that?

Because your quality data, as you indicated, are pretty thin in terms of what you're going up to look at. Could you do inpatient satisfaction or is that not going to be an option?

MR. PETTENGILL: That's something we'll have to explore. I hadn't considered that. But certainly, if there are data at CMS, but I'm not sure about that. We'll have to talk to Karen and see what we can dig up.

MR. DURENBERGER: Of course, since I made that crack about being your mother...

DR. WAKEFIELD: People who weren't here yesterday won't understand that.

MR. DURENBERGER: Alan, are you Medicare-eligible yet?

DR. NELSON: Yes.

MR. DURENBERGER: Oh, there's two of us.

I have two suggestions. One of them does go to sort of the heart of the study. But the study is really great and it's really terrific.

One is sort of like a suggestion about focus. And I think as I look over what the specialty hospitals say about themselves, efficiency, quality, satisfaction, innovation, and things like that, that is the same thing that people care about. And so I just think if the focus of the report, like the very last thing up there, really is on answering the question which is what should communities look like in terms of high quality, innovation, access, choice, a whole variety of things like that.

The other issues, which are the complaints from general hospitals, probably are not necessarily the first choice of priorities by the vast majority of citizens,

although they are important to some and they do need to be dealt with.

But if we focus this not just as one group versus another group and who's right and who's wrong and so forth, but just think about it as a community of people and highlight the things that people ought to be concerned about, which are efficiency, quality, satisfaction, innovation, access, choice and so forth, you can still get to the same issue. But I think the report has more meaning to legislators who asked you for it.

The second one is related to that. In the study plan I think the selection of the communities you go to is very important because there are communities in this country that are already starting to deal in some way with this issue not just legislatively.

And in that regard, if you would add to the list of people that you talk to purchasers, particularly large employers. And if you can get beyond the sort of level of frustration that they have when they see this competition going on and they know they're paying for it but they don't understand it, try to understand better as you look at various of these communities what role the purchasers believe, on behalf of employees and all that sort of thing, they could or might be able to play in this whole

process. I think it would give us some helpful information.

And I'm assuming the people at the Center for Studying Health System Change, who I know help us out at various times, can be helpful to you in both regards.

MR. HACKBARTH: Anybody else?

Okay, thank you very much.

So we are now to the public comment period and we will briefly accept comments.

With all the usual ground rules, which you should know very well by now.

MR. FENNINGER: I do indeed. And I've been told before that if I'm the only one up here I still don't get all the time.

Randy Fenninger. I represent the American Surgical Hospital Association, which is the trade organization for about 60 of the 100 or so specialty or surgical hospitals which have been identified. We appreciate the opportunity we have had so far to meet with the staff and are delighted that they will be making a site visit or site visits.

I would note that each of your will receive, if you have not yet received, an invitation to visit a hospital as close to your home as we can possibly find to

give you the opportunity to see what a specialty hospital is and is not, because they are designed to do certain things and they are not designed to do other things.

I think we all know what a community hospital, is either professionally or personally. We hope you will take advantage of the opportunity that will be provided over the coming months to learn more by such a site visit either with some of your staff or independently.

I would just add a couple of cautions. I actually think the design of the study, the way it was laid out, is very good, it's very thorough and queues closely to what Congress said.

I'm a little bit concerned, having heard this morning's conversation and discussion about measuring revenues and costs and impact, how you're going to compare what may or may not be happening to community hospital revenue and finances, given the difficulties you have already defined in your previous discussions of measuring that exact element. And yet that's quite key, I think, to the overall debate that is going on.

So I guess we'll just all have to live with two-year-old data in whatever you find because I don't think you'll fix the one prior to the other.

A couple of things. First of all, I would urge

all of you to take a very open mind into this debate and discussion. I think you pride yourselves on doing that and I can only encourage you to continue to do that as this goes forward. This has been contentious and emotional, as you will know, in Congress and in communities where these hospitals are under development or have been developed. And good analysis is an extremely short supply. We're very hopeful that we get more good analysis coming out of this particular effort.

We would suggest you take a very careful look at why these hospitals grow up. Why are they developed? They are very unique to the community setting in which they occur, whether that's Durango, Colorado; Kalispell, Montana; Modesto, California or some other city, Milwaukee, Wisconsin which I refer to as ground zero of this whole debate.

But I think it's important that as you go through your analysis that you understand the rationale in those committees because they are different. And the different kinds of hospitals are different. We represent primarily hospitals that perform elective surgery for patients who are otherwise healthy, be they Medicare or non-Medicare. You will find perhaps cardiovascular hospitals having a somewhat different structure, a

different model, a different in the community.

So just as you have commented in the past on ASCs, they all don't look alike, they all don't function alike, there are differences. And those will be important, I think, to your consideration. And I urge you to take cognizance of that, as well.

As you go through this, it might be interesting as a sidelight to examine some of the tactics that are being used in communities where these hospitals are either consideration or under development. As you do this analysis at the staff level, I cite economic credentialing and exclusive contracting as two issues that you might find interesting.

On the timeliness of data, the earlier discussion, I want to volunteer our association and our members to be the first to say you want it in a week, we'll get it to you in a week. What can we do to help? We think we're efficient and we think we could probably provide that information to you far more quickly than it's currently coming out, if that's at all helpful.

Let me close by saying it will be difficult I think, and I think your staff has told you this, it is going to be difficult to answer all of the questions with a great deal of depth partly because of data limitations

in the Medicare data about our members and the communities in which they operate.

We hope you will not use that as a reason for encouraging Congress to extend the moratorium. We know that we are the new kids on the block. We know that much of the data that you will be looking for is not going to be readily available. We don't think that's a reason to continue to aid and abet monopolization by one set of providers in many communities. And we hope you will consider that as you go forward and reach your conclusions for your final report.

Thank you.

MS. THOMPSON: Hi, I'm Ashley Thompson with the American Heart Association. And I just wanted to commend the commissioners for their discussion on the data needs and the need for more for timely data.

Our organization absolutely shares the same desire in this respect, and we've been working with the hospital field in order to provide more timely data through avenues such as NHIS and Databank, which have been listed. And we do know that those have some limitations.

What we wanted to share with you is, as you continue this very important discussion, we share Mr. Muller's concerns about jumping thoroughly into using the

Medicare Cost Report and requiring a timely or a more timely turnaround of that document as it does contain some data that is difficult to obtain. We just want to look at that more thoroughly.

However, the idea of using Schedule G as an avenue to get at more timely information is something that we would like to look at with you. So we do want to offer our help and assistance as you move forward in this area.

Thanks.

MR. HACKBARTH: Okay, thank you. We're adjourned. [Whereupon, at 12:17 p.m., the meeting was adjourned.]