MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
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Thursday, December 7, 2006
9:51 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
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JOHN M. BERTKO
KAREN R. BORMAN, M.D.
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FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: Welcome to our guests. We have a

3 long and challenging session planned for today.

4 This morning will be devoted to the mandated

5 report on the SGR. We'll have three distinct sessions on

6 that. And then this afternoon we will turn to our update

7 recommendations.

8 So the first item on the SGR is a discussion of

9 outliers. Niall, why don't you lead the way.

10 MR. BRENNAN: Thank you, Glenn. Good morning.

11 As you all know, the Deficit Reduction Act

12 mandated MedPAC to complete a report on alternatives to the

13 current SGR and a payment system based on the identification

14 of physician outliers was one of the mandated areas for

15 analysis.

16 Today, we'll be presenting our latest findings

17 related to our assessment of two commercially unavailable

18 episode groupers and how they perform on Medicare claims and

19 their suitability for measuring physician outliers.

20 Again, I'd like to thank Megan and Jennifer, both

21 of whose work is represented in this presentation.

22 To briefly review, the two groupers we're using

1 are Episode Treatment Groups, created by Symmetry Data
2 Systems, and the Medstat Episode Grouper created by Medstat.
3 These groupers are designed to comb through administrative
4 claims to create clinically distinct episodes of care.
5 These episodes can vary in length and a beneficiary can have
6 more than one episode open at any given time. For example,
7 a beneficiary can have concurrent episodes of diabetes and
8 sinusitis.
9 Over the last few months, we've presented a range
10 of findings related to our use of these groupers on Medicare
11 claims. In the next slide, I'll briefly reprise some of
12 what we told you last month and map out what we'll talk
13 about today.
14 In the November presentation, we presented two
15 analyses. The first analysis attempted to quantify the size
16 of spending on outlier physicians in the Medicare program by
17 specialty.
18 The second analysis focused on the use of episode
19 groupers to identify outlier physicians and presented
20 information on some of the technical issues that have to be
21 confronted in the use of these tools, such as attribution,
22 the calculation of expected values, and the fact that

1 because of sample size problems not all of the physicians in
2 a given market are going to be measured.
3 We concluded with some distributions of overall
4 physician scores for cardiologists and urologists in the
5 Boston MSA where we showed that it was possible to identify
6 both low and high resource use outliers, for example 10
7 percent of the cardiologists in Boston used 44 percent more
8 resources than average.
9 Today we're going to focus on two critical issues
10 in the use of these groupers, the ability of the groupers to
11 account for differences in health status between patients,
12 and the ability of groupers to provide detailed information
13 that can show physicians the precise drivers of their
14 resource use patterns.
15 One of the most important factors that we have to
16 deal with in using episodes of care to assess physician
17 resource use is risk adjustment. From our experience in
18 talking with people who have used these tools in the private
19 sector, a common reaction from physicians is that their per
20 episode costs are higher because their patients are sicker.
21 In order for these grouping tools to have face validity with
22 practitioners, you have to be able to show that the groupers

1 do not unfairly reward or penalize physicians based on the
2 underlying health status of their patients.
3 Both groupers employ risk adjustment techniques.
4 ETGs uses an approach known as episode risk groups or ERGs,
5 while the MEG grouper uses the diagnostic cost grouper
6 method, DCG. Using these methods you can calculate a risk
7 score for each episode and eventually build an overall risk
8 score for a physician's panel of patients. In the next few
9 slides, we'll provide some examples of the MEG DCG risk
10 adjustment approach on Medicare claims in the Boston MSA.
11 We're also conducting analyses using the entrance
12 ERG risk adjuster and expected to have results from that
13 early next year.
14 One thing I'd like to add here is that risk
15 adjustment systems are only as good as the coding that they
16 rely on. For example, in this process we've documented
17 instances where in certain MSAs, such as Miami,
18 beneficiaries are significant more likely to be coded as
19 having coronary artery disease. Risk adjustment systems
20 will then treat these beneficiaries as having poorer overall
21 health status.
22 What we wanted to show you with this table is how

1 risk adjustment techniques can impact a physician's overall
2 score. This is a simple cardiologist in the Boston
3 Metropolitan Statistical Area. If you look at the table you
4 can see that this cardiologist has a total of 250 episodes,
5 the majority of which -- 156 -- are hypertension episodes,
6 with smaller but still sizable numbers of coronary artery
7 disease episodes and arrhythmia episodes.
8 The expected value in this case is calculated as
9 the per episode average for all hypertension episodes seen
10 by cardiologists in Boston and all CAD episodes and all
11 arrhythmia episodes. Using this averages as our expected
12 value, the non-risk adjusted overall resource use score for
13 this cardiologist is 1.04, meaning this cardiologist uses 4
14 percent more resources than his peers. However, once you
15 incorporate the effects of the MEG risk adjustment approach,
16 this cardiologist's overall risking use score increases to
17 1.13, which if you remember our distribution of physician
18 scores in last month's presentation, would place him roughly
19 in the 75th percentile of cardiologists. So high, but not
20 excessively high.
21 I'd also like to note here that it's the
22 physician's resource use score on hypertension, the 1.76,

1 that's driving his overall resource use score here. So this
2 physician appears to use more resources than average in the
3 treatment of hypertension, about an average amount of
4 resources in the treatment of CAD, and fewer resources than
5 average in the treatment of arrhythmias.
6 So what drove the increase in this cardiologist's
7 overall resource use score? It turns out his patients
8 weren't sicker. They were actually healthier than average
9 than other hypertension patients seen by Boston
10 cardiologists. Of this cardiologist's 156 hypertension
11 episodes 141, or 90 percent, fell into the lowest disease
12 stage of hypertension compared to 80 percent of all Boston
13 cardiologists. And we'll talk a little bit more about
14 disease staging and risk adjustment in the next slide.
15 Yet despite having healthier than average
16 patients, his observed resource use was still greater than
17 his peers.
18 Before we continue, I'd like to take a moment to
19 talk about the concepts of disease staging versus risk
20 adjustment. The MEG grouper uses disease staging, which
21 classifies each episode into one of three disease
22 progressions. So stage one of a particular condition is

1 less severe than stage three. Decisions on which stage of a
2 disease an episode is classified into are made based on
3 specific ICD-coding on the claims. Risk adjustment looks at
4 all diagnoses an individual has, an addition to age and sex,
5 in order to create an overall picture of health status for
6 that person.
7 In the MEG grouper, within each episode disease
8 stage, based on your risk scores, you are assigned to one of
9 five possible severity levels ranging from lowest overall
10 severity, severity level one, to the highest overall
11 severity, severity level five. We'll see some of these
12 concepts in the next table.
13 This table focuses just on the 141 episodes of
14 stage one hypertension by our selected cardiologist in
15 Boston. If you look at the rows, we present information
16 both on the number of episodes within each severity level
17 and the level of resource use, both for our selected
18 cardiologist and his Boston area peers. The last row on the
19 table calculates a resource use ratio for our selected
20 cardiologist.
21 What the columns show is the stratification
22 approach employed by the risk adjustment in the MEG grouper,

1 which further subdivides each disease stage into five
2 different levels of overall patient severity.
3 As you can see, our selected cardiologist's
4 resource use is higher than his Boston peers across four of
5 the five severity levels within stage one hypertension. If
6 you focus on the severity level two column, you can see that
7 his observed resource use of $660 is more than twice that of
8 other Boston cardiologists who see similar hypertension
9 patients. Remember in this analysis, we've standardized all
10 dollars and that our episode costs are comprised of both
11 Part A and Part B dollars, although with a condition such a
12 stage one hypertension we would expect that the majority of
13 costs would occur in the ambulatory care setting. I'll show
14 you in a table later that that is indeed the case.
15 The last table is meant to illustrate the ways in
16 which episode groupers can retain detailed claim level
17 information that can then be used to explain to physicians
18 with the drivers of their resource use are. I'd like to
19 stress that this should not be viewed as a report card but
20 rather as a very simple, very specific example, of the type
21 of information that might be appropriate for inclusion on a
22 report card.

1 So if you look at the first column, the total
2 dollars, the numbers in that column are the same as the
3 numbers in the last column on the previous table. It
4 represents spending for that cardiologist across the
5 different severity levels.
6 The types of service we examine are evaluation and
7 management, procedures, imaging, tests and other. The
8 previous slide established that our selected cardiologist
9 was above average in his treatment of stage one
10 hypertension. This slide can help us show why.
11 Overall, the cardiologist has a resource ratio of
12 1.74, observed resource use of $623 versus $357 for his
13 peers. If you look at the evaluation and management column,
14 you will see that a large proportion of the overall
15 difference is accounted for by E&M dollars with smaller
16 shares accounted for by imaging, tests and other.
17 It's also important to note here that you have to
18 take into account both the amount of dollars you're looking
19 at when you look at the resource use ratio. For example,
20 the selected cardiologist has a resource use ratio of 0.67
21 for procedures but procedures count for a very small
22 proportion of overall stage one hypertension costs. We

1 continue to work on these types of drill down analyses and
2 will present more findings again early next year.
3 In conclusion, we feel that our ongoing work and
4 the work of others demonstrates that episode groupers can be
5 used as a tool in identifying outlier physicians. We've
6 drawn your attention to several technical issues over the
7 preceding months that may need to be addressed a little
8 further.
9 Once we're confident that we are actually
10 identifying outlier physicians, a number of policy options
11 could be pursued. These range from confidential feedback
12 and educating physicians in an attempt to change their
13 practice style, to more direct interventions such as the
14 public reporting of physician outlier scores or differential
15 copayments or payment updates for outlier physicians.
16 Later this morning Kevin is going to talk to you a
17 little more on ways in which this could be integrated with
18 some of the other options that we're looking at.
19 That concludes our presentation and I'd be happy
20 to answer any questions that you might have.
21 MR. BERTKO: More of an observation than a
22 question, Niall, and that's just to confirm that that table

1 that you had, the last one, which shows tests, imaging, E&M,
2 et cetera, has proven -- at least in private sector -- to be
3 a pretty effective tool in displaying the kind of results
4 that come out. A physician would say what do you mean I'm
5 out? When we've shown a tool like this and explained the
6 mechanics behind it, it has worked pretty well.

7 So again, recognizing that this is only
8 illustrative but still it's pretty useful.

9 The other observation on risk adjustment, I can't
10 speak to the use of the DCGs as well, but to the ERGs, the
11 Society of Actuaries is now finishing its third study over
12 about a 10-year period. I've seen the draft of it and I
13 would comment to my fellow commissioners that there has been
14 a gradual improvement in the predictability of these, either
15 as measured by R-squareds or by predictive ratios. That
16 will be out soon.

17 So I'd like to at least acknowledge that while
18 these tools will never be perfect, they're actually getting
19 better as we adapt the systems. And the ERGs will be one of
20 those that are displayed in this study.

21 MR. HACKBARTH: Niall, over a course of months
22 now, has done a terrific job, for me at least, in terms of

1 making this more understandable, more concrete. Thanks,
2 Niall, for the great work you've done on it.
3 John, at various points in the past you've talked
4 about how this tool is applied by private payers, Humana in
5 particular. It would be helpful for you to again, just very
6 briefly, describe how you apply it. In addition to feeding
7 back information, what are the other uses?
8 MR. BERTKO: The primary use for it is in setting
9 up a tighter network. We call them high performance
10 networks and there is basically three categories of
11 physicians. Two of them are in. There are physicians who
12 we have enough episodes and we say you clearly are inside
13 the network. There are some outlier physicians and those
14 are clearly excluded. And then every physician without
15 sufficient data gets a free pass, and so they remain inside
16 the network here.
17 We then would go out, as we have say in Milwaukee
18 where we have a big effort underway, and walk through the
19 results in general, the methodology to the physician,
20 hospital and employer community -- usually all mixed up,
21 which is useful. And to the extent that individual
22 physicians may have a question about that, we have produced

1 something which is very much like that third chart that
2 Niall had. And that's been fairly effective.
3 Frankly, one of the reactions that I know from the
4 leader of a county medical society was oh, I didn't know
5 that. And I think that's a good implication for the use of
6 information.
7 MR. HACKBARTH: So feedback, network development.
8 Do you ever use it to alter the amount paid to physicians,
9 either to allow them to somehow share in gains or different
10 unit prices?
11 MR. BERTKO: No, at this stage it's strictly are
12 you in the network. It's a beneficiary copay then, but not
13 at this stage a differential amount paid to the physician,
14 although we've talked about that in theory.
15 MR. HACKBARTH: Arnie, in your experience, have
16 you seen it used for purposes other than education and
17 network development? Have you seen it used to set payment
18 rates or penalties for inefficiency or sharing in gains for
19 relative efficiency?
20 DR. MILSTEIN: Yes, there are some self-insured
21 plans that have been doing this for several years. In
22 addition, the largest of the physician pay-for-performance

1 programs, which is the IHA California pay-for-performance
2 program, is this year introducing a resource use measure
3 into its formula for P4P.
4 MR. HACKBARTH: Just say a little bit more about
5 how that works. How do they use it in P4P?
6 DR. MILSTEIN: The way the California program
7 works is the participating physician organizations are
8 scored historically based on quality only. And now they
9 will be quality and resource use. It's always been left to
10 each participating plan to decide how to weight the
11 different elements of the scores in their P4P formula.
12 So what they're committed to do is to weight it in
13 their P4P formula, but there will be freedom among the plans
14 as to how much weight to assign, for example to patient
15 experience, to effectiveness, to resource use, and IT
16 adoption.
17 DR. REISCHAUER: Niall, this is fascinating and
18 once again the further down we dig, the more difficult the
19 solutions become.
20 I was wondering whether you had done a similar
21 analysis of arrhythmias? We have the case in which this
22 physician, with respect to hypertension, seems to be less

1 efficient than his peers. But with respect to arrhythmias,
2 it would be quite a different story. And one, of course,
3 doesn't know whether he's underserving, in a sense, not
4 providing significant appropriate care or not, or where the
5 source are. One can just look at this picture of
6 hypertension and come up with hypotheses about why there is
7 so much E&M going on. But if one found, with respect to
8 E&M, he was well below the average then there would be a
9 different set of hypotheses.
10 When you look across the different severity levels
11 there is a sort of a bizarre pattern in which the lowest
12 costs are associated with the highest severity level in this
13 physician's practice, as opposed to the monotonic rise in
14 costs across severity levels for the average hypertension
15 cardiologist in the Boston Metropolitan Area.
16 So you think maybe this is a case where we need
17 reeducation and you might get very significant improvement
18 in the quality of care if the average physician is a measure
19 of appropriate quality, and that's sort of a big question in
20 and of itself. But how much you'd save in the way of
21 overall resources is really an unknown.
22 MR. BRENNAN: Those are all very good questions.

1 We do have information on arrhythmias. However, it was
2 produced pretty close to the meeting and we haven't had time
3 to fully absorb it. But it is something that we could maybe
4 check and get back to you relatively quickly.
5 And then also, on the differences in E&M costs,
6 one thing I should have added in the presentation perhaps is
7 we know that it's a utilization component that's driving it.
8 It's an average of 14 visits compared to 11. And then, just
9 on your point on the higher severity level, actually his
10 resource use ratio is less than one.
11 Again, we're not entirely sure what's going on
12 here but also if you look at the N's in those columns, the N
13 gets lower. And once the N gets lower more noise comes in.
14 He has a sprinkling of patients in stage two and stage three
15 and those N's are even smaller. There would be a lot of
16 information to present on the table and some of them were
17 slightly counterintuitive.
18 But if you only have one observation in the cell,
19 you can sometimes get strange results.
20 DR. HOLTZ-EAKIN: Niall, a similar set of
21 questions. In your first table, you showed numbers for non-
22 risk adjustment and then risk adjustment. Is literally risk

1 adjustment or is that disease staging plus risk adjustment?

2 MR. BRENNAN: That's disease staging plus risk

3 adjustment.

4 DR. HOLTZ-EAKIN: So it's everything?

5 MR. BRENNAN: Yes.

6 DR. HOLTZ-EAKIN: Because one of the things that

7 jumps out in that table is it's the all other where the big

8 difference is. I was just curious if you had some intuition

9 about what's going on there?

10 MR. BRENNAN: Off the top of my head, I don't. We

11 could check into it. Again, it's not a lot of episodes.

12 It's only 16 episodes, so it's probably not practice.

13 MS. DePARLE: My question is kind of related to

14 Doug's. I thought I was following you now in stepping

15 through this. When you get to page nine, which is very

16 interesting, those numbers are risk-adjusted? Or is that a

17 separate analysis?

18 MR. BRENNAN: The numbers reflect risk adjustment.

19 I guess the best way to describe it would be to go to the

20 preceding slide, on slide eight. In that one, for stage one

21 hypertension, people have been subdivided into their varying

22 risk levels. And then the far right-hand corner presents

1 the aggregation of that information. So that's the 141,
2 $623, 357 is then the first column in the last table.
3 Because we sort of collapsed it back up again, just for ease
4 of presentation.
5 MS. DePARLE: Okay.
6 And then what is other? Because he or she seems
7 to be quite off the chart in respect to the categorization
8 of other.
9 MR. BRENNAN: Other is hospital inpatient, SNF,
10 non-physician outpatient dollars, not classified dollars.
11 We will, down the road, be able to classify that with a
12 little more precision. Right now we can't.
13 MS. DePARLE: There's no Part B drugs or anything
14 like that in there?
15 MR. BRENNAN: No, I don't believe there are. I'll
16 check that.
17 DR. MILLER: But as a general thing, in the
18 database Part B drugs could be --
19 MS. DePARLE: When you use the betas, that's --
20 DR. MILLER: In this particular example is what
21 you're saying?
22 MR. BRENNAN: I'm almost positive it doesn't

1 reflect Part B drugs so that the other was zero. That would
2 reflect the cats and dogs that don't fall into E&M
3 procedures, imaging and tests.
4 MR. MULLER: You almost have an implicit acute
5 adjustment just by seeing how much of it is in E&M. That's
6 the giveaway right there. I'm not sure that's statistically
7 valid, but you can just see it right there, you have such a
8 high proportion right there.
9 DR. KANE: I think the resource group stuff is
10 very interesting, but is it an outlier analysis? Because we
11 start off defining outlier as sort of the two standard
12 deviations out, 2 percent of the people with the highest --
13 of course, we don't talk about the lowest -- but the highest
14 payment. And here you're really saying who's off the mean.
15 So I guess is this responsive to really doing the
16 pluses and minuses of an outlier strategy as opposed to an
17 episode-based resource use? I didn't feel we really, in
18 this paper, described the pluses and minuses of an outlier
19 strategy statistically. Should you just pick the top -- the
20 guy is two standard deviations out on their payments, and
21 try to adjust their payment for that? Here we really much
22 more talk about a tool, which is a great tool, a very

1 promising tool, and then how people look relative to the
2 mean in their population of specialty and geography.
3 So I guess overall I didn't know that this type of
4 analysis falls into what we would call outlier, if you mean
5 what you start off in the paper by talking about, this is
6 that you're two standard deviations or one standard
7 deviation out on per capita payment.
8 I'm just trying to reconcile the use of the word
9 outlier for this type of analysis.
10 MR. HACKBARTH: In fact, let me pick up on that.
11 This has focused on the tool and basically we've picked up
12 work that has been ongoing now, before the SGR mandated
13 report, focused on the tool and saying the tool could it be
14 applied to the outlier issue.
15 Indeed, in order to identify outliers, you need
16 some tool, some metric, for saying here is an outlier. But
17 I agree with your basic point that the focus is principally
18 on the tool, as opposed to what you do once you've
19 identified the outliers.
20 DR. KANE: I think it's also saying that you can't
21 just look at the outliers because they don't mean anything.
22 There's no risk adjustment. Until you do, this outlier

1 doesn't make a lot of sense.

2 DR. REISCHAUER: But also you have, this

3 particular individual is an outlier in one area and is an

4 outlier on the downside somewhere else. So don't know if

5 somebody who you don't pick up for the average is really an

6 outlier for certain procedures.

7 DR. KANE: I think we need to do a little more

8 systematic addressing of the pluses and minuses of the use

9 of the concept outlier. This is a great general education

10 tool that may or may not be hitting outliers but it may be

11 hitting pieces of a physician's practice that aren't in

12 consonant with their area norm. That's not an outlier,

13 certainly at a physician level. And it's really not

14 statistically driven. It's much more here's how you stand

15 relative to your group's norm.

16 MR. BERTKO: Nancy, let me say it is, as Glenn

17 said, mainly a tool analysis. And the next question is how

18 you use it. But let me confirm, in a group in one city to

19 be not identified, we have lots of cardiology practices.

20 They tend to be small practices, five, seven, 10 folks. And

21 frequently we would have one or two physicians who would

22 show up in a pattern just like this who were unknown.

1 So if you have any kind of organized payment
2 arrangement, the first step is what we're doing compared to
3 what's going on in California. You give this information
4 and the physicians all look at each other and went oh, Bob,
5 did you know you're doing it? And that's the next step in
6 terms of the budget.
7 But it is a true outlier and it's a useful tool if
8 someone were to manage their practice more efficiently.
9 DR. KANE: I just don't think you need to use the
10 word outlier. I think this is a general tool to help people
11 learn where they're efficient and inefficient. There are
12 other issues around the use of the word outlier and the
13 statistical tool that we haven't addressed here. That's my
14 only point.
15 MR. HACKBARTH: Let me just pick up on what Nancy
16 is saying, because I think I understand where she's headed
17 with this.
18 What you need in order to have an outlier payment
19 policy, is several elements. One, you need a tool for
20 identifying, and that's what this is all about. Second, you
21 need to make decisions about set points. Where in the
22 distribution are you drawing your line to say who is an

1 outlier?

2 And then third, do you need to say what are the

3 consequences of being beyond the set point and being in the

4 outlier category?

5 On his last slide, Niall had a list of potential

6 consequences, ranging from simply feedback to education,

7 public reporting, differential payment rates, and so on.

8 I think, to complete the list, based on what John

9 has described the other use private payers had for the tool

10 is exclusion, or putting providers in a nonpreferred tier.

11 So that would be sort of a more complete list of the range

12 of the potential consequences.

13 One more thought and then you can leap in.

14 As I look at that range of consequences, they have

15 very different implications in terms of how strong the tool

16 needs to be. Arnie and I have had several e-mail exchanges

17 about this.

18 Generally, as you move down this list, the stress

19 that the tools are under increases. People are going to

20 resist it more, debate it more, go to their Congressmen more

21 as you move down the list because the consequences get more

22 and more dire. If you add to that risk exclusion, that's

1 the atomic weapon of Medicare.

2 So not only do you need a tool, not only do you

3 need set points, you need to think about which use we're

4 applying and how much stress that applies to your tool to

5 have sort of a complete discussion.

6 DR. KANE: But you're not talking actually about

7 physician outliers so much as particular practice outliers

8 within a physician's practice, too. So as we find with his

9 physician, I don't know if I'd classify the whole person as

10 an outlier, but certainly there are things they do that make

11 them an outlier on their practice.

12 I'm just worried about the word outlier. I don't

13 think that's appropriately used here. And the word outlier

14 has a statistical significance in the inpatient side that I

15 think we're not using here.

16 So I just wouldn't call this an outlier analysis.

17 I think I'd call it something else, and maybe a tool to

18 improve overall medical practice across the board, as

19 opposed to some kind of let's hit the weird thing that's two

20 standard deviations out. It's a much broader tool than

21 that.

22 And then we still haven't said well, should we

1 really be focusing on the one standard deviation out or two
2 standard deviation out or not. We're not talking about that
3 here. Do we need to or not, to address Congressional
4 concern?

5 MR. MULLER: As the dialogue that you had with
6 both John and Arnie indicated, insofar as there's a lot of
7 use of this by the private payer community, the data you
8 presented today is on all the Medicare beneficiaries. But
9 how then, in any Boston area, where I assume there's a
10 multiplicity of plans, does a Humana or a Wellpoint or
11 whoever's up there, Blue Cross, use the whole Medicare
12 database? I assume they focus mostly on the beneficiaries
13 that they have. And therefore in the essential subsample,
14 is Niall pointed out, you already have cell size problems in
15 some of these areas.

16 If you're then looking at it divided by three or
17 four plans and how they may look at that data, in some ways
18 it may not be in the interest of the plans but they probably
19 want access to the whole Medicare database rather than just
20 their subsample of the database, in terms of what you're
21 looking at and if you want to look at individual physician
22 practice.

1 And therefore anyplace where you have three or
2 four plans, it's going to make the data aggregation or de-
3 aggregation problems much more difficult. So that probably
4 is an argument for using the Medicare full database in
5 conjunction with the database that the plans have, obviously
6 understanding that have the greatest incentive to manage the
7 population that they've signed up.
8 DR. MILSTEIN: I don't think, in thinking about
9 the readiness of this tool for various intermediate to
10 higher stress uses, I don't think we should regard the fact
11 that physicians vary on how they score by diagnosis to be a
12 problem. I think that if you look at almost any other use
13 of performance evaluation affecting compensation across
14 other professional services, this is the case.
15 Now whether you're talking about attorneys or
16 investment bankers or baseball players. If you were to, for
17 example, characterize a baseball pitcher that had an earned
18 run average of 2.5 and stratify for how that earned run
19 average is distributed on early, intermediate, and later
20 innings, you would find substantial variation. But
21 nonetheless the compensation, in effect even the retention
22 of the team by the pitcher is based on their aggregate

1 performance across all hitters, all innings.

2 So I think that we should absolutely expect that

3 there be variation by diagnosis. I don't think we should

4 regard that variation as evidence of a flaw in the tool.

5 That's first comment.

6 The second comment is that, following on Nancy's

7 point, I don't know whether it's at this point in the

8 discussion or later, I think we should perhaps elicit more

9 opinion as to given what we know about the flaws and the

10 strengths of this particular tool, that it's using episode

11 groupers to assess resource use, what is our sense as to how

12 far down the list of stressful applications we feel the tool

13 is ready for use?

14 As I referenced earlier, the private sector is

15 moving ahead with this. It's certainly true that a public

16 program like Medicare, those providers who feel

17 disadvantaged do have a lot more avenues of redress that

18 they may have in the private sector, although John may

19 disagree with that.

20 But we have a circumstance in which private sector

21 users have moved ahead with this over the last several

22 years, and it has been translated into meaningful

1 improvements in affordability of health insurance premiums.
2 And that latter result is something that this program
3 obviously is -- Medicare is striving for.
4 I think, if you were to ask is this conceivably a
5 better approach, granted its flaws, than current SGR, I
6 personally think it is even for higher stress uses.
7 I mean group punishing all physicians based on the
8 entire nation of physicians not hitting a GDP growth target,
9 that is hard to defend. I think moving to something that's
10 better, even if flawed in a high stress use, is something I
11 personally do feel comfortable supporting, particularly in
12 view of the improvements in affordability that have already
13 been delivered over the last several years by private sector
14 payers using this very approach.
15 DR. REISCHAUER: On this particular point, these
16 are arranged in sort of order of both severity and possible
17 political backlash. And we don't know anything about what
18 the response would be to each of these. And there's a
19 logical order, I think. You have to do, in a sense, the
20 first before you can do the fifth.
21 But I would think you would start and begin
22 measuring what the impact is. And you might not have to go

1 very far down this list before you got 90 percent of the
2 possible response from the provider community. And
3 certainly it would be more harmonious.
4 DR. HOLTZ-EAKIN: Briefly, Arnie is right about
5 variation. I won't repeat that.
6 Secondly, in terms of the stress on using this, I
7 think it's important to remember that the tool itself is not
8 static. If you put it into the mix, it will improve as it
9 gets feedback. And so we should remember that. It's not a
10 static entity.
11 And the last is I would be curious what we can
12 learn from the private sector about what sample sizes seem
13 to be big enough to work. A lot of this focuses on things
14 where you look at the number and you say oh, that's too
15 small and I don't trust it. But I don't have any empirical
16 basis for knowing what sample sizes matter.
17 DR. MILLER: Niall, you've talked about a rule of
18 time that you've run across, haven't you?
19 MR. BRENNAN: For aggregating a group of episodes
20 to a single provider, and John can speak to this too, it
21 seems like anything between 20 and 35 -- and obviously
22 people like NCQA have looked at standard errors around

1 measurement and things like that.

2 MR. BERTKO: I would agree.

3 And to Ralph's point earlier, the physicians who

4 practice in Medicare fee-for-service have lots of episodes.

5 And so the 20 of 35 is common in commercial. If you get up

6 to, as I was indicating, 50 you've got the guy or woman

7 nailed in terms of their performance.

8 Scored appropriately, sorry.

9 DR. WOLTER: I was just thinking about the

10 possibility over time, as the ability to get into the

11 information improves, of looking at how we could do more

12 innovative approaches to payment that would combine Part A

13 and Part B. Because if we can take congestive heart

14 failure, look at an episode it's longer than an inpatient

15 stay, combine it with the care that then occurs in the

16 outpatient sector before and after, and of course,

17 ultimately the hardest thing is to look at sort of

18 utilization, how many admissions are appropriate, that sort

19 of thing.

20 But this tool, appropriately refined, might allow

21 us to create something that is more patient centered, follow

22 patients across the silos and over a longer period of time

1 than just a DRG admission, which often would be the highest
2 cost part of the episode.
3 So that might be worth plugging in as we continue
4 to analyze and refine the ability to use the information.
5 MS. HANSEN: This somewhat relates to what Nick
6 just brought up but it's a question really for John.
7 I know hospitals have tiering kind of copayments.
8 The question is have you used this for tiering of
9 beneficiaries' copayments with the physicians?
10 MR. BERTKO: We, as my company, have not. But
11 other insurance companies, Tufts in particular I know of,
12 has used something like this. And the sorting which can be
13 done can be done either at the physician or at the hospital
14 level or across both. So the tool is quite flexible in
15 this.
16 And it goes back to Nick's point here of combining
17 A and B services together.
18 DR. SCANLON: Quickly, I think that we can learn a
19 lot from essentially what the demonstrations are that are
20 going on in the private sector.
21 But the question, in terms of moving forward with
22 respect to Medicare, that I think it's important to keep in

1 mind is that the private sector has the advantage of being
2 able to pick where they're going to have their fights. And
3 not all markets are the same.
4 That's the difficulty with the national program,
5 it's got to have something that fits into all markets.
6 Maybe not one thing but it has to have a set of thing that's
7 going to be compatible with all markets. That's a big
8 handicap in terms of what we can move forward.
9 MR. HACKBARTH: Thank you, Niall. Good job.
10 Next, continuing on the theme of the SGR report,
11 is a discussion of some cross-cutting issues that apply
12 under multiple or all of the SGR options that we've been
13 looking at.
14 Jennifer, you can proceed when ready.
15 MS. PODULKA: Moving from a single national SGR,
16 as the current system is, to a subnational target system,
17 such as those listed in our DRA mandates, raises several
18 issues. Some issues are unique to each alternative and
19 you've heard presentations on those. But others are cross-
20 cutting and must be considered before choosing and
21 implementing any of the alternatives.
22 Before I continue with the presentation, I'd like

1 to thank Megan Moore for her data analysis which is
2 reflected in my presentation.
3 The cross-cutting issues that we'll be discussing
4 today are how to set targets, making trade-offs among
5 multiple goals, attributing beneficiaries and their spending
6 to physicians, possible unintended consequences of
7 subsetting the SGR system, and options for secretarial
8 authority under a system.
9 Under the current SGR system, spending targets are
10 cumulative and they include GDP as an allowance for volume
11 growth. Possible alternative target allowances can be
12 categorized into three distinct groups. First, are
13 objective defined standards, such as GDP which is used by
14 the SGR and has been a little bit over 2 percent over the
15 past few years.
16 Secondly are historical trend, as was used under
17 the previous target system, the VPS. For the past six years
18 spending has averaged almost 10 percent while volume growth
19 has averaged almost 6.
20 And third are targets that haven't been tried yet,
21 such as basing updates on growth in MA plan bids.
22 Once a target allowance, either objective,

1 historical trend or other, is selected the next key question
2 for moving to a subnational target system is should the
3 target be cumulative or not? Using a cumulative target, as
4 the SGR does, tends to exacerbate fee cuts if spending
5 exceeds the target. When this happens, the system must both
6 reduce future updates to slow the next year's spending
7 growth and to recoup previous excess spending. The
8 arguments for including a cumulative target are that it
9 serves as a budgeting tool and it allows a target system,
10 when combined with fee cuts, to recoup excess spending over
11 multiple years.
12 At the bottom of the slide, a non-cumulative
13 target system, like what was used under the VPS, would
14 compare spending in a single year to that year's target and
15 recoup any excess spending in an upcoming year's update. If
16 a non-cumulative target system also limited fee updates, as
17 the SGR does, then excess spending that could not be
18 recouped in a single year would have to be forgiven. This
19 type of system, depending on design, could result in more
20 favorable updates but at the cost of greater program
21 spending over time.
22 The current SGR system is designed to constrain

1 spending growth. A subnational system could be designed to
2 measure and respond to different rates of growth in each of
3 the subnational units, geographic areas, types of service,
4 et cetera. Alternatively, it could be designed to address
5 the different initial volume levels in each of the units or
6 a combination of the two.

7 In a subnational target system, ideally the units
8 that have both low volume growth and low volume level would
9 be rewarded with better physician fee updates. Conversely,
10 units with both high volume and high growth level would be
11 penalized with lower or negative fee updates. It is less
12 clear how the other two combinations, high growth/low level
13 and low growth/high level, should be treated.

14 For example, in a geographic target system
15 addressing growth solely or primarily, risks rewarding
16 already high-cost areas such as Miami for keeping their rate
17 of growth low while penalizing already low-cost areas such
18 as Minneapolis for potential higher growth rates.

19 However, a geographic target system that focused
20 only on initial levels could fail to provide an incentive
21 for physicians to control growth going forward and could cut
22 physician fees so deeply in high-cost areas that beneficiary

1 access could be jeopardized.

2 One option for addressing these trade-offs is

3 designing a target system to address a hybrid of levels and

4 growth which is each unit's contribution to total growth.

5 To explore the various effects of designing a target system

6 to address growth, levels and contribution to growth, we

7 analyze claims for physician services for 2001, 2002, and

8 2003 in CMS's 34 prescription drug plan regions. For each

9 area we ranked areas growth, levels and contribution to

10 growth in each of the three years. We then compared these

11 ranks to see how strongly one rank correlated with another.

12 To illustrate our results, I've included two

13 examples. These are the PDP drug regions of Florida and the

14 large Upper Midwest multi-state region. Before going

15 through the numbers, note that there are a total of 34

16 regions. On the first two columns of numbers, you can see

17 that the two regions are nearly at opposite ends of the

18 rankings. Florida is ranked relatively high on spending

19 level, both in the first year and in 2003, and the Upper

20 Midwest region is ranked relatively close to the bottom.

21 However, looking at the next column, 2001 to 2003 growth,

22 you can see that the ranking for growth rates are different.

1 Both PDP regions are ranked at or near the bottom, in terms
2 of growth rate.
3 And finally, if you compare the far right column,
4 you highlight the impact of measuring contribution to
5 growth. Although Florid is 27th in terms of growth, it
6 moves up to 15th on contribution to growth because the
7 growth rate is added to an already high base level and the
8 Upper Midwest region remains in the same lowest rank.
9 Some criticize the SGR system because it applies
10 only to physicians. These critics contend that the SGR
11 therefore fails to recognize that physician services may
12 increase as they substitute for other services, especially
13 inpatient and outpatient care. One way to address this
14 concern is to extend an SGR-like target system to payment
15 updates for all Medicare services. To design such a global
16 Medicare target system, several questions must be answered.
17 First, should the global target system apply to all Medicare
18 services or should exceptions be made?
19 Secondly, how would a global target system fit in
20 with the rest of Medicare's payment update framework?
21 And third, would a global target system result in
22 different physician updates and targets than the current SGR

1 system or one of the subnational, physician-only target
2 systems we've been discussing?
3 For the next part of the presentation, I will
4 focus on the final question here. And for illustrative
5 purposes, we explore how geographic areas compare in terms
6 again of level, growth and contribution to growth under a
7 physician-only target system versus a more global target
8 system. To do so we used our previous analysis and extended
9 this to Parts A and B services for which we had data.
10 Revisiting our same two example PDP regions yields
11 similar results to the physician-only analysis. One notable
12 difference when we compare Parts A and B spending to
13 physician-only spending is that in terms of contribution to
14 growth, that final column, the Florida PDP region fell from
15 15th physician-only to 24th for A and B spending.
16 To summarize the results for our comparison of all
17 areas ranks for physician-only and Parts A and B spending,
18 we found that areas were fairly strongly correlated. In
19 other words. PDP regions tend to have similar spending
20 growth. level and contribution to growth ranks as they do
21 when you measure just physician service only versus Parts A
22 and B only or Parts A and B together.

1 Moving on to the cross-cutting issue of trade-
2 offs, a subnational target system will have to balance
3 trade-offs among a few key goals, generally alternative
4 systems that use larger units, emphasize administrative
5 feasibility and limiting volatility but do so at the cost of
6 decreased physician accountability. Alternatively. smaller
7 units may be more difficult to administer, introduce greater
8 volatility into the system, but may benefit from more
9 physician accountability.
10 In each of the five alternatives that we are
11 studying for the report, the number and therefore the size
12 of the subnational units, differed greatly. On the first
13 bullet there, for administrative feasibility, to make
14 estimates for the SGR CMS actuaries must rely on claims that
15 are only partially complete. In a subnational target
16 system, many data items might have to be disaggregated or
17 collected at a subnational unit. This would introduce
18 greater complexity into the actuaries' work and could
19 further hinder timeliness if the subnational units data
20 completed at a different rate.
21 Replacing the SGR with a subnational target system
22 would require CMS to conduct potentially exhaustive overhaul

1 the data payment algorithm and other systems. These changes
2 would need to be communicated to contractors, physicians and
3 beneficiaries and new appeals processes would also have to
4 be implemented.
5 Given the amount and complexity of work that would
6 have to be done, CMS would likely need additional resources
7 to effectively implement a new target system such as the
8 special appropriation they received for the new Part D
9 benefit.
10 On the next bullet for volatility, the data
11 collection estimation and projection issues also affect the
12 volatility of year-to-year updates. Problems like this
13 would likely be greatly exacerbated by a subnational target
14 system because of the greater empirical volatility
15 associated with smaller units and Medicare-specific issues
16 such as MA enrollment affecting the number of fee-for-
17 service beneficiaries differentially locally.
18 And finally, on accountability a key shortcoming
19 of the SGR system is it provides no incentive for individual
20 physicians to limit the volume of services that they
21 provide. Ideally a subnational target system would
22 incorporate subnational units that were either small enough

1 or organized enough for physicians within those units to
2 know their peers and able to encourage them to practice
3 efficiently.
4 Most of the subnational target system alternatives
5 would require establishing rules for attributing
6 beneficiaries and spending to physicians. Attribution would
7 not be necessary for the type of service alternative because
8 different payment would attach to the services rather than
9 the physicians.
10 For the other alternatives that create subsets of
11 physicians -- geographic, group practice, hospital medical
12 staff, and outliers -- the system would need to compare the
13 spending within each pool either to a national target or to
14 every other pool. Such analysis requires attributing
15 spending to these pools of physicians. In other words,
16 defining for which spending each pool is responsible.
17 The simplest option is to hold physicians
18 responsible only for the services for which they bill.
19 However, this fails to capture much of the volume that
20 physicians generate through referrals. Other options for
21 attribution are complex, given that fee-for-service Medicare
22 allows beneficiaries to see any willing provider and many

1 beneficiaries see multiple physicians.

2 Here you see a table with a brief description of
3 the attribution rule and resulting issues for each of the
4 alternatives. I won't go through all of these but I will
5 discuss the first one listed.

6 In a geographic target system, and to varying
7 degrees the other target systems, a significant obstacle to
8 attribution is border crossing. The most extreme example of
9 border crossing are snowbirds. Addressing the issue of
10 border crossing involves trade-offs between fairness and
11 accuracy. Border crosser spending can be omitted entirely,
12 assigned to physicians in a single area, or divided among
13 physicians in multiple areas. For example, CMS can
14 attribute a snowbird's spending to two main physicians, one
15 in each area, but this is somewhat more administratively
16 complex and it would be unclear which physician was
17 responsible for the overall care that the beneficiary
18 received.

19 Attribution for all of these alternatives raises
20 the companion issue of risk adjustment. Once a circle is
21 drawn around a pool of physicians and their attributed
22 beneficiaries, the target system should use risk-adjustment

1 to determine to what extent differences in pool's spending
2 is accounted for by variation in their attributed
3 beneficiaries' health status. At that point the target
4 system can be designed to address only the excess spending
5 that can now not be explained by sicker beneficiaries.
6 However, while risk adjustment has improved greatly it
7 cannot account for all variation in spending because not all
8 health care is predictable.
9 Replacing the SGR system with a subnational target
10 system could have multiple unintended consequences. For
11 example, a type of service target system that reduced
12 payments for one set of services could provide an
13 inappropriate incentive for physicians to substitute other
14 higher priced services.
15 Secondly, if a subnational target system were to
16 use additional or higher payments to reward more efficient
17 physicians, then policymakers would want to consider how to
18 adjust beneficiary cost-sharing. If they did not,
19 Medicare's beneficiary cost-sharing requirement, generally
20 20 percent coinsurance for physician services, would
21 penalize beneficiaries for seeing more efficient physicians.
22 In fact, it may desirable to offer even lower copayments or

1 other incentives to encourage beneficiaries to choose more
2 efficient physicians.
3 The DRA mandate that calls for our SGR report
4 specifically requires that we identify the appropriate level
5 of discretion for the Secretary of HHS to change payment
6 rates under the Medicare physician fee schedule or otherwise
7 take steps that affect physician behavior.
8 Under the VPS, the Secretary was required to
9 recommend the Congress each year if the VPS determined
10 physician update should be modified. In other words,
11 although it was never exercised, the Secretary had the
12 authority to recommend a different physician fee update.
13 The Secretary was instructed to confer with physician
14 organizations and consider inflation, changes in the number
15 and age of Medicare beneficiaries, changes in technology,
16 evidence of inappropriate utilization of services, evidence
17 of lack of access to necessary physician services, and any
18 other factors the Secretary considered appropriate.
19 Secretarial discretion was not included under the
20 SGR. It could be reinstated under an alternative target
21 system. Similar to the VPS, the Secretary could be
22 authorized to suggest to Congress a different target or

1 update than the one automatically calculated by the system.
2 Of course, the Secretary should consider a list of criteria
3 and consult with physician and beneficiary groups, as well
4 as the Commission. The criteria could be similar to those
5 used under VPS but could also include others, such as
6 changes in the health status of beneficiaries.
7 The slide includes a scheme for possible options
8 for Secretarial authority. Under the first option, which
9 emphasizes Secretarial authority, there would be no
10 automatic update as under the SGR. Instead, first the
11 Secretary would set an update and then this would become law
12 unless the Congress acted to override it.
13 Under the second option, which emphasizes the
14 formula under law, the formula would determine the update.
15 Secondly, the Secretary could recommend a different update
16 if he or she choose to do so. And third, there would be no
17 change to the formula unless the Congress acted on the
18 Secretary's recommendation.
19 And under the final option, which incorporates
20 elements of the two above, the update would also be
21 determined by formula. It would be overridden by the
22 Secretary if he chose to act. And of course, Congress could

1 always override the Secretary's authority.

2 In the either or any of these three cases, there

3 could be a requirement added that the Secretary provide a

4 letter to the Congress similar to the letter that they

5 provide to MedPAC detailing volume, growth and breaking it

6 out by the various subnational units.

7 Thankfully for my cold, that concludes my

8 presentation and I look forward to your comments.

9 MR. DURENBERGER: I think that was a strong

10 presentation and a strong product, so thank you very much.

11 My question relates to under trade-offs, and then

12 I think it came up again under attribution, and that is the

13 issues raised relative to data, and the complications in

14 accumulating data. And it really deals with the role that

15 Medicare carriers and intermediaries could or should play in

16 gathering the kind of information. Since they're all

17 basically localized, even though there aren't as many as

18 there used to be, but they're dealing with local practices

19 and making a variety of decisions on the basis of data they

20 accumulate for CMS at that level.

21 Is that an opportunity within the Medicare system

22 to simplify access to the kind of information that's needed

1 when we go to targets that are subnational?

2 MS. PODULKA: That's a very good point. I believe

3 it was in October when Dana discussed some of the vision for

4 other options for physician payment. There is an

5 opportunity right now, given the contractor reform that's

6 going on, to possibly require additional efforts from the

7 contractors to sort through these data and provide reports

8 to CMS.

9 And then it becomes a policy issue, do you want

10 action at the local contractor level? Or do you want them

11 merely to provide information for CMS to act upon?

12 DR. SCANLON: You've highlighted some of the

13 really tough points that we need to be thinking about

14 dealing with. Let me add one, to make our lives little more

15 complicated, and that's the dynamics of a system when we're

16 talking about changing the updates.

17 It comes to me in terms of two questions. One is

18 how much variation in fees would we tolerate? If we have

19 differential updates because we have subnational targets,

20 over time these are going to start to diverge and there is

21 going to be, at some point, it's going to exceed some level

22 and people may get uncomfortable with that. And to build in

1 some type of a mechanism that puts a control on that and
2 keeps it in balance is something to think about.
3 The second issue is the dynamics of what might be
4 the accountable groups, particularly when we get down to the
5 lower levels of disaggregation. And the reality that
6 there's going to be a lot of turnover in those groups over
7 somewhat more extended periods of time and there is the
8 potential for good groups going bad and bad groups becoming
9 good. The question is historically how should their
10 historical updates affect their current fees?
11 In a pay-for-performance context, we're usually
12 looking at the moment and we're saying someone has done
13 well, we're going to reward you. And then we look at the
14 next moment and we make the decision again.
15 In an SGR or a formula driven update context, we
16 potentially build in baggage from the past. We talked about
17 it in terms of having to pay off a cumulative deficit. It
18 also potentially applies in terms of individuals and whether
19 they've been rewarded or penalized in the past.
20 MR. HACKBARTH: You can imagine how the payment
21 system itself could start to affect movement across systems.
22 DR. CROSSON: Just on that point, while I agree

1 that over time the quality or resource responsible focus of
2 a group could morph, and what Bill brings up is a good
3 point, you wouldn't want to continually reward a group that
4 had been great 10 years ago and how wasn't great by whatever
5 you were measuring, there is another aspect to the choice of
6 whether you use the incentive as an annual reward or whether
7 you create a cumulative reward. And it has to do, I think,
8 specifically with the issue of physician payment.
9 In previous discussions we've been commenting on
10 the fact that when we're talking about incentives for
11 institutions, like hospitals, numbers like won or 2 percent
12 can make a big difference. If you're dealing with, for
13 example, an institution whose entire margin for the year is
14 2.5 percent, a won or 2 percent difference seems to have
15 been -- at least in demonstration models -- enough to get
16 significant change.
17 We've had some concern though that the evidence
18 seems to show that when you're dealing with individual
19 physicians rewards, of that size don't seem to make the same
20 sort of change. And it may be simply that since volume is
21 able to be influenced, let's say, that that 1 or 2 percent
22 difference in payment may not be viewed as the same as it is

1 for institutions.

2 So there is a strength to using a cumulative

3 reward system because if you're going to be in the physician

4 payment arena anyway -- and I don't know about what it would

5 be when we link the two, A and B -- but there is a strength

6 in the sense that you can make small changes that over time

7 result in large changes. And when a physician or a practice

8 is looking at that prospectively they may say, in effect, 1

9 or 2 percent isn't that much. But 1 or 2 percent per year

10 over a decade, based on the pattern that we do or don't

11 adopt, may make very significant changes.

12 And so you have to trade that off against the

13 perspective that in doing that you might over reward over

14 time or perhaps under reward based on changing patterns.

15 MR. HACKBARTH: I think the term trade-off is very

16 important. Jennifer used it in her presentation. On a lot

17 of these design issues you're trading off multiple

18 variables, multiple potentially good things and multiple

19 risks. And trying to balance them up properly is, to say

20 the least, tricky. But there's no avoiding the need for

21 trade-offs.

22 DR. CROSSON: Just one more technical point on

1 some of these charts, for example on page seven. So the
2 first column is the standing in terms of the level of cost.
3 The third one is the growth over those years. The last
4 column is called contribution to growth. I think that's
5 really contribution to spend; right? It's the product of
6 the level and the rate of growth? Am I missing something?
7 MR. HACKBARTH: Jennifer, it would be helpful, I
8 think, for the broader audience if you just defined how
9 contribution to growth is calculated.
10 MS. PODULKA: Sure. Contribution to growth, in
11 the way we calculate it, is you take the change in terms of
12 dollars. So not the growth rate. And you're dividing that
13 by the total growth in terms of dollars.
14 So because growth rates differ, but the level can
15 also be different, you can have a low growth rate on a high
16 base. So in this instance, let's say Miami. So Miami is
17 towards the top in terms of level, but it may be growing
18 very slowly, but the total dollar change then can be just as
19 great as an area that starts off at a very low level, such
20 as Minneapolis, but may experience very high growth rate.
21 So in that instance, contribution to growth is
22 picking both growth rate and level.

1 DR. REISCHAUER: All of this is done on a per
2 beneficiary level.
3 MS. PODULKA: Correct.
4 DR. REISCHAUER: So it's a complicated thing when
5 you get to the contribution to growth.
6 DR. CROSSON: It seems to me then the growth is
7 being used in two ways. One is growth rate and the other is
8 growth in dollars.
9 MR. HACKBARTH: Contribution to growth focuses on
10 dollar growth as a percentage of the total dollar growth on
11 a per beneficiary basis.
12 MS. BEHROOZI: Thank you, Jennifer, in particular
13 for pointing out the impact on beneficiary copayment rates.
14 when we think about incenting efficient providers or high-
15 quality providers that's so important that you pointed out
16 that it's then got a really perverse effect in terms of
17 beneficiaries who may then -- particularly people on limited
18 incomes, lower income beneficiaries, who are going to make
19 their choice based on who's the cheaper doctor to see. And
20 actually I will guess that some other people might have had
21 the same question that Jay whispered to me.
22 But then ultimately they're going to have fewer

1 visits with that better doctor, that more efficient doctor.
2 But in anticipation of that question or kind of responding
3 to Jay, I would say that for people again on limited
4 incomes, that initial cost is what they're going to look at.
5 They're not going to be in a position to make the judgment
6 about instead of five visits I'm going to have four, so I'm
7 going to save in the long run. It's today, the dollars in
8 my pocket, where am I going to spend it?
9 So I think you're absolutely right to point out
10 that if we make any recommendations in this area it's got to
11 be in conjunction with recognition that beneficiary
12 copayment should not be impacted in the same way.
13 DR. SCANLON: On this point I think we also need
14 to remember what's going to be the accountable unit and
15 whether the beneficiary is going to have the choice of going
16 to physicians that are being paid differently. Because if
17 the accountable unit is a geographic area, then everybody
18 within the area is going to be paying the same.
19 Even if it goes down to being the hospital-based,
20 the extended hospital accountable unit that we talked about
21 before, there are going to be many, many beneficiaries that
22 don't have choices. They're going to be in a situation

1 where the geographic proximity of the physicians is going to
2 be such that they're all going to be in that one accountable
3 unit. And so their choice on the basis of price does not
4 exist.

5 DR. WOLTER: It seems like this issue of where
6 decisions get made is an important discussion point because
7 certainly right now there's a lot of frustration that
8 annually some legislation needs to occur at the last minute
9 to address these issues. I'm sure counterbalanced by the
10 fear that in a different situation arbitrary decision-making
11 might be made by a few.

12 But it does seem like a critical issue, when you
13 look at the complexity of the situation, the complexity of
14 some of the recommendations or the options that we're
15 starting to outline.

16 I guess I would be interested, for those of you
17 with experience in this area, Nancy-Ann, Dave, others, if
18 you have given any thought to how one might approach the
19 issue of authority and decisionmaking. If I put you on the
20 spot, I apologize.

21 MR. HACKBARTH: Who wants to go first?

22 MR. DURENBERGER: I was reflecting, during the

1 earlier presentation, about the way in which members of
2 Congress make decisions about these sort of things, which is
3 largely in response to an experienced need we substitute a
4 different formula, if you will, for addressing that need and
5 then send the accountability for implementing it to Nancy,
6 which I would like to do right now.
7 [Laughter.]
8 MR. DURENBERGER: But in this context, there's a
9 different kind of a dynamic. And I was reminded of the last
10 conversation in 1989, before I turned to Jay Rockefeller and
11 said let's go with the old VPS, of a conversation I had with
12 a former chair of this commission when she was in serving in
13 a different capacity, in which we both agreed that the
14 vulnerability in the implementation of what we thought was a
15 replacement for an inadequate former reimbursement for
16 physicians, the vulnerability was in the volume performance
17 standards because they would discourage accountability
18 basically at the physician decisionmaking level or at the
19 physician/hospital decisionmaking level in terms of the
20 physicians' use of hospital services.
21 I think we knew that from the beginning. We knew
22 that it would impact on accountability. Because the DRGs,

1 when you have a large group called a hospital, you give the
2 hospital an opportunity to change its behavior and the
3 authority with which to get rewarded for changing their
4 behavior, hospitals do it. But individuals perform very
5 differently unless they're in groups.

6 And was also had before us at that time the
7 evidence of the TEFRA risk contracts and cost contracts that
8 were conducted in the mid-80s in which groups, accountable
9 groups or whatever we may call them, in various parts of the
10 country took the opportunity at 95 percent of the fee-for-
11 service payments system to do all of the things we're
12 talking about here, resource use changes, outcome payments,
13 things like that.

14 And we had that evidence before us, but it didn't
15 come from all over the country. So we were in a kind of a
16 quandary, I guess, as to -- and again, it's the same
17 quandary I sense sitting here -- which is should this be a
18 national system, operated in the same way in every part of
19 the country? Or should it be a national program which holds
20 individuals accountable in ways in which they can be
21 rewarded for good behavior and not for bad behavior?

22 And that seems to be the essence of where we're

1 trying to go with this SGR reanalysis and the subnational
2 target. Is that your question?
3 MS. DePARLE: In answer to your question about the
4 authority, I think I was at OMB, and Mark I think you were
5 there too, during the very brief time period when the
6 Secretary did have some authority around this. And I can
7 remember looking at the proposed rule one year and thinking
8 should we do something, and by then it was too late.
9 I think you could do this though. And I'm
10 thinking of your comments earlier about you would have a
11 process, and Lord knows they have plenty to do at HHS, but
12 this is important because everything we look at today, the
13 physicians are at the center of driving for it and quality,
14 controlling costs and all of those things.
15 You would have a series of conversations around
16 the country with data like this and put on the table what
17 should we do and do a proposed rule that might say -- it
18 might do a lot of things. It might say physicians in one
19 area get a lower update. It's sort of whatever you're big
20 enough or have the nerve to put forward. So do a proposed
21 rule and allow everybody to comment.
22 You could do that. It would take a lot of time.

1 In a year you would have a group of staff devoted full-time
2 to it, but you could do it.
3 I guess, I think Arnie you made this comment in an
4 earlier section, it would be hard administratively and all
5 that and messy and probably ugly, politically. But
6 sometimes I think we hold the new thing to a higher standard
7 than we hold the old thing that we've been doing that we all
8 know doesn't work very well.
9 So I think, in some ways, Nick, physicians would
10 be less likely to receive that. If you really went out and
11 engaged them in a conversation and showed this kind of data,
12 along the lines of what you said John, as an on high, black
13 box, who knows what they're doing in Washington, kind of
14 decision then what they receive now, which is sort of how
15 they perceive what we're doing here. If you really went out
16 and said I have some authority to make some adjustments
17 here, what do you think?
18 Maybe it's naive but I think some would engage and
19 would begin to understand that.
20 Even if it's something like the GDP, which I
21 disagree with as the standard, but even if it were that at
22 least they would have an honest discussion of what they were

1 being judged against.

2 MR. HACKBARTH: Nancy-Ann, let me just follow up
3 on that.

4 As a general matter, it seems to me that if you're
5 implementing a new complex, many moving part system, having
6 discussion to override formula is probably a good thing so
7 you don't get driven into very bad corners the way we've
8 been driven into a bad corner by the existing formulaic SGR.
9 So having a stronger secretary with more discretion seems
10 like a good thing.

11 Although if the path that you want to go is
12 subnational and making distinctions by region or system,
13 that's the sort of situation where it seems to me that a
14 secretary might have the greatest difficulty with
15 discretion. It's one thing to say well, I'm going to ease
16 off a national target for all of physicians. But when the
17 secretary is implicitly saying I'm going to push harder on
18 Miami, not give them any relief, and maybe give Minnesota
19 some relief, politically that is I think tougher ground for
20 a secretary to stand on and exercise reasonable discretion.

21 DR. REISCHAUER: That is what I was going to point
22 out.

1 MS. DePARLE: It's probably a second term kind of
2 thing.
3 DR. REISCHAUER: If we look at the one through
4 three, strong secretary/strong law mix, this is really a
5 question of who's going to be holding the hot potato. And a
6 lot of what's going on here is because of congressional
7 scoring rules. If the Secretary has the potato, there is no
8 scoring problem in the Congressional budget process. What's
9 going to happen? Well, we're probably going to get an
10 outcome much like we had before but with a lot less
11 turbulence, anxiety, uncertainty in the process.
12 I agree with Glenn completely. You're sitting
13 there in the Secretary's seat and the data seems to suggest
14 the update for the Florida area should be much lower than
15 the average, but the upcoming Senate election in Florida
16 seems to be extremely tight. And no matter how much
17 integrity you as the secretary has, you'll get a phone call,
18 whether it's a Republican or a Democratic administration,
19 from the person in Karl Rove's seat saying you know, I don't
20 think you're looking at the data quite right.
21 [Laughter.]
22 DR. REISCHAUER: And we've collected some new

1 information.

2 And so we shouldn't kid ourselves. There is the

3 objective argument about the necessity for flexibility but

4 the flexibility is not going to be exercised always in an

5 analytical way.

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

7 Jennifer.

8 Thanks for fighting through the cold. Good job.

9 Our final SGR item for the morning is on a phased

10 approach to SGR. Kevin.

11 DR. HAYES: Good morning. We begin this session

12 with a question about the content of the SGR report and that

13 has to do with this idea of a phased approach.

14 At the November meeting, Commissioners started

15 talking about a way to replace the SGR that would have

16 multiple parts and that would occur over time. It would

17 draw upon different SGR alternatives that are listed in the

18 mandate and it would consider other ideas. From that

19 discussion, we come to this idea of a phased approach.

20 So the question for the session would be under

21 such an approach, replacing the SGR, what are the specifics?

22 What changes in policy would occur? And in what order?

1 To outline what could be included in this
2 approach, I will summarize options that were listed and
3 discussed in the paper we sent you for the meeting. We will
4 review a possible timeline, noting links between phases, and
5 we'll list some advantages and disadvantages.
6 In moving from the current national SGR, the
7 purpose would be to fulfill three goals simultaneously.
8 First, it would address geographic differences in the volume
9 of services. Second, improve accountability. And third,
10 providers would receive information they could act on to
11 change their practice style.
12 In concept, this approach would apply more
13 pressure in high spending areas; assess spending in all
14 sectors, not just physician services; give feedback on
15 resource use and identify outliers; and reward efficient
16 care.
17 How would this work? Under this option each
18 geographic area would have a spending target and payment
19 updates for the area would depend on whether the area has
20 met its target. Within each area feedback would be provided
21 to outliers showing how their resource use compares to that
22 of their peers.

1 Accountable care organizations, these would be
2 entities composed of physicians and other providers, would
3 be able to share savings with the program if they furnished
4 care more efficiently than other providers in their area.
5 To identify the specifics of this approach, we
6 need some kind of design parameters. In the discussion so
7 far, commissioners have expressed certain themes that could
8 be considered in replacing the SGR. The paper that we sent
9 you goes over these in a little more detail but let me just
10 go through these quickly now.
11 First, it would encompass all fee-for-service
12 Medicare; apply most pressure where service use is the
13 highest; provide a way to perform apart from the SGR and
14 share in savings; maintain budget control; reward efficient
15 care in all forms of organization; and allow time for data
16 systems and analysis tools to develop.
17 Let me just pause here for a second and note the
18 budgetary environment in which all of this would occur. As
19 we know, any alternative to replacing the SGR would be very
20 expensive because of baseline spending projections. As with
21 other approaches to the SGR, we're talking here about a way
22 to go forward in a new environment while acknowledging that

1 there are some very difficult scoring issues here.

2 This is kind of the timeline in total, and I'll go
3 through each of these items, each phase, one by one. But
4 for now, I would just note a couple of things here. First,
5 we have four phases with multiple policy changes occurring
6 during three of the four phases.

7 Clearly, replacing the SGR in this way would be
8 complex with some elements of the policy working in concert
9 with each other. In addition, CMS would have to develop
10 necessary infrastructure along the way and there would be
11 some sequencing of steps necessary.

12 Such complexity is not surprising, however. The
13 goal here is to foster provider accountability in what is
14 now a very fragmented and decentralized system.

15 We should also acknowledge, just in looking at
16 this timeline overall, that it would be very burdensome for
17 CMS. To do this the Agency would need clear administrative
18 flexibility and new resources. These resources could be
19 identified explicitly the way they have, say, for the new
20 drug benefit.

21 Just to kind of give you some kind of perspective
22 on numbers here, what we're talking about, CMS has

1 identified costs of implementing legislation passed
2 previously. For example, they estimated that the Balanced
3 Budget Act cost $77 million. That's in 2001 dollars. The
4 Deficit Reduction Act, more recent, smaller in scope than
5 what we're talking about here, but that was $60 million.
6 And then, of course, we're all aware of the benchmark, if
7 you will, of the Medicare Modernization Act and the $1
8 billion that was identified there for administration of that
9 law and its provisions.
10 Moving on now to each of the phases, some of the
11 steps toward using this approach could begin to happen
12 almost right away, as CMS would start to work on the
13 infrastructure necessary for subsequent changes in policy.
14 Certainly, to reduce the likelihood of multiple
15 years of negative payment updates, there are different ways
16 to set up the target to set its level. Jennifer went over
17 some of that in her presentation, so I won't go into that
18 here.
19 Also in this initial phase, we could see budget
20 neutral bonuses for meeting quality standards. That could
21 occur also here in the same way.
22 Moving along to phase II, here the policy would be

1 drawing on groundwork that had been completed previously.
2 At this point, Medicare would start to differentiate among
3 physicians. The SGR could transition here from a national
4 system to one that has targets in payment adjustments for
5 specific geographic areas. There would be different ways to
6 define these geographic areas, of course, and we talk about
7 that some in the paper.

8 Rewards and penalties would accrue to physicians
9 and also possibly to hospital outpatient departments. The
10 rationale for including the OPDs would be first off that it
11 would be a step toward adjusting payments for all providers
12 that could occur in a subsequent stage. Also, there's some
13 substitutability among services, physicians offices say
14 versus hospital outpatient departments. Many of the
15 services are provided visits, some imaging, tests, some
16 procedures are provided in both places.

17 There is a question, though, about what to include
18 in the target. Would it be not just other Part B services
19 but also Part A? And what about Part D?

20 Moving on to other aspects of this phase, we could
21 see providing confidential feedback to outliers at this
22 stage, using methods of the type that Niall went over

1 earlier this morning.

2 It could also be an opportunity for accountable
3 care organizations to emerge and to begin some public
4 reporting of their performance as a step toward them
5 participating in shared savings programs later on.

6 Phase III could expand upon the policy of
7 adjusting payment rates, adjusting payment rates whether
8 spending has been consistent with the target, but here to
9 include all providers, not just physicians and hospital
10 outpatient departments. Commissioners have discussed the
11 importance of all providers collaborating to make providing
12 care for beneficiaries more efficient and it may be more
13 equitable also to hold all providers accountable for volume
14 growth, given Medicare's problems with long-term
15 sustainability.

16 Although we have listed this change in policy as
17 occurring in phase III, it's possible that some of what's
18 discussed here could happen in earlier phases, depending
19 upon whether preparations have been made and completed or
20 not.

21 In phase IV, here is where we begin to talk about
22 the shared savings. Building on groundwork that was laid in

1 phase II, accountable care organizations could begin to
2 receive shared savings here with the physician group
3 practice demo possibly serving as a model. CMS would be to
4 establish eligibility criteria for entities, criteria that
5 would address such things as IT, care coordination, things
6 that you're familiar with, having responsible compensation
7 programs and so on.
8 In addition, the size of the accountable care
9 organizations would need to be large enough so that there
10 would be some stability in the measures that are used to
11 judge performance against the criteria.
12 Shared savings could serve as a way to earn back
13 losses under the SGR and also to receive bonuses. They
14 could also foster organized systems of care.
15 Beyond shared savings we could contemplate some
16 other changes in payment incentives, ideas that you've
17 discuss previously having to do with things like bundling
18 and gain sharing.
19 We come now to our advantages and disadvantages of
20 this approach. Overall, the advantage to this approach is
21 that it would allow pursuit of multiple goals
22 simultaneously, the things that we listed earlier in terms

1 of addressing geographic differences in volume, improving
2 accountability, and providing information to outliers.
3 The disadvantage of this approach include first,
4 there likely would be some resistance to what could be large
5 redistribution of payments. The complexity of this approach
6 demands more data and would increase the administrative
7 burden for CMS. Smaller spending pools in the nation as a
8 whole could raise concerns about attribution to care and
9 volatility.
10 Just to close here with a revisit of the timeline,
11 brings us back to our question about what to say about this
12 approach in the report, what specific policy changes to
13 discuss, sequencing of them, and so on.
14 Thank you and I appreciate your comments.
15 MR. HACKBARTH: I have no doubt that Kevin would
16 be honored to have this known as the Hayes plan but in all
17 honesty, Kevin didn't go off into his office and work this
18 up by himself. I am the instigator behind this, and let me
19 just say a few words about why.
20 What I've tried to do was capture important
21 themes, ideas, and proposals that I've heard from various
22 commissioners in response to the question if there is a

1 formulaic aggregate cost limit of some form, how might that
2 be best structured?
3 Now I do think this reflects the point of view
4 that I've heard from many of you, both in our public
5 meetings and in individual discussions. But I should be
6 clear that I don't think there is unanimous agreement on any
7 of these things, let alone on all of the pieces.
8 But from my perspective there are a few key
9 elements where there seems to be fairly broad commissioner
10 support and identification. One is that if Congress decides
11 that there's a limit to how much we can afford to spend and
12 chooses to express that in terms of an aggregate Medicare
13 spending limit, it would make sense to apply that
14 differentially on a geographic basis.
15 We've got well documented differences in the cost
16 of care within the Medicare program that are not getting
17 smaller over time. They're getting bigger over time. If,
18 as a society, there are limits, those limits ought to be
19 applied in a way that recognizes those differences in the
20 cost of the program. And if there's pressure to be applied,
21 it ought to be applied first and foremost, to the greatest
22 extent, to the highest cost areas. So that's one idea.

1 A second is that if, in fact, Congress decides
2 we've got a Medicare cost problem, it's a total cost
3 problem. It's not just the cost of physician services, as
4 the existing SGR would imply. It's the total program cost
5 per beneficiary that is of concern.
6 In fact, in the not too distant past I've heard
7 individual commissioners at least speculate that in an
8 optimal health care system we may, in fact, want to have a
9 higher proportion of spending on physician services, not a
10 lower proportion, to the extent that excellent physician
11 care can obviate the need for some more expensive
12 institutional services or treat illnesses at in earlier
13 stage and avoid unnecessary admissions and the like.
14 So to have a physician-only system that squeezes
15 only physicians may be, in fact, moving us in the wrong
16 direction in important respects. That's a second idea.
17 Then the third is that even if you were to go from
18 a national system to a geographically-based system, there is
19 variation within those geographic areas, even if you would
20 go down to something like MSAs. Some are higher cost than
21 others, some are higher quality than others.
22 One of the fundamental flaws in the existing SGR

1 is that there's not enough individualized accountability and
2 reward for good performance and penalty for poor
3 performance. So even if you go to a more geographically-
4 based system, you need to have a way to individualize
5 accountability. Hence, you would want to look at options
6 like allowing accountable care organizations or individual
7 practices to get rewarded based on their individual
8 performance and not just getting hit because they're in the
9 high-cost region, for example.
10 In the abstract, those three ideas I think have
11 fairly broad support within the Commission. In the
12 abstract, they're relatively easy to say and I think
13 commonsensical applying them, operationalizing them though,
14 is a much, much more challenging task. And hence, the
15 notion of a phase-in.
16 We're talking about capabilities, developing
17 capabilities, new payment systems, new tools like episode
18 groupers that would take time to develop and apply, gain the
19 confidence of providers, not to mention members of Congress,
20 and we should have no illusions that that's not something
21 you would do overnight. We are talking realistically about
22 a process that would unfold over a period of years, and I'm

1 thinking more like five or 10 years as opposed to next year.
2 That's why it seemed to be important to at least think
3 conceptually about how you might phase it in.
4 And then last but certainly not least, given the
5 complexity of the challenge we're talking about, it's
6 obvious that we're talking about a huge challenge for CMS,
7 an agency that is already straining under its existing
8 workload, let alone this one. In order to have any
9 reasonable chance of succeeding in such a major redesign of
10 the Medicare system there would have to be a huge new
11 investment in CMS.
12 To the extent that you tried to do it on the
13 cheap, so to speak, the risk of error, unintended
14 consequence, inequity would greatly increase. And frankly,
15 the risk that we'd find ourselves back in a situation not
16 unlike today's where we are with the existing SGR, trying to
17 dig out of a hole, finding that the system is driving us not
18 towards a better system but maybe in some ways towards a
19 worse one, those risks would greatly increase if you don't
20 invest in the necessary infrastructure.
21 So those are the real points that I'd like to come
22 through out of the very good presentation that Kevin made

1 and offer them for further discussion by the commissioners.
2 MR. MULLER: I think the Hackbarth-Hayes plan is
3 well done, so I commend you for it.
4 We're not as explicit in here about the role of
5 Medicare Advantage, although obviously an awful lot of this
6 could perhaps even be done faster inside the plans than it
7 can inside fee-for-service. They already have a lot of
8 incentives to move in these kind of directions already.
9 So I think I would urge that we be a little bit
10 more explicit about that, that in fact those incentives are
11 there, and some other capacity is within those plans. I
12 think a lot of what we, in the sense, committed to in the
13 Modernization Act was by, in a sense, betting on or pushing
14 in that direction, we were counting on their performance
15 being able to achieve certain outcomes that were not as
16 achievable in the regular fee-for-service, the less managed
17 fee-for-service system.
18 So I don't know whether you want to put this into
19 this language in any kind of way, but thinking about how
20 these kind of goals could also be achieved perhaps in a --
21 if not sooner but in a more experimental way -- inside
22 Medicare Advantage, I think that is something we should

1 speak to as well.

2 DR. REISCHAUER: Yes, I was going to ask to be

3 recognized because the question that this raised with me as

4 if we went down this path for fee-for-service Medicare, what

5 kind of advantage are we giving to private fee-for-service

6 plans within the Medicare Advantage program? We might be

7 shifting the playing field very radically in favor of an

8 option which some of us have questions about its appropriate

9 inclusion in the Medicare program.

10 DR. KANE: One minor point is that on the face,

11 when we're talking while providing confidential feedback, I

12 would like to change that to everyone rather than outliers.

13 Again, I'm not sure we've convince ourselves that it's just

14 the top 5 percent of doctors who need this information and

15 it's not clear that we can identify them as such. But it

16 makes a lot of sense to have a whole community see their

17 information. Then you get improvement even at the general

18 level of practice.

19 In England, in Great Britain, they tried to do a

20 similar kind of phase-in of the primary care trust and

21 created a set of criteria that if you could hit those

22 criteria as a provider unit, you got different kind of

1 payment and different level of accountability and different
2 level of budgetary discretion. And they did it, I think,
3 over a five-year period perhaps.
4 Instead of seeing it as you have to do this
5 everywhere across the whole nation all at the same time --
6 granted CMS still has to come up to speed -- but I think the
7 phases could be done differentially, depending on how
8 capable each provider system is to achieving it. And then
9 every time you move up a level of capability you get more
10 accountability and more responsibility for your own costs
11 and more opportunity to save in those. And the ones who
12 can't pull it off stay down there with the SGR either as it
13 is or maybe differentiated somewhat by -- I don't like
14 geography as much as I like service myself. I think it's
15 less politically vulnerable and perhaps -- I don't know. I
16 like the idea of saying imaging gets less of an update than
17 primary care.
18 But in any case, this notion that you can build
19 the phases to be more oriented towards the providers'
20 ability to hit performance criteria and then they get more
21 discretion, more accountability, more savings. And let it
22 happen differently across the country, depending on where

1 those different parts of the country are.

2 It definitely worked in other countries and so I

3 don't think it's -- it's just a different way of thinking of

4 it than some sort of massive national roll-out that you have

5 to achieve all at once.

6 DR. WOLTER: Just a couple of things. As I've

7 said before, I do hope that we can manage to stay with our

8 past comment that we don't think the SGR as it's currently

9 put together has been effective and, in fact, has put us in

10 a very difficult spot in many ways.

11 But moving on from that, in the online that we

12 received and in the exec session this morning there's a list

13 called me the Vision of a Physician Payment System, which I

14 assume is going to find its way into the final report,

15 although it's not in today's materials.

16 Along the lines of your comments, Glenn, maybe

17 that's broader than just physician payment system because

18 some of the things that are there, in fact, include others

19 than physicians and we may want to include some other things

20 that would include payment to other silos.

21 And I think that as far as the phasing goes, as

22 early as possible there are some things that could be done

1 that I believe would significantly help us with cost
2 constraint and, to some degree, volume, pricing maybe being
3 at the top of the list. That's pricing not just in the
4 physician payment system but in the hospital payment system,
5 where right now there is so much going on in terms of
6 investment and the drive to increase volume in a handful of
7 services that I think if we could accelerate the DRG re
8 basing, for example, and continue to look at imaging
9 pricing, there are some very, I think, high leverage there
10 that we don't want to wait too long on if we're going to try
11 to deal with the sustainability issue.
12 Another thing that concerns me greatly, as I've
13 mentioned in the past, right now to me there is an
14 unfortunate coupling of measures, measure reporting, and
15 pay-for-performance with the SGR problem. The reason I
16 think it's unfortunate is there's a great drive to create
17 measures for 40 or 50 physician specialties, most of whom
18 are incredibly ill-prepared to provide the measures. And
19 that is diverting attention away from what could be a focus
20 in pay-for-performance on high-volume high-cost disease
21 states where I think we could achieve much more in a timely
22 manner than the current situation where we're trying to

1 design measures for everybody but without really a sense of
2 strategy and tactics about what will the outcomes of that be
3 other than it's a way to tie payment to physicians to
4 something.

5 I think it's really an unfortunate thing that's
6 going on right now in terms of how pay-for-performance is
7 being approached, but it does relate to the SGR, which is
8 why I bring it up now.

9 And then I think that I'd also move things like
10 bundling and gain sharing from phase IV to a much earlier
11 phase because I think that ties to a focus on high-volume
12 high-cost disease states, and it is an area where we could
13 create both quality and cost gains if we tried to move that
14 along more quickly, recognizing I know there are opponents
15 to that in Congress. But I think it does have a place in
16 what we're trying to tackle.

17 MR. HACKBARTH: If I may, let me just pick up on a
18 couple of things that Nick said.

19 Regardless of what path Congress elects in the
20 future, whether it elects to continue the existing SGR or a
21 new SGR along the broad lines described in Kevin's
22 presentation, or repeal the SGR, there are certain things

1 that need to be done under any of those scenarios. And very
2 high on my list would be what Nick said earlier about
3 continuing to improve the accuracy and equity in our
4 pricing.

5 I believe, as I know Nick does, that the amount
6 we're paying for certain services is sending very
7 inappropriate signals to the delivery system and producing
8 unproductive unhelpful behavior. And that's true both in
9 the physician payment systems and in the hospital payment
10 systems, and I suspect in all of our payment systems.

11 That type of work, trying to improve payment
12 accuracy, has been one of the staples of MedPAC and its
13 predecessor commissions. I don't see that going away under
14 any of these scenarios. If anything, my personal sense of
15 urgency is growing about that work, not declining. So I
16 wanted to clearly identify myself with Nick's point there.

17 The other thing that I wanted to say is I, with
18 Kevin's help, have tried to outline a potential path. What
19 I envisioned, and this is more directed at the public
20 audience, is that this is not the only path, it's not the
21 only path that has some support within the Commission. And
22 I want people to understand that. And what I envision in

1 our final report is that we will lay out some potential
2 alternative paths that Congress might take.
3 Here again, I would emphasize that there are some
4 common elements. So if, as Nick proposes, we stick to our
5 traditional MedPAC position that the SGR doesn't work, it
6 ought to be repealed, and formulaic national volume plus
7 price targets are not have a helpful tool, even if you go
8 down that path, I think we all still agree that we need new
9 payment systems that improve accountability for both cost
10 and quality like the examples that Nick alluded to,
11 bundling, the group practice demo model. There are a
12 variety of those potential systems that we have discussed.
13 I think those are things that you want to do under
14 any of the SGR scenarios and they all are important. They
15 all require resources to take them from concept to
16 operation. And so under any of these scenarios I think a
17 major investment in CMS is going to be required to increase
18 the accountability for performance in the Medicare system.
19 DR. CASTELLANOS: I think this is just going to
20 expand on some of the topics that Nick just said. Under the
21 Hayes-Hackbarth proposal, you mentioned that you -- and
22 again I'm not trying to beat you up. You said you really

1 were listening and listening to the commissioners and all of
2 that. But under phase I, I still see we're talking about
3 adjusting the SGR.
4 Why are we try to expand it? I don't see anybody
5 saying it's working. I agree that you just said let's go by
6 the original MedPAC position, and I certainly agree to that.
7 MR. HACKBARTH: Thanks for making this more
8 pointed. The traditional MedPAC position has been repeal,
9 as Nick described. That position was first taken four years
10 ago, five years ago, back early in my tenure. The
11 composition of the Commission has changed. We could easily
12 go around the table and identify commissioners who want to
13 keep an SGR mechanism in place. It's no surprise. People
14 aren't concealing that. Over the months of discussion about
15 this, there are a number of commissioners who have said they
16 do not want to endorse a recommendation that the first step
17 is repeal.
18 And so I don't, in talking about the Hayes-
19 Hackbarth plan, I don't pretend for a second, Ron, that it
20 is the unanimous view. Not for a second. But what I've
21 tried to do is assemble in some reasonable fashion elements
22 that I've heard from a lot of different commissioners.

1 DR. CASTELLANOS: Thank you.

2 Again you know, the target system, as we all said,
3 is going to lead to inappropriate substitution. It hasn't
4 worked. What we really need and what we're all talking
5 about is individual physician accountability.

6 But as we also said this morning, it's not just
7 the physician but it's all providers that need to be held to
8 responsibility.

9 I like what we've been talking about over the last
10 three months. I think we need to phase in some of these
11 visions that we have had. The accountable care
12 organization, I think is workable. Whether it's the
13 hospital staff, whether it's geographic, whether it's a
14 clinic, I don't know. But where the physician and the
15 hospital are that entity working together.

16 As Nancy said this morning, we need to get the
17 physician involved. You need to get it done on that level.
18 You don't want to get it done up in Washington because the
19 message never gets out.

20 I like the outliers. It works in private. And I
21 know it works in my practice, because when I talk about it
22 to my partners, they listen. We all have egos and we're

1 going to try to do it.

2 I think we need to start with the private first
3 and then work down that cascade of beating up people for
4 resource use.

5 We need to go down this path carefully and
6 thoughtfully. As we said maybe the SGR, when we looked at
7 that, maybe we didn't go down it as careful as we should.
8 Maybe we didn't do the right thing or it wasn't done then.
9 We can't cry over spilled milk but we can certainly prevent
10 that at this time.

11 What we're doing is trying to address the
12 spiraling costs. And maybe you all know it, but I haven't
13 seen any cost estimates or anything like this. I certainly
14 would like to see some cost estimates. I know the staff is
15 busy, busy, busy but maybe they can provide some cost
16 estimates. I think that's a tremendous advantage for
17 looking at that because that's what we're talking about.
18 We're talking about addressing the spiraling costs.

19 Thank you.

20 DR. HOLTZ-EAKIN: Glenn doesn't have to carry my
21 water. I'll defend what I believe is the appropriate need
22 for some sort of aggregate cap, which has worked in the

1 following sense. It has highlighted to the political
2 community and to the medical community and to the U.S. as a
3 whole that this system is not working, period. It delivers
4 inadequate care at extraordinary costs, and it's growing
5 every day.
6 So I think it's appropriate to use these kinds of
7 caps to provide pressure, not just financial but also for
8 change. What's wrong with this one is it's just on the
9 physician.
10 So when I look at that phasing, the thing that
11 jumps out at me as if we're going to have an SGR-like
12 mechanism which is what we know inadequate from any standard
13 of perfection but which does provide impetus to change, it
14 should apply broadly. And it should place pressure on all
15 providers to get together and coordinate care and give
16 incentives to get out of the SGR by providing cost-effective
17 care that works.
18 That's what I think we need to focus the
19 discussion on. That's the value of the cap, I think. It
20 has produced this kind of discussion. It's forced Congress
21 to ask us to come up with some solutions. I think that's
22 all entirely appropriate.

1 Cost estimates, left unchecked, the numbers are
2 frightening. We've seen the sustainability report. You can
3 do more narrow things with just this SGR. If you waive it,
4 you're looking at $200 billion in a price tag. This is very
5 expensive, and it merits the attention of the community and
6 the Congress to have a cap that doesn't let health care eat
7 the entire federal budget and then gives, underneath that,
8 incentives for better care.
9 That's the real goal.
10 DR. CROSSON: Thanks.
11 I just wanted to compliment you on the choice of
12 Kevin Hayes to carry the standard here, not just because of
13 the quality of his thinking and the quality of the work.
14 But I assumed that since he's the only member of the staff,
15 I believe, whose shares a surname with a former president,
16 that this was actually a very clever way to help us in the
17 future with the Hayes plan or the Hayes-Hackbarth plan.
18 [Laughter.]
19 DR. CROSSON: I just might make a couple of
20 comments, and some of it has already been said. I think
21 this is a good direction. I think it potentially provides a
22 way to deal with geographic differences, and you've made

1 that point.

2 I also think over time that it may very well lead
3 to the development of whatever we want to call them, but
4 accountable organizations. I think, as Nancy said, we've
5 seen the same development in England and at least so far it
6 seems to be going in a good direction.

7 I do have the problem with the use of the term
8 SGR. It would be an interesting discussion but I actually
9 would wonder whether or not all of the commissioners don't
10 agree with the previous position, and that is that the SGR,
11 as it now exists, ought to be dispensed with, that it is in
12 fact a bad system for all of the reasons that have been
13 said. The linkage to the GDP doesn't appear to have been
14 the right thing to link it to. And the cumulative nature of
15 it has created the political problem.

16 But that's a separate issue from Doug's issue,
17 which is to say that if the Congress decides or if the
18 economics of the Medicare program dictates that there has to
19 be some constraint on spending that there ought to be some
20 linkage to volume or linkage to resource use or the like.
21 But those are separate things. And I think we get tangled
22 up now increasingly with the term SGR.

1 So if you look at slide six, even within the
2 context of our own discussion slide six talks about this
3 path as a replacement for the SGR. But on bullet three it
4 says -- and I think this is in the context of the
5 accountable organizations -- provide a way to perform apart
6 from the SGR and share savings.
7 Well, we're not talking -- we're talking about a
8 system that would have replaced the SGR. It would be to
9 part from whatever the rest of the universe is that is
10 described in the previous slide that is not within that
11 accountable organization.
12 So we're getting a little tied up with SGR. And
13 since that carries such political baggage, I think we ought
14 to restate the fact that we think it's a flawed way of going
15 about managing volume or appropriateness of care and needs
16 to be dispensed with and replaced with some other system
17 that doesn't have any of those three letters in its acronym
18 to avoid confusion.
19 The last one, and I think I would just reiterate
20 points that Nancy and Nick made, and it has to do with the
21 phasing. And I think I would agree that a change of this
22 nature would require phasing. It's going to take time. But

1 I would like to see, in some way, the incentive aspects of
2 this either not limited to phase IV and included in some
3 ways earlier, or that the timing between phase III and phase
4 IV be very short. Because I think unless the incentives are
5 in place, the dynamics are not going to work.
6 MR. HACKBARTH: Let me just pick up on that point.
7 I, not Kevin, my coauthor, was the one who put
8 that in phase IV. It certainly didn't signify that I think
9 that we ought to hold back on doing that. If we could do it
10 tomorrow, those things tomorrow that establish better
11 accountability, better reward, individual performance, if we
12 could do them tomorrow, I would do them tomorrow.
13 I put them in a later phase simply to signify that
14 I think that while we've got attractive concepts, they are
15 at this point just concepts and they would take time to
16 actually develop and operationalize. And so I wanted to put
17 them later to signify that I, unfortunately, don't think
18 that they're ready to go tomorrow.
19 But it's not a strategic decision to hold them
20 back or a decision of lower priority. I agree with you, Jay
21 and Nick, that those are among the most important things to
22 do and they ought to be done as early as possible.

1 MR. BERTKO: I'll be a math person and shorten the
2 timeline to now an H-squared timeline.
3 The comment would be, I think this last discussion
4 has just noted the usefulness of the timelines themselves.
5 And whether it's one or maybe two or three, having that in
6 the report, I think, is very good because it will allow
7 staff and Congress to perhaps discuss it in the substance of
8 something that's somewhat concrete, while not suggesting
9 that this is the answer.
10 The second comment is a quick one and it's a
11 lesson. Kevin gave dollar amounts in the budget that were
12 learned from the BBA and the MMA. I think the MMA also has
13 a very good time line one. The two years for implementing
14 something of perhaps equal magnitude, namely the Part D
15 benefit, was clearly -- I mean, people on both sides were
16 running flat out and it was still less than adequate.
17 So Glenn, you're five-year time frame might be
18 something we might explicit mention in the context of our
19 past experience.
20 DR. MILSTEIN: Before I comment, one aspect of the
21 plan that could be elaborated on is this idea of phase one,
22 provide performances for high performance. Before I

1 comment, Kevin, could you elaborate what unit of reward?
2 What measures?
3 DR. HAYES: This would be a policy oriented toward
4 what the Commission has recommended in terms of pay-for-
5 performance for physicians. That's what my conception of it
6 was, but I might have it wrong.
7 MR. HACKBARTH: In all honesty, Arnie, it's
8 probably the piece of this I have thought least about. So
9 I'd be open to suggestions.
10 Basically what I wanted to signify is that even if
11 we extend the existing SGR for some period while we gear up
12 to do something fundamentally different, we may well want to
13 go down the path that Congress has already begun thinking
14 about, well let's exempt people from cuts or provide modest
15 updates for physicians who are doing good things and trying
16 to move us in the right direction.
17 So that's the concept. Exactly how we
18 operationalize that and define those good things is very
19 much an open question in my mind.
20 DR. MILSTEIN: Let me make two comments. First of
21 all, I think this plan looks -- I'm very supportive.
22 Secondly, time is of the essence. We are in an

1 affordability crisis. By doing nothing, I believe we're
2 just continuing to expose the beneficiaries to more of their
3 Social Security increases going to Part B premiums in the
4 program. That is, for me, the burning platform. And the
5 chunk of Social Security increases that has been going to
6 this use is very sizable.

7 So for me, I think assuring that this provide
8 bonuses for high performance, even though the bonuses we
9 know initially will be quite modest as a percentage of
10 physician payment, for me it's very important that it
11 encompass not just quality parameters but also the best
12 resource parameters we have, whether it's episode groupers
13 or -- but something that is a reasonable proxy for spending
14 growth.

15 So that my support comes with a request that the
16 dimensions included in high performance and phase one
17 include resource use, as well as quality.

18 Secondly, I just wanted to say I may be misreading
19 my fellow commissioners, but I don't think there's need to
20 have question marks in this, whether we want to include Part
21 A, B and D. It's the total spending that is the problem and
22 physicians are in a tremendous position to affect A, B and D

1 use. So I would hazard a guess that there is, if not
2 unanimity, at least substantial support among commissioners
3 for -- if total spending is what we're after -- including
4 all three buckets.
5 MR. HACKBARTH: Maybe Kevin and I can answer this
6 together.
7 I'm not sure why the last question mark is there
8 in that bullet, include Part A and other Part B and Part D
9 in target. I definitely included a question mark about Part
10 D, and I included a question mark because the Part D
11 spending is flowing through a completely different system
12 right now, through a private health plans system, each
13 private plan having its own formulary and rules of the game.
14 And so it's got a different dynamic to it that at least
15 raises questions.
16 In principle, I absolutely agree, you want all of
17 the expenditures. But how you incorporate Part D, when you
18 do it, seems to me to be a question, given that it is
19 operating through a different payment system altogether.
20 DR. REISCHAUER: It's technically probably
21 impossible if you're going to include the employer/retiree
22 policy amounts included there.

1 DR. MILSTEIN: My comment here would be, granted
2 that these technical problems are real. But there are
3 parallel problems in the private sector profiling. Many of
4 the employers carve out pharmacy, have very employer-
5 specific rules as it applies to their formularies and is
6 administered by their PBM. And yet the private plans make
7 do and find ways of bringing that back into the profiling,
8 understanding it does introduce some noise in the
9 measurement.
10 DR. REISCHAUER: I'm just saying geographically, I
11 don't think we can allocate the resources when we give it to
12 General Motors.
13 MR. HACKBARTH: This is an important conversation
14 but I don't want it to obscure an even more important point.
15 I think one of the areas where there is a very strong
16 consensus, if not unanimity, among the commissioners is if
17 you have a system like this with formulaic limits, to apply
18 it only to physicians and think that you are meaningfully
19 addressing the long-term cost problems of Medicare is a
20 mistake. And so you want to make it as comprehensive as
21 possible. We're concerned about system costs, not just
22 physician costs.

1 I think that's a point on which there is
2 substantial agreement.
3 DR. SCANLON: In response to that, I think that
4 while we do care about total cost we need to also recognize
5 that it's the physician that's the decisionmaker in terms of
6 volume.
7 So between phase two and three, I see a big
8 distinction, which is in two one might hold physicians
9 accountable for all costs because they are signing the
10 certification that someone uses home health, DME, even
11 prescription drugs.
12 But when we move to phase three, and if we're
13 thinking about adjusting the payments for all providers,
14 we're talking about a much bigger task because we need to
15 think about the incentives that are already built into the
16 pricing systems that we've got for these individual
17 providers and what they have under their control. Because
18 they don't necessarily have volume under their control.
19 They may have the quality of the service that they can
20 influence.
21 The idea that they're more efficient, we're back
22 to this national system because we have national rates for

1 home health and SNF and other providers. So the idea if I
2 become more efficient I'm going to be rewarded in terms of
3 the underlying rate is not the case. So three is a big
4 change in terms of all the payment systems that we have.
5 MR. HACKBARTH: Your point is well taken. My
6 objective, my hope in this, would be that if Congress were
7 to elect such a path, what you want is for all providers,
8 physicians, hospitals, home health agencies, you name it, to
9 be engaged in the task of trying to reduce total costs while
10 increasing quality, not maintaining it. While increasing
11 quality.
12 To the extent that the squeeze is applied only to
13 physicians, even if the metric is a total cost metric, I
14 worry that the other providers are going to have less
15 enthusiasm for the task. The hospitals, for example, are
16 going to say oh, reducing admissions is reducing my revenue.
17 No thank you, I'm not going to provide operational support
18 to activities that are designed to reduce hospital
19 admissions and readmissions. It's physicians who are going
20 to get hit with any fee cut, their problem not mine.
21 So there are lots of very important questions
22 about how you would operationalize it. But the goal needs

1 to be to get all providers engaged in that conversation, as
2 difficult as that is.
3 Who else has comments? We are at the end of our
4 appointed time for this, but I don't want to cut off any
5 conversation.
6 Okay. Thank you, Kevin. Excellent job.
7 Now we'll have a brief public comment period, with
8 our usual ground rules. Please identify yourself, first of
9 all. And then keep your comments very brief, no more than a
10 couple of minutes.
11 MR. CONLEY: Thank you, Mr. Chairman. Jerry
12 Conley on behalf of the American Academy of Family
13 Physicians.
14 I appreciate many of the comments of the
15 commissioners, and particularly one that I think Doug made,
16 as far as using the SGR as a continued pressure point as far
17 as the political and the other kinds of environments that
18 we're dealing with.
19 It reminds me of the Bowl Championship Series
20 using the bowl series and the bowl playoffs as a mechanism
21 to create pressure on the NCAA to get them finally to a
22 single playoff.

1 But it is clear, I think, that the SGR has not
2 worked, it's not effective and, in fact, it can be used very
3 effectively as a pressure point for change. It has created
4 a fractionalization and fragmentation within particularly
5 the outpatient health care community. It places, in our
6 view, an insufficient emphasis, because of this
7 fragmentation, on primary care.
8 Reimbursement is not the only factor, of course,
9 that devalues or diminishes the emphasis on primary care.
10 As you see, throughout the entire sector there is a
11 diminishing selection of primary care as a specialty, from
12 medical students and residents. And this whole deemphasis
13 on primary care we've witnessed in this country, while we
14 are recognizing an emphasis on primary care in other
15 countries, in other countries that have exemplified a higher
16 quality of life, a higher quality of their health care
17 delivery system and a lower cost.
18 So we would really encourage continued discussion
19 around this SGR replacement or this expenditure target
20 replacement by holding up your decisions to the grid of what
21 effect would those decisions or those recommendations have
22 on the primary care system in the United States?

1 And with that in mind, then try to reflect on how
2 those decisions would help redistribute or reemphasize that
3 comprehensive care that we have seen be used effectively in
4 other countries where there is higher quality of health
5 care, higher quality of life and decreased cost on health
6 care system.
7 MS. McILRATH: Sharon McIlrath with the AMA. I
8 hardly know where to start.
9 Just to talk about what have we accomplished with
10 the SGR. I think one could argue that the payments to
11 physicians, the payment rates today, are lower than they
12 would have otherwise been. You cannot argue that it has
13 controlled volume. Volume has gone up lots more under the
14 SGR than it did before there was one. So then, if you think
15 that the reason to have this is so we can force discussions
16 about the overall spending in this country, I would ask -- I
17 mean, aren't we going to have to do that anyway with the MMA
18 cap?
19 Then I would say think of the ways in which the
20 SGR has actually hampered what you would like to do. And to
21 follow up on what Jerry said about primary care, just note
22 that on January 1 things are going to change drastically on

1 a lot of payments for a lot of different surfaces. And keep
2 in mind that actually physicians, the surgeons and everyone
3 else, gave up a lot of money and they gave it to primary
4 care in the last five year review. Some of the primary care
5 services are going up by 37 percent. In order to accomplish
6 that, you had to take a 5 percent hit on everybody else.
7 What is taking that away is the SGR and the budget
8 neutrality. So when you have the SGR in place, you actually
9 are putting in a lot of incentives that are exact opposite
10 of where you want to go. If what you want to do is pay
11 physicians on an individual basis for high performance, what
12 you have going on today in the discussions up on the Hill,
13 is that in order to pay anybody anything, we are going to
14 next year put people in a position of unless we come in with
15 some other one-year kind of solution that is paid for by
16 making the situation even worse in the following year.
17 And so what's happening is we're talking about
18 giving people increases if they meet certain reporting
19 standards. And I would pick up on what Dr. Wolter said,
20 those standards are not necessarily being applied in a way
21 that makes sense. They're being applied in a way that makes
22 it possible for everybody to have an opportunity to get at

1 least some kind of a positive update.

2 And the price of that is that next year you're

3 looking at, in the formula, cuts of 13 to 10 percent, and

4 you've got the next year to ride in and it will be even

5 lower the next year. So you set up this system where you

6 can't give physicians an update that even makes sense

7 because of the scoring implications.

8 If you were to change and eliminate the SGR, you

9 could, under the system that you have previously

10 recommended, as you do with all of the others, if you

11 thought that volume was going up too high, if you thought it

12 was going up too much in a particular service area, you

13 still would have the option of making a recommendation to

14 Congress that they gave differential updates or that they

15 cut everybody by a certain amount or that they only gave the

16 update to those that met the reporting requirements.

17 But if you did that, then you would be creating

18 savings under the system instead of a cost. It is ironic

19 that if you cut the hospitals by 1 percent, you get a huge

20 savings. If you get the physicians even up to a freeze,

21 it's a huge cost. It just doesn't make sense.

22 On the administrative issues, I would say that is

1 a huge issue. If you just look at the back of the rule and
2 look at changing the SGR, if you go back two years, just
3 look at the numbers in there and imagine doing that on a
4 regional basis.
5 But another problem is that some of the things you
6 can't solve with just putting more staff in there. You're
7 making a lot of projections and no matter how many staff you
8 have, you're going to have to make projections.
9 And I would remind you that in each of the last
10 two years there was a letter that came out in the spring
11 that said this is what the volume increase is going to be.
12 And by the fall, we had discovered that it was still high
13 but it wasn't as high as it had originally been projected to
14 be.
15 So administratively then, if you're looking also
16 in terms of the scope of the target, I think if you asked
17 physicians to be held responsible and have their pay cut
18 dependent upon what happens in every other part of the
19 health system, then it would be hard to deny them the
20 ability to go off and form specialty hospitals, to increase
21 the number of ambulatory surgical centers, to do the sorts
22 of things and create the kinds of settings where they have

1 total control. So I think that should be part of the
2 discussion as well.
3 That's probably enough.
4 MR. BUSHMAN: I'm Jesse Bushman with America's
5 Health Insurance Plans.
6 I've been following the SGR issue for a number of
7 years. And sitting here listening to this conversation
8 reminds me of a quip that Dave Barry made that we should all
9 take comfort from the fact that there's no problem in
10 government that won't be solved once the sun explodes.
11 There were a couple of things that I thought of as
12 I was listening to this idea of creating various geographic
13 regions with distinct SGRs for each one. The number one
14 item was that the target under the current system has been
15 an issue of debate for a long time. There's a lot of
16 argument about what should be included in the target and
17 what not. If we create multiple geographic regions, each
18 with their own target, it seems to me that that problem
19 would just propagate throughout all of these different
20 regions. It would be something that would be a battleground
21 every year if it wasn't carefully designed and agreed upon
22 by the people who are receiving payment and folks who are

1 making the payment.

2 Another problem that you would need to think
3 about, it seems to me, is the issue of physician migration
4 to areas where payment is higher. Recruiters do actually
5 use varying levels of physician payments under the GPCI-
6 based adjustments right now. And if the variation in
7 physician payment was increased further than it is right
8 now, it seems to me that that would just motivate physicians
9 to go more to an area where the payment is higher, you get
10 more physicians, you get more services, then maybe that
11 would result in lower payments because of an inefficient use
12 of resources, which would create this kind of yo-yo-effect.
13 It's something to think about.

14 It could also create the perception of a different
15 Medicare benefit across the country, in the same way it
16 happened with the managed care plans. You had varying
17 payments and then there were political arguments about
18 whether or not the benefit being supplied was different.

19 It seems to me that you would also get political
20 battles, representatives, senators supporting a system that
21 resulted in high levels of payment in their areas versus
22 those who had low levels, and you would have to deal with

1 that on a regular basis. That would be a tough thing.
2 And then, I guess the major point is something
3 that folks on the Commission have recognized, is that even
4 if you have a geographic area that consists of a single
5 state, it still doesn't get to the individual physician
6 behavior. And that really, it seems to me, is what's going
7 to drive a real change. It's individuals seeing how their
8 payment is getting impacted, not their whole state. If it's
9 their whole state, that could be 50,000 physicians. In the
10 larger states it be tens of thousands of physicians. In
11 that situation, the physician doesn't have as much
12 individual motivation to modify his or her behavior.
13 Speaking as a person who has a health savings
14 account and a high deductible health plan, I would be really
15 interested in seeing the kind of individual level
16 information on physician resource use that I could access as
17 a consumer, not speaking for the organization that I work
18 for. So I would encourage that, any movement toward that.
19 I think that kind of goes along with the administration's
20 emphasis on transparency in pricing.
21 The last thing is that up until a couple of months
22 ago I worked with CMS over in the Humphrey Building. I came

1 in one morning and there was a guy with a cart going up and
2 down all of the aisles, and he was taking two light bulbs
3 out of every one of the four light bulb fixtures. So as you
4 think about the resources that you would recommend that CMS
5 get -- and by the way, they never put the light bulbs back
6 even after it got colder. It wasn't just to reduce the
7 electrical usage during the hot spell. So do think about
8 that.
9 MR. HACKBARTH: Thank you.
10 We will reconvene at one o'clock.
11 [Whereupon, at 12:17 p.m., the meeting was
12 recessed, to reconvene at 1:00 p.m. this same day.]
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1 AFTERNOON SESSION [1:12 p.m.]
2 MR. HACKBARTH: It's time to get started.
3 This afternoon we have a series of presentations
4 related to updates. We start with hospitals and then
5 proceed through a series of post-acute care related
6 presentations.
7 Just as a reminder about the process, of course we
8 must make our update recommendations for inclusion in our
9 March report, which means that we will vote on
10 recommendations in January. In each of the discussions
11 today there will be a draft recommendation presented. The
12 draft recommendation, in each case, is based on our
13 recommendation from a year ago for that particular sector.
14 So it's no more, no less than a repeat of where we were last
15 year.
16 Obviously, to the extent that circumstances are
17 different this year, we are free to depart from those drafts
18 but we did want to have a starting point for discussion.
19 With that preface, Jack and Craig, lead the way.
20 MR. ASHBY: Good afternoon.
21 This session will address payment adequacy for
22 hospitals, including IME and DSH payments. The IME and DSH

1 segment, by the way, at the end will only include new
2 material, following up on our presentation from the last
3 meeting. The draft recommendation on uncompensated care
4 data that we developed at the last meeting, we'll hold that
5 until January for further consideration.
6 Before I start though, I wanted to take just a
7 moment to thank several people who contributed to the
8 numerous set of analyses that we will be presenting on
9 today. That includes Tim Greene and Dan Zabinski, Julian
10 Pettengill, David Glass, Jeff Stensland, Ann Mutti, and
11 Sarah Friedman. We have a cast of thousand here.
12 One more preliminary matter, and that is that
13 we'll be presenting draft update recommendations today for
14 acute inpatient and outpatient services. But you'll
15 remember that we consider the adequacy of payments for all
16 services that hospitals provide to Medicare beneficiaries
17 taken together. And that includes inpatient, psych and
18 rehab, SNF, home health and graduate medical education.
19 Following the Commission's framework for assessing
20 payment adequacy, we will present findings on access to
21 care, volume of services, quality, access to capital and
22 payments and costs in the current year, which is fiscal

1 2007.

2 So first, in the area of access, we first look at

3 the share of hospitals offering certain services. We've

4 been monitoring a set of 10 specialized services for several

5 years now. These are things from burn care to open heart to

6 MRI. And we found that the share of hospitals offering

7 eight of these 10 services has increased. The share of

8 hospitals offering outpatient services, including emergency

9 room services, rose after the outpatient PPS was implemented

10 in 2001 and then it has remained stable since that time.

11 Then we monitor the number of hospital openings

12 and closings. In each year since 2002 more hospitals have

13 opened than closed. In addition to that, the annual number

14 of closures has dropped by 60 percent between 1999 and 2005.

15 A large number of hospitals have converted to

16 critical access hospitals, about 1,100 over the last six

17 years. And for the first time this year, we also identified

18 conversions to long-term care hospitals. We found that

19 we've had an average of 10 conversions a year over the last

20 six years, including 10 more in 2005.

21 Turning to the volume of Medicare services, growth

22 in outpatient services has been strong but the rate of

1 increase is falling. It's dropped from about 12 percent in
2 2001 to 4 percent in 2005.
3 Inpatient discharges have grown more slowly but
4 following a similar pattern. In 2002, 2003, and 2004
5 discharges grew faster than the number of fee-for-service
6 beneficiaries but in 2005 the growth rate slipped to 1.3
7 percent, which is slightly less than beneficiary growth.
8 Beyond Medicare volume, growth in all-payer
9 discharges also dipped in 2005, as did growth in all-payer
10 outpatient visits, as reported by the American Hospital
11 Association. In a survey of 600 hospitals that we co-
12 sponsor with CMS, it suggests that the slowdown in volume on
13 both the inpatient and outpatient side has continued into
14 2006.
15 As the volume growth slowed, we've had larger
16 increases in inpatient case-mix and outpatient service mix.
17 These increases are fully paid for under prospective
18 payment. In other words, a 1 percent increase in CMI
19 produces a 1 percent increase in payments, all else held
20 constant.
21 The outpatient increases of around 3 percent in
22 2004 and 2005 were heavily influenced by increases in

1 observation services which may, in part, reflect a
2 relaxation of coding requirements. We're not sure exactly
3 what has caused the 1.3 percent increase in inpatient case-
4 mix in 2005, but it is the largest increase that we've seen
5 in a decade.
6 Turning to quality, we have three analyses that
7 together support the conclusion that quality is generally
8 improving. Mortality has declined in most of the conditions
9 we've measured over the last seven years. Performance in
10 delivering recommended care to beneficiaries also improved
11 in most categories in this, the first year that we've had
12 these data available on the CMS Hospital Compare website.
13 And finally, patient safety results have been
14 mixed. The rate of adverse events declined, that is the
15 performance got better, in seven of 13 available measures
16 over the last seven years.
17 On this next slide we display the results for the
18 nine most common patient safety measures for you, although
19 we thought we would not spend any more time on the details
20 of this right now.
21 On access to capital, the most direct indicator of
22 hospitals' access is the level of their actual capital

1 expenditures. As we see here, hospital construction has
2 increased steadily since 1999 and we've seen by far the
3 largest increase, 30 percent, in 2006.
4 In addition to construction spending, the growth
5 in taxes and bond issuances has been strong and the value of
6 debt for hospitals with upgraded credit ratings far exceeds
7 the value for hospitals with downgraded ratings.
8 The median values of several financial indicators
9 that we monitor, things like days cash on hand and a couple
10 of measures of debt service coverage, reached their highest
11 value ever recorded in 2005.
12 A recent survey indicated that 83 percent of
13 nonprofit hospitals plan to add capacity in the next two
14 years, implying that they expect to have continued access to
15 capital.
16 And finally, in the for-profit sector, the big
17 story this year is the $33 billion buyout of HCA by a
18 private investment group. Most of the cost of the buyout
19 will be financed through debt, again demonstrating very
20 robust access to capital.
21 Turning to financial performance, our first chart
22 presents Medicare margins through 2005. Going from 2004 to

1 2005 the overall Medicare margin declined by two-tenths to
2 minus 3.3 percent. Looking at our to key component
3 measures, the inpatient margin fell by four-tenths while the
4 outpatient margin increased for the second year in a row.
5 This is due primarily to low outpatient cost growth, as
6 we'll see directly in a later chart.
7 The next slide shows 2005 overall Medicare margins
8 by hospital group. The rural margin is three-tenths higher
9 than the urban margin for the first time. This change is
10 due to several years of increased payments to rural
11 hospitals and to the fact that we've had a number of rural
12 hospitals with low margins drop out to become CAHs.
13 The group with the poorest financial performance,
14 of course, is non-teaching hospitals, as has been the case
15 for a number of years and I'd like to point out that about
16 70 percent of non-teaching hospitals are in urban areas.
17 None of the rural subgroups that we monitor had margins as
18 negative as this non-teaching figure.
19 Our projection for 2007 is for about a 2
20 percentage point decline in margin to minus 5.4 percent.
21 This projection captures the impact of policy changes
22 affecting inpatient, outpatient and hospital-based post-

1 acute care services in 2006, 2007 and 2008. It also
2 reflects an assumption about cost growth that I'll explain
3 in a moment. So the projection represents our best estimate
4 of what margins would be in 2007 if 2008 policies applied at
5 the time.
6 We used the same rate of cost growth for every
7 hospital, so the projection does not reflect any behavioral
8 responses. Unless there are different rates of cost growth
9 between urban and rural hospitals we expect the 2007 margins
10 of these two groups to be about the same.
11 This next table shows the rate of growth in
12 Medicare inpatient costs per discharge, outpatient costs per
13 service, and a weighted average of the two, all adjusted for
14 changes in case-mix. Even before the case-mix adjustment,
15 the rate of growth in inpatient costs drops over these three
16 years. But with the accelerated growth in case-mix that we
17 saw a couple of charts back, the drop is more pronounced
18 here and the rate of growth also declines, as you can see,
19 on the outpatient side.
20 In 2005 the combined 3.3 percent cost growth you
21 see in the bottom corner here exactly matches the market
22 basket update for that year.

1 But unfortunately we have evidence that the rate
2 of cost growth may be edging back up again in 2006. Our
3 survey of 600 hospitals, as well as data from six for-profit
4 chains, suggests that rate of cost growth has written about
5 a percentage point into 2006. This would be either six or
6 nine months into the year, depending on the measure.
7 These data sources cover all payers and they don't
8 offer a case-mix adjusted result. But if we assume that
9 case-mix will continue to increase in 2006, since we know
10 that it's been increasing for Medicare patients over the
11 last several years, then the increase in the rate of growth
12 will probably be a little less than the 1 percentage point
13 suggested by these data sources.
14 Of course, we don't yet have a complete picture of
15 what's going on in 2006 but we would cite two possible
16 factors in the higher growth rates. One is capital
17 expansion. The rate of growth in capital costs, that's
18 measured by interest and depreciation, increased by more
19 than a percentage point in 2005 over 2004. And with the
20 record capital investment we showed earlier for 2006, a one-
21 year increase of 30 percent, another jump in capital costs
22 growth rate is virtually inevitable.

1 The other factor is up with the volume growth
2 tailing off into 2006 the patient volume grew more slowly
3 than hospital employment in the first half of the year.
4 This could be a temporary phenomenon with equilibrium
5 reached later in the year. And if that's the case, then the
6 rate of cost growth may drop back somewhat for 2007.
7 In our margin forecast we assumed an annual rate
8 of cost growth, case-mix adjusted, of 4 percent between 2005
9 and 2007. That's seven-tenths higher than what was actually
10 observed in 2005.
11 Now Craig will present some further analysis of
12 financial performance.
13 MR. LISK: I'm now going to talk about our
14 analysis of hospitals that consistently performed well or
15 poorly under Medicare. This analysis is consistent with our
16 negative margin analysis that we've presented with you in
17 the past, but here we have altered the analysis to base it
18 on adjusted overall Medicare margins. By doing this we
19 remove IME and DSH payments over the empirically justified
20 amounts. This means that these payments are not a factor in
21 determining who consistently performs well or poorly under
22 Medicare. Hospitals get in the bottom or top group if their

1 adjusted margins were in the bottom or top third every year
2 from 2002 to 2005. 18 percent of hospitals fall into each
3 of these groups, in terms of in the top and bottom groups
4 here.
5 In general, what we see is that hospitals with
6 consistently low margins have had smaller declines in length
7 of stay and higher cost growth than those with consistently
8 high margins. From 1997 to 2005, Medicare length of stay
9 fell on average of 2.3 percent per year in the low-margin
10 group compared to 3.1 percent in the high-margin group.
11 From 2002 to 2005 annual growth in Medicare costs per case
12 was a percentage point higher for the low-margin group, 6.3
13 percent compared to 5.2 percent for the high-margin group.
14 So what may contribute to this disparate
15 performance? Hospitals with consistently low margins do not
16 appear to be under as much financial pressure as hospitals
17 with consistently high Medicare margins. The non-Medicare
18 ratio of revenues to cost, a measure of financial pressure,
19 is very different for these two groups of hospitals. This
20 ratio stands at 1.16 for the low-margin group compared to
21 0.99 for the high-margin group. The low-margin group may
22 face less pressure to control their Medicare costs as non-

1 Medicare revenues greatly exceed costs and they can rely on
2 these excess revenues to offset their Medicare losses.
3 These hospitals also have a large private self-pay
4 share of cases, 39 percent compared to 29 percent for the
5 high-margin group. Moreover, along with their higher cost
6 growth, the low-margin group has actually seen revenues grow
7 faster, another sign that this group faces less financial
8 pressure to control costs.
9 In contrast, the ratio of the high-margin group is
10 only 0.99, which means that these hospitals are almost
11 breaking even on their non-Medicare business and that they
12 need to do well under Medicare in order to perform well
13 overall. The low ratio could come from uncompensated care,
14 low Medicaid payment rates, or some other factors, but it
15 does appear that these hospitals have responded to this
16 pressure with smaller cost increases and bigger reductions
17 in length of stay than other hospitals.
18 And this difference that we observed on a previous
19 slide translates into bigger differences in costs between
20 these two groups of hospitals. Here we use a measure of
21 standardized costs to compare facilities' Medicare costs per
22 case. Our standardized cost measures, standardized costs

1 for case-mix, patient severity, outliers, wages and teaching
2 intensity. What we find is much higher standardized costs
3 for hospitals in the low-margin group. As you can see here
4 -- I'm sorry.
5 What we find here is much higher standardized
6 costs for hospitals in the low-margin group, $6,200 compared
7 to a little over $4,500 for hospitals with consistently high
8 Medicare margins.
9 If we compare these hospitals to their neighbors,
10 we see that those in the low-margin group have higher costs
11 than their neighbors, $6,200 compared to $5,700 for their
12 neighbors within 15 miles. In contrast, hospitals with
13 consistently high margins had lower costs than their
14 neighbors, $4,500 compared to $5,100 for their neighbors
15 within 15 miles.
16 We also see that hospitals with consistently low
17 margins have other hospitals closer by than the higher
18 margin group.
19 We also examined how overall Medicare margins
20 would change if we exclude hospitals with consistently high
21 costs. For this part of the analysis, remove from the
22 overall Medicare margin calculation hospitals whose

1 standardized Medicare costs per case were in the top third
2 each year from 2003 to 2005. Excluding these high cost
3 facilities from our margin calculation, we find that the
4 overall Medicare margin in 2005 would be 3 percentage points
5 higher, or just about at zero. About 20 percent of
6 hospitals fall into that group of hospitals to be excluded.
7 MR. ASHBY: We now turn to our update
8 recommendations for inpatient and outpatient services. To
9 start the conversation we have put the same recommendation
10 the Commission made last year, an increase of market basket
11 less half the expected increase in productivity for both
12 inpatient and outpatient services.
13 These recommendations though might represent an
14 appropriate balancing of our findings for this year, as
15 well. On the one hand we have positive outcomes in our
16 assessment of payment adequacy. We have access to care
17 appearing stable, volume of services increasing although at
18 a somewhat reduced rate lately, quality of care generally
19 improving and access to capital reaching new highs.
20 On the other hand, while hospitals' margins under
21 Medicare were fairly stable this year they do remain low,
22 which is cause for concern. The rate of cost growth rising

1 again in 2006 is also a concern, but at the same time the
2 potential for escalating cost inflation emphasizes the need
3 for some degree of constraint and we continue to believe
4 that providers should be able to achieve at least a small
5 improvement in productivity as other sectors of the economy
6 have done.

7 As you know, our standard for expected
8 productivity growth is the 10-year average in total factor
9 productivity in the general economy which currently stands
10 at 1.3 percent. So the recommendation would be market
11 basket minus 0.65 percent. The budget implication is a
12 decline relative to the current baseline and we expect this
13 recommendation to have no major implications for
14 beneficiaries or providers.

15 Now we turn to IME and DSH.

16 MR. LISK: I'm going to move on to review a couple
17 of charts related to our IME and DSH analysis. This chart
18 that's up here now, you saw at the last meeting, shows
19 overall Medicare margins by teaching status and show how it
20 changes under different scenarios.

21 As you can see, as we move from the baseline
22 margin, baseline policy, current policy, to reducing the IME

1 adjustment to the empirical level, the margins converge. A
2 difference of 12 points narrows to 10 points with one point
3 reduction in the IME adjustment. It narrows further to a
4 5.5 percentage point gap if the IME adjustment is reduced to
5 the empirical level.

6 This next chart was requested at the last
7 Commission meeting and it shows how teaching and non-
8 teaching hospitals are affected by the DSH subsidies
9 included in the current payments. Essentially what we show
10 here is that the DSH subsidies are not a major factor
11 in explaining differences in financial performance between
12 major teaching and non-teaching hospitals.

13 Here we see only a small narrowing in the gap in
14 margins between major teaching and non-teaching hospitals
15 from reducing the DSH adjustment. A one point adjustment in
16 the DSH adjustment would result in only a 0.3 point
17 narrowing of the difference in margins between major
18 teaching and non-teaching hospitals.

19 If the DSH adjustment were reduced all the way to
20 the empirical level for urban hospitals over 100 beds, the
21 difference in margin narrows but only 1.5 percentage points,
22 so there would still be a 10.5 percentage point gap in

1 performance here.

2 Thus, DSH payments over the empirically justified
3 about are not a major factor giving teaching hospitals their
4 higher margins. The major factor contributing to the
5 difference in Medicare margins between major teaching and
6 non-teaching hospitals are IME payment above the empirically
7 justified amount.

8 As you can see on this chart, from the last set of
9 points to the right, the difference between major teaching
10 and non-teaching hospitals narrows to 3.4 percentage points
11 if both the IME and DSH adjustments were brought down to
12 their empirical level.

13 We have also included in the chapter a discussion
14 of potential uses of IME payments that are above the
15 empirical level. We discuss three potential uses of these
16 funds. One is returning them to the base rates to improve
17 payment equity across all providers.

18 A use is to use the funds to support pay-for-
19 performance initiatives for hospitals.

20 A third potential use of these funds is to help
21 support innovations in residency training. This might
22 include funding special fellowships to train a new

1 generation of physician faculty, or rewarding specific
2 curriculum innovations such as benchmarking, integrating
3 geriatrics training into curriculum, and reengineering.
4 Given the results of our analysis, which finds
5 that IME adjustment is set substantially above what is
6 empirically justified, and that this contributes
7 substantially to large disparities in financial performance
8 under Medicare between teaching and non-teaching hospitals,
9 and also that teaching hospitals will benefit from impending
10 implementation of severity adjustments, the following draft
11 recommendation is presented for your consideration.
12 The recommendation reads with the implementation
13 of severity adjustment to DRGs, the Congress should reduce
14 the indirect medical education adjustment by 1 percentage
15 point to 4.5 percent in fiscal year 2008. The funds
16 obtained from reducing the IME adjustment should be used to
17 increase the base rates for all hospitals.
18 Spending implications under this would be none, as
19 the proposal is budget neutral. Beneficiary and provider
20 implications, it would reduce payments to teaching hospitals
21 and increase payments to non-teaching hospitals, improving
22 the equity of payments across providers. No effects on

1 beneficiaries would be anticipated.

2 With that, we will conclude and we can discuss the
3 recommendations and other things in the other chapter.

4 MR. MULLER: In terms of the draft recommendation,
5 we've had this fall a series of discussions about not just
6 increasing the base rates but also funding pay-for-
7 performance and, on page 21, rewarding innovations in
8 residency training. I would prefer to have a different rank
9 order if we're going to do this adjustment.

10 If you could go to 21 please.

11 The recommendation ranks the base rates. I would
12 probably rank them in the other order, with rewarding
13 innovations in residency training. Arnie and others and
14 Jennie have spoken over the last few months about the need
15 for either -- some people want to focus on primary care.
16 Other people want to look at collaboration among physicians.
17 Rather than reprising all of the arguments, given the
18 shortness of the time this afternoon, I would prefer that we
19 put the money either into the rewarding of innovations or --
20 this Commission has a long history, three or four or five
21 years now, in P4P recommendations. So if we increase the
22 pool of funds, I would kind of rank order them in that order

1 rather than the base rates.

2 I think in the base rates we've had, with the

3 growth of critical access hospitals, a lot of protection for

4 the sole community providers and so forth. So I prefer the

5 ranking be done in that order.

6 DR. MILSTEIN: I would very much like to support

7 Ralph's last suggestion of flipping the order. I think,

8 again, going back to our sustainability chapter and the

9 notion that long-term what we need is a health care system

10 that can innovate quickly enough in generating new

11 efficiencies that we can have a prayer -- perhaps

12 stabilizing health care spending as a percentage of GDP

13 while raising quality of care.

14 I think the only way you get there is if you take

15 the subset of health care professionals that have the most

16 leverage on how health care works, which is physicians, and

17 begin to train them in the disciplines that they're

18 currently missing.

19 I would, in addition to geriatrics, lean towards

20 process reengineering and health care informatics because

21 that's what, in our testimony from the IOM Committee on

22 Reengineering and Virginia Mason we heard, has the most

1 opportunity for not just one time but dynamic ongoing
2 increases in the rate at which efficiency is captured by our
3 health care system year in and year out.
4 It's only through such a dynamic change that you
5 can hope to stabilize spending as a percentage of GDP. So
6 this is, I think, our single highest leverage investment
7 that we can make and hear's some of what appears to be some
8 discretionary funds to work with.
9 So I want to second Ralph's suggestion of
10 reordering the recommendations.
11 DR. CROSSON: On this point then, it seems to me
12 as we go through the logic of the presentation that one of
13 the points of doing this, it's not necessarily linearly
14 related to the fact that there's overpayment based upon the
15 empirically justified amount. It's can we use this as a
16 tool to narrow the gap that appears to exist between the
17 profitability of teaching hospitals and the profitability of
18 other hospitals?
19 So if that's the logic, then I could see the
20 argument for perhaps taking the second bullet point and
21 making that the first bullet point because that would apply
22 to all hospitals; right? Pay-for-performance for all

1 hospitals could be open to all hospitals and it's something
2 that we've been in favor of, at least in some ways.
3 But I don't understand the logic for elevating the
4 third bullet point, because that applies only to hospitals
5 that have residency training programs. So it seems to me
6 that that doesn't follow from the purpose of the policy
7 change we've argued for.
8 DR. REISCHAUER: After hearing Ralph and Arnie, I
9 thought I would just offer the counter argument. The
10 counter argument would be after we took the 1 percentage
11 point away, we would still be overpaying -- based on the
12 empirical level -- teaching hospitals and it would not be
13 unreasonable to say for that excess payment we should get
14 something for not cutting it still further. And then ask
15 what social values do we want to pursue with the 1 percent
16 that we took away? I could go for either raising the base
17 rates or a pay-for-performance system.
18 DR. WOLTER: I'd actually fall on increasing base
19 rates with this recommendation. The reason I say that is
20 when you look at the margins, the differential is pretty
21 striking. We already have 2 percent of a base rate that's
22 tied to performance measures and that could evolve over time

1 to some sort of more performance.

2 But when you look at the negative margins in the

3 other teaching and non-teaching, you wonder about the

4 ability for organizations to invest in the infrastructure to

5 improve quality and costs and those kinds of things.

6 If I'm remembering the history of IME, the dollars

7 were taken out of base rates to start with. To me there

8 would be a great amount of logic in following the

9 recommendation as it's outlined here.

10 DR. BORMAN: On this specific point, I would

11 support the reversal of order that Ralph has outlined and

12 pretty much agree with him for all of the reasons that he's

13 mentioned to you and the things that Arnie has said.

14 As we link this, and the counter argument has been

15 or part of the contentions on the other side would be that

16 linking this, there will be adjusted DRGs coming which will

17 return some percentage, presumably disproportionately in

18 favor of the teaching hospitals because of their acuity.

19 And for that reason, I would couple -- whether or

20 not we do this -- I would also advance the notion that the

21 draft recommendation should start out assuming the

22 implementation of severity adjustment DRGs rather than with

1 the.

2 I'm very concerned that these two things will get

3 disassociated fairly quickly. I recognize that it may be a

4 fine semantic point. I would like to see us be on record

5 that we have some stronger linkage there.

6 MR. HACKBARTH: On that specific issue, I agree

7 with your point. Let's not try to wordsmith the language in

8 the recommendation itself. Maybe concurrent with is the way

9 to put it.

10 But in addition to the wording of the

11 recommendation, we will make that connection clear in the

12 following text, so that's unmistakable.

13 Who else on the issue of either the recommendation

14 or the particular point of how to use the funds?

15 MR. DURENBERGER: Just to restate a comment that I

16 made the last time we covered this, if we're talking about

17 access for beneficiaries to adequate Medicare services, I'd

18 vote for an option that isn't up there, which is reduce it

19 either to the empirical level or to 4.5 percent period. And

20 then the rest of that money would get spent not on medical

21 education but it would get spent on accessing beneficiaries

22 to services.

1 And again, to restate the fact that Medicare is
2 the only third-party payer, public or private, that is
3 contributing except Medicaid -- not even Medicaid, I guess -
4 - contributing to medical education. And that at a time
5 when we are reducing payments in general, my preference I
6 stated. And so I would support the draft recommendation.
7 DR. KANE: I just wanted to weigh in for having
8 any reduction go to the base rate because the way the non-
9 teaching hospitals make up for this is by raising their
10 charges to the private sector. And we're just making the
11 affordability problem worse. And it shows up actually a
12 little bit in your hospitals with the low margins trying to
13 cost shift, as well.
14 So I think there are broad social goals and yes,
15 it would be nice to have the right residency trainings.
16 But I think the way to do the residency training
17 incentives is really to make the payment system more
18 accurate, create the incentives for people to go into
19 primary care and into geriatric care because there's an
20 income stream there that's attractive. Right now all of the
21 innovation in the world isn't going to get what we want if
22 we can't create the accuracy in the payment system to

1 attract people into the residencies that we want.

2 So I would vote for trying to stop the non-

3 teaching hospitals from taking their losses on Medicare and

4 putting them into the private sector and making insurance

5 that much less affordable in the private sector.

6 Actually, I have one other question. And that is

7 there is a different coefficient empirical level for major

8 academic health centers versus minor teaching hospitals.

9 And I notice no one's mentioned that.

10 But it's a fairly significant difference. I think

11 we should be discussing that as well, whether there should

12 be an adjustment differentially for the academic health

13 center, the major ones that have a much higher -- a 2.6

14 versus a 1.5 empirical rate for the cost impact of teaching.

15 So I would rather that we went after some of those

16 differentials than an across-the-board reduction.

17 DR. REISCHAUER: I just want to know where you're

18 going to put the money Nancy?

19 DR. KANE: Back into the base rate.

20 MR. HACKBARTH: On using the money to achieve

21 changes in medical education, there's a lot of that that I

22 find appealing, although it seems like if you really believe

1 it, to link it to this almost diminishes it. And say well,
2 what we ought to do is 1 percent worth as opposed to a
3 broader effort.

4 I think this is what Bob was suggesting. If you
5 really believe that we need to affect those changes in the
6 types of physicians we're training and what they learn, why
7 link it to this? Why not take that on as a separate
8 initiative in its own right and appropriately fund it or
9 appropriately apply leverage to it?

10 It's the connection that seems weak. The
11 connection that seems most logical to me is either the base
12 rates or pay-for-performance. And that's not to diminish
13 the significance of the medical education points. It just
14 doesn't seem like the logical nexus is as strong to me.

15 DR. REISCHAUER: Why shouldn't it be tied into the
16 GME payment, as opposed to the IME?

17 MR. HACKBARTH: Right.

18 MS. BEHROOZI: To the extent that there are people
19 in Congress or wherever who think that it's really about the
20 accountability factor -- I mean, that's a factor that we've
21 talked about here a lot, that that's one of the problems
22 with the above the empirical value portion of the IME. I

1 guess that's where there's some attraction to tying it to
2 the type of medical education. Then you address
3 accountability. Maybe redistribution is harder to achieve.
4 So I think it's worth keeping that in the mix.
5 MR. HACKBARTH: That's, to me, also part of the
6 rationale for pay-for-performance. There you're putting it
7 into an accountability fund. Teaching hospitals or other
8 hospitals that achieve at high levels would be eligible to
9 get the money.
10 MS. BEHROOZI: I agree, but then you'd have more
11 redistribution, in terms of being able to address each of
12 the concerns separately. I agree that pay-for-performance
13 is absolutely a valid use of the money, as well.
14 MR. HACKBARTH: We're going to need to leave this
15 particular topic in just a minute. The last word on this
16 one, Jennie.
17 MS. HANSEN: I thought that since I've been
18 certainly one of the ones who has brought up the whole
19 aspect of accountability for the IME, I too have thought
20 about and talked actually with Glenn about the GME side of
21 this.
22 But I just know that the idea of having a separate

1 pocket to address this big issue, because it is about the
2 reimbursement. So if the primary care isn't getting
3 reimbursed or the geriatricians, there isn't the endpoint
4 incentive to go into it even if you have the education.
5 As I guess my statement is that I just would like
6 to figure out how to put a perimeter around all of this
7 because it does fall in different pockets and it is about
8 the workforce in the future with process innovation and
9 using that to achieve the pay-for-performance.
10 So if I were to weigh in on those three options, I
11 probably would use the more generic pay-for-performance on
12 it over the other, even though I know I've expressed strong
13 feelings about the educational accountability.
14 MR. HACKBARTH: So let's, for a moment, set aside
15 the IME recommendation and go back to the broader topic of
16 the hospital updates.
17 Comments or questions on that?
18 DR. REISCHAUER: I have a question for Craig on
19 this analysis of hospitals with consistently high and low
20 margins.
21 I'm just wondering what fraction of the beds in
22 America are we talking about here in these two categories?

1 And are we placing too much emphasis on this? You have to
2 be high or low, in the top or bottom third, four years
3 consistently. And then I'm looking and I'm seeing that one
4 is, on average, seven miles away from another hospital and
5 another is 12. And I'm thinking none of these could be in
6 the core areas of any major metropolitan area.
7 So we're talking about not, I think, what many
8 people here are thinking about in the way of hospitals;
9 right? Ex-urban, semi-rural kind of hospitals.
10 MR. LISK: There's a distribution around here, so
11 this is the median -- we're showing you the median values.
12 So you're seeing kind of the distribution is a little bit
13 different. So they are in the different locations in terms
14 of --
15 DR. REISCHAUER: What fraction of the beds --
16 MR. LISK: -- we haven't looked at the core --
17 DR. REISCHAUER: What fraction of the beds would
18 be in the consistently high or the consistently low?
19 MR. LISK: I'd have to get back to you.
20 DR. REISCHAUER: We count hospitals, but...
21 MR. LISK: There's not really any disparity for
22 this group on terms of number of beds that it has, I don't

1 think, but I can get back to you folks on this.

2 MR. MULLER: You said it was 18 percent of the

3 hospitals?

4 MR. LISK: 18 percent in each of these groups.

5 MR. MULLER: That's out of the 4,000? This is

6 after the critical access; right?

7 MR. LISK: No, critical access hospitals are not

8 in here.

9 MR. MULLER: So it's a 3,800 number, 18 percent of

10 that twice is one-third of that?

11 MR. ASHBY: Out of 3,400 that we have now --

12 MR. MULLER: So one-third of that. So about

13 1,100. And then the question is how big are they, compared

14 to -- I had the same sense that Bob did --

15 DR. REISCHAUER: It's not a third. You have to be

16 in it every year, in the bottom third or the top third. So

17 some would fall out.

18 MR. MULLER: What's the 18 percent then?

19 MR. LISK: 18 percent of hospitals are

20 consistently in the bottom third or consistently in the top

21 third.

22 MS. DePARLE: The market basket that we're looking

1 at here, what cost report is it based on? Is it 2003 or
2 2002?
3 MR. ASHBY: The market basket doesn't really come
4 from the cost report. The market basket is a separate
5 phenomenon.
6 In which area are you talking about?
7 MS. DePARLE: I guess I just mean the cost report
8 data. Which year are you using for that, for the hospitals?
9 MR. ASHBY: The basic information we presented was
10 2005 and then we projected to 2007, a two-year projection.
11 MS. DePARLE: I had the impression that the data
12 that we were using was very lagged when it came to
13 understanding hospitals' costs and incorporating new
14 technology and innovation. So do you think that the data
15 that you have adequately captures the expenses they have?
16 Because I think some of the charts you showed
17 would have indicated that those costs are rising.
18 MR. ASHBY: One of the key things to remember is
19 that the technology is in the base. So our 2005 information
20 by all means represents the cost of all technologies that
21 are applied to acute inpatient care and it includes the
22 payments for new tech, approved new technologies in that

1 year, which came out to about two-tenths of a percent that
2 year.
3 Now it varies from year to year because
4 technologies come in and out but it, by all means, does
5 respect the cost of technology
6 MS. DePARLE: There is an issue though, isn't
7 there, with weighting of it? Because I had the impression
8 that some of the newer things are probably underweighted
9 just because of the lagging of the data.
10 MR. ASHBY: You're speaking of the market basket
11 right?
12 MS. DePARLE: Yes.
13 MR. ASHBY: Yes, the market basket weights are
14 fixed for five years. It's a statistical concept, a fixed
15 weight market basket.
16 We've looked at that in the past, though, and
17 found that reweighting more often than five years would have
18 a very, very small effect. And in fact, CMS did an analysis
19 of that and put it in the rule last year. They moved from
20 five to four years as they were required to do so and it
21 made very little difference.
22 MS. DePARLE: I guess what I'm struggling with,

1 Glenn, is whether or not our recommendation adequately takes
2 into account the costs that hospitals are truly incurring,
3 the concern that some of this data may be lagged, and that
4 they are bearing the brunt of incorporating new technologies
5 without really being -- you know, we're making a
6 recommendation for a year from now based on data that, I
7 think, probably doesn't reflect some of these new
8 technologies.
9 I think MedPAC used to specifically account for
10 technology in its recommendation and we quit doing that.
11 MR. HACKBARTH: And one of the reasons for doing
12 that is Congress made a series of changes that basically
13 liberalized payment for new technology both on an inpatient
14 and outpatient basis.
15 And so thinking of it as an add-on, if you will,
16 in the update seemed to be overtaken by events when Congress
17 adopted a different approach to encouraging new technology,
18 which was special payment adjustment.
19 MS. DePARLE: Yes, although I think one could
20 argue about whether -- with respect to certain things, yes,
21 I think there has been some liberalization really by CMS. I
22 don't know that I think that the new technology add-ons on

1 the inpatient side have had that kind of an impact.
2 Outpatient, at the beginning I think maybe it did but I'm
3 not sure it does on the inpatient.
4 But at any rate, I'm not sure that we adequately
5 take that into account. And therefore, we recommend market
6 basket minus one-half of productivity factor. And I guess
7 now is as good a time as any to discuss why we say one-half
8 of the productivity factor.
9 MR. HACKBARTH: Before we turn to that, it might
10 be helpful, Jack, for all of us if you would briefly
11 describe the payment policy changes directed at new
12 technology in recent years.
13 MR. ASHBY: The new tech payment, there's an
14 approval process where technology has to be major. It has
15 to have a major cost effect, if you will. It has to be what
16 amounts to a quality improving technology. And they are
17 approved on an annual basis so there are new ones coming in
18 and old ones coming out each year.
19 But for each approved technology there is a unit
20 payment paid in addition to the basic DRG rate, and it is
21 not budget control. This is additional money that comes in.
22 MS. DePARLE: How many of those have there been?

1 MR. ASHBY: I believe that this year there are two
2 and the number varies from year to year.
3 MS. DePARLE: My understanding is it's been a very
4 small number. Now that may be appropriate. I don't have
5 that granular knowledge. And it also may be what Congress
6 intended. But by sense is that it does not fully account
7 for the cost of those new technologies, both because it's a
8 pretty difficult filter to get through by design; and
9 secondly because I think some of the data is lagged.
10 DR. REISCHAUER: The market basket is basically an
11 estimate of what input prices will change over the year. So
12 what you're talking about is really a level issue, the level
13 upon which this inflationary adjustment is imposed is wrong.
14 The year-to-year change in technology would be infinitesimal
15 change, in a sense, in the level for this.
16 So if there is a problem like this, this isn't, I
17 think, the place in which you should go to try and fix it.
18 MS. DePARLE: I disagree a little bit because it's
19 my understanding it's based on -- and I think I said this
20 the wrong way but it is based on 2002 cost reports. So that
21 is not just year-to-year, that's four years.
22 DR. MILLER: 2005.

1 MR. ASHBY: What is based on 2002?
2 MS. DePARLE: The market basket.
3 MR. ASHBY: The market basket weights you're
4 speaking of.
5 MS. DePARLE: The weights, yes.
6 DR. REISCHAUER: The weights of it. It's like the
7 Consumer Price Index, you have the weight for food, for
8 clothing, whatever. And then you apply expected increases
9 in the price of those, adjusting for quality improvement.
10 MR. LISK: In that last point that Bob said,
11 adjusting for quality improvement, it's holding the same set
12 of products constant. So the market basket has never been
13 intended to measure changes in product. It's holding
14 product constant. It does reflect changes to the input
15 prices over time, every single time. If pharmaceuticals are
16 going up at twice the other things, the pharmaceutical
17 weight is automatically rising. But if you're having
18 certain pharmaceuticals that are costing twice as much, the
19 market basket -- that are new, the market basket doesn't
20 reflect that type of change.
21 MS. HANSEN: Mine is actually a question on the
22 aspect of technology, not just individual devices but the

1 whole cost of the information systems. Is that built into
2 this formula as kind of part of the average?
3 MR. ASHBY: Information systems are not included
4 in the new technologies for which we make specific payments.
5 Of course, the thought is that over time they will have a
6 return in improved quality and decreased costs and hopefully
7 will, in essence, pay for themselves.
8 MS. HANSEN: Actually then that does segue. Does
9 that still fall under capital? Or is capital really bricks
10 and mortar?
11 MR. ASHBY: No, those would be capital
12 expenditures, as well. The cost of them are paid for as any
13 other capital item would be.
14 DR. REISCHAUER: To the extent technology would be
15 in the market basket, you would hope that it wouldn't be,
16 because its price per constant quality has been falling like
17 a stone.
18 MR. MULLER: Not information technology.
19 DR. REISCHAUER: Overall.
20 MR. MULLER: Not in this area. The things that
21 we've been urging in other discussions around electronic
22 medical records, all the stuff that Arnie and Jay and John

1 and others have been talking about, that Leapfrog has been
2 pushing in terms of order entry, those are very expensive
3 tickets. The benefit is obviously to the general health.
4 DR. REISCHAUER: The question is they're very
5 expensive, but what's the price next year? Is it cheaper
6 than it was this year for a software of equal capability?
7 And if it's like every other piece of software available,
8 it's falling like a stone.
9 MR. MULLER: A lot of the costs have to do with
10 reengineering. They are very expensive line items. I don't
11 know if we're going to get into this right now. It would be
12 very hard to say the cost of these are going down. And the
13 benefit of that doesn't necessary accrue to the hospitals'
14 cost structure. It may accrue to the general health of the
15 population, et cetera, and so forth. But I can assure you
16 it's not going down.
17 DR. KANE: I just have a quick question. To what
18 extent does recalibrating the DRGs based on costs now
19 incorporate new technology? And how fast does new
20 technology get put into the recalibrated weights?
21 MR. ASHBY: The weights are recalibrated every
22 year and, by all means, they would reflect the cost of any

1 technology that was part of spending for the previous year.

2 DR. KANE: So one year.

3 MR. ASHBY: Yes. There's basically one year's lag

4 in the process.

5 DR. BORMAN: I have two questions. One is in the

6 productivity section we reiterate that the target is equal

7 to the BLS, a multifactorial 10-year item. Do we have any

8 separate analysis that would allow us to say in retrospect

9 that the assumption that that is a good measure of health

10 care industry productivity is correct?

11 MR. HACKBARTH: The productivity adjustment has

12 never been an empirical adjustment or an estimate of change

13 in hospital productivity, but rather a policy adjustment, an

14 objective if you will, an expression for some of us at least

15 that it's reasonable to expect that health care providers

16 paid under Medicare will strive and achieve improvements in

17 productivity much in the same way as the taxpayers who

18 finance the program are under relentless pressure to improve

19 their productivity.

20 So it is not an estimate.

21 Now more specifically to your question, obviously

22 to the extent that actual productivity improvement lags,

1 costs will be higher than projected and it will ultimately
2 be reflected in the margins. So margins, if we're
3 consistently off on that and the hospitals are not achieving
4 productivity gains, our costs will be higher. And as we
5 look back, we'll see actual margins are less than we might
6 have projected for that year.
7 DR. BORMAN: I think the other piece potentially
8 being -- I understand the linkage to the mechanism of
9 funding, and sort of the philosophic piece of that. I guess
10 the other implication could be that, in fact, even the
11 productivity gains are higher. But obviously, the margins
12 provide the answer to the question over the long-term.
13 My other question would be in looking at -- you've
14 made a very convincing set of arguments about the access to
15 capital and the boom that does appear to be going on.
16 Is there any reason to believe that that capital
17 access is better or worse for the IME or DSH hospitals,
18 particularly the major teaching hospitals? I think it would
19 go a little bit like this, in that we have both operating
20 and capital adjustment. And if everybody can get to
21 capital, then maybe the capital adjustment is a piece of
22 what's less equitable, malaligned or whatever it may be, as

1 opposed to perhaps the operating. Do we have any
2 information that would speak to that?
3 MR. ASHBY: The short answer is that we don't have
4 any information that would speak to that. I'm not aware of
5 a breakdown in the literature that we follow out of Wall
6 Street that way. And of course, they are by and large not
7 responding only to the Medicare situation anyway. They are
8 responding to the broader picture.
9 MR. HACKBARTH: Just to leap into the queue here,
10 and to pick up on Karen's initial question, the big question
11 in the room this year and every other year is what is
12 Medicare's role in setting payments? One view of that might
13 be what we want to do is set payments so that we properly
14 account for new technology and accurately account for real
15 productivity gains, not policy adjustment factors, that we
16 accurately track increases in hospital costs. And
17 ultimately the goal is to stabilize margins or hit some
18 target margin or be within some range of margins. That's
19 sort of one general mindset about this.
20 Another very different approach is to say Medicare
21 has some serious long-term financing issues. As a society
22 we've got big issues with health care costs. And not only

1 what it means in the budgetary sense but what it means in a
2 real-world sense for workers paying payroll taxes into the
3 system who are not necessarily getting increases in their
4 compensation that anywhere near match the increase in their
5 health care costs. Workers are losing their jobs.
6 And if you adopt that view, the objective for
7 Medicare, and private payers as well, is not to track the
8 increase in hospital costs but to change the cost trend and
9 continue to apply pressure as long as is necessary to induce
10 change in the trend.
11 So there are two very different mindsets that one
12 might bring to the table on this.
13 When I first came to MedPAC six years ago, more
14 than six years ago now, I think the first was predominant.
15 That we had a pretty detailed, some would say arcane,
16 approach for trying to calculate all of these different
17 adjustments that you would make off of a market basket to
18 try to get as precise as possible, new technology add-ons
19 and deletions for this and that, to try to track what
20 hospital costs were and the pressures they faced.
21 As the years have gone by, I've undergone my own
22 personal migration here, and I'm probably moving more

1 towards the second view. Maybe that's because we're now six
2 years closer to the retirement of the baby boom generation
3 and all of these -- and me, right, my retirement. All of
4 these things somehow seem much more immediate than they felt
5 six years ago.

6 So at the end of the day that's the real debate
7 not just for us but for Congress, which of those things are
8 you about? Are you about accommodating cost increases or
9 changing cost trends. That's just an observation of my five
10 year or six year experience.

11 DR. CROSSON: Now you've got me thinking that I'm
12 three years from being a beneficiary, so I'm not sure about
13 my question.

14 What I was going to ask what is, I think, on the
15 same topic, because I've been asked this question myself. I
16 think I heard it in the point that what happens if, in
17 creating the market basket, we really miss the technology
18 piece? But the more fundamental question is that when we
19 are talking about market basket here and whether we should
20 be at it, above it or below it, we're talking about a
21 projected market basket. And so we're now talking about the
22 payments in 2008.

1 And if, in fact, at the end of 2008 the actual
2 market basket turns out to have been different is that
3 something that we learn about, consider or should consider
4 in terms of thinking about subsequent updates? At least I
5 don't think I've heard that in our previous deliberations.
6 DR. MILLER: I think part of that answer goes back
7 to some of the other discussion on productivity. What you
8 end up with in the margin is if the performance of the
9 hospitals, for whatever sets of reasons, because the cost
10 was estimated wrong, because some new technology hit it that
11 somebody didn't anticipate two years later, or because the
12 market basket estimate was wrong, then our margins are going
13 to generally look worse and we're going to drive our
14 decisions off of that. I think that's at least part of the
15 answer.
16 DR. CROSSON: So if markets are deteriorated, it's
17 become a proxy to that.
18 MR. HACKBARTH: If I remember correctly, Jack, we
19 used to have a correction for forecast error as one of the
20 many adjustments in the update framework.
21 MR. ASHBY: Yes, at ProPAC they used to consider
22 forecast area in developing their recommendation.

1 DR. CASTELLANOS: My comment was a comment about
2 10 minutes ago and it's about to Bob's answer about the cost
3 of IT.
4 I can tell you in the physician's office, we had
5 hoped that that was going to be, it was going to go down.
6 But we waited and waited and waited and it went up and up
7 and up. I can tell you the costs in a physician's office
8 for IT and EMR is still going up.
9 DR. WOLTER: I do also worry a little bit about
10 the technology issue, I will say. I think this is
11 expensive. It's kind of a long-term implementation and the
12 operating expenses, in addition to the initial capital
13 expense, are significant. And I think the productivity
14 return from it, there's a gap between implementation and
15 when that productivity return occurs.
16 Some of the productivity return is initially in
17 lower paying positions, certainly. And so I think there's
18 something about all of that that we ought to at least
19 recognize, whether it's the right thing to do a different
20 approach to technology adjustment I guess can be debated.
21 But I don't think the current system is maybe capturing what
22 some people believe is really an important issue in health

1 care. And there may be significant barriers to some
2 institutions in adopting technology solutions as well.
3 So I think that's a reasonable concern at least to
4 raise.
5 I'm also personally a little bit concerned about
6 the productivity adjustment. I understand the philosophy
7 certainly. This year it jumped up quite a bit from previous
8 years also, even though it's a rolling 10-year average. I
9 worry about an industry that is so labor dependent, and in
10 some states even legislative staffing ratios and those sorts
11 of things. Having said that, I understand the philosophical
12 commitment to it but I do worry about it.
13 And then I wanted to say I really was fascinated
14 by the analysis of the top one-third hospitals and the
15 bottom one-third margins. I guess one lesson from that is
16 it's nice to live in a market where you have a nice private
17 payer mix, which would be obvious. But it does leave other
18 institutions under a fair amount of pressure.
19 I guess when I see that after we exclude the top
20 one-third cost hospitals, which is 20 percent of hospitals I
21 think you said, we still have margins down around zero. If
22 there was a year when you might argue for a full market

1 basket update, this would certainly be one, at least based
2 on the data, recognizing that the sustainability issues and
3 the cost issues remain significant.
4 MR. HACKBARTH: One quick point about the
5 technology issue, as I'm sure is evident to people, I'm a
6 believer in clinical information technology. I think it's
7 critically important. When I ran a group we invested
8 heavily in it because we believed in it.
9 Having said all of that, a higher update is a very
10 crude tool for promoting that since people will get the
11 update regardless of whether they choose to invest in the
12 clinical information technology or not. They can just as
13 well use the funds to go out and buy another scanner which
14 will have maybe an even more attractive return on
15 investment.
16 And so I agree with the goal. I'm not sure that
17 this is the appropriate policy tool to advance the goal.
18 MR. MULLER: This morning we had the Hackbarth-
19 Hayes theory on SGR and this afternoon we have the Hackbarth
20 simplicity theorem on how to look at these margins.
21 I think all of us have evolved in bit in terms of
22 how to think about payment updates, obviously from where we

1 were a number of years ago where we looked at payment
2 adequacy and we kind of massaged that, perhaps endlessly.
3 It seems to me we've moved now towards these
4 categories of the hospitals -- I want to call them worthy
5 and unworthy -- but the ones that have the higher and lower
6 margins and there seems to be some characteristics of the
7 ones that are performing less well.
8 I think if we're going to keep going in that
9 direction we need to put a little bit more flash on the
10 description of those kind of hospitals. We can all kind
11 guess based on mileage or size and so forth as to what they
12 might be.
13 With so many critical access hospitals now, up to
14 1,300, it seems to me we've taken a whole segment of
15 hospitals that many people are worried about and have kind
16 of put them in a more protected status.
17 So the question is really what is left here, the
18 ones that are lower performing. I think intuitively if
19 hospitals have low occupancy and have higher cost increases
20 than others, one tends to think perhaps they're not either
21 managing as well or they have less fortunate circumstances
22 and so forth. But I think we need to flesh it out a little

1 bit more. I'm not saying we're going to do this by next
2 month. But if we're going to go in that direction, as
3 opposed to the where we used to be on payment adequacy, I
4 think we need to get a better sense of what they are.
5 I think the projected margin that we're looking at
6 for next year is going down another basically minus 2
7 percent; is that correct?
8 So to have a 2 percent drop in the margins to
9 negative 5.4, it starts getting to be a serious number. And
10 I think, like Glenn I haven't been on the Commission as
11 long, but it strikes me that's the biggest drop we've
12 projected in all those years, in terms of year-to-year drop
13 in projected margin.
14 So I, like the other Commissioners, are very
15 sensitive to the taxpayer and the overall sustainability of
16 the program but I think I would want to note that this is
17 probably the biggest drop, if I'm accurate in that, that
18 we've projected in all of these years, in terms of a margin.
19 To just say that there are some hospitals that
20 have less occupancy and higher cost curves, and that's what
21 it is, if we're going to come to that conclusion I would
22 like to flesh it out a little bit more and say that's what

1 it is, as opposed to just kind of inferring at that.

2 I do think the point I tried to make earlier about
3 information technology -- and this builds also on what
4 Nancy-Ann was raising earlier -- a lot of technology
5 investments that happen in our siloed system, the benefits
6 of it get reaped elsewhere. They get reaped either by the
7 taxpayer, they get reaped by health plans, they get reaped
8 by beneficiaries. Those are good things. But they are
9 incurred at a hospital level.

10 So I agree with Bob that while in general maybe
11 iPods and desktops are getting cheaper, but information
12 technology in hospitals is by no means getting cheaper. The
13 drug prices are still what they are.

14 And so we do capture it a year or two later, but
15 given that this Commission has been on record over the last
16 few years of really encouraging investments in information
17 technology, that benefit the general health system, I think
18 we should be sensitive and try to get a better estimate as
19 to what that really is doing to the cost.

20 If it's a trivial number, then we should say it's
21 a trivial number and it doesn't make that big a difference.
22 If it's a more substantial number, as I suspect it is, then

1 I think we should try to get a better handle on that rather
2 than just saying it's a small number and get caught up in
3 the cost curve two years later and then recapture it.
4 Because we are really asking now, especially in
5 light of -- whether it's what CMS is asking, whether it's
6 the Leapfrogs and the British Excellence Programs are
7 asking, there's more than 100 reporting systems out there
8 right now that are asking hospitals. An awful lot of what
9 they're asking us to do is make major investments in
10 information technology so that we can do both the process
11 measures and the outcome measures the people all want to do
12 as part of pay-for-performance.
13 So I would say there is a heightened expectation
14 of investments in technology that we're down to the benefit
15 of the health system. I think that's a very substantial
16 number that we're being asked to bear, and I think we should
17 probably not guess at it and try to get a better estimate of
18 what that might be, especially if it lags a number of years.
19 It may just be that maybe teaching hospitals and
20 the critical access hospitals can afford to do it and nobody
21 else can. I would think in general we would want to have
22 hospitals be able to make those kind of investments in

1 information technology.

2 MR. HACKBARTH: As I say, I agree with the

3 importance of the investment. The issue, to me, is the best

4 way to reward appropriate investment. As this Commission

5 has discussed in the past, I think a better approach, as

6 opposed to a higher update, is the avenue of pay-for-

7 performance. Let's create a return on investment for

8 improvements in quality and efficiency, for which investment

9 in clinical IT may be a tool. And let's create an incentive

10 that's targeted to the results as opposed to updates for

11 everybody.

12 MR. MULLER: Can I go back to where I started

13 history this thing about a half hour ago. Your

14 recommendation was increasing base rates. Then why don't

15 you put it into pay-for-performance?

16 MR. HACKBARTH: As I said in my response to that,

17 I can see the argument for pay-for-performance. The one

18 that I stretch most with is the medical education one. So I

19 could easily switch to the pay-for-performance use of the

20 dollars.

21 MR. MULLER: That's why I preferred the way I

22 ranked it, but still I see the pay-for-performance as a

1 clear second ranking.

2 DR. HOLTZ-EAKIN: One more time with the

3 economists on technology, and that is these investments in

4 technology are one-time expenses that are quite large. We

5 know that. But if you wait one year, all the evidence is

6 you will get a lot more for your money the next year. They

7 are going down in cost, correctly adjusted for what these

8 systems can do year by year. There's no evidence against

9 that.

10 They are embedded in what we're doing because the

11 margins include some allocation of the fixed costs, so

12 they're built into the margins. And as they get embedded

13 into the market basket, they're correctly caught there as

14 well. It would be wonderful if we saw such a broad adoption

15 of new technologies so that a year-to-year change in the

16 market basket was dramatic and we're missing it. But that's

17 not happening or we wouldn't be talking about incentivizing

18 investments. So I don't think there's a big problem here in

19 missing technology costs.

20 I do think it's worth just being realistic about

21 the whole business of projections and margins and things

22 like that, because it comes with the turf. We're going to

1 be wrong. You can't project anything using the data that
2 are a year old two years out. It's part and parcel of the
3 business, including projecting margins. So I don't think
4 projecting a 2 percentage point drop in margins means that
5 there's a 2 percentage point drop in margins. It tells you
6 something about trajectories and not the actual outcomes.
7 With that in mind, when I look at what was put
8 together here, I think it was a nice effort to use a bunch
9 of indicators, a broad swath of indicators, about access
10 which seems good, quality which seems to be not
11 deteriorating or even improving. And in the industry where
12 everyone wants to get in. That suggests things are in
13 pretty good shape.
14 In those circumstances, you might want to ask why
15 can't they do as well as the rest of the economy?
16 MR. MULLER: Total margins, because that's what's
17 driving that, not the Medicare margin.
18 DR. REISCHAUER: Let me just try this one more
19 time. What is the market basket trying to do? To do a
20 hospital, you have some labor. You have some equipment.
21 You have utilities. You have drugs. You have other inputs
22 and IT. The market basket is asking to buy the same things

1 that you bought to do a hospital this year what will it cost
2 next year? What percent increase will it cost?
3 It's not saying well, we should change this and
4 expand our technology or improve the kind of care we give.
5 It's saying to produce the same thing we produced this year.
6 All of these things are objectives which I agree
7 with you, but they're different from what this exercise is
8 trying to do. That's all.
9 MR. MULLER: If that's the argument on the market
10 basket, then in the question is what's in the underlying
11 costs that get updated year-to-year and lagged and so forth?
12 And if it's showing that those costs are now running at a
13 minus 5 percent, that's telling you that it's not capturing
14 all of those costs.
15 If you're saying that those costs -- I know with
16 the economists lined up there, I'm going to be over my head
17 pretty fast.
18 DR. REISCHAUER: It might be telling you that
19 you're improving each year by providing a different kind of
20 product in a different kind of way. Or it might be telling
21 you you're becoming increasingly inefficient. It could be
22 doing all sorts of things and you don't want to, in a sense,

1 reward people without knowing what it's telling you.

2 MR. HACKBARTH: Okay, having resolved that --

3 [Laughter.]

4 MR. HACKBARTH: We will have to move on and

5 proceed to our next presentation, which is the first of a

6 series on post-acute care. We're going to start with an

7 overview of post-acute and then proceed to the individual

8 types of facilities.

9 MS. CARTER: Medicare pays for post-acute care,

10 that is services furnished by home health agencies, skilled

11 nursing facilities, inpatient rehab facilities and long-term

12 care hospitals using separate payment systems. The

13 Commission has previously noted that these individual silos

14 do not function as an integrated system in which a comment

15 patient instrument is used to assess patient care needs and

16 outcomes and where payments reflect the resource needs of

17 patients and not the site of delivery.

18 While CMS envisions an integrated system, it is

19 years away from implementing one. Several barriers inhibit

20 the integration of the current systems, undermining the

21 program's ability to purchase high-quality care in the least

22 costly PAC setting. These include the lack of adequate

1 case-mix measurement, data on the care needs and outcomes of
2 services furnished, evidence-based standards to identify
3 which beneficiaries need how much post-acute care and the
4 incentives for PAC providers to treat beneficiaries in the
5 most appropriate setting.
6 These same barriers also limit our ability to
7 understand differences in financial performance across
8 providers. We do not know, for example, if low costs
9 reflect efficiencies, patient selection or stinting on care.
10 Within each PAC setting we have found considerable variation
11 in Medicare margins across providers, with some performing
12 consistently better than others.
13 Today I'm presenting work done to better
14 understand these differences. We examined whether
15 consistent financial performance, as measured by unit costs
16 and Medicare margins, was related to resource use and cost
17 growth. We examined each PAC setting separately and then
18 compared our findings across the four settings. These
19 analyses are similar to the ones done of the acute care
20 hospital sector.
21 Within each PAC setting, we found that providers
22 with consistently better financial performance used fewer

1 resources than other providers, had much lower unit costs
2 and had slower cost growth. Now let me back up and walk
3 through how we did this and the specific findings.
4 Because a provider's performance can vary from
5 year to year, we examined consistent performance over
6 multiple years as listed in the slide. We defined
7 consistently low cost as having been in the bottom quartile
8 of the cost distribution for each of the years studied.
9 Consistently high cost providers were in the top quartile of
10 the cost distribution each year.
11 Similarly, high and low margin providers were in
12 the top and bottom quartile respectively of Medicare margins
13 for each year in the study. All analyses were done using a
14 cohort of providers with valid data for every year in the
15 study
16 The costs were standardized for wages and case-
17 mix, and we also adjusted the costs for long-term care
18 hospitals for short stays. And in examining SNFs and home
19 health agencies we looked at freestanding providers.
20 To assess if there were different patterns within
21 each of the industries, we examined separately hospital-
22 based and freestanding IRFs, hospitals within hospitals and

1 freestanding long-term care hospitals, and rural and urban
2 SNFs and home health agencies. Generally, we did not see
3 different patterns across these subgroups.
4 One way providers with consistently low costs --
5 and those are the ones in the yellow -- achieve their cost
6 position was through their more sparing use of resources
7 within the episode or discharge. On average, home health
8 agencies with consistently higher costs provided 22 percent
9 more visits per episode than low-cost agencies. Likewise
10 stays at consistently high cost IRFs and long-term care
11 hospitals were 22 and 9 percent longer respectively than
12 their low cost counterparts.
13 We found a different result for SNFs. SNFs with
14 consistently low costs had longer stays. This result is
15 consistent with the incentives of their payment system,
16 which pays on a per day basis. Longer stays increase a
17 facility's Medicare margins and lower their unit cost by
18 spreading their fixed costs over more days.
19 Looking at occupancy rates for the whole facility,
20 consistently low cost IRFs and long-term care hospitals also
21 had considerably higher occupancy rates compared to
22 consistently high cost providers. For these two settings

1 the occupancy rates are driven by Medicare, which makes up
2 about 70 percent of their days.
3 We did not see this pattern in SNFs. Low and high
4 cost SNFs both had quite high occupancy rates. And here
5 Medicare is a fairly small share, about 12 percent, of SNF
6 days. Their occupancy rates are primarily driven by
7 Medicaid.
8 We also looked at differences in margins for these
9 providers. I want to remind you here that the groups of
10 providers are very different from the groups that we
11 typically report on. Here we're looking at providers with
12 consistent unit cost performance over multiple years and the
13 providers in these groups are a select group. For example,
14 in the home health analysis the consistently high and low
15 cost groups included about 250 facilities in each group. So
16 the margins that you see here will not be the same as any of
17 the margins we've presented in other analyses.
18 With that in mind, you can see that the
19 differences in 2004 Medicare margins between providers with
20 consistently low and high costs were considerable. While
21 providers with consistently low costs had aggregate margins
22 in the 20 to 30 percent range, providers with consistently

1 high costs had aggregate margins that were negative,
2 sometimes quite negative. High cost IRFs had aggregate
3 margin in 2004 of negative 16.3 percent.
4 As might be expected, we found similar
5 relationships between Medicare margins and resource use.
6 For example, consistently high-margin home health agencies,
7 IRFs, and long-term care hospitals also used fewer resources
8 within the episode or discharge.
9 Next we looked at unit costs for providers with
10 consistent Medicare margins. We see that providers with
11 consistently high Medicare margins had considerably lower
12 unit costs. Unit costs for consistently high margins were
13 generally half to two-thirds of the costs of consistently
14 low margin providers. For example, SNFs with consistently
15 high margins had daily costs of $199 compared with $320 for
16 SNFs with consistently low margins.
17 We also looked at SNFs and their competitors. We
18 compared the daily costs of SNFs with consistently high and
19 low margins to the daily costs of SNFs with which they
20 compete. We defined here competitors as within 15 miles of
21 the references SNF. We found that consistently high-margin
22 SNFs had daily costs that were 18 percent lower than their

1 competitors and, in contrast, we found that consistently low
2 margin SNFs had daily costs that were 20 percent higher than
3 their competitors.
4 We did not do this analysis for other providers.
5 Many markets do not have multiple IRFs or long-term care
6 hospitals in them, while home health agencies have more
7 fluid markets because the care is furnished in the
8 beneficiary's home.
9 Last, we looked in cost growth. Except for home
10 health care, unit costs grew more slowly for providers with
11 consistently high margins. For example, costs per discharge
12 for IRFs with consistently high margins annually grew at
13 one-third the rate of IRFs with consistently low margins.
14 The difference in cost growth between consistently high and
15 low margin long-term care hospitals was even larger, a 1
16 percent decline compared to a 7 percent increase. And even
17 for home health agencies, the difference between agencies
18 with consistently low and high Medicare margins was small.
19 It was 1 percent.
20 In conclusion, in recent years PAC providers with
21 consistently better financial performance had lower resource
22 use, lower unit cost and generally slower cost growth.

1 Before concluding that low-cost providers are efficient, we
2 need to know if they attained their financial performance
3 without compromising quality of care or selecting certain
4 types of patients.
5 Because of the limitations I outlined at the
6 beginning, broad PAC reform that is favored by the
7 Commission is years away. In the meanwhile, Medicare is
8 likely to continue to pay for PAC services under the
9 respective prospective payment systems. Within each setting
10 then, the program must ensure that payments are adequate.
11 With that in mind we now are going to turn to the
12 assessment of the adequacy of payments in each of the
13 settings. Kathryn is going to start with SNFs.
14 MS. LINEHAN: In our March report, we will be
15 making an update recommendation for skilled nursing facility
16 services for fiscal year 2008, and I'm going to review the
17 latest data on payment adequacy to inform your
18 recommendation.
19 SNF spending grew 8 percent between 2004 and 2005.
20 This was slightly lower than the average rate of growth of
21 SNF spending between 2000 and 2005, which was 11 percent per
22 year. But that growth was variable, and the variation

1 larger reflects a number payment changes, including several
2 temporary payment add-ons that went into effect and some of
3 which expired during that period.
4 Volume also contributed to spending changes during
5 the period, and was also variable from year to year. During
6 this period, volume grew as much as 14 percent between 2001
7 and 2002 and as little as 5 percent between 2003 and 2004.
8 Case-mix increase also contributed to spending
9 growth, as I'll discuss just a bit later.
10 First, we'll look at the supply of facilities.
11 Change in the overall supply of Medicare participating SNFs
12 was nearly flat between 2005 and 2006, and it's been nearly
13 flat since 2000. The most recent data show a net decrease
14 of 0.1 percent facilities.
15 As in previous years, and as we discussed at last
16 month's meeting, the number of hospital-based SNFs declined
17 and the number of freestanding SNFs participating in the
18 program increased since the implementation of the PPS. This
19 means that the share of all SNFs that are freestanding has
20 increased and they now make up 92 percent of all facilities.
21 Last month we presented information from site
22 visits about hospital-based SNFs reasons for remaining in

1 the program given payment reductions under the PPS and
2 consistently negative average margins for hospital-based
3 SNFs which are minus 85 percent in 2005. We found that
4 hospitals' decisions were generally a function of the SNFs
5 role in carrying out their acute care mission, things like
6 their ability to shorten the length of stay in acute care
7 hospital. And for those that closed, they cited costs but
8 also a more profitable alternative use of space.
9 Now turning to access, the latest IG study on
10 access to SNFs found, based on interviews in 2004 with
11 hospital discharge planners who oversee the placement of
12 patients, that Medicare beneficiaries appear to have little
13 or no delay in accessing SNF care, especially if they need
14 rehabilitation therapy. 84 percent of discharge planners in
15 their sample could place all Medicare beneficiaries who
16 needed SNF care. This was a statistically significant
17 increase from the share in 2000, the last time they did this
18 study.
19 In addition, continued growth in the volume of SNF
20 services, as I'll show you in a minute, suggest access to
21 care for benes. Medicare patients are also considered
22 financially attractive patients for nursing homes that

1 generally treat a largely Medicaid population.

2 However, beneficiaries with certain condition or

3 needs may experience delays that mean they stay longer in

4 the hospital. The IG also reported that Medicare patients

5 were harder to place if they need IV antibiotics or

6 expensive drugs, wound care, vent care or have certain

7 behavior problems. Several of these services are non-

8 therapy ancillary services long identified as costs for

9 which the SNF payment system was not designed to allocate

10 payments. These same services were also identified as high

11 costs in our interviews with hospital-based SNFs.

12 Last year we showed you volume data through 2003.

13 Looking at volume of services, we see that Medicare

14 beneficiaries had 2.4 million SNF admissions in 2004, which

15 is an increase of 1 percent, and the number of covered days

16 increased 5 percent. The average length of stay has

17 increased only two days between 2000 and 2004.

18 We hope to have 2005 data finalized for you in

19 January. I ran the data for 2005 and found a pretty big

20 increase, bigger than we've seen in past years, in the

21 number of covered days between 2004 and 2005 and it made me

22 a little nervous so I wanted to verify the result with CMS,

1 since we've used their data in the past to establish this
2 time series.
3 But the latest data suggest that volume is
4 growing, even without looking at the 2005 data.
5 While volume is growing, the volume of days has
6 increased at different rates among case-mix groups, known as
7 resource utilization groups or RUGs. Just a note here, you
8 might wonder how I can have days for 2005 but not have it in
9 the previous slide. This is from a different data source.
10 This is from cost reports, so that's the explanation.
11 We see two changes related to case-mix in
12 freestanding SNFs. First rehab RUGs make up a large and
13 growing share of total Medicare days. Second, we see a
14 greater share of rehab days in the two highest categories of
15 RUGs, ultrahigh rehabilitation and very high rehabilitation,
16 and reduction of the share of says in all the other groups.
17 Together the ultra and very high rehab RUGs represent about
18 42 percent of SNF days in 2005. This is an increase of 14
19 percentage points from three years earlier.
20 As a result of these shifts toward a greater share
21 of days and higher rehab case-mix groups, the average
22 therapy case-mix has increased and the average nursing case-

1 mix has declined slightly among freestanding SNFs. Overall,
2 the program still spends more on nursing than therapy, but a
3 growing share of the program's skilled nursing dollars is
4 going to therapy payments.

5 Now turning to quality, our two measures of SNF
6 quality, discharge to the community and a composite of
7 potentially avoidable rehospitalizations, show that between
8 2000 and 2004 quality has gone down. These measures are
9 risk-adjusted facility rates and are measured within 100
10 days of admission to the SNF.

11 The decline in the average facility rate of
12 community discharge between 2000 and 2004 means that
13 slightly fewer beneficiaries were discharged from the SNF to
14 their home, assisted living, or other non-institutional
15 setting immediately following their SNF stay. But the
16 decline seemed to have reversed just slightly in 2004.

17 The increase in the rate of potentially avoidable
18 hospitalizations means that a greater share of benes are
19 being rehospitalized from the SNF at some point during their
20 stay for one of five conditions. We are pursuing additional
21 research to get behind this trend and see, for example, if
22 trends are different for different categories of facilities

1 or if they're related to facility characteristics.

2 Now looking at SNFs' access to capital, when we
3 talk about access to capital for skilled nursing facilities
4 we're really talking about nursing facilities that provide
5 long-term care to most of their patients.

6 Evidence suggests that access to capital for this
7 sector is good this year. For-profit chains report new
8 acquisitions in construction financed by debt and private
9 equity investors have been investing in this sector. The
10 National Investment Center, a nonprofit that provides
11 information about business strategy and capital formation
12 for the senior living industry, reported that key financial
13 and operational indicators showed continued strength in
14 senior housing, including SNFs.

15 Loan volumes for all the sectors they track was
16 highest in the second quarter of 2006 than any time since
17 they began collecting the data in 1999 and loan performance
18 has been strong.

19 Overall, the NIC reported this year that it's a
20 good type to be a borrower in this sector but they were
21 cautious moving forward because of interest rates,
22 obsolescence of physical plants and some labor issues.

1 We spoke with industry analysts who reported that
2 several factors are making this industry attractive to
3 investors. Among these were SNFs being well positioned to
4 be the beneficiaries of Medicare's efforts to rationalize
5 the provision of post-acute care and provide such care in
6 the lowest cost setting, increasing demand for short stay
7 SNF care as a result of the aging population, and nursing
8 facility properties have attracted investors who are
9 interested in the real estate component of the nursing
10 facility business.
11 They also noted that they've seen what they
12 described as stability in the reimbursement environment
13 including a RUG refinement that took place on January 1st,
14 2006. Some chain providers have reported faring better
15 under RUG refinement than they had estimated and they're
16 seeing increased Medicare payments under the new system as a
17 result of shifting towards higher acuity cases.
18 They also noted improving state fiscal situations
19 that mitigate the prospect of Medicaid rate cuts, although
20 one note to this is the threat of the reduction in minimum
21 provider taxes that flow back to nursing homes under
22 Medicaid payment systems in several states.

1 Medicare payment is undoubtedly an important
2 source of revenue for these providers and a factor in their
3 access to capital, but Medicaid is the biggest payer of care
4 in nursing facilities. The nursing facility industry has
5 reported to the Commission that Medicaid rates are too low
6 and has been arguing that the Commission should consider the
7 total margin, including Medicaid, in our Medicare payment
8 adequacy analysis. But the Commission has held that
9 increasing the Medicare payment rate to subsidize Medicaid
10 rates is an inefficient way to target subsidies.
11 Now we're going to look at financial performance.
12 We see in fiscal year 2005 that the aggregate Medicare
13 margin for freestanding SNFs was 13 percent. We continue to
14 see some variation across facilities. Margins are much
15 higher in for-profits than for nonprofits.
16 I just wanted to note that the margin for the
17 small share of facilities in the government categories is
18 difficult to interpret because of subsidies that may affect
19 their incentives for efficiency, and therefore this might
20 not be a good indicator of payment adequacy. But overall,
21 based on the 2005 cost report data, we estimate that the
22 2007 aggregate Medicare margin for freestanding SNFs is 11

1 percent.

2 This estimated 2007 margin is the function of
3 payment changes including a full market basket update in
4 2006 and 2007, changes due to RUG refinements, and the
5 accompanying elimination of add-ons, plus a policy change
6 that makes 70 percent of bad debt reimbursable for non-duals
7 starting in 2006.

8 We also considered cost growth in recent years
9 when modeling future costs. Cost growth, and this is
10 unadjusted for case-mix for all freestanding SNFs
11 accelerated from 2004 to 2005. But some of this is
12 undoubtedly due to case-mix changes, as shown earlier. Cost
13 growth has shown different trends in for-profit and
14 nonprofit facilities between 2002 and 2005 with the rate of
15 growth declining in nonprofits but increasing in for-
16 profits.

17 In addition, based on Carol's analysis of the
18 consistent cohort, average ancillary cost growth has been
19 greater than routine cost growth, suggesting that facilities
20 are spending more on rehabilitation services, which is also
21 consistent with shifting case-mix towards higher intensity
22 higher payment therapy case-mix groups.

1 So to summarize what you just heard, the number of
2 facilities providing SNF care to Medicare benes remained
3 almost constant between 2005 and 2006. Benes have good
4 access to SNF care, although those who need certain services
5 may experience delays. Volume increased modestly in 2004 as
6 measured by SNF stays but days increased 5 percent. Data in
7 2005, that I didn't show you but I will show you next month,
8 suggest a sizable increase in days.
9 Two outcome measures show facility rates of
10 avoidable rehospitalizations increased and discharge to the
11 community declined.
12 SNFs have good to access to capital and their
13 Medicare margins are estimated to be 11 percent in 2007.
14 To start our discussion on the recommendation,
15 last year we recommended no update to SNFs. This year it
16 would decrease spending relative to current law but
17 providers should be able to accommodate cost increases in
18 the next year without an increase in the base rate for SNFs.
19 And this should have no major implications for
20 beneficiaries.
21 Before I turn it over for questions, I wanted to
22 raise two topics that I touched on in the paper and that the

1 Commission has raised before.

2 Although RUG refinement increased payment for some
3 patients with high non-therapy ancillary costs if they
4 qualify for the new RUG, the payment system still does not
5 allocate payment based on the need for non-therapy ancillary
6 services. Consistent reports of differences in access for
7 these patients suggest that facilities may select against
8 these expensive patients or that facilities who treat these
9 patients may be disadvantage. We're continuing to look at
10 refinements to the case-mix system to improve this.

11 On a related note, the case-mix weights underlying
12 the current system, as we noted, should be based on more
13 current data, and CMS has undertaken the collection of these
14 data for the first time since the implementation of the PPS.

15 And second, increasing use of therapy still adds
16 another reason for measuring the value of these services,
17 which the Commission has previously recommended measuring
18 functional status at admission and discharge to assess
19 whether patients' functional status is improving with this
20 therapy.

21 As the Commission has previously recommended also,
22 given the evidence of declining quality, the program may

1 want to consider improving data on nursing costs and
2 staffing to facilitate evaluation of the relationship
3 between nursing costs, staffing levels, turnover, experience
4 and quality of care.
5 This concludes my presentation and I'll take your
6 questions now.
7 DR. CASTELLANOS: Just a quick question. I see
8 you have financial performance for freestanding and costs
9 for freestanding. Do you have any data on hospital-based?
10 MS. LINEHAN: No, we don't have cost growth for
11 hospital-based SNFs calculated separately. The margin for
12 2005 is minus 85 percent.
13 That's an improvement over last year. It was
14 minus 87 percent.
15 DR. CASTELLANOS: Is there a reason why you don't
16 have it?
17 MS. LINEHAN: This issue has a long history with
18 the Commission.
19 DR. CASTELLANOS: We can talk about it later.
20 MR. HACKBARTH: The challenge in the hospitals,
21 many hospitals have multiple lines of business, the
22 inpatient care, the SNF care, home health agency, and so on.

1 And so there's a question about how you allocate costs
2 across those different lines of business within a single
3 enterprise.
4 Now there are cost allocation formulas used in the
5 cost reports but we've had some reservations about how
6 accurate those individual line of business numbers are. So
7 actually, when we do the hospital update and look at the
8 hospital financial performance, as we just did a few minutes
9 ago, we're looking at the aggregated financial performance
10 for all of the hospital-based lines of business, including
11 the hospital-based SNF.
12 And so when we get to this particular group, to
13 the skilled nursing facilities, here we're focusing on the
14 freestanding as opposed to the hospital-based.
15 DR. KANE: On my page seven, which I think is also
16 yours, on the quality measures, the rehospitalization, I
17 would assume that means they go from the SNF to the
18 hospital?
19 MS. LINEHAN: Yes.
20 DR. KANE: Did something change in the way
21 Medicare pays for a bed that's occupied by someone in a SNF
22 who gets moved back to the hospital? Did they started

1 paying to hold the bed? Because that would encourage
2 rehospitalizations. And I know in some markets I've heard
3 something like that.
4 MS. LINEHAN: I don't think Medicare has a bed
5 hold policy. Medicaid does in some states. I can look into
6 this, but I don't think so. I don't think Medicare has that
7 kind of policy.
8 DR. KANE: I think it may have, in some markets
9 because I think in Massachusetts we started seeing more --
10 MS. LINEHAN: I see what you're saying.
11 DR. KANE: I'm just wondering if there isn't
12 something in the --
13 MS. LINEHAN: You're saying it's a state policy
14 that applies to any facility, regardless of the payer?
15 DR. KANE: No, I thought it was a Medicare policy,
16 so I'm not sure why it happened. But I know my group
17 started seeing an increase in rehospitalizations because the
18 nursing home is being paid to hold the bed, whereas in the
19 past they weren't.
20 MS. DePARLE: I think it's Medicaid.
21 DR. KANE: This affects Evercare and Evercare is
22 Medicare only.

1 MR. BERTKO: Evercare, I believe, is duals.

2 DR. KANE: No, they have Medicare.

3 MS. LINEHAN: I can little look into it and answer

4 the question.

5 DR. MILLER: We can run this fact down.

6 MS. HANSEN: Thank you for the point about the

7 continuity of care of staffing issues, because I think that

8 would be an interesting aspect that I think you're planning

9 to plumb.

10 My question is also then about the whole challenge

11 of people who have more complex issues, such as IV therapy

12 and other areas. I found that this issue was not only for

13 the SNF, it was one of the other post-acute care access

14 points, as well, it seemed.

15 MS. LINEHAN: I think Evan mentions that in the

16 home health.

17 MS. HANSEN: But with that in mind, just how we

18 deal with that -- because it seems like, of course, if you

19 have a therapy diagnoses coding then you get in. It's just

20 some of these areas that require more nursing skill, these

21 kind of complex medical issues, which represent a fair

22 number of patients I would imagine. So this brings to me

1 the question of access and payment.

2 MS. LINEHAN: In looking at some of our case-mix
3 refinement work going forward, we're going to be dealing
4 with this issue and hopefully have some kind of solution.

5 DR. SCANLON: Just to follow up Nancy, if it's
6 Evercare, then as a Medicare Advantage plan they can choose
7 to do this on their own and it would only be that particular
8 instance, not a Medicare policy. Does that make sense?

9 DR. KANE: What they're finding is people don't
10 sign up anymore for the Medicare SNP because of the fact
11 that now they get the bed hold paid for by regular Medicare.
12 But I'll get the details.

13 DR. SCANLON: I was going to say I think you gave
14 us an incredible amount of information and leave us not in a
15 gray area in terms of recommendations. It seems that things
16 are pointing pretty much in one direction.

17 I would say, though, as we make comparisons here
18 to other sectors, that we have to be careful because our
19 data here reflect organizations that are in two businesses.
20 One, the Medicare business, which is to provide care to
21 people in a post-acute setting; and another which care is a
22 part of their business but sort of residential environment

1 and long-term living is another part of that business. I
2 don't think we have the data we to capture all of the things
3 that might contribute to higher or lower costs for that
4 other business.
5 It's kind of like if you think about single-family
6 homes, and if the only thing you knew about single-family
7 homes was they had three bedrooms it doesn't tell you much
8 about why prices vary for those homes. I think that's our
9 problem with skilled nursing facilities, is that they're
10 really in this separate business which we've never ever
11 really captured what's the cause of variation.
12 Fortunately, I say we're not in the gray area
13 where we really need to worry about interpreting that.
14 MR. MULLER: This may be for Carol. Where you are
15 showing the lower cost higher margin facilities, is that
16 largely a function of occupancy, so therefore just by
17 dividing fixed cost by high occupancy you get lower costs
18 and therefore better margins?
19 MS. CARTER: It could be occupancy. We also
20 looked at volume. And we also saw that low-cost facilities
21 had higher volume. So it would probably be both of those
22 things, which I suppose are different aspects of the same

1 phenomenon.

2 MR. MULLER: And a question, are we going to speak

3 to the hospital-based SNFs at all? Is it just captured in

4 this? I mean, at minus 85 you probably can't do too much to

5 change that but are we going to speak to that at all?

6 MR. HACKBARTH: The chapter does discuss the

7 research.

8 MR. MULLER: I meant in recommendation.

9 MR. HACKBARTH: We'll be more specific then.

10 MR. MULLER: I mean, we're saying that we're

11 recommending zero update for SNFs, so I assume that applies

12 to freestanding and hospital-based? Or not? What does that

13 apply to?

14 MR. HACKBARTH: The zero update -- help me Mark,

15 I'm getting confused. The zero update applies to the

16 hospital-based SNFs.

17 DR. MILLER: That's correct.

18 MR. MULLER: Minus 85 is overwhelming so we

19 figured we won't deal with it? It can't be all cost

20 allocation.

21 MR. HACKBARTH: Probably not.

22 The reason I'm hesitating, Ralph, is my mind is

1 working slowly and I'm trying to access the file that has
2 our discussion on this last year where we had, as I recall,
3 quite a bit of discussion about the idea of a separate
4 update for hospital-based SNFs.
5 MS. DePARLE: I thought we did that.
6 MR. HACKBARTH: We did a number of years ago and
7 you'll be able to correct me, Mark, in just a minute. We
8 did several years ago, maybe even four years ago now,
9 actually recommend a separate update for hospital-based
10 SNFs. We have not repeated that recommendation since.
11 The last couple of years we've tried to do some
12 research understanding the dynamics of hospital-based SNFs,
13 why people go into the business, why they exit from the
14 business and so on. The piece that I can't remember, Mark,
15 is exactly why we decided not to resurrect, if you will, the
16 separate update last year. We talked about a lot.
17 DR. MILLER: There's a couple of, I think, three
18 things to keep on track here, and Kathryn help me out.
19 We had some of these conversations, and there is
20 the allocation issue, which I know is not completely
21 satisfactory. There was sort of a pushing and pulling on
22 that. There was also, we couldn't quite determine whether

1 these hospital-based facilities were treating really
2 different patients that might explain some of that
3 difference.
4 So we have three things that we set in motion to
5 start to try and answer that question. The first was the
6 research that was reported out -- I want to say in the last
7 meeting or the meeting before, maybe it was the last meeting
8 -- in the last meeting, which then talked about this two or
9 three different models that people could pursue in hospital-
10 based SNFs. Explicitly, at least one of those models was it
11 was viewed as a way to make the hospital operation more
12 efficient. There were a couple of other models that I'm
13 sure Kathryn could detail.
14 A couple of other things that we have going on is
15 Kathryn has a bunch of work, which she just referred to in
16 response to Jennie's question, going on on further
17 refinements in the SNF case-mix system because we also think
18 that there are certain costs that are not being covered well
19 -- and this is were I want to be careful -- which may impact
20 this issue that we're talking about here.
21 MS. LINEHAN: Some of the work that's been done
22 previously showed that hospital-based SNFs

1 disproportionately treat patients with high cost care needs
2 that the payment system doesn't reimburse well.
3 DR. MILLER: Is that the non-therapy --
4 MS. LINEHAN: Yes.
5 DR. MILLER: So we're taking a look at that to see
6 if that may be part of it.
7 And then also another analysis that we're trying
8 to get ginned up in the midst of everything else that's
9 going on is looking at their margins, their indirect
10 margins.
11 MR. MULLER: Maybe sometimes they take care of
12 patients that nobody else will care and there's not the
13 supply. I just find it difficult to say that in between
14 cost allocation on the one side or saying that the hospitals
15 do it because it allows them to open beds for acute care --
16 it just makes it difficult for me to explain 85 percent that
17 way.
18 I think sometimes you have to do it because you
19 can't get anybody else to take care of the patients. And
20 therefore, if that's the case, then it would be interesting
21 to see what kind of evidence we have towards that. If
22 there's evidence of lack of supply of other freestanding SNF

1 sin the area where the margins -- like we did on the
2 hospitals just now, are there other freestanding SNFs around
3 there and so forth, then there might be some indirect
4 evidence of that. Because if there's no place else to put
5 them -- and I've had my own experience of that -- then you
6 just have to do it as a way of protecting your patients
7 because you have no place else you can put them.
8 DR. REISCHAUER: Can I just ask whether the RUG-
9 III adjustments were thought to disproportionately help
10 hospital-based SNFs?
11 MS. LINEHAN: In the impact analysis that CMS did
12 with the proposed rule, it did disproportionately help
13 hospital-based SNFs. But not enough to overcome a margin
14 that negative.
15 DR. MILSTEIN: In forming an opinion about this,
16 if it hasn't been done it would be very helpful the next
17 time we discuss this to have some perspective in this
18 comparison of low cost and high cost, in this case, SNFs,
19 whether when segregated that way there's any systematic
20 difference between the two groups with respect to either --
21 I guess you'd call it rehab creep because there certainly
22 seem to be a very major move in that direction -- and our

1 two quality of care measures.

2 Coming up with a more rather than a less stringent

3 recommendation update, for me, would partly depend on

4 feeling reassured that the low-cost operators were not

5 achieving their low cost through either rehab creep or

6 reductions in either of the two quality of care measures

7 that you brought to bear.

8 Maybe you already know the answer to that and, if

9 so, it would be helpful to know that now.

10 MS. LINEHAN: I don't know the answer but we're

11 looking at that question. We're looking at a lot of

12 differences in these quality measures by facility

13 characteristic and cost growth is one of them.

14 DR. MILLER: The only thing I was going to say is

15 that what gets complicated in these situations is being able

16 to truly adjust for differences in the mix of patients. And

17 Kathryn says all of the time when we have these

18 conversations internally, you have a case-mix adjustment

19 system for SNFs but it's too gross to capture what we think

20 are the actual differences of patients who might be going --

21 hospital-based, freestanding, but even just from facility to

22 facility if you're trying to measure.

1 So we are doing this work but it's not as
2 straightforward as oh, you just drop the case-mix adjuster
3 in there and then you've got it. It's a little more complex
4 than that.
5 That's all fair; correct?
6 MS. LINEHAN: The same thing that makes pricing in
7 this sector difficult, having a good case-mix system makes
8 adjusting for case-mix in any analysis difficult.
9 MR. HACKBARTH: Any other comments or questions on
10 SNFs?
11 Okay, thank you.
12 Next is home health.
13 MR. CHRISTMAN: Good afternoon.
14 Next, we're going to go through the most recent
15 data on home health as it relates to the Commission's update
16 framework.
17 Before we begin, I just wanted to remind everyone
18 that this work includes important contributions from Sharon
19 Cheng here and Sarah Friedman.
20 The first issue we're going to turn to is access.
21 For access to care we asked two questions. Do communities
22 have providers? And are beneficiaries getting care? This

1 map provides a graphical answer to the first question. It
2 shows how many providers operate in each ZIP code inhabited
3 by a Medicare beneficiary in 2005.
4 As you can see, most beneficiaries have at least
5 one provider and many have two or more. 99 percent of
6 beneficiaries lived in a ZIP code with only one provider and
7 97 percent lived in a ZIP code with two or more. This map
8 generally suggests that access to care in most areas is
9 adequate and in many areas beneficiaries have access to
10 multiple providers.
11 In addition to this map, we can look at surveys of
12 beneficiaries to measure their access to care more directly.
13 A quick review of two surveys suggests that access
14 to care is generally adequate. Last year we shared data
15 from the 2004 CAHPS survey with the Commission. This data
16 showed that about 90 percent of beneficiaries that needed
17 home health had little or no difficulty accessing it. And
18 then another review of access was conducted by the IG in
19 2004. As a part of their study, they surveyed discharge
20 planners and 79 percent of discharge planners reported that
21 they could place all of their beneficiaries that needed home
22 health in a typical month. We would note that this is a

1 decrease relative to the 2003 number, where that IG found
2 that 89 percent could be placed in a typical month but still
3 pretty high at 79 percent.
4 Next, we're going to take a look at the supply of
5 providers. The table on this slide shows that the number of
6 agencies in Medicare continues to grow. It's still below
7 the 1997 peak of 10,900 agencies, but it's been growing
8 rapidly in recent years. Most of the new agencies, about 90
9 percent, are for-profit. Though the growth is robust, we'd
10 also note that it's pretty concentrated. About 70 percent
11 of the new agencies are in Florida and Texas and, in
12 contrast, many states have seen little or no growth. For
13 example, since 2002 41 states have seen a net gain of 10 or
14 fewer providers or a decrease. These growth numbers
15 generally also suggest to us that home health agencies have
16 good access to capital for expansion.
17 In our next section we'll review trends in
18 utilization and intensity. This table displays the recent
19 trends in episodes per user and visits. I think it's
20 similar to what you've seen in recent years. For the first
21 three measures -- episodes, users and episodes per user --
22 they continue to increase. And the exception to the upward

1 trend has been visits per episode, which has been slightly
2 decreasing since 2002. and we see that trend here between
3 2004 and 2005. This suggests to us that home health
4 agencies have been able to control costs and reduce the
5 number of visits they provide even as volume has increased.
6 Next we're going to take a look at quality.
7 This table shows risk-adjusted quality measures
8 for the home health benefit. And with a few notable
9 exceptions, the table shows that the quality trends have
10 gradually improved.
11 For the first five measures, the yellow lines,
12 those are measures of a beneficiary's functioning. What you
13 can see is that year-over-year the number of beneficiaries
14 who showed some improvement on that measure of function at
15 the end of their episode of home health has increased. If
16 you look at the two lines at the bottom, the blue lines,
17 those measure rates of adverse events, hospital readmissions
18 and unplanned ER use. You can see that those lines are
19 straight. They have not declined. The rate of hospital
20 readmission and unplanned ER use has not fallen, even as the
21 other measures we've seen improvements on.
22 CMS is planning a quality initiative next year

1 with the home health area to address those two measures at
2 the bottom and try and work with home health agencies to
3 reduce the rate of readmission and unplanned ER use.
4 I'd also note really quickly that last year the
5 Commission discussed process measures such as fall
6 prevention to complement these measures in the future.
7 Next, we're going to take a look at financial
8 performance. This table shows margins for different
9 categories of providers. The top row shows the margins
10 overall for the industry. For the freestanding providers in
11 2005 it was 16.7 percent.
12 I just want to note, it's important to remember
13 that there is a lot of variation in the margins that
14 providers experience and the second and third line shows
15 some of that variation. The second row you can see that the
16 home health agency at the 25th percentile in the
17 distribution of margins had a margin of 2.3 percent, whereas
18 the home health agency at the 75th percentile in the margin
19 distribution had a margin of 27.2 percent.
20 If you look below, you'll see tables on geography
21 and type of control and the trends there are unchanged from
22 what you've seen in previous years. Under geography

1 agencies that served both urban and rural areas, referred to
2 as mixed on this table, had the highest margins of 17.7
3 percent. And then the rural providers, they had the lowest
4 margins. Those margins were 13.7 percent.
5 Under type of control, the story is the same to
6 what we compared to previous years. The private providers,
7 the for-profit providers, have the highest margins of 18.2
8 percent and the government providers have margin of 10.7
9 percent. These margin estimates are our starting point for
10 estimating margins for 2007 and next I'm going to walking
11 you through the changes to payments and costs.
12 For payments, the first two lines are the major
13 changes for 2006. One is that the home health agencies were
14 held at the 2005 rates for a year in 2006. They got no
15 market basket update.
16 The second change in 2006 was there was a
17 temporary add-on of 5 percent to every episode provided to a
18 beneficiary who lives in a rural area, and that's in effect
19 for one year, as well.
20 The key changes for the upcoming year are there's
21 a new pay for reporting requirement. Medicare can reduce
22 the market basket update of any agency that does not report

1 quality data in 2007 by 2 percentage points. However, CMS
2 opted to use data that agencies are already required to
3 submit to satisfy this requirement. So we expect that few,
4 if any, providers will be affected by the reduction.
5 Also in 2007, home health agencies will receive a
6 3.3 percent market basket update.
7 The next section takes you through costs, and it's
8 very similar to what we've shown you in recent years. The
9 first line, cost growth again is 0.7 percent and that's
10 consistent with what we found in previous years.
11 We would note that this is below the inflation
12 suggested by the market basket in 2005, which was 3.1
13 percent. Again those two factors, it's very similar to what
14 we've seen in previous years, where the cost per episode has
15 been under 1 percent and the market basket inflation has
16 been between 3 percent and 3.5 percent.
17 Really quickly, I just want to summarize what
18 we've gone through. We found that access to care is
19 generally good. Communities have providers. Quality is
20 improving. More providers are entering the program. Volume
21 is increasing. Cost growth is less than 1 percent. The
22 home health agencies will get a full update in 2007. Based

1 on this information, we project that margins in 2007 will be
2 16.8 percent.
3 Next I want to show you a draft recommendation for
4 2008, and this is based on last year's recommendation.
5 The Congress should eliminate the update to
6 payments for home health care services for calendar year
7 2008. The spending implications is this would decrease
8 spending relative to current law. For beneficiary and
9 provider implications, we don't think there would be a major
10 impact.
11 Before I finish, I just want to outline a few
12 future issues that we may be bringing. CMS is planning to
13 issue a rule next year that will refine the case-mix and
14 other aspects of the PPS. We plan to review this rule to
15 see if it addresses the issues previously identified by the
16 Commission.
17 Also, we note that the growth in the number of
18 providers underscores that Medicare's rules for certifying
19 new agencies are critical for safeguarding the interests of
20 beneficiaries in the Medicare program. We plan to take a
21 look at this issue as well to better understand the growth
22 in the program.

1 That completes my presentation.

2 MS. DePARLE: Thanks. I'm interested in the data

3 that you mentioned about the changes in the supply of

4 agencies and wondered whether there have been some changes

5 in the Medicaid law, I think, in the DRA that made it easier

6 for states to -- or maybe required them to pay not just for

7 nursing home care but for more home-based care. Is that

8 part of what's driving the increase in home health agencies?

9 I may not have it exactly right about what the change in

10 policy or law was.

11 MR. CHRISTMAN: I don't know specifically. I'm

12 aware of that change, but I don't know that we have any data

13 that we can connect that to the change in the trend of

14 providers. It's kind of hard to tell because a lot of

15 states require Medicaid certification as a part Medicaid.

16 So we can't tell.

17 The number of agencies that are Medicaid only

18 agencies is very small, it's like 100. We can take a look

19 at that.

20 MS. DePARLE: I'd be interested in knowing what

21 the utilization is. I know this isn't exactly part of our

22 job, but I'm kind of interested in whether the change in

1 Medicaid has had any affect on utilization of home health,
2 what the trend is in Medicaid and whether that would be part
3 of what's happening here.
4 And you said 70 percent of this new -- what's the
5 number of new agencies?
6 MR. CHRISTMAN: The number of new agencies, I
7 believe it's increased by about 1,700 since 2002. About 70
8 percent of those have been in Florida and Texas.
9 MS. DePARLE: It's interesting, because having
10 been here before, these are the ones that left or we were
11 never sure whether they left or they sold or closed down
12 branches. It was always hard to get a handle on it. But
13 it's interesting that those states and then Louisiana and
14 Illinois.
15 DR. MILLER: When he told me, I had the same
16 reaction, that it was the same states.
17 MS. DePARLE: Oklahoma was big, too. It's just
18 interesting to note.
19 DR. SCANLON: Relating to this, in terms of my
20 understanding of the DRA provision, it is to give states the
21 option to offer home and community-based services not only
22 through a waiver but as part of their regular program with

1 some more flexibility there.

2 The reality has been that the home and community-
3 based, even though the waivers were required, has increased
4 dramatically. There's about 900,000 people now being served
5 through those waivers under Medicaid, compared to about 1.1
6 million being served in nursing homes.

7 Over 25 years, actually nursing home use overall,
8 when you take into account the changing age-mix of the
9 population and the number of elderly, has declined by about
10 30 percent, the utilization rate. So even though people
11 still talk about institutional bias, there really has been
12 an incredible rebalancing of how long-term care is financed
13 by public programs.

14 MS. DePARLE: Is it your sense that those people
15 are getting care from home health agencies or is it personal
16 care attendants?

17 DR. SCANLON: I think the more typical model is
18 the agency will be a home care agency, not necessarily a
19 home health agency. Before we had the Medicare home health
20 PPS, there was certainly the effort on the part of states to
21 Medicare maximize. Dave's not here, but Minnesota had a law
22 which they called the Medicare Maximization Law, and other

1 states had similar efforts either in law or through policy
2 efforts on the part of their Medicaid programs.
3 DR. CASTELLANOS: Again, the naive question, I
4 just see freestanding. I know there are hospital-based.
5 You've got to understand, I'm new on the Commission and I
6 don't have history.
7 MS. CHENG: As we mentioned during the SNF
8 presentation, the situation is similar in this case as well.
9 We look at the freestanding home health agencies as a model
10 of the efficient provider because they don't have costs
11 allocated to the hospital side of the house. And so we do
12 use freestanding cost reports to make our estimate here.
13 So the similar caveat, we don't have the cost
14 growth for hospital-based home health agencies, but the
15 margin in 2005 for hospital-based home health agencies, our
16 current estimate is that it's negative 1.5.
17 MR. HACKBARTH: In the respects that Sharon just
18 mention, this is the same as the hospital-based SNF, but it
19 seems to me that it's potentially different in an important
20 respect. There is at least some reason to believe or fear
21 that the hospital-based SNF patients might be different and
22 we've got a problem with accuracy in payment.

1 I think there's less reason to believe that the
2 hospital-based home health agency patients are different.
3 In each case, we're talking about people who have been
4 deemed ready to go home and they're being served by a
5 provider. The only question is whether they're affiliate
6 with a hospital or whether they're freestanding. So I think
7 the risk that we've got a payment error mixed into this
8 problem is somewhat less.
9 If hospital-based home health agencies simply have
10 higher costs because of overhead or some other factor and
11 freestanding agencies are systematically able to do it at a
12 lower cost, you wouldn't want to increase Medicare payment
13 to cover the cost of less a efficient provider.
14 But as I say, the hospital-based SNF issue is
15 potentially a little bit different because we have this
16 uncertainty about whether we're really comparing apples to
17 apples.
18 DR. SCANLON: On this point, and I don't have
19 facts to dispute what you just said, but let me set up a
20 potential hypothetical, which is that given the problem in
21 terms of the Medicare standards of what it takes to be a
22 home health agency, you can imagine in some areas we have

1 very minimally qualified home health agencies. And you
2 juxtapose that with the complex cases that some home health
3 agencies deal with, particularly in terms of wound care,
4 there would be a concern that people may end up back up in
5 the hospital because there isn't an adequate home health
6 agency to deal with them in a community.
7 I don't know to any degree what the extent of that
8 problem might be.
9 MR. MULLER: I have some concern about, we have
10 this long-running debate about the spreading of overheads,
11 to all of a sudden call that -- therefore, they're less
12 efficient providers. I mean, to go to that, I have some
13 objection to that.
14 The fact is if there's overhead in these hospital-
15 based home care or SNFs doesn't mean necessarily mean
16 they're a less efficient provider. There's case-mix issues
17 and so forth.
18 So I wouldn't want to necessarily want to
19 immediately concede that the freestanding ones are the
20 example of the more efficient provider.
21 MS. CHENG: With all the caveats about the
22 strength of case-mix systems throughout these settings, we

1 have consistently over previous years compared to case-mix
2 of home health patients in freestanding and in hospital-
3 based agencies and we don't find substantial differences in
4 the case-ix. So it does appear, at least from what we know
5 about the assessment of the patient once they're admitted to
6 home care, that they appear to be very similar patients.
7 DR. MILLER: I think the other point that you were
8 making was what is it about running a home health agency out
9 of a hospital versus a freestanding one that would
10 inherently make the overhead costs higher? She may have
11 used a shorthand by saying the word efficiency, but I think
12 in this instance it is also a little bit different than what
13 we were talking about a minute ago. And I think that's
14 really the point that she was driving at, if I'm getting you
15 right.
16 DR. WOLTER: My comments really are more aimed at
17 rural. And on our map, at least in the West, why would
18 there be fewer home health agencies in rural areas in the
19 West than in certain other rural parts of the country? I
20 don't know the answer to that.
21 I do know that the home health agencies in my
22 state have pulled back a bit. There's a bit less service

1 than there had been in the past and they feel that it's
2 very, very hard for them to travel the distances and that
3 sort of thing that goes on in rural areas.
4 It does look like rural providers have been
5 successful with these add-ons in Congress. So it might be
6 worth our while to see in the future if we can learn a
7 little bit more about why, in the Intermountain West, there
8 does seem to be a little different pattern in terms of
9 availability than there is elsewhere in the country.
10 MR. HACKBARTH: Although the piece of that
11 geography that I know best, the Oregon/Northern
12 California/Northern Nevada, that blue area where there's
13 zero, there are very few people in those places either.
14 It's very sparsely populated.
15 MR. MULLER: Montana is all blue and he's
16 sensitive to that.
17 MR. HACKBARTH: I don't know about the other
18 parts.
19 DR. WOLTER: I saw in one of the lists here that
20 something like 12 percent of home health agencies are rural
21 and I think more than 12 percent of the population is rural,
22 if I recall. So there may be some patterns there worth

1 looking at. That's all.

2 MS. CHENG: One of the things that you have to try
3 to keep in the back of your mind also, and with this map as
4 well, one of the things that we can't capture when we do a
5 head count of home health agencies is their capacity. It's
6 been something that has bedeviled our understanding of this
7 for a long time. But we don't know whether one agency is 10
8 times the size of another agency, and we do know that
9 there's a wide variety of the size and the capability in
10 terms of staff from agency to agency.

11 So we'll certainly try to get a better description
12 but we're going to be a little limited by just our ability
13 to quantify the capacity of home care.

14 DR. MILLER: To the point on the 12 percent is
15 that you're referring from this table here. The other thing
16 here is that there's 25 percent who are mixed who, if I
17 understand, they serve both urban and rural; right?

18 MS. CHENG: Right.

19 DR. MILLER: So I don't know that 12 is quite the
20 -- it's the rural only number. But I don't know that that
21 means that's all that's serving rural areas.

22 MS. CHENG: No, all of the agencies in the mixed

1 category serve some rural beneficiaries.

2 MR. HACKBARTH: The other take we have on this
3 issue is the beneficiary survey, where we ask beneficiaries
4 in rural areas -- now admittedly, it's a sample and it's not
5 covering every part of that map. But the beneficiary
6 reports in rural areas are that they do have access. And as
7 I recall, I think even higher access from a beneficiary
8 perception standpoint than urban beneficiaries. Is that
9 right; Sharon or Evan?

10 MR. CHRISTMAN: That's right. I think it was in
11 the mailing materials. According to the 2004 CAHPS data, 84
12 percent of rural beneficiaries had no issue with access,
13 compared to 77 in urban. And then we also mentioned the IG
14 survey, and they also in their work did not find any
15 significant differences between urban and rural access.

16 MR. HACKBARTH: Undoubtedly there are some issues
17 in some places, and quite possibly in the West. But in
18 terms of the bigger picture, it looks like access is pretty
19 good.

20 MS. HANSEN: I'm just really pleased that we cover
21 next time, perhaps, the standards for entry. But just
22 generally speaking, aren't they fairly low? That's one

1 question in terms of generally what we know. I know you'll
2 go in further depth. That being number one.
3 And number two is with this degree of margin, at
4 the 75th percentile of the 27 percent. Again, whether there
5 is some correlation with the ease of entry to obviously the
6 availability for the kind of rapidity of growth that's
7 starting up again with these kind of financial incentives
8 seemingly in mind.
9 This is just something that is a noticeable pop-up
10 trend, as compared to all of the other sectors we look at.
11 MR. CHRISTMAN: On the standards for entry, I
12 don't think we're in a position to say that Medicare
13 standards for home health are any lower than other
14 providers. What I could say is different is that there's no
15 bricks and border investment you have to make when you want
16 to start a home health agency. So there are other barriers
17 to entry that are present in the home health area.
18 And then on entry, the correlation between whether
19 an agency is relatively new and it's margins of entry, we
20 haven't taken a look at that but that's definitely something
21 we could look at.
22 DR. MILLER: Can I ask you something, Evan? Am I

1 forgetting this? Didn't we have a conversation on something
2 about in order to get in you actually have to provide some
3 care for a period? Was that here, home health? Or did I
4 confuse one of the other parts?
5 MS. CHENG: That's correct. You have to have
6 served patients for some period of time before you will be
7 certified for Medicare precisely because of the bricks and
8 mortar problem. There has to be something for us to measure
9 during the survey and certification process.
10 MS. HANSEN: I recall from last year when we
11 looked at it, you had an array of all of the different kind
12 of home health agencies. If we could tuck that back into
13 this next report, just as a reference point as to what the
14 spread is relative to the size. And then also by the
15 ownership type again. That was a previous area.
16 MR. HACKBARTH: Any other questions or comments?
17 Okay. Thank you. Good job.
18 Next is inpatient rehab facilities.
19 DR. KAPLAN: The third post-acute care sector
20 we're going to assess for payment adequacy is rehabilitation
21 hospitals and units, also known as inpatient rehabilitation
22 facilities. I also called them IRFs. We will be looking at

1 the most recent data available for our assessment.

2 The IRF PPS began in 2002. What you will see

3 throughout this presentation is a period of growth after PPS

4 began in volume of cases and payments, in particular, and

5 costs per case declined.

6 CMS modified the 75 percent rule which requires

7 IRFs to have 75 percent of admissions with one or more of a

8 specified list of conditions. As the new 75 percent rule

9 phased in, starting in 2005 you'll see volume of patients

10 admitted to IRFs and spending declined and the trends

11 changed.

12 IRFs provide intensive physical, education and

13 speech therapy on an inpatient basis. Intensive therapy is

14 generally defined at three or more hours of therapy a day.

15 Medicare paid $6.4 billion for IRF services in 2005 and

16 Medicare pays for about 70 percent of IRF patients.

17 To be paid as an IRF, facilities must meet a

18 number of conditions of participation like those on the

19 screen. To be admitted to an IRF, patients generally must

20 be able to tolerate and benefit from three hours of therapy

21 a day.

22 75 percent of all patients must have specific

1 diagnoses. At the end of your slides are a list of the
2 conditions. The 2004 change to the rule means that most hip
3 and knee replacement patients are not appropriate for IRFs.
4 This was the largest category of patients IRFs treated prior
5 to 2005.
6 IRFs out of compliance with the 75 percent rule
7 are declassified and paid acute hospital rates for all
8 Medicare patients. The rule is phased in according to the
9 schedule on the screen.
10 The 75 percent rule already has had an effect. As
11 you can see on the screen, in 2006 stroke became the top
12 diagnoses while joint replacement dropped to second. Hip
13 fracture also increased its share from 2004 to 2006.
14 Cardiac, another category not included in the 75 percent
15 rule, also dropped during this period.
16 About 80 percent of IRFs are hospital-based, the
17 red dots on this map. As you can see, IRFs are generally
18 located where the population is located.
19 The number of IRFs increased slightly after the
20 PPS started in 2002, at 1 percent per year. Between 2004
21 and 2005 there was a net increase of four IRFs. Rural IRFs,
22 however, have had a different pattern. The number of rural

1 IRFs increased more than 4 percent a year after the PPS
2 started. Between 2004 and 2005 growth was even faster at
3 almost 7 percent. This growth is consistent with a 21
4 percent payment adjustment for rural inpatient
5 rehabilitation facilities under the PPS and critical access
6 hospital's ability to have IRF units starting in October
7 2004.
8 Between 2002 and 2004 the volume of cases and
9 Medicare spending increased rapidly while average length of
10 stay decreased. Spending increased 16 percent per year
11 during this period because of market basket updates and
12 coding improvements.
13 In 2005 the story changes, as hospitals had to
14 make sure that at least 50 percent of their cases were
15 compliant with the new 75 percent rule. Spending fell
16 almost 3 percent and case-mix increased. This case-mix
17 increase is inconsistent with the length of stay increasing.
18 Cases compliant with the 75 percent rule have a
19 much higher Case-Mix Index than those that are not
20 compliant.
21 The decrease in cases is difficult to interpret
22 from an access perspective. We don't know where

1 beneficiaries who needed rehabilitation were treated, nor do
2 we know their outcomes. For example, CMS assumed patients
3 not treated in IRFs would be treated in SNFs. There are
4 indications that access has become more limited in some
5 areas where IRFs closed and less limited where IRFs opened.
6 This is difficult to interpret because IRFs do not exist in
7 every community.
8 The number of unique beneficiaries using IRFs is
9 another indirect measure of access. After PPS, this number
10 increased almost 7 percent per year. After the new 75
11 percent rule went into effect, the number dropped 9 percent.
12 To assess changes in quality of care for these
13 facilities, we use a measure commonly tracked by the IRF
14 industry. These scores represent a slight gain in
15 functioning from 2004 to 2006. The thing to remember is
16 that a higher score is better.
17 The scores represent the difference between
18 discharge and admission functioning using the functional
19 independence measure known as the FIM, which is incorporated
20 in the assessment tool for inpatient rehabilitation
21 facilities. The FIM measures physical and cognitive
22 functioning.

1 We are interested in whether the scores are
2 stable, indicating no change, an improvement and increase in
3 the difference, or deterioration, a decrease in the
4 difference.
5 To compare quality on a national basis, we used
6 the average difference in FIM at discharge versus admission
7 for all Medicare patients and for Medicare patients
8 discharged home. These scores suggest that quality has
9 improved slightly from 2004 to 2006.
10 They are not adjusted for case-mix.
11 As I said before, 80 percent of IRFs are hospital-
12 based. Hospital-based IRFs have access to capital through
13 their parent institutions. As you heard in the hospital
14 presentation, hospitals' access to capital is quite good.
15 As far as freestanding IRFs are concerned, a new
16 chain plans to open 36 IRFs, suggesting that freestanding
17 IRFs also have access to capital.
18 After PPS, starting in 2002, payments per case
19 increased rapidly. Costs started to accelerate in 2004. In
20 2005 the new 75 percent rule went into effect and costs per
21 case increased 10 percent. What we saw in 2005 is
22 consistent with the assumptions we used to project margins

1 last year. We estimated a 10 percent decrease in volume
2 between 2004 and 2005, that 90 percent of IRFs patient care
3 costs would disappear but that there would be no change in
4 their indirect costs or overhead for the loss in patients.
5 In 2005 the aggregate Medicare margins for IRFs
6 was 13 percent. IRFs at the 25th percentile had a margin of
7 negative four. IRFs at the 75th percentile had 22 percent.
8 As you can see, for-profits have a margin twice that of
9 nonprofits. Government IRFs have few Medicare patients and
10 don't operate under the same constraints as other
11 facilities.
12 We've estimated a margin of 13 percent in 2005 and
13 a margin of 2.7 in 2007. This latter estimate assumes a 20
14 percent reduction in cases going to IRFs as a result of the
15 new 75 percent rule phase-in. We also assume IRFs will be
16 able to eliminate the majority of patient care costs but
17 will not be able to eliminate overhead. These are
18 reasonable assumptions and, as I just said, they are
19 consistent with the first year implementation of the 75
20 percent rule. If we vary those assumptions, the margin
21 would be between 5.5 percent and 0.5 percent.
22 To sum up, we see that supply is stable, although

1 there have been rapid increases in rural IRFs. Volume and
2 spending declined in 2005. Access is difficult to assess,
3 although there has been a decrease in the unique
4 beneficiaries using IRFs. In quality indicators, there was
5 a slight improvement. And IRFs have access to capital. The
6 estimated margin in 2007 is 2.7.
7 To kick off your discussion, last year's
8 recommendation is on the screen. The update in law is
9 market basket, so the implication of this recommendation
10 would be a decrease relative to current law.
11 That concludes my presentation.
12 DR. REISCHAUER: I thought I would preempt Ron by
13 asking if we didn't want to consider hospital-based home
14 health and SNFs, what are they doing here?
15 DR. MILLER: I think Craig is probably best to
16 give this answer in detail, but you may remember about a
17 year ago we went through this and we did a specific analysis
18 where we went through and tried to look at the effects of
19 the overhead here and found that we did -- well, maybe I
20 should let you.
21 MR. LISK: Basically, we went through an exercise
22 to look at the differences in the costs and looking at the

1 overhead contribution here for the IRFs. And we didn't find
2 that overhead allocation was necessarily an issue here for
3 this sector.
4 The other thing to remember in this sector is over
5 80 percent of the facilities are hospital-based and over 50
6 percent of the patients are in those facilities, as well. I
7 think it may be 60 percent, I can't remember. So a
8 substantial portion of the facilities are hospital-based.
9 Eventually, if we get to psych hospitals and
10 units, we'll face the same issue again for those in the
11 future.
12 DR. MILLER: This is what I'm having a real hard
13 time dragging up because this was fairly complex. We
14 started disaggregating things like direct and indirect
15 costs. We were looking at freestanding and hospital-based.
16 We weren't finding large differences. And then we did some
17 comparison with skilled nursing facilities, I think, and you
18 found very big differences there when you compared them but
19 not on these.
20 And then there was something about when these got
21 created and came into the process that played into this
22 argument, too.

1 MR. LISK: That's right. Basically, these guys
2 have historically been part of it. One of the things we did
3 look at was the people who came in after versus before, to
4 see if there was any cost allocation issues as well between
5 those who came in earlier verses later. We found basically
6 no differences there.
7 Whereas on the SNF side, we actually did find
8 differences, some differences.
9 MR. MULLER: If we have such a big change in
10 margin due to the implementation of the 75 percent rule, I
11 don't see why going to a more conventional thinking about
12 that it's appropriate to have an update doesn't apply here,
13 being we have -- from 15 to 2.7. So probably the hospital-
14 based ones are roughly around zero. So since the
15 freestanding ones are 2.5 times that.
16 So I don't understand why -- this might be a place
17 to both consider some kind of update recommendation, since
18 we've already had a lot of the course correction through the
19 75 percent rule. The number is in here, I just forgot it.
20 DR. KAPLAN: The margin went from 13 percent to
21 2.7, is our median estimate.
22 MR. HACKBARTH: Just as a reminder again, the

1 draft recommendation was a repeat of last year. And Ralph
2 is making, I think, a legitimate point that in this area,
3 more than perhaps any other, there was a dramatic policy
4 change with a corresponding effect on the margins, projected
5 margins, which probably all adds up to a case that just
6 doing what we did last year in this instance may not be the
7 right thing. We need to have a clean slate.
8 Just one other observation. We've got sort of
9 three different profiles out there now. We've got the
10 hospitals that we began with today, where we have negative
11 margins that have been gradually going down. We've got home
12 health and SNF where we've had consistently high margins.
13 And now we've got a different case where we've got a pretty
14 abrupt change based on a policy change.
15 And so I think those are cases that we need to
16 think differently about.
17 DR. CROSSON: In terms of the recommendation, I
18 was thinking pretty much the way Ralph was. But I just had
19 a question on a slide 12, if you could put that up.
20 If you were trying to make the case ever that
21 payment pulls costs along with it, this slide would make it.
22 So the question is, to get back to your point earlier about

1 pressure or whatever you want to call it, in projecting the
2 2.7 percent margin, what would the point on this cost curve
3 then look like that led to that calculation?
4 In other words, is there already pressure on the
5 costs? Or are we just simply, in doing what Ralph said,
6 would we be just rewarding cost growth that seems to come
7 along with added opportunity?
8 MR. HACKBARTH: This doesn't capture the change in
9 the 75 percent rule.
10 MR. LISK: The 2005 number captures part of the
11 change. Do you see that cost growth --
12 MR. HACKBARTH: Part of it, the beginning of the
13 phase-in.
14 MR. LISK: The beginning of the phase-in. So you
15 see part of the cost increase is related to change in case-
16 mix. This is cost per case. And you saw a fairly large
17 increase in case-mix. It was due to the shift in cases and
18 taking out the cases that were -- the hips and the knee were
19 the lowest weighted cases. And so they were removed. The
20 cases that remained were higher weighted cases. And you
21 also had a drop in volume, so you had overhead costs that
22 had to be allocated across fewer cases.

1 MR. HACKBARTH: So there are some things going on
2 in this that makes it so it's not a neat illustration of
3 costs following payment.
4 Although I remember last year when we talked about
5 post-acute care, we had some similar graphs. And Nancy
6 pointed, as we went to PPS systems, payments went up and
7 cost tended to follow. And there we weren't talking about
8 situations where the data were contaminated by case-mix
9 change, but they were, I fear, an illustration of your
10 point, Jay.
11 But this one is a little bit different because of
12 the implementation of the rule and the resulting case-mix
13 shift.
14 And then we get to the 2.7 by projecting outward
15 to 2007 and they're coming together or converging.
16 DR. SCANLON: It seems like there's a lot of
17 things going on here and many of them end up being
18 disturbing. When we come down to the margin and we look at
19 the margin and we say okay, we potentially need to think
20 about a different recommendation, we have to juxtapose that
21 with what Sally mentioned, that the overhead costs are
22 unlikely to change a lot. That's going to be a major

1 driving force behind the margins.

2 So then we have to ask ourselves about the
3 efficiency of these providers that we're going to maintain
4 thorough a higher update.

5 Nothing is against the providers. Maybe our
6 problem is, in some respects, the 75 percent rule and what
7 brought us to the 75 percent rule. We have an industry here
8 than, in some respects, is dominated by Medicare. And we
9 worry about the incentives that our payment policy creates
10 and how the industry burgeons because of the incentives that
11 we've created.

12 The 75 percent rule gets us out of that directly
13 by moving people away from this sector. But is that the
14 best way we should have responded? Or should we have
15 adjusted our payment rates so that we were serving more
16 people in these facilities at the right rates and
17 potentially getting the right outcomes?

18 Part of this goes back to the fundamental question
19 which Carol started with earlier, which is we don't really
20 have a good understanding of these different post-acute care
21 providers and how they should be distinguished in terms of
22 who they serve, how well they serve them, what outcomes we

1 can expect. So we have all of this uncertainty in these
2 variety of areas and it's leading us to the point where
3 we're now going to potentially make a recommendation that
4 says they've become inefficient because of our policies.
5 But we've got to increase our payments to them because of
6 that.

7 That's the box that we're in because we lack the
8 kinds of information about post-acute care that we really
9 need. And we should be moving in that direction as well.
10 And I think we should be making that point in what we do.

11 MR. HACKBARTH: If I remember last year in our
12 report we had a similar conversation to this and expressed
13 concerns about these payment systems collectively and
14 whether we had payment systems that encouraged appropriate
15 and efficient care and expressed many of the same concerns
16 that Bill just outlined.

17 I thought we included like a preface to the post-
18 acute update chapters expressing that and saying we really
19 need -- Medicare really needs to look at this whole sector
20 in a much more holistic way with common assessment
21 instruments and develop tools that will allow us to better
22 increase are confidence that the patients are going to the

1 best facility and the lowest cost facility for their given
2 needs.
3 I think those ideas are every bit as true today as
4 they were a year ago. So we may want to think about lifting
5 that language from last year and reintroducing it into this
6 year's report.
7 MR. MULLER: If I could just speak to Bill's
8 point. The 75 percent rule, in part, is a policy direction
9 that takes some of the lower acuity cases out of rehab and
10 says perhaps do them in home care or do them elsewhere. And
11 therefore on average, other things being equal, it raises
12 the average acuity, and therefore the cost.
13 I wouldn't necessarily call that that they've
14 become less efficient. They just have a higher acuity
15 population for roughly the same payment.
16 DR. SCANLON: But I think, from what Sally said,
17 they are less efficient because we have a higher proportion
18 of the costs are overhead, as opposed to direct care costs.
19 And what I was basically saying is we can afford to have a
20 lower acuity level, as long as we're paying for lower acuity
21 level. That is potentially our problem. We were paying for
22 a higher acuity level and we said we didn't have it there.

1 So we're trying to create that by the 75 percent rule.

2 I think instead, if you target the payments to the

3 acuity level that you've got -- I mean this question of what

4 happens with someone with an ordinary joint replacement, do

5 they really always do better or as well in SNFs and home

6 health, as opposed to a rehab facility? I don't know if

7 that's the question. And that's a big part of the

8 populations that's being affected by this.

9 MR. MULLER: I don't disagree with the point you

10 made first, which is that perhaps the 75 percent rule went

11 too far as a way of getting the lower acuity cases out of

12 the IRFs into other settings and perhaps into alternatives.

13 So I agree with your point that perhaps another way of doing

14 that was to modify the payment on that, as opposed to just

15 driving the cases out through the 75 percent rule.

16 That being said, when we have a high acuity mix,

17 calling that less efficient is something I have concern

18 about.

19 MR. HACKBARTH: For our next meeting, if you could

20 pull out that language from last year so we can all take a

21 look at it and see if we think it's still appropriate for

22 this year's report, that will be hopeful.

1 DR. KAPLAN: There also is a little bit of hope on
2 the horizon in that the Congress mandated a demonstration
3 for post-acute care with a unified assessment instrument and
4 that contract has been awarded. So hopefully by -- I
5 believe it's 2008 or 2009 -- there will be some hope on the
6 horizon that we might get toward at least being able to
7 measure things similarly across post-acute care settings and
8 measure and compare quality from the different settings.
9 MR. BERTKO: Two quick questions, Sally. I think
10 I heard you say that your margin assumptions at the 2.7
11 percent included no change in the fixed overhead?
12 MR. LISK: In terms of fixed overhead, our
13 assumption to get us to 2.7 percent was in fixed overhead no
14 change in that. And that the direct costs related to the
15 care of the patients that left, 90 percent of that would go
16 away.
17 If we said let's say 25 percent of fixed overhead
18 was reduced and 100 percent of the direct costs went away,
19 that's where we get the 5.5 percent margin estimate. So
20 that's the way we get the upper end.
21 MR. BERTKO: My question would be for next month's
22 meeting, when I guess we're voting on this, is it possible

1 to call a couple of these facilities or chains and see how
2 much they can move it? I'm looking here at your 9 percent
3 reduction in volume in one year is a pretty big change and
4 people generally don't sit still when that happens.
5 And then a related question is do they expect more
6 change or no change as they ramp up to the 75 percent phase-
7 in? Is there another 9 percent drop that's going happened?
8 DR. KAPLAN: It's basically 10 percent per year
9 for each year after that. In 2005 we found a 10 percent
10 decrease in volume. For 2007 it was 20 percent, which is 10
11 percent a year. And then there's another year in the phase-
12 in.
13 MR. BERTKO: Where does that number come from?
14 From talking to folks or your assumptions?
15 DR. KAPLAN: Basically the 10 percent came right
16 off the cost reports, in the volume.
17 MR. BERTKO: But the next 10 percent is the
18 question.
19 DR. KAPLAN: Basically those are projections that
20 have been done that show what it will take to reach the
21 level of the 75 percent rule at that point.
22 MR. BERTKO: You don't think that most of the

1 cases fit under that? That is, the effect doesn't happen
2 all at once.
3 DR. KAPLAN: The compliant cases, there's limited
4 ability to replace noncompliant cases with compliant cases,
5 and that's part of the issue. So as far as how are they
6 adjusting, we can call and find out how they're adjusting.
7 MR. BERTKO: I know your workload.
8 DR. MILLER: Also, some of it is what you expect
9 to hear. There is that.
10 There is some adjustment. I thought you were
11 saying that there was more stroke patients going to the
12 facilities.
13 DR. KAPLAN: Exactly, yes. The percentage of
14 stroke patients has gone up.
15 DR. MILLER: But has the number of stroke patients
16 gone up? I guess that's what I was asking.
17 DR. KAPLAN: That number is not going to me right
18 now. I'd have to answer that question later.
19 MR. HACKBARTH: Any other questions or comments?
20 Okay, thank you.
21 We are now to long-term care hospitals, which is
22 the last one for today.

1 DR. KAPLAN: We're going to end the day with long-
2 term care hospitals.
3 We've seen a lot of growth in this sector, which
4 has raised questions about the role of these facilities.
5 MedPAC has studied long-term care hospitals for several
6 years and recommended that CMS implement new criteria to
7 define these facilities and their patients. Although CMS
8 has made several payment policy changes, the Agency
9 continues to review our recommendations.
10 Long-term care hospitals must meet the conditions
11 of participation of acute care hospitals and, in addition,
12 have an average length of stay greater than 25 days for
13 Medicare patients. Medicare spending for long-term care
14 hospitals was $4.5 billion in 2005 and Medicare pays for
15 about 70 percent of these patients, of long-term care
16 hospital's patients.
17 On the screen are the top 10 long-term care
18 hospital DRGs. Only one DRG, respiratory system with
19 ventilator, accounts for greater than 5 percent of cases.
20 Half of the top 10 LTC-DRGs are respiratory related and
21 they're shown in yellow on the screen. Although there's
22 been no change in the DRGs that are in the top 10, there has

1 been increased concentration of cases in these DRGs. Last
2 year the top 10 made up one-fourth of cases. This year they
3 make up almost one-half.
4 As you can see, long-term care hospitals are not
5 distributed evenly in the nation. The red dots represent
6 long-term care hospitals that entered the program before
7 October 2003, while the stars are those that entered in or
8 after October 2003. As you can see, there are a lot of
9 stars close to or on top of dots. That indicates that long-
10 term care hospitals are not always opening up in new
11 markets.
12 The number of long-term care hospitals has grown
13 rapidly since 1990 when there were fewer than 100 hospitals.
14 Growth has accelerated under PPS, especially for hospitals
15 within hospitals.
16 Actually, it's surprising to see continued growth
17 in hospitals within hospitals, considering the
18 implementation of the 25 percent rule in 2005. I'll discuss
19 this rule in more detail later, but it seems clear that we
20 have not seen a slowdown in growth yet. Exactly the same
21 number of long-term care hospitals entered the program in
22 2005 as in the previous year.

1 The number of cases increased 10 percent per year
2 under PPS. Medicare spending increased 29 percent per year.
3 I've already talked about case-mix change with the
4 consolidation of cases in the top 10 DRGs. Length of stay
5 went down 1 percent per year.
6 How did beneficiaries' access to care change under
7 the long-term care hospital PPS? Although we have no direct
8 indicators of access, the number of long-term care hospitals
9 increased and the volume of unique beneficiaries using long-
10 term care hospitals increased, both of data at 10 percent
11 per year.
12 From these increases, we conclude that
13 beneficiaries' access to long-term care hospitals increased
14 under the PPS.
15 We used four different indicators of quality for
16 long-term care hospitals and we found mixed results. The
17 rate of death in the long-term care hospital improved by 4
18 percent from 2004 to 2005. The rate of death within 30 days
19 of discharge improved 1 percent. Readmissions to acute care
20 hospitals got worse by 3 percent.
21 We also used four AHRQ patient indicators or PSIs,
22 although we removed from the analysis the long-term care

1 hospital patients that had these conditions in acute
2 hospital before transfer to the long-term term hospital.
3 Three out of four of the PSIs worsened between 2004 and
4 2005. One PSIs improved during the same period.
5 Long-term care hospitals appear to have access to
6 capital. Private equity firms have invested over $3 billion
7 in long-term care hospitals between 2004 and 2006.
8 How have payments per case compared to costs per
9 case for long-term care hospitals? Under TEFRA, which is
10 the part over on the left of the chart, a cost-based system,
11 costs were slightly higher than payments for three out of
12 the four years before the PPS began. Payments have
13 increased significantly under PPS, and as payments went up,
14 so have costs. The increase in payments has been driven by
15 observed case-mix. However, almost two-thirds of the case-
16 mix increase were coding changes.
17 The growth in hospitals within hospitals resulted
18 in CMS establishing a new policy to ensure that hospitals
19 within hospitals don't act like hospital-based units and
20 that decisions are made for clinical and not financial
21 reasons.
22 The new rule limits to 25 percent the share of

1 cases a hospital with a hospital can admit from its host
2 hospital. For cases greater than 25 percent, hospitals
3 within hospitals will be paid by IPPS rates. The phase-in
4 will be complete in 2008, the year for which we are
5 recommending an update. There are some exceptions to the
6 rule. Hospitals within hospitals in rural hospitals located
7 in the only hospital in an urban area or in a hospital that
8 is dominant in its city have a 50 percent threshold instead.
9 CMS may not have the tools to enforce this policy
10 at this time.
11 There are also a lot of possible ways to respond
12 to the rule. For example, hospitals within hospitals can
13 take a larger share of outliers from the host hospital,
14 which are not included in the threshold. They can make
15 arrangements to take a greater share of patients from
16 hospitals other than their host, including trading patients.
17 Hospitals within hospitals can become freestanding long-term
18 care hospitals. Or there can be other arrangements that can
19 make hospitals within hospitals willing to take a financial
20 hit on patients over 25 percent.
21 The 2005 Medicare margins are on the screen.
22 Hospitals within hospitals and for-profit long-term care

1 hospitals are more likely to have positive margins.
2 Government long-term care hospitals are few in number, they
3 have Medicare patients, and they operate under different
4 constraints than other long-term care hospitals.
5 For purposes of projecting the 2007 margins with
6 2008 policy we modeled the changes on the screen. As you
7 can see, there are a number of policies to include in the
8 model.
9 There was a net increase in payment in 2006 and a
10 net decrease in payment in 2007. The big question is
11 whether behavior will change in response to the 25 percent
12 rule?
13 With these payment changes, we estimate that the
14 Medicare margin is between zero and 2 percent, depending on
15 hospitals within hospitals' response to the 25 percent rule.
16 To sum up, we see no indication of a slowdown in
17 growth. We've seen that long-term care hospitals are able
18 to control their costs. They are very responsive to payment
19 changes. Long-term care hospitals have a large amount of
20 discretion over the patients they admit.
21 The zero percent margin assumes that every case
22 over the 25 percent threshold is paid at the lower rate and

1 there is no behavior change. Alternatively, the 2 percent
2 margin assumes that hospitals within hospitals change the
3 mix of patients and there are various ways to do that, as
4 I've discussed.
5 To start the discussion, last year's
6 recommendation is on the screen. Before you start
7 discussing, I'd like to give you several reasons for staying
8 with this recommendation this year. Long-term care
9 hospitals have been earning 9 to 12 percent margins for two
10 years and we estimate that the 2006 margin will be at least
11 as high.
12 Long-term care hospitals have shown themselves to
13 be nimble. Their costs appear to be under their control and
14 they are responsive to payment changes. Then also select
15 their patients. There are several ways to change behavior
16 to avoid the 25 percent rule.
17 These are all arguments for staying with this
18 recommendation for one more year to see how hospitals within
19 hospitals behaviorally respond to the 25 percent rule.
20 That concludes my presentation.
21 MR. BERTKO: Sally, can you go back to the map?
22 I'm a Westerner. Having said that, I guess the

1 question that I really have is is it more expensive to pay
2 for the same kind of admission in a state with long-term
3 care hospitals, the whole episode, than it is in one
4 essentially without? Does it cost Medicare more or less?
5 And secondly, and I have to ask this, and maybe
6 Ralph is the right guy. But clinically, are these
7 necessary? I'm asking out of total ignorance.
8 DR. KAPLAN: CMS is doing a study that may give us
9 some insight on the episode of care. We really have not
10 looked at episodes of care post-PPS. I can tell you what we
11 found in the study that we did that we published in June
12 2004, which was pre-PPS. What we found was that for most
13 patients for an episode of care long-term care hospital
14 patients cost Medicare more money.
15 However, if they focused on the very sickest
16 patients, it basically was a statistically insignificant
17 difference.
18 MR. HACKBARTH: That was the factual foundation
19 for our recommendation that there ought to be patient and
20 facility criteria developed for long-term care hospitals to
21 determine when they're appropriate for Medicare.
22 But, as Sally reported at the outset, we're still

1 not there. There are now beginning to be some proposals
2 about what those criteria might look like. But they're not
3 in place at this point.
4 So from my perspective, and I think I'm coming
5 from a similar direction as you, we've got a rapidly growing
6 type of new facility. There are parts of the country that
7 seem to do perfectly fine without it. And we ought to,
8 while we develop appropriate criteria that focus access on
9 the patients who most need this intensive high-cost service,
10 until we have those, we ought to keep a tight rein on the
11 payment and not allow it to go up as a way of slowing the
12 expansion of the industry until we get some better, more
13 focused, rules in place.
14 I think that's what Sally was alluding to in her
15 statement that we may want to continue last year's
16 recommendation for another year.
17 MS. DePARLE: In addition to continuing last
18 year's recommendation, what has it been, three years since
19 we said there should be criteria other than greater than 25
20 days average length of stay? To me, it's crazy for the
21 kinds of practices that Sally talked about to be going on,
22 which we've all heard about, and the growth to be continuing

1 without any criteria around who is an appropriate patient
2 for this kind of facility.
3 I think we spent time, and Nick and Pete DeBusk
4 went out and looked at these. And I became convinced at the
5 end of it that yes, there is a legitimate place in the
6 continuum for this kind of care. But lets define it.
7 Maybe it's silly to make the same recommendation
8 again but I think we need to because it doesn't seem to be
9 getting any action.
10 MR. HACKBARTH: Sally, in your presentation while
11 I was out, did you talk you know about the status of trying
12 to get criteria place and what's happened?
13 DR. KAPLAN: Basically, yes, I did. CMS has put a
14 lot of these payment policy levers in place where they've
15 change the short stay outlier rule. They gave a zero
16 update. They basically have implemented the 25 percent rule
17 for hospitals within hospitals.
18 They contracted with RTI to do a study on the
19 feasibility of our recommendations, and reportedly that
20 study should be out fairly soon. But I don't have a firm
21 date. I would say hopefully by the first of the year or
22 shortly after the first of the year.

1 MS. DePARLE: Is the idea that that will have some
2 proposed criteria in it?
3 DR. KAPLAN: Yes. And that also will have things
4 like a more up-to-date episode, an analysis of the cost of
5 these things post-PPS, which ours was pre-PPS and that would
6 be post-PPS.
7 DR. MILLER: So we expect that to have proposals
8 in it?
9 DR. KAPLAN: Let me also say that the industry --
10 there are two associations affiliated with this industry and
11 they have both proposed criteria. They're not completely
12 mutually exclusive but they pretty much are very different,
13 but they are a starting place for criteria.
14 MS. DePARLE: I think they did that two years ago.
15 DR. KAPLAN: I can't say.
16 MR. LISK: They've only recently come close to
17 finalizing what they think the appropriate thing is. They
18 started working on these after the Commission made the
19 recommendation. So they're just kind of putting those final
20 things out to the public now though, I think.
21 MR. HACKBARTH: I think the basic message of the
22 chapter is something like this: from our prospective it's

1 much better to deal with the rapid growth and escalating
2 costs through criteria on the patients that are appropriate
3 for this intensive type of care.
4 The approaches that have been done instead of
5 criteria, like to 25 percent rule or limiting updates, are
6 inevitably cruder tools. You do crude when you can't do
7 more sophisticated. But the longer you do the crude, the
8 more problems you're going to generate, the more gaming
9 behavior, and the more legitimate institutions and
10 legitimate patient needs are going to go unmet. So there is
11 some urgency about getting on with a more focused approach.
12 But in the meantime, we've got to keep a tight
13 rein on the payment.
14 MS. HANSEN: Along with the criteria, going back
15 to page eight, which was the quality of care factor, I just
16 wonder if we could really shine a light on that because this
17 is not a robust way to keep a system going when there are
18 readmissions that are worse, as well as three out of the
19 four safety indicators are worse.
20 Just intuitively, it just doesn't feel right to
21 support a growth when their quality indicators are not
22 positively robust.

1 So it is an area I just would like to make sure
2 gets highlighted.
3 And then a final comment is going back to the fact
4 that home health agencies and other resources exist
5 elsewhere. Is the CMS study such that it is trying to
6 compare it on characteristics of beneficiaries period,
7 regardless of what resources there are? Meaning home health
8 agencies, long-term care hospitals as well as IRFs.
9 I know that their core foci may not always be the
10 same, but using a comparable sample to say what difference
11 does it make in terms of their getting better or getting
12 good quality of care? Does it matter? If you don't have
13 any out West, what happens if -- I think I brought this up
14 last year. If you don't have the facilities, do you still
15 get better?
16 That's a fundamental question. When you have a
17 broken hip or you have a COPD, what happens to you if you
18 live in Wyoming? That is, to me, a fundamental question
19 about the characteristics of the beneficiary.
20 MR. HACKBARTH: Part of what happens is that the
21 capabilities of home health agencies and SNFs in the
22 community may be altered by the presence of a long-term care

1 hospital. If that alternative doesn't exist, then the SNF
2 and home health capabilities may be more robust because they
3 know they need to care for some patients with a lot of
4 needs.
5 MR. MULLER: That's the minus 85.
6 MR. HACKBARTH: Exactly.
7 DR. REISCHAUER: Compare Louisiana with Oregon.
8 MR. HACKBARTH: These are dynamic systems. I
9 think Bill made that point last year. What you've got in a
10 given community, in terms of capabilities, it's not uniform.
11 Agencies aren't uniform. Skilled nursing facilities aren't
12 uniform. This is a tough area, the post-acute care.
13 DR. CASTELLANOS: My question was answered about
14 quality, but it was answered already.
15 DR. KANE: I think part of what was bothering me
16 last year and continues to bother me about these update
17 issues is not just looking at any one silo on its own but
18 the cross-sectoral equity of this. And I think it really
19 bothered me last year and continues to bother me this year
20 they we're looking at a negative update for physicians,
21 acute hospitals have been pretty much losing money, looking
22 at a market basket minus productivity factor.

1 And then historically the post-acutes have all
2 gotten market basket, if you look at what's actually
3 happened, even though we recommend no update.
4 I guess, given the level of their profits compared
5 to all of the other sectors, except physicians -- other than
6 looking at their incomes, I guess we're not looking at their
7 profits. It just seems inconsistent to do anything but no
8 update, given what's going on with the other recommendations
9 we've made, even though we get overruled as soon as it goes
10 to Congress anyway.
11 MR. HACKBARTH: Other comments? Thank you.
12 MR. HACKBARTH: We'll now have a public comment
13 period, with the usual ground rules. Please keep your
14 comments to no more than a couple of minutes.
15 MS. COYLE: Carmela Coyle, the American Hospital
16 Association.
17 My apologies, I have brief comments but on four
18 different areas addressed since lunchtime.
19 First of all, on the indirect medical education
20 discussion, the Commission's discussion seemed to be about
21 the best place to reallocate some of the IME dollars that
22 were discussed in terms of reducing the IME adjustment by a

1 percentage point. And that discussion seemed to be about
2 where to place it, but perhaps without resolution.
3 We would urge the Commission to thoroughly think
4 through and then articulate where those dollars should go
5 before taking it away, before making the cut.
6 And to suggest perhaps a somewhat different
7 approach. Since we don't yet know how CMS is actually going
8 to implement the severity adjustment, the Commission --
9 since you're considering linking it to the implementation of
10 that severity adjustment -- may want to consider directly
11 suggesting that whatever the increase is that that is then
12 the amount that may want to be taken from the IME
13 adjustment. We just don't have any idea how that might
14 ultimately be phased in, but just so there's a more direct
15 connection.
16 A second issue on the issue of the update, and
17 specifically on the issue of technology, there seemed to be
18 some confusion and at least perhaps an unintended error in
19 some of the information shared that I just wanted to
20 clarify.
21 That the new costs that are experienced by
22 hospitals when information technology or other clinical

1 technologies are adopted are not, with few exceptions,
2 included in the Medicare payment system and are not included
3 in the Medicare market basket. They are not covered in the
4 new technology payment adjustments that are part of the
5 inpatient payment system with the exception of only seven
6 new technologies that have been improved in the last five
7 years.
8 They are not, in fact, captured in the DRG
9 weighting system. Recall that the DRG weights for any one
10 DRG where technology may be employed may go up, but that
11 it's all done relatively and it's all done in a budget
12 neutral manner. So that all the other weights for the other
13 DRGs go down. There is no new money that goes into the
14 system as a result of that DRG weighting system.
15 That increased adoption of IT is also not captured
16 in the market basket. As was suggested, I think it was
17 clarified by the Vice-Chair, the market basket is just a
18 year-to-year increase in the price change of that
19 technology. It does not capture an increased adoption by
20 the hospital field.
21 And unfortunately, it's not well captured in the
22 market basket itself. The price proxies don't capture

1 hospital purchases of technology. It's broader technology
2 in the economy, which includes many, many things.
3 We would suggest that a specific adjustment to the
4 market basket to take this into account been made, as MedPAC
5 did for years. An upward adjustment for the market basket,
6 it was suggested, may be crude given that some hospitals may
7 be adopting at a faster rate. I suppose one could argue
8 that a downward adjustment for productivity may suffer from
9 the same problem, given hospitals have different rates of
10 productivity.
11 But if the update recommendation is going to
12 reflect both inflation and a policy target in the area of
13 productivity, an update recommendation could also include
14 inflation plus a policy target in the area of information
15 technology.
16 And one last issue, a question was asked about the
17 forecast error. The market basket has been under estimated
18 for seven of the last eight years to the cumulative tune of
19 about 3.8 percentage points or a total of about $4 billion,
20 that this Commission recommended and that Congress
21 recommended be paid that was never received.
22 A third issue, very quickly, on skilled nursing

1 facilities, a negative 85 percent Medicare margin for
2 hospital-based skilled nursing facilities is really
3 impossible to ignore. We would urge the Commission to
4 consider a separate hospital-based update in that area.
5 And finally, in the area of rehab facilities, also
6 encourage a full update given the data, given the 75 percent
7 rule. Policy changes have been made. Now it's time to go
8 back to an inflationary concept, an inflationary adjustment
9 in that area.
10 Thank you.
11 MR. CALMAN: Good afternoon. My name is Ed Calman
12 and I'm General Counsel to the National Association of Long
13 Term Care Hospitals. I have just two brief comments for
14 you.
15 The staff recommendation today did not mention
16 that CMS policy and rules require a one-time adjustment to
17 the standard amount in 2008. We expect to see that in
18 proposed rules that will be proposed in January. That
19 should be a negative amount, a reduction to the standard
20 amount.
21 Our own research has shown that with the cuts that
22 took place last year, in 2007, that margins are about zero.

1 They're a positive 2 percent for proprietary hospitals, zero
2 for not-for-profit hospitals, and for some reason in the
3 West there's significantly negative margins. And public
4 hospitals have the worst margins.
5 So when you come to your final recommendation, our
6 request would be that you make an assessment of the effect
7 of the 2007 cuts, an assessment of the one-time adjustment
8 which you may see in proposed form before the next meeting.
9 Secondly, we are very concerned that CMS has not
10 moved forward with criteria. As an association, we have
11 endorsed most of the recommendations of the June 2004 report
12 that was made by this Commission. And we feel that it is
13 inequitable to patients to subject them to rules that
14 percentage thresholds which provide incentives that they not
15 be admitted to hospitals.
16 We have developed clinical criteria which we have
17 shared with all policymakers. But I do agree that you
18 should put a very strong statement in your chapter that CMS
19 -- I'll put it this way. It's been two-and-a-half years
20 since your recommendation and it's time for CMS to act in a
21 way that provides for continuity of care, access, and safety
22 for patients.

1 Thank you.

2 MR. HUNTER: Chairman Hackbarth, Executive

3 Director Miller, ladies and gentlemen of the Commission,

4 Justin Hunter with HealthSouth. I am Vice President of

5 Government and Regulatory Affairs for our company. We own

6 and operate 92 freestanding inpatient rehabilitation

7 hospitals across the country, 10 LTCHs.

8 I will be very brief and say, first and foremost,

9 that the comments with respect to the concerns and

10 observations over the effects of the 75 percent rule on

11 patients and providers is appreciated. It's very real.

12 There's no question about it.

13 I wanted to, and I know that a lot of data

14 discussed relative to IRFs -- or excuse me, rehabilitation

15 hospitals. I'd like to point out the latest findings of an

16 independent study that was commissioned by the American

17 Hospital Association, the American Medical Rehabilitation

18 Providers Association and the Federation of American

19 Hospitals entitled Utilization Trends in Inpatient

20 Rehabilitation, updated through Q2 2006, revised edition.

21 The report was prepared by the Moran Company, Don

22 Moran and his colleagues. I will read one bullet point from

1 the executive summary. In program year 2006, caseload in
2 our sample was 292,677, which is down 12 percent from
3 program year 2005 and by 18.4 percent relative to program
4 year 2004. Since our sample comprises approximate 75
5 percent -- coincidentally enough -- of all Medicare IRF
6 discharges, we estimate that total Medicare caseload
7 declined by 88,053 cases over this two-year span.
8 Clearly this rule is having an impact.
9 There is another issue that was not discussed in
10 today's presentation relative to rehabilitation hospitals
11 that I think merits a mention for the Commission to consider
12 in your deliberations, and that is the impact of what are
13 known as local coverage determinations or formerly known as
14 local medical review policies.
15 I'm getting down into the granular aspects of the
16 Medicare program here. What I'm talking about is
17 essentially medical necessity. There are a number of
18 medical necessity review activities that are occurring
19 within the rehabilitation hospital and unit space, resulting
20 in a material number of medical necessity based denials. It
21 is a legitimate and serious problem and issue that is
22 affecting rehabilitation hospitals and patients. It is

1 discouraging, in some instances, admission of certain types
2 of patients. After a while, when you see certain types of
3 denials being repeatedly sent to you, you begin to wonder
4 look, is it really worth the admission? And that has
5 serious potential implications on access to care long-term,
6 and it's worth considering.
7 I appreciate your attention and thank you for this
8 opportunity to make these points.
9 MS. KENDRICK: Good afternoon. My name is Marty
10 Kendrick. I represent the American Medical Rehabilitation
11 Providers Association, and on behalf of AMRPA, I just wanted
12 to express appreciation to MedPAC for your continued
13 interest and diligence and the competence with which the
14 MedPAC staff have consistently addressed inpatient rehab
15 issues.
16 I want to underscore our support for a full market
17 basket. It is absolutely critically needed, given the
18 fragility and instability of this sector. The combination
19 of the 75 percent rule, the impact of LCDs, the RAC reviews,
20 and a number of other factors have significantly effected
21 access to Medicare patients to inpatient medical
22 rehabilitation services in a very negative way.

1 The actual capacity of the field is seriously
2 jeopardized at this point in many geographic areas of the
3 country, not necessarily showing up as direct closures but
4 staff reductions, conversions of beds and a real undermining
5 capacity in this sector. It's not going to be easy to
6 reinvent in the future.
7 So we thank you for your independence and for your
8 work and contributions and we just would plead that you stay
9 in the forefront in the competent way that you have in the
10 past.
11 Thank you.
12 MR. HACKBARTH: Okay. We are adjourned and
13 reconvene tomorrow at nine o'clock.
14 [Whereupon, at 4:38 p.m., the meeting was
15 recessed, to reconvene at 9:00 a.m. on Friday, December 8,
16 2006.]
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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 8, 2006
9:05 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
MITRA BEHROOZI
JOHN M. BERTKO
KAREN R. BORMAN, M.D.
SHEILA P. BURKE
RONALD D. CASTELLANOS, M.D.
FRANCIS J. CROSSON, M.D.
NANCY-ANN DePARLE
DAVID F. DURENBERGER
JENNIE CHIN HANSEN
DOUGLAS HOLTZ-EAKIN, Ph.D.
NANCY KANE, D.B.A.
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
WILLIAM J. SCANLON, Ph.D.
NICHOLAS J. WOLTER, M.D.

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

2 MR. HACKBARTH: It's time to get started.

3 Good morning. We have three sessions planned for

4 today. The first of them is the final discussion of our

5 mandated report on the impact of the changes in payment for

6 Part B drugs. We will have a vote on that.

7 And then we have two update-related presentations,

8 one on physicians and the other on dialysis.

9 So Joan, would you do the Part B drugs?

10 DR. SOKOLOVSKY: Thank you. Good morning,

11 everyone.

12 Today, I am bringing before you for the final time

13 the Congressionally mandated report on the impact of changes

14 on Medicare payments for Part B drugs provided to Medicare

15 beneficiaries.

16 We have given you a draft report and, as you've

17 seen, we've tried to respond to your comments. So for

18 example, there is a more extended discussion of both least

19 costly alternative and CAP program.

20 At this meeting, I will present a draft

21 recommendation for your consideration.

22 I just want to briefly remind you of the mandate.

1 This study is the second of the two Congressionally mandated
2 reports. Last year we studied the effect on the payment
3 changes on chemotherapy services for Medicare beneficiaries.
4 This year we studied the effect of the changes on other
5 specialties that provide physician administered drugs.
6 We focused on the experiences of urologists,
7 rheumatologists, and infectious disease specialists. We
8 also continued to meet with oncologists and beneficiary
9 advocates to track access to care for beneficiaries needing
10 chemotherapy.
11 We found that the payment changes resulted in
12 savings for the Medicare program and its beneficiaries.
13 Beneficiaries continue to have access to drugs and the
14 volume of drugs provided, in general, has continued to rise.
15 However, because of a change in practice patterns, fewer
16 beneficiaries received drug treatment for prostate cancer in
17 2005 compared to 2004.
18 The payment changes appear to have had an effect
19 on where some beneficiaries receive care. Interviewees told
20 us that beneficiaries without supplemental insurance are
21 more likely to be treated in hospitals than other
22 beneficiaries.

1 We also found that there are few common measures
2 available to determine of quality of care has been affected
3 by the payment changes.
4 In the past few months we have talked about a
5 particular issue connected to ASP. Some manufacturers make
6 discounts of one of their products contingent on the
7 purchase of one or more other products. The way in which
8 manufacturers allocate these bundle discounts in calculation
9 of average sales price can affect the accuracy of the ASP
10 payment methodology.
11 That leads us to the draft recommendation. The
12 Secretary should clarify ASP reporting requirements for
13 bundled products to ensure that ASP calculations allocate
14 discounts to reflect transaction prices for drugs.
15 The ASP payment method has resulted in substantial
16 savings for the Medicare program and its beneficiaries.
17 Medicare payment systems are based on averages and no
18 payment system is expected to be totally accurate. In order
19 to maintain the close to accuracy of individual ASPs,
20 discounts should be allocated to ensure that ASP reflects
21 the average transaction price for drugs.
22 The spending implications of this recommendation

1 are indeterminate. Reallocation of bundled discounts could
2 increase the payment rates for some drugs and decrease it
3 for others. This recommendation would support access to
4 drugs for beneficiaries and providers by ensuring the
5 integrity of the ASP payment system.
6 I welcome your comments.
7 MR. HACKBARTH: Thank you, Joan.
8 MS. BURKE: Joan, I think you've done a terrific
9 job of capturing, I think, the concern that we had. And I
10 think that you've also captured the concept that bundling
11 isn't good or bad, which is an important concept for us to
12 underscore. We're not trying to presume that, in fact, the
13 history here and the direction that we've tried to go, which
14 in some cases bundling makes sense in terms of an array of
15 services.
16 But rather, in this case, I think what we want to
17 make sure is clear is that the allocation of the discounts
18 are, in fact, quite clearly directed to the product for
19 which they were intended, that there is a clear indication
20 there and that they are not lost, and as a result have this
21 skewing in terms of how people ultimately are choosing
22 drugs.

1 That, in fact, there is an intention here that the
2 clinical opportunities for physicians are left quite clear,
3 that they are able to make decisions based on the right
4 kinds of decisions but that, in fact, to the extent there
5 are discounts, they are directed and are clear in terms of
6 what the product relationship is.
7 I think we are, in fact, having said this, making
8 it very clear that we're not neutral on this topic. We are
9 quite clear that this is an important thing for us to
10 clarify. And that again I think that bundling in and of
11 itself is not bad. The question is whether or not the
12 result of it skews the decisionmaking in any way or skews
13 the knowledge we have about the actual ASP in a way that's
14 not clear.
15 So I think you've done a terrific job and I
16 appreciate it and I appreciate the work the staff has done
17 and the materials that support it. So well done, and well
18 said.
19 DR. REISCHAUER: Just with respect to the wording
20 of the draft recommendation, and this may not to be needed
21 or an improvement, given the text around it. But where it
22 says ASP calculations allocate discounts to reflect the

1 transaction prices for drugs, I wonder if we shouldn't say
2 reflect the true or actual transaction prices for individual
3 drugs.
4 The way it's worded now is a touch squishy.
5 MR. HACKBARTH: But true, as I recall, was in the
6 first draft and we deleted that because of some questions
7 about exactly what true meant.
8 DR. REISCHAUER: I gave you a choice of actual or
9 true, but you might say what is actual?
10 MR. HACKBARTH: The other thing that you did was
11 for individual.
12 DR. REISCHAUER: For individual drugs.
13 MS. BURKE: I agree with the direction that Bob is
14 going, that it's allocated to the product for which it was
15 intended essentially. But make it quite clear.
16 DR. SCANLON: Since I was the one that confessed
17 that I didn't know what true meant, I think that inserting
18 the word individual drugs or each drug or something like
19 that takes care of that ambiguity. I don't know what the
20 adjective in front of transaction price would mean.
21 DR. MILSTEIN: I thought we had developed this
22 concept of conditionality. That is, if you get a 5 percent

1 discount on drug A but that discount goes to 10 percent if
2 you also buy drug B, that the incremental 5 percent was
3 conditional on --
4 MR. HACKBARTH: That's certainly what the
5 accompanying text will explain. The issue is how to capture
6 that in the much brief language of the recommendation
7 itself.
8 DR. MILLER: Also, in that conversation, and Bill
9 I think you will remember this, also in the text it will
10 describe other ways to think about allocation. But
11 certainly the one that you just said, the incremental
12 difference is described in the text.
13 MS. DePARLE: I think this has been in earlier
14 versions and I think it will be at the text but I want to, I
15 think, echo what Sheila said, in that I want to be sure that
16 this specific example is one that we've chosen to highlight
17 because it was in the proposed rule discussion and we've
18 heard about it.
19 But that we want to make sure that the Secretary
20 is being vigilant about anything that might be going on to
21 undermine the integrity of this new ASP system. Because I'm
22 sure there are other things that could be going on, as well.

1 And that we're taking a stand that this is one that we're
2 concerned about, but that we also want to make sure that
3 other things -- other things ensure the integrity of the ASP
4 payment system.
5 You put that in here in implications, but I'd like
6 to see some language like that in the text, too.
7 MR. HACKBARTH: If I recall, it is in the text.
8 That is sort of the focal point of the rationale for this,
9 is that it's important to maintain the integrity of the
10 payment system.
11 MS. BURKE: Can we just go back to Bob's point?
12 Are we modifying the language to reflect the actual drug? I
13 want to finish that.
14 DR. MILLER: I was letting it play out a little
15 bit further, just to see if anyone else had comments. But
16 what I took from that exchange, if everybody's on board with
17 that, is that the word each would be put in front of the
18 last word of the recommendation, for each drug.
19 And we would obviously make it singular in that
20 instance.
21 But I took that from that, but I was going to let
22 it play to see if anybody objected.

1 DR. CASTELLANOS: Joan, I just want to continue
2 the comments that Sheila made. I think you did a very good
3 job.
4 And I really appreciate what you've done to go out
5 into the provider community, the medical community, and to
6 talk to patients. Because I think that's what we need to
7 do. We need to get down on that level sometimes to find out
8 what's going on. And I think you did a great job.
9 There's no question that ASP is much better than
10 what AWP was for the Medicare system and I'm glad we did
11 that. Is it a perfect system? No. Can it be improved?
12 Yes. There's a competitive acquisition program that gives
13 us a backup on that, and I would just hope that maybe CMS
14 would improve that program for the provider community.
15 Thank you.
16 DR. HOLTZ-EAKIN: I want to echo the comments
17 before on the quality of the draft and also the particular
18 recommendation, I think, is exactly right.
19 There was one other issue that came up which I'm
20 not sure the status of, and that was those narrow
21 circumstances in which you've got a very cheap drug and the
22 6 percent doesn't cover things like shipping. Are we going

1 to say anything about that? It seems like -- I don't know
2 how pervasive it is. It just seems like something no one
3 thought of at the time, when they did the ASP plus 6. We
4 want to make sure that these things actually cover the costs
5 of getting cheap drugs. That would be a bad thing to not
6 have happen.

7 DR. SOKOLOVSKY: Aside from mentioning it, we
8 haven't talked about a solution to it. There could be
9 language in the text that would say that one possible way of
10 dealing with this would be sort of a fixed price below which
11 we wouldn't pay.

12 I don't know, there wasn't enough commission
13 discussion on that.

14 DR. HOLTZ-EAKIN: The reason I raise it is it's
15 the one example that's very concrete, where just saying you
16 want ASP plus 6 to work well doesn't solve the problem,
17 because even if it works right you don't get the costs
18 covered. So I just didn't know if we wanted to get into
19 territory where this wasn't working. That's the real issue.

20 DR. MILLER: Consistent with Joan's comments, we
21 didn't come away with enough to feel like we had a strategy
22 on that. But, like all of these issues, we're not done with

1 this. If there is enough interest, we can continue to
2 pursue that. Joan and I have had some conversations about
3 that. There are sort of fees that you could think about
4 using there.
5 The nut to crack there would be how you define a
6 drug when it falls in that category and then how you define
7 it in a way that people don't have an ability to kind of get
8 drugs into that category.
9 But Joan has a lot of free time, on her weekends.
10 [Laughter.]
11 DR. HOLTZ-EAKIN: I think we need a draft
12 recommendation to fill her free time.
13 DR. MILLER: This is work that we can continue to
14 pursue. There are issues in this payment system that have
15 to be chased down further, and we can put that on the
16 agenda.
17 DR. SCANLON: There was a second issue which also
18 seems to be troublesome and actually may be even more
19 pervasive, and that was the states that have sales taxes.
20 Given what sales tax rates are these days, it's easily seen
21 that they would use up the plus 6. And that goes for drugs
22 of any price.

1 DR. REISCHAUER: I thought there were only two
2 states that imposed -- no?
3 DR. SOKOLOVSKY: No, I gave examples of two but
4 nobody has collected for all 50 states. And sometimes it's
5 not the state, it's the city, which makes it even harder to
6 collect everything that's going on.
7 DR. MILLER: On that one I thought, and I may be
8 just dreaming this. But I thought I remembered some
9 conversation and a concern about action here, that if you
10 try and take that into account, if you do it on an averaging
11 basis it doesn't help anyone. And if you fix it in the
12 specific market, you just encourage the state and the city
13 to step in and actually generate revenue.
14 So I felt, at least Joan and I, I think, walked
15 away from that conversation that the Commission didn't feel
16 there was a place to go. But we definitely have the
17 problem.
18 Joan, I'm correct, it is spelled out in the text
19 of the report; correct?
20 DR. SOKOLOVSKY: Yes.
21 MS. BURKE: I think, to your point, I think this
22 is something we're bound to come back and get a better

1 understanding of. To Doug's point, as we get more
2 information and see what happens, I think we may want to
3 continue to look at whether this works.
4 I think the critical thing is that CMS gets a
5 clear message from us, this is something important, this is
6 something that needs to be fixed. And this recommendation
7 needs to be dealt with and moved in this direction. But I
8 think this is something we're going to continue to want to
9 look at to whether or nit, in fact, it achieves the results
10 we want it to achieve.
11 MR. HACKBARTH: Any others?
12 Okay. We're ready to vote then the recommendation
13 as modified. So that concluding passage will be to reflect
14 transaction prices for each drug.
15 All opposed to the recommendation? All in favor?
16 Abstentions?
17 Okay. Thank you, Joan. Good job.
18 Next is payment adequacy for physicians.
19 MS. BOCCUTI: Good morning. I'm going to mention
20 just a brief note before we start that, as you know, our
21 annual payment update recommendations will be sent to
22 Congress and released publicly at the beginning of March,

1 which is the same time as the SGR report that you've been
2 discussing over the last year.
3 The SGR report will reflect your discussions on
4 ways Medicare's physician payment system could include
5 incentives for physicians to provide better quality of care,
6 to coordinate care, and to use resources judiciously.
7 But however, for our annual update analysis, also
8 required by law, we recognize that the current payment
9 system is based on a single conversion picture for now and
10 that updates across all -- that that conversion factor
11 updates across all services and all physicians.
12 So our approach for recommending updates for 2008
13 adheres to that context and we first consider payment
14 adequacy from the most currently available data and then
15 assess the factors that are going to affect efficient
16 providers' costs in the coming year.
17 With that said, first I'm going to present an
18 assessment of payment adequacy for physician services using
19 the indicators that we typically use, which are listed on
20 the slide. And then I'll review expected cost changes for
21 2008. And finally, we can discuss the draft recommendation.
22 This year MedPAC sponsored a physician survey,

1 which was conducted over the summer by NORC at the
2 University of Chicago and the Gallup organization.
3 The survey included 934 nonfederal office-based
4 physicians who spent at least 10 percent of their patient
5 time with fee-for-service Medicare beneficiaries.
6 Physicians with closed practices, that is practices that are
7 not taking any new patients of any insurance type, were
8 excluded from the survey.
9 The first topic on the survey which I will discuss
10 relates to physician willingness to accept new patients.
11 Our survey found that the majority of physicians, or 96
12 percent, accept at least some new Medicare fee-for-service
13 patients, but a somewhat smaller share accept all or most.
14 Only 3.3 percent of physicians indicated that they were not
15 accepting any new Medicare fee-for-service patients.
16 Acceptance of new Medicare fee-for-service patients compares
17 very favorably, as you can see, to Medicaid and HMO patients
18 but it's a little lower than for private non-HMO patients.
19 For comparison, I want to mention right here that
20 these numbers are very similar to two other national
21 surveys, namely the NAMCS and the HSC physician surveys,
22 both of went though only go through 2005. But there is

1 similarity in the 2006 numbers here.

2 So on the last line on the slide, it's regarding

3 referral difficulty. Physicians more frequently reported

4 difficulty referring Medicare fee-for-service patients than

5 private non-HMO patients, 7 and 3 percent comparatively.

6 But referring HMO or Medicaid patients appeared more

7 difficult that Medicare fee-for-service patients.

8 Acceptance rates of Medicare fee-for-service

9 patients varied by physician characteristics, and I've put

10 some of those characteristics on the slide. But this

11 variation generally corresponds with physicians' overall

12 patient acceptance across insurance types. So compared to

13 urban physicians, a lower share of rural physicians reported

14 accepting at least some Medicare fee-for-service patients,

15 that's 97 and 93 percent comparatively. But note, however,

16 that for almost all payers, rural physicians were less

17 likely to accept new patients compared to their urban

18 counterparts except in the case of Medicaid.

19 Similarly, non-proceduralists such as primary care

20 physicians were less likely than other types of physicians

21 to accept new patients by each given insurance type.

22 In our survey, the majority of physicians

1 indicated that they were very or somewhat concerned about
2 reimbursement levels across patients of all insurance types.
3 Specifically, 53 percent of physicians were very concerned
4 about reimbursement levels for their private non-HMO
5 patients. 62 percent were similarly concerned for their
6 non-Medicaid HMO patients, and 72 percent for Medicare fee-
7 for-service, 78 percent for Medicaid.
8 Physicians also reported concern regarding
9 administrative burdens imposed by insurers, namely billing
10 and paperwork, listed on the slide. For private non-HMO
11 patients and Medicare fee-for-service patients about half of
12 all physicians reported being very concerned about this
13 issue. Again, rates for Medicaid and HMO were a little
14 higher.
15 Another factor we surveyed, which is not listed on
16 the slide, is physicians' concern about the timeliness of
17 claims payments. Across all insurers, physicians appeared
18 less likely to be anxious about this issue relative to the
19 two others on the slide.
20 Many physicians reported recent changes to their
21 practice to increase revenue or streamline costs.
22 Specifically, 70 percent of physicians reported that they've

1 increased the number of patients they see in the last year.
2 And about 27 reported that they expanded in-office testing
3 and lab services, 19 percent reported expanding imaging
4 services, and approximately 38 percent reported changes to
5 the mix of personnel they have in their practice. These
6 findings are similar to those found by the Centers for
7 Studying Health Systems Change. Those results are a bit
8 more dated.

9 Perhaps related to efforts to increase patient
10 caseloads, another survey question we asked but is not shown
11 on the slide found that almost half of the physicians
12 reported that in the past year they had increased the number
13 of hours they worked per week.

14 Our survey also asked physicians about the factors
15 that affect their individual compensation. Most, 80
16 percent, reported that their own productivity, typically
17 measured by their service volume and even RVUs, was a very
18 important determinant of compensation. Other factors
19 include patient satisfaction, quality measures, and resource
20 use. But those factors were considerably less likely to be
21 determined as a very important indicator.

22 As you recall, MedPAC sponsors also a phone survey

1 for beneficiaries. So we're switching now from the
2 physician survey to beneficiary survey. These were both
3 conducted during the previous summer. We do this, as well,
4 to obtain the most current beneficiary information possible
5 for our update analysis. In our last three rounds, we've
6 surveyed both Medicare and privately insured individuals
7 aged 50 to 64 to assess the extent to which any access
8 problems are unique to the Medicare population.
9 This year's survey found that most Medicare
10 beneficiaries and privately insured people did not regularly
11 experience delays getting an appointment due to scheduling
12 issues. Rates across the survey years have remained steady,
13 with Medicare beneficiaries reporting delays less often.
14 So in 2006, among those who tried to schedule a
15 routine care appointment, 75 percent of the Medicare
16 beneficiaries and 69 percent of privately insured
17 individuals reported that they never experienced delays. As
18 expected, for illness and injury, timely appointments were
19 more common for both groups.
20 MS. BURKE: Can you define for me what's delay?
21 MS. BOCCUTI: The delay is -- there's a bit of
22 subjectivity to it in the sense that we ask did you have to

1 wait longer than you wanted to get the appointment? So if
2 they wanted to be able to schedule the appointment that
3 week, but they couldn't get an appointment until a week or
4 whatever longer. But it is up to the beneficiary and the
5 individual to say what is longer than I wanted.
6 We also asked respondents about their ability to
7 find new physicians when they needed one. We're a bit
8 statistically challenged in this line of questions because
9 the share of people actually looking for a new physician is
10 considerably smaller than those who are making doctor
11 appointments. So many of the differences we see between
12 groups and between years does not have statistical power.
13 So among those looking for a new primary care
14 physician, almost the same share of Medicare beneficiaries
15 and privately insured individuals reported that they
16 experienced no problems. That is 76 percent of Medicare
17 beneficiaries and 75 percent of privately insured
18 individuals.
19 Although access appears good for most
20 beneficiaries on finding new physicians, we continue to
21 monitor the increasing number of beneficiaries reporting a
22 big versus a small problem relative to private individuals.

1 And so then, on to specialists, we found that
2 access to new specialists was generally better than access
3 to new primacy are physicians. However, I will note that in
4 2006, from this past summer, we see a significant dip in
5 beneficiary access to specialists. This is the first year
6 we saw this change, and we'll be monitoring it closely.
7 We're unable to confirm these results with other
8 surveys because there aren't any that are this up to date.
9 CMS did not conduct the CAHPS fee-for-service
10 survey in 2005, so I'm going to quickly review the 2004
11 findings, which generally found that Medicare access, or
12 their report of access to physicians, is generally good and
13 it's consistent with responses from the MedPAC Beneficiary
14 Survey.
15 Specifically, more than 90 percent of
16 beneficiaries reported either no problem or small problems
17 accessing a specialist. Also, the majority of beneficiaries
18 reported being able to schedule timely appointments for
19 routine care, either always or usually.
20 We also compare payment rates between Medicare and
21 two large commercial insurers. Our analysis shows that the
22 difference between Medicare and private fees is steady over

1 the last several years. Averaged across all services and
2 areas, the 2004 ratio of Medicare payments to private rates
3 was essentially at the same level as it was in 2004, with
4 Medicare rates at about 83 percent of private rates.
5 Within a given market area, of course, or for a
6 given service, the difference between Medicare and private
7 payments may vary substantially, but this is averaged across
8 all services and across all areas.
9 It's important to note for our MedPAC payment
10 adequacy analysis that the research by HSC has found that in
11 areas where Medicare fees are closer to private fees,
12 beneficiary access is not measurably better than in areas
13 where the fee differential is greater. So this suggests
14 that other factors are playing a role here, more than just
15 say payment reimbursement levels.
16 To examine physician supply, we include only
17 physicians who saw at least 15 Medicare patients in the
18 year. This removes from our analysis physicians who don't
19 regularly see Medicare patients, and perhaps they only saw a
20 few to fill in for a colleague.
21 So the numbers inside the table give you the
22 number of physicians per 1,000 beneficiaries. So among

1 physicians who regularly see Medicare patients, we continue
2 to see that physician supply has kept pace with beneficiary
3 enrollment.
4 We also examined supply trends for physicians with
5 large case loads. We found that the number of physicians
6 per 1,000 beneficiaries continued to grow, even for
7 physicians with large Medicare caseloads. Indeed, the
8 higher the caseload, the faster the growth rate between 2000
9 and 2005. Incidentally, we found that a little more than
10 half of physicians billing Medicare had caseloads of at
11 least 200 Medicare patients.
12 So the supply numbers that I just reviewed prompts
13 me to step away just for a moment from our update analysis.
14 I want to mention that in future meetings we plan to analyze
15 differences in access and payments among physicians, with
16 particular attention to private care providers.
17 Specifically with the aging of the baby boom generation, we
18 plan to examine workforce issues of physicians and non-
19 physician providers, a topic we don't generally consider in
20 our update analysis.
21 Consistent with the Commission's work over the
22 last couple of years, we may recognize and discuss ways that

1 primary care providers would take a role in care
2 coordination and medical home policies, as well as
3 performance measurement, often heavily weighted by primary
4 care providers.
5 We may also examine the alternative methods of
6 calculating the work RVU that may consider additional
7 components not currently captured in physician time and
8 effort studies. For example, some procedures have grown
9 rapidly, which may indicate that physician productivity for
10 that procedure has also grown rapidly, and thus the work RVU
11 may need to be reassessed.
12 Primary care providers may contribute especially
13 to episode efficiency and their services may be valued
14 differently and grow at different levels. So we'll keep
15 watching that. I just wanted to mention that.
16 So back to the payment adequacy analysis, we
17 looked at claims data through 2005. When we look at these
18 data, we do not see decreases in per capita volume, at least
19 among broad categories of services which are shown in this
20 chart. Rather across all services per capita volume grew
21 5.5 percent between 2004 and 2005. This growth includes
22 increases in both service and intensity.

1 I should note that it is a little bit lower than
2 it was for 2004, which I think was about 6.2 percent.
3 So looking across the years, you see that imaging
4 continues to have a high growth rate, in 2005, 8.7 percent
5 per beneficiary. But volume in the other procedures is
6 close behind at 8.5 percent.
7 Overall we only saw a couple of instances for
8 specific services of volume decreases. For those, they are
9 usually explained by general trends in practice patterns.
10 The cumulative impact of these annual increases in
11 volume is shown in that dark line that's upwardly sloping.
12 In a recent report, GAO also found growth in both the share
13 of beneficiaries using services and the volume of services
14 they used. GAO concluded that increases in utilization and
15 complexity of services may demonstrate that beneficiaries
16 are able to access physician services, but does note that
17 these utilization trends have implications for the long-term
18 fiscal sustainability of the Medicare program.
19 As we did last year, we examined the quality of
20 ambulatory care through a claims-based measure set, which we
21 call MACIEs. Those are derived from the ACE-PROs, which
22 were developed nearly 10 years ago by RAND. MACIEs are

1 designed to reflect basic clinical standards of care for
2 common medical diagnoses, and they focus on two types of
3 measures. First, the percentage of beneficiaries who
4 received clinically necessary services for these diagnoses.
5 Those can be considered process measures, such as lipid
6 testing for people with coronary artery disease. The second
7 type of measure is the percentage who had potentially
8 avoidable hospitalizations directly related to their
9 diagnosis.
10 So here are the results, and I'll take you quickly
11 through the table. The table tracks change between 2003 and
12 2005. The numbers in the table refer to the number of
13 indicators within each medical condition that showed
14 improvement or stable or worsened. As you can see, most of
15 the indicators we measured were steady or showed small
16 improvements between 2003 and 2005. Among 38 measures, 22
17 showed improvement and 13 were stable.
18 We found that for several conditions declines in
19 potentially avoidable hospitalizations occur concurrently
20 with increases in the use of clinically necessary services
21 for the same condition. So for example, for diabetes we see
22 lower rates of amputations and diabetic coma, with higher

1 rates of lipid and hemoglobin testing.

2 In only three out of 38 measures did we find a

3 decline in quality and all three of these were related to

4 breast cancer, for which we found small declines in

5 mammography screening and imaging for women with a history

6 of breast cancer. But we do note that these slight declines

7 are consistent with ones recently found by NCQA in HEDIS

8 reporting measures.

9 So for the second part of the adequacy framework,

10 we look at changes in costs for 2008. CMS's preliminary

11 forecast for input price inflation is 3.3 percent. As you

12 know, within this total CMS sorts the specified inputs into

13 two major categories. That is physician work, which is

14 expected to increase by 3.3 percent, and physician practice

15 expense, expected to increase by 3.4 percent.

16 I'd like to note that these input cost forecasts

17 on the slide exclude productivity adjustments that are

18 integrated into CMS's publicly released MEI, so they are

19 higher than the MEI that comes out in public.

20 Our update framework requires an examination of

21 input costs for each sector separate from productivity

22 adjustments, and that's why we pull that out. Calculated

1 from BLS statistics, our analysis of trends and multifactor
2 productivity suggests a goal of 1.3 percent.
3 In sum, the indicators I've reviewed today do not
4 suggest current payment adequacy problems for physician
5 services. We cannot, of course, analyze data for 2007,
6 which currently and technically is slated to include a
7 negative 5 percent update.
8 I'll mention again that the Commission's update
9 recommendation will be sent to Congress at the beginning of
10 March, the same time as the SGR report, which will reflect
11 your discussions of late.
12 So for your discussion, here's the draft
13 recommendation that you've seen from last year. The
14 Congress should update payments for physician services by
15 the projected change in input process, less expected
16 productivity for 2008.
17 So drawing on the numbers from the previous slide,
18 we would have a preliminary update of 2 percent for 2008.
19 I'll be happy to take your questions.
20 MR. HACKBARTH: I'd like to remind people, in the
21 audience in particular, that the draft recommendations that
22 are being presented are simply a reflection of what we

1 recommended for each of the groups a year ago and don't
2 reflect any new analysis, new thinking. So take them for
3 just that. Obviously they are subject to change.
4 Before we begin the discussion, it also may be
5 worthwhile to call people's attention to this document,
6 which reflects the conference agreement that's now pending
7 before Congress, including in particular the Medicare
8 provisions on physician payment. Basically, what that boils
9 down to is a proposed freeze in the rates except for
10 physicians who comply with reporting requirements, who would
11 get a 1.5 percent increase.
12 DR. MILLER: There's also a third provision that
13 establishes a fund to promote payment stability and
14 physician quality. A lot of this is very fluid. The best
15 we can figure out is that fund looks like it's about $1.4
16 billion for 2008. But I've got to say, these facts are very
17 much in motion.
18 MS. DePARLE: What does that mean for payment
19 stability?
20 DR. MILLER: I don't know.
21 MR. HACKBARTH: That's why I didn't mention it,
22 because I had no idea what it meant.

1 DR. MILLER: It's not clear how this money gets
2 out, from what we can see in this legislation but there's an
3 amount of money allocated from the Part B Trust Fund, it
4 looks like, of about --
5 MS. BURKE: [Inaudible.]
6 MS. DePARLE: I thought it was a contract for
7 MedPAC to do more work.
8 DR. MILLER: We're trying to get that in. So
9 there's some more money floating around. Exactly how it
10 gets out to physicians is not clear.
11 MR. HACKBARTH: At this point I don't think it's
12 productive for us to focus on the conference agreement.
13 It's uncertain whether it will become law. And if it does,
14 it will become law hopefully before we need to make our
15 final recommendation in January.
16 The problem that we've often faced with the
17 physician update in recent years is that we're asked to make
18 an update recommendation for a future year when we don't
19 even know what the rates will be for the current year, which
20 is at least a difficult task. And hopefully that much will
21 be clarified before we do need to vote in January.
22 MR. DURENBERGER: My question relates to the issue

1 of productivity and trying to get a little help to
2 understand it in the physician context as opposed to the way
3 we talked about it yesterday with regard to hospitals, and
4 particularly because -- I think it's on slide six --
5 physicians report practice changes and compensation factors
6 for the past year. In the second section there is a
7 reference to physicians' own productivity, and it says 80
8 percent.

9 I'm not real sure exactly what that means. But
10 since they expressed it, perhaps you can help me understand
11 that. Then I want to follow up.

12 MS. BOCCUTI: Yes. The term productivity has a
13 dual meaning here in some respects, though clearly related.

14 The productivity on the second section of that
15 slide, think of it as the physicians' productivity in the
16 office, perhaps relative to their peers. It's often
17 measures in RVUs. So at the end of the day, the end of the
18 week, or the end of the year, their counts of RVUs would be
19 a measure for the office as to that physician's
20 productivity. So given a certain block of time, how many
21 units were they able to produce?

22 We also consider, when we're looking at

1 productivity, there's more elements within the office to be
2 able to help physicians increase their productivity, with
3 technology and physician extenders and other issues like
4 that.

5 So that's kind of a little bit more of the BLS
6 productivity in sort of efficiency gained over time in doing
7 services.

8 MR. DURENBERGER: That is the second part of this
9 question. On the valuing primary care providers section
10 logically and importantly there is a set of future research
11 or ongoing research, one on workforce and then other issues.
12 I guess the question that I had or where it would be helpful
13 to me to understand it is specialty physician, particularly
14 surgeons and so forth, radiologists and so forth, may look
15 at productivity one way because technology substantially
16 enhances productivity unless it happened to be controlled by
17 the hospital. Then in the wrong site of hospital setting it
18 may not, and so they seek other ways in which to enhance
19 their productivity like a setting up their own system.

20 On the primary care side, generally again, and I'm
21 sure there's a crossover in here someplace, what you call
22 physician extenders and I might call -- and I don't know if

1 they're the same or different -- but ancillary health
2 professions, everything from the physician's assistants to a
3 variety of other professionals, are really a very, very
4 important part of whether we call it physician productivity
5 or enhancing the quality of the care for the patient, that I
6 wonder if you wouldn't speak just briefly to how this future
7 research will tie with our ability to use productivity as
8 part of a compensation adjuster, if you will.
9 MS. BOCCUTI: Yes, I have two relevant points to
10 that to make, one on the nonphysician staff. I think I
11 mentioned when I was speaking that when we think of primary
12 -- and I was careful to put primary care providers, not
13 primary care physicians, in the sense that many staff can
14 really provide primary care services. And so I hope that
15 when we're looking at this issue, and if we focus on primary
16 care, that we conclude how the nurse practitioners et cetera
17 are able to provide that service.
18 I think in many models that increases the
19 availability of primary care services. So I hope that we're
20 able to include that in the analysis.
21 The other part you mentioned about productivity, I
22 think that hits a little bit in the alternative methods of

1 calculating work RVUs. In some sense, what are the
2 physicians -- primary care physicians for this example --
3 what are they able to do with their time and effort? And
4 what constraints do they have on them with regard to that?
5 And how could potentially that be a factor in measuring
6 their work RVUs? So if there are other items like their
7 ability to do more, which may be more constrained for the
8 cognitive services. Potentially the work RVUs may address
9 that issue, that you need physicians' time right then, right
10 there and sometimes that's all you can do and you can't
11 increase their abilities to produce more at that moment.
12 Is that where you're going?
13 MS. BURKE: I want to talk a little better about
14 the indicator relating to cancer and the decline there.
15 But Dave, to your point, on behalf of the nurses
16 of America, physician extenders always makes me think of
17 Hamburger Helper. So I think nonphysician providers works,
18 nurse practitioners, but stay clear of the physician
19 extender thing.
20 Going to the cancer indicator, and your indication
21 that it appears to be related specifically to mammography as
22 it relates to patients that have been treated in the past,

1 do we know anything more? I know it's a little off the
2 specific topic we're talking about, but it's a trend that
3 would certainly concern me.
4 Do we know, in the course of the work, what the
5 nature of the problem is? Nancy-Ann and I were sort of
6 having an off-line conversation. Is it a function of the
7 payment rates? I can't believe that it is a change in the
8 pattern of behavior with respect to the recommendation for
9 follow-up screening as a result of someone who has been
10 treated the past.
11 I wondered if it's something that we needed to
12 discuss separately as a unique set of circumstances.
13 Because it was so off track with all of the other indicators
14 that are moving in the right direction in terms of behavior,
15 is it a physician behavior? Or is it, in fact, the failure
16 to pay adequately for the service and therefore people
17 aren't doing it or they are not offering it?
18 MS. BOCCUTI: Because NCQA found in their HEDIS
19 performance measures that same drop, and that's going on in
20 private insurers, it's not necessarily a reimbursement issue
21 for Medicare. While our measures are for Medicare fee-for-
22 service that we're seeing the same finding in the private

1 insurance population, either it would be a reimbursement
2 across-the-board. But we can't just say it's a Medicare
3 reimbursement issue.
4 But NCQA also noted that there's been some public
5 debate on the effectiveness of mammography and that could be
6 a contributor to confusion for the patients on seeking the
7 treatments. And that they're actually thinking that that is
8 affecting the screening. So there seems to be a need for
9 coordination of public education efforts.
10 I think that the data that we show, it covers a
11 long period of time. And to the extent that that is an
12 issue that has gone away, and maybe we're moving back
13 towards realizing that regular screening, particularly if
14 you've had a history of breast cancer, is a good thing, that
15 maybe once we get the old data out we'll be able to pull in
16 the newer data and see that.
17 But that's what NCQA was thinking may be a
18 contributor.
19 MS. BURKE: It's something I'd like to keep an eye
20 on and track as we get more information and I think get some
21 better understanding. If it is, in fact, not a
22 reimbursement or if it's a combination of reimbursement and

1 the story being told or people's lack of understanding. But
2 it's certainly a worrying trend that I'd certainly want to
3 comment on if it had anything to do with either the way we
4 are talking about it or the way we're paying for the
5 service.

6 DR. CROSSON: Just a note on that, and we've
7 noticed the same phenomenon in our program. In fact, in the
8 last couple of years, in all eight of our regions, slippage
9 of a few points in mammography screening. Of course, it's
10 not related to payment.

11 We're not actually sure what it is. But the sense
12 we have is that it is due to increasing resistance. So
13 we've been able to move the numbers back up, but it just
14 simply has required more encouragement, more follow-up, more
15 hectoring of people to get it.

16 The sense we have is that it is, in some way,
17 related to increasing resistance on the part of at least
18 some people to the test.

19 MR. HACKBARTH: Two other comments on this
20 specific issue, Bill and Karen.

21 DR. SCANLON: I just wanted to make a comment but
22 also a question, which is I thought you said that the

1 changes were small. And I was wondering what small might
2 mean?
3 MS. BOCCUTI: Across all indicators or for the
4 breast cancer?
5 DR. SCANLON: For the breast cancer; right.
6 MS. BOCCUTI: That numbers I don't know, but they
7 are enough to be statistically significant, otherwise they
8 would have been in the no change. But we're probably
9 talking about a percentage point.
10 DR. SCANLON: But in working with claims data,
11 when we have so many observations, statistically significant
12 can mean a small number.
13 MS. BOCCUTI: Oh, I thought you meant percent
14 decline.
15 DR. SCANLON: Yes.
16 MS. BOCCUTI: Yes, about a point. But there's so
17 many patients that this indicator qualifies for it.
18 DR. SCANLON: It makes it significant, I know.
19 That was one question, what are we talking about.
20 The second one was a question of whether, when we
21 compared this to other indicators, that we've actually had
22 more success with respect to these indicators and it's

1 harder to maintain success than it is necessary to move up
2 from a very bad situation.
3 MS. BOCCUTI: If it's not in the paper, I'll note
4 the exact numbers for you and get back to you, and for you
5 too, Sheila.
6 DR. BORMAN: One other factor you might recall is
7 that probably one of the higher risk areas in radiology,
8 relative to professional liability, is failure to diagnose
9 on mammography. And that may, in fact, also be playing a
10 role here.
11 MR. HACKBARTH: Going back to our original list,
12 Bob.
13 DR. REISCHAUER: First, Cristina, let me just say
14 that each year this analysis has become increasingly
15 sophisticated and useful. And I applaud you and your
16 colleagues who worked on it. This is really good stuff.
17 And now I'm going to suggest maybe an additional cut for
18 next year, if it's not available this year.
19 My comment really is motivated by the findings of
20 Elliott Fisher and Jack Wennberg and others about supply
21 sensitive services that seem not to have huge impacts on or
22 any impacts on health outcomes. And that is can we take the

1 various measures of patient satisfaction here or ability to
2 get an appointment, et cetera, et cetera, and look at them
3 by hospital referral districts or whatever, those that in
4 Elliott's scheme of things are very parsimonious in their
5 use of services and those which are very generous, and see
6 if there are huge differences in ability to get appointments
7 satisfaction.
8 Because I think a lot of this then plays into how
9 you view this workforce issue going forward. And if it
10 turns out that those areas where there are fewer supply
11 sensitive services available that people seem to be as
12 satisfied, then we're talking really about changing
13 expectations and behavior, not sort of denying people care.
14 And it will, I think, reflect on that.
15 So the real issue is can we, if not this year next
16 year, sort of oversample certain areas and try to get a
17 geographic cut on some of these dimensions?
18 MR. HACKBARTH: I vaguely recall that, in fact,
19 they have looked at that and looked at access to care and
20 patient satisfaction to access to care. And it's the other
21 direction, that in the intensive areas satisfaction is lower
22 and access is --

1 DR. MILSTEIN: Satisfaction is equal and quality
2 is lower than the high standard area.
3 MR. HACKBARTH: I think there is some work on
4 this.
5 MS. BOCCUTI: In some literature there's been
6 findings. I'm not sure what time frame that's referring to.
7 The CAHPS fee-for-survey is very, very large and
8 we would potentially be able to look at that in different
9 areas. Our beneficiary survey, we'll have to work very hard
10 to get a sample size that we could split up by region. But
11 the point and we'll see about a --
12 DR. REISCHAUER: Just oversample a handful of
13 hospital referral districts.
14 MS. BOCCUTI: We'll look into that. I think it's
15 a good idea.
16 DR. MILLER: To take another pass on this, if
17 you're not concerned about -- the thing about our
18 beneficiary surveys is it's relatively small but very
19 timely. As she said just a minute ago, you can't even
20 compare what we're finding because it's pretty out in front.
21 But if you are willing to fall back a year or so, then we
22 might be able to divide this up using larger surveys.

1 MS. BOCCUTI: Right, it's just that the CAHPS fee-
2 for-service wasn't done in 2005. So if they do it, and I'll
3 find out about that, that's easy. We'll CMS and see. But
4 we'll look at other literature and see what we can do.
5 DR. MILLER: I was going to say, HSC sort of
6 looked at this about a year or two ago.
7 MS. BOCCUTI: Their household survey will probably
8 be the field about 2008.
9 DR. MILLER: But they had also looked at this
10 issue a year or two ago and then there's Elliott's stuff.
11 And we can look into oversampling on the bene survey, but
12 there's always a cost issue that comes along with that.
13 MS. HANSEN: Thank you, Cristina, also for I think
14 even the fuller section on beneficiaries this year that I
15 certainly feel and notice.
16 My comments actually corroborated both Dave's and
17 Sheila's relative to the other primary care providers.
18 Since there's such an issue of primary care as a field, and
19 given the discussion I just wonder if we could -- and I
20 think you're planning to do this with the whole area of the
21 other primary care providers; i.e. for example, the nurse
22 practitioners to kind of see the fullness of that. Because

1 I believe some states allow nurse practitioners now to do
2 some billing under some protocols and to provide the primary
3 care. So that actually can probably be seen more visibly in
4 terms of their role to primary care.

5 So I'm taking a look at this as access for primary
6 care for beneficiaries.

7 In the larger sense, in addition to physicians, if
8 we're having a very hard time recruiting and doing this, I
9 know that there is an increased supply coming actually of
10 nurse practitioners, and even specifically geriatric nurse
11 practitioners, because of scholarships in that area. And
12 just to begin to see how that trend may have some future
13 impact or considerations on access.

14 MS. BOCCUTI: We will want to follow up with you
15 about those reports about who's coming into the field from
16 these scholarships. That will be interesting. I'd like to
17 learn more about that.

18 DR. BORMAN: Cristina, analogous to what Mark was
19 saying earlier about Joan's free time, I need to reserve
20 just a little piece of your free time to have you walk me
21 through one of the calculations about volume and units of
22 service and that kind of thing.

1 A couple of philosophical comments and some very
2 fine here that triggers them. As you mentioned at the
3 beginning, we have a lot of comments on the SGR report that
4 sort of interdigitate with things that are in here. And I
5 would like to hope that we can kind of maintain the
6 appropriate emphasis here on the physician payment piece for
7 the here and now, and indicate where it folds in but perhaps
8 avoid reprising everything we're also going to say in the
9 SGR chapter.
10 Coincident with that, I think that the work on SGR
11 perhaps should stimulate us to think about do we need to do
12 a little bit of out-of-the-box blue sky thinking in terms of
13 the RBRVS. I think a couple times ago Bill Scanlon made
14 some comments about resource inputs and are we really
15 reflecting that. And we can say that well, perhaps in our
16 idealized world the RBRVS will go away. I'm not sure it
17 will. Maybe Part B FMS goes away, but I'm not sure that an
18 RBRVS goes away in terms of we've created bigger pots of
19 money but the distribution of those pots may still require
20 some sort of relativity relationship.
21 And so I think maybe some more blue sky thinking
22 about the RBRVS is in order. I don't know, maybe we have

1 another chapter in which it's appropriate to say that. But
2 it would seem to me maybe here might be the case.
3 MR. HACKBARTH: I agree with that, Karen, and we
4 talked a bit about that yesterday, as I recall. Even under
5 the various SGR options that we've been talking about, they
6 assume that there's still going to be a traditional Medicare
7 program and you need a method for paying physicians and
8 hospitals and all the other providers.
9 As Nick pointed out during that discussion, our
10 past work indicates that there are real issues in how those
11 prices are set and whether they're accurately set and
12 whether the distortions in the prices are causing behavior
13 that we may not want in the Medicare program.
14 So even if magically there was a new SGR apparatus
15 put into place, that agenda would be still very important to
16 pursue. And so the comments that Bill has made in the past
17 and you have made in the past about looking at that are
18 still on the MedPAC agenda.
19 DR. BORMAN: I was very intrigued by your comments
20 yesterday in framing the issue of accuracy of each input
21 versus a general philosophic kind of step back and sort of
22 say what the drivers should be and the tension maybe between

1 these. I think this is an area where that tension comes
2 forward very directly.
3 Just an example, CMS has stated in one of the
4 rules or one of the NPRMs, I can't remember which, that
5 practice expenses are not being covered to the tune of a
6 third to two-thirds of the total that it believes may be
7 there. We can slice and dice that to some other number, but
8 those are pretty real numbers.
9 So that kind of input starts to make the accuracy
10 piece look a little bit more cogent then just sort of
11 setting a philosophy and I think we need to be sensitive to
12 the multiplicity of changes that are going on both in RVWs
13 and in practice expense at the same time.
14 There is a very large shift going on to E&M
15 services in the 2007 fee schedule, as everybody here knows,
16 and the time lag problem or the advance time problem we
17 have, I think, will be very important to monitor that piece
18 of it. I would just sort of say as a prospective item, the
19 $4 billion that's moving into E&M is more than the combined
20 allowed charges of general surgery, vascular surgery,
21 colorectal surgery, plus neurosurgery and CT. And I think
22 we would all agree that general surgery, vascular surgery

1 and colorectal surgery certainly have a lot of
2 nondiscretionary services in the geriatric population.
3 I was going to make a comment about nonphysician
4 providers, but it's already been said very well.
5 I would support wholeheartedly the workforce piece
6 of access. And I understand some of the historic reasons
7 about not looking at that, but I think we're at a time where
8 the costs of training and the kind of things we need to
9 accomplish, maybe the planets are in the right houses that
10 it's time to do that.
11 Just a brief comment about coordination of care.
12 One of the things that major service global packages do is
13 combine kinds of services and sites of services in one
14 payment. You can make the argument that it doesn't include
15 Part A or Part D, but it is a microcosm of some of the
16 combination payment we've been talking about. And I would
17 point out that major procedures are growing at a good bit
18 smaller rate. And whether that is a valid test of the
19 hypothesis about combining payments could be debated, but
20 that could be one interpretation of that.
21 I think, however, a lesson from that is that when
22 you start to cross sites of service types of service,

1 defining a meaningful global quality measure becomes
2 enormously harder. And so if we're going to move
3 simultaneously in the direction of combined payments and
4 more specific quality measures, I think we're going to have
5 to remember that tension.
6 MR. HACKBARTH: It gets harder and more important
7 as you move to bundles of services that span sites.
8 DR. BORMAN: With regards to coordination care, I
9 would point out to you that coordination of care is a
10 defined element of evaluation and management services and
11 just some crude first pass calculations with some
12 assumptions about pre- and post-service work would suggest
13 that anywhere from 5 to 25 percent of current E&M payments
14 or projected E&M payments for 2007, or something on the
15 order of $2 billion to $12 billion, is indeed being expended
16 currently for coordination of care, although it doesn't
17 parse out as a line item.
18 And so I would say that we do need to be very
19 careful about making sure we know what we're spending and
20 what we're getting for what we spend in that particular
21 arena.
22 I think I'm going to stop there. Thanks.

1 DR. MILSTEIN: Following up on Karen's metaphor of
2 alignment of planets, and also reflecting on our discussion
3 yesterday in which we made a recommendation on allocation
4 which went so far as to indicate in what pool we thought a
5 particular allocation should go, I would like to raise for
6 consideration whether or not in this year's update factor we
7 offer a recommendation with respect to how the update should
8 be allocated to the base versus P4P pool.

9 We're at a point in history now where the
10 Secretary has had a limited P4P voluntary program for
11 physicians up and going. It has relatively limited
12 subscription because the amount, I believe, among other
13 things, the amount of dollars in play are not large enough
14 to attract interest.

15 And so might this be the first year in which we
16 pair our recommendation on the update with a recommendation
17 with respect to its allocation between P4P and base,
18 understanding that that recommendation would only apply to
19 the range of medical specialties for which the Secretary had
20 adopted quality measures, which at this point is not all
21 specialties.

22 MR. HACKBARTH: Several people have mentioned that

1 connection between updates and pay-for-performance and let
2 us think about how to bring that into the January
3 discussion. I think it spans multiple provider groups.
4 DR. CASTELLANOS: Just a few comments. I agree
5 with you about the finance. It's much too early to talk
6 about that. But there are some mandated cuts under DRA,
7 imaging and, as Karen said, the direct practice expenses.
8 The survey data, that's interesting. It depends
9 on where you look and who you're looking at and who's doing
10 the survey. But I think the important thing here is we're
11 beginning to see some cracks, especially with the
12 availability this year of maybe not getting a specialty
13 referral.
14 I know when I call and try to get somebody into an
15 office when I'm seeing a patient, sometimes I can't get the
16 person that I would prefer to do. I send it to somebody
17 else or the third one down on the list. So maybe we also
18 think about maybe we don't get always the right person.
19 The issue of Medicaid, I know that's not our
20 domain, but it's really kind of pitiful to look at what's
21 happening with Medicaid. Under the law they should have
22 equal access to care, and they don't. I don't care what

1 anybody says, they do not have equal access to care.
2 I don't know if this commission can do anything
3 about that or make any statements about that, but this is
4 one of the most vulnerable aspects of our care, the pregnant
5 females and the children.
6 As far as the workforce goes, I totally agree.
7 One of the things that I would also like you to look at on
8 there is the aging of the workforce. I know in Florida 40
9 percent of the primary care doctors are 60 years old and
10 older. So it's not just the number of doctors, it's the
11 aging, especially with the oncoming of the baby boomers.
12 As far as the nonphysician providers, Sheila, if I
13 ever called them Hamburger Helper, I would be decimated. I
14 think that's cute though.
15 But that also, also involves the specialty
16 practices and I couldn't have my practice if I didn't have
17 these providers.
18 My only saying is maybe some of the newer -- you
19 don't have access to care problems they say, but maybe
20 they're seeing an extended care provider rather than a
21 physician. And 75 percent of the people say they don't have
22 any problems. I think we need to put it in perspective that

1 25 percent do. And 25 percent of the Medicare population is
2 about 12 million. If that was one of us, I think we would
3 be upset.
4 Thank you.
5 MR. HACKBARTH: Let me just pick up on Ron's
6 initial comment about what the data say, the access data.
7 As Cristina indicated in her presentation, there
8 are a couple of numbers that -- I think the term that you
9 mentioned was something like bear watching because they
10 represent a little different than we've seen in the past.
11 And in at least some of those cases, we're talking about
12 very small sample sizes, so it's in particular when we're
13 talking about patients looking for a new physician, since
14 that's a subset. And so we need to be cautious in
15 interpreting those. But I agree that they bear watching.
16 The other point that I think is essential is that
17 we are looking at national averages in all of these data.
18 On occasions where I've testified before Congress on this,
19 often individual members will say this doesn't match what's
20 happening in my community, your data are wrong. And I think
21 that it's easy to reconcile. These are the national trends
22 and they're important to watch. But what's happening in any

1 given community could depart from this. For example, where
2 I lived in Bend, Oregon, I think there are significant and
3 growing issues with access to primary care for new Medicare
4 beneficiaries moving into the area. It's regularly on the
5 front page of the local newspaper and I've heard anecdotally
6 of similar situations in other communities.
7 The question then becomes how much of that is
8 attributable to Medicare and Medicare patent policy versus
9 broader dynamics in the community? I won't pretend to speak
10 for all communities in this situation, but I think part of
11 the problem where I live is that we have a rapidly growing
12 community where the population growth is outstripping growth
13 in physician supply.
14 And in fact what you see is it's not just Medicare
15 beneficiaries having problems finding a new primary care
16 physician, it's much broader than that. And I suspect that
17 that's true in a lot of places where we're seeing a very
18 acute problem with Medicare access to primary care. It's
19 not just a Medicare phenomenon, it's a broader issue. So
20 just that observation.
21 MS. HANSEN: Just to that point as well, I wonder
22 because I note in the report, Cristina, CMS is taking a look

1 at 11 communities in particular. I just wonder if we could
2 define what those community are in the text.
3 MS. BOCCUTI: Name the communities?
4 MS. HANSEN: By name.
5 And also, I think the Census data is starting to
6 show that there are new -- more quickly defined. I don't
7 know how they crosscut with these 11 communities that CMS
8 has defined. But it his this whole phenomenon of certain
9 communities that are not your usual growth centers, but have
10 become major growth centers. If we could kind of
11 geographically get a sense of the demographic Census
12 components.
13 And a third component of it that has to do with
14 just also the area of diverse population growth, there's a
15 whole component of health disparities from the IOM reports
16 that we haven't really kind of crosscut in some of the areas
17 of access in a more refined way.
18 So that may not be for this immediate period. But
19 since the population trends are also changing and the
20 Medicare beneficiaries will start to look more diverse, if
21 we could begin to take a look at the trend as well.
22 MS. BOCCUTI: Are we planning for the June chapter

1 to be looking at trends in beneficiaries for the 21st
2 Century?
3 MS. THOMAS: That is something we've talked about.
4 I'm not sure if we had really wanted to necessarily drill
5 down on the access question. We did several years ago do an
6 analysis of access by different groups, and it may be time
7 to revisit that. We can certainly share with you the
8 findings, which I don't think you would find surprising.
9 MS. BOCCUTI: And the changes in the diversity
10 that you were mentioning about the population to come, I
11 think is something -- the demographic issues I think we are
12 tracking.
13 DR. CROSSON: Just a point, the NORC survey, does
14 that have more cells in it than what we have here? In the
15 future could we get down to more geographic information? Or
16 is this summary information pretty much what they put out?
17 MS. BOCCUTI: It's a pretty comprehensive survey
18 and I do have it beside me, so we can get a look at it
19 together if you want. It does separate by region, but the
20 significance than drops a bit. But we can look at sort of
21 the base and the raw numbers that we see by region, gross
22 regions like Central, Northwest, that kind of thing.

1 We'll look into that. That's the physician
2 survey.
3 DR. BORMAN: A quick comment to this point.
4 Cristina, I know the IOM report about access to emergency
5 care, and certainly the American College of Emergency
6 Physicians and other organizations have some similar
7 studies.
8 All of these things ask about or sort of circle
9 around can you get an appointment. And I think there is a
10 category of care here that probably is not preference
11 sensitive service that we're not perhaps biopsying to see
12 where there are issues in that arena. That would be things
13 for acute conditions or exacerbations of chronic conditions
14 and also acute conditions like appendicitis or acute things
15 that might require a craniotomy or something like ruptured
16 aneurysms, some of those kind of issues.
17 And if not necessarily in this particular cycle,
18 if we could start to look for a vehicle that does sample
19 urgent care access. Because I think we all know our EDs are
20 overcrowded and I think we need to understand a little bit
21 more about that urgent care sector.
22 MS. BOCCUTI: The MCBS does look at some more

1 emergency room indicators, but that would be a beneficiary
2 survey. So we'll look into that and I have some results.
3 DR. CASTELLANOS: On that point, when we looked at
4 specialties and increased volume, if you look the highest
5 one was ER, the emergency room. When we looked at the
6 specialty categories for increased volume, I think it was
7 last month. If you look at that carefully, you'll see that
8 the emergency room was largest increase in volume.
9 MS. DePARLE: This analysis excludes Medicare
10 Advantage because we're only looking at the physician
11 payments under fee-for-service Medicare. But it made me
12 think this is the time of year that we look at these
13 beneficiary indicators. I can't remember the last time we
14 looked at it for Medicare Advantage, the CAHPS information.
15 When we look at Medicare Advantage, do you present that,
16 Scott?
17 DR. HARRISON: We haven't presented in lately.
18 MS. DePARLE: It's been a while since I've seen
19 it. It's a little off point of the purpose of why you're
20 doing this, but at some point I'd like to at least see the
21 most recent CAHPS information for Medicare Advantage and how
22 that's going.

1 MS. THOMAS: We did take a look at this and I
2 can't remember exactly what the finding was. But I think it
3 was the year that we made the series of recommendations.
4 One of the recommendations was actually to do more
5 comparative studies between MA and fee-for-service. We do
6 have a few measures of access, and I can go back and find
7 those and get those to you.
8 MS. DePARLE: I'm not even necessarily looking for
9 comparisons. I just don't have a baseline anymore. I know
10 it started in Medicare Advantage. They've been doing CAHPS
11 for 10 years now. I'm just interested in seeing some data
12 on how it's going.
13 MS. THOMAS: It would be no problem to get that
14 data together.
15 MS. BOCCUTI: I do have to caution, technically
16 the beneficiary survey that MedPAC has sponsored doesn't
17 really weed out the Medicare Advantage patients.
18 MS. DePARLE: I wondered about that. So do you
19 ask that as a threshold question?
20 MS. BOCCUTI: It takes too many questions to get
21 that accurate. And for beneficiaries to really know in this
22 kind of large omnibus survey --

1 MS. DePARLE: I wondered if you're able to just
2 ask them if they knew what plan they were in.
3 MS. BOCCUTI: Many surveys have showed that it's
4 not reliable to ask a couple of questions, are you in a
5 Medicare Advantage? They're just not going to know and not
6 going to know the difference. So we always have to footnote
7 the beneficiaries.
8 So the comparison is going to have -- if it's 17
9 percent of beneficiaries in Medicare -- there is going to be
10 some difference. But if you have only Medicare Advantage,
11 you can certainly see how it relates to the survey at large.
12 I just needed to say that for full information.
13 MS. DePARLE: That could dramatically change the
14 way I would interpret these results.
15 MS. BOCCUTI: Depending on the share of them in
16 the survey.
17 MS. DePARLE: Depending on the plan, in some plans
18 I think they have great access. In others they might not.
19 So that's an interesting fact.
20 MS. BOCCUTI: In fact, it could have something to
21 do with the access to specialist issue, where these surveys
22 are or something, but we don't know and we can't really

1 parse that out. But we could compare it to a Medicare
2 Advantage only survey and see what comparisons there are.
3 MS. DePARLE: We're getting into some cans of
4 worms here. I'd at least like to know as a baseline how
5 that program is doing. I have a feeling that it's doing
6 great but I just would like -- I think if this is the time
7 of year that we look at it, we should look at it for
8 Medicare Advantage, too.
9 DR. MILLER: When we did the managed-care stuff,
10 Sarah was all over that a while back. And we'll just bring
11 that back up and make sure that you guys get it.
12 MS. BEHROOZI: I was originally thinking of this
13 question in the context of types of service, but maybe it's
14 also relevant to look at it regionally. And it's got to do,
15 I guess, with implications for the future, the study of
16 workforce issues going forward.
17 On slide five, where you look at physicians'
18 concerns about levels of reimbursement, that kind of jumped
19 out at me, that fee-for-service Medicare looked like
20 Medicaid -- as you say, Ron -- in terms of physicians being
21 very concerned about the levels of reimbursement.
22 Obviously up until now I guess it hasn't had the

1 kind of impact that you might worry about, but maybe it has
2 implications for the future, especially in terms of what
3 areas of practice physicians go into or in which regions
4 they choose to practice.

5 So I wonder if you have that drill-down
6 information, if you have it broken out by areas of practice
7 or specialties or primary care or whatever? Or as I said,
8 maybe it's relevant regionally, as well.

9 MS. BOCCUTI: We do and we'll provide that to you.

10 DR. WOLTER: I just wanted to urge extreme caution
11 on the idea of recommending that we tie pay-for-performance
12 measures to the physician update. The reason I say that is
13 in the voluntary program currently in place, a very small
14 number of physicians are participating, many of whom are
15 being added into the numbers simply because they're in the
16 group practice demonstration project.

17 I've talked to no physician group that feels it's
18 going to be easy to supply measures. I think, even in my
19 own organization, which is extremely committed to patient
20 safety and quality, our quality resources staff are pulling
21 their hair out about the number of staff we need to add to
22 do chart abstraction.

1 I think, as I've mentioned before, we're in grave
2 danger at this moment in time around pay-for-performance of
3 trying to graft a series of measures onto a bunch of
4 fragmented silos and the opportunity right now to think
5 strategically and tactically about how pay-for-performance
6 could create true improvement in quality and cost is
7 present. But we are, I think, in a dangerous direction on
8 it right now and I really worry about that.
9 It will be a very interesting test case to see
10 what happens if the current bill goes through with that 1.5
11 percent update to physicians being tied to measures. First
12 of all, do all specialties have measures? And secondly, for
13 a small office is a 1.5 percent incentive going to cause you
14 to add the staff required to do chart abstraction?
15 So I think we just have to be really thoughtful
16 about how we want pay-for-performance to unfold as we look
17 at updates.
18 DR. CASTELLANOS: I'd like to comment on that,
19 too. Right now it's a voluntary program where a physician
20 does not get paid. We have an electronic medical record.
21 To change our computer system to comply with the voluntary
22 program, it would have cost my practice about $20,000. I

1 don't have that excess money to contribute to a non-
2 compensated fund and I would have to look at the 1.5 percent
3 to see if it would work out.
4 MR. HACKBARTH: I have mixed dealings on this.
5 When we did our pay-for-performance work, I think our
6 reports show that we recognized that doing pay-for-
7 performance for physicians was both very important and very
8 difficult, and in some ways much more complicated than doing
9 it for some other provider groups. Not that it's easy for
10 any of them.
11 But when we approached the issue, we said that
12 Medicare Advantage plans would be a good place to start.
13 ESRD, because there is fairly strong consensus about
14 appropriate measures of quality. Hospitals.
15 Not that in any of these cases they're perfect or
16 that they deal with some of the issues that both you and
17 Arnie have raised about where we want to go in the long-term
18 with pay-for-performance.
19 But I can readily imagine how we could be taking
20 more aggressive steps in Medicare advantage and ESRD and the
21 hospitals. But the way the political process has unfolded
22 it seems like physicians, one of the more complicated areas

1 has become sort of the rate limiting step. We can't move on
2 any front until we figure out how to do physicians, and
3 physicians are, I think, inherently complicated for a bunch
4 of different reasons, including the fact that we have small
5 units with not a lot of informational infrastructure, a
6 higher degree of specialization, we can go on and on about
7 that.

8 But I would like to see us, I would like to see
9 the Congress more importantly, make progress in some of the
10 areas that are somewhat less complex and not have the whole
11 process at a standstill until we figure out how to deal
12 appropriately with physicians.

13 MR. MULLER: Just on that point, and I agree with
14 all that. I think reiterating, at the same time, some of
15 our support for bundling, some of our support for
16 gainsharing, and some of our support for payments across the
17 silos which we discussed in SGR and other vehicles
18 yesterday, that could be helpful in that context. It has to
19 be seen in that context in order to put those together.

20 Certainly, as our numbers indicate, the number of
21 solo practices and the points that both Nick and Ron have
22 just made about the lumpiness of these costs in order to

1 comply, tend to cause people to not make those investments.
2 It's going to be a long time before you get over
3 that lumpiness. So unless they are part of larger
4 accountable units and there's a way of doing the gainsharing
5 across A and B, et cetera, and so forth, you're not likely
6 to secure the compliance one wants in P4P in this sector.
7 DR. WOLTER: I just wanted to clarify, I'm all for
8 aggressively getting going. But I would really prefer it if
9 we could focus the initial efforts in the high-volume high-
10 cost areas because I think there's so much return that can
11 come here. And how to do that in a way that people don't
12 feel left out, et cetera, of course is important.
13 But if we could really get going on congestive
14 heart failure and diabetes and hospital infections and some
15 of the areas where there are currently good evidence-based
16 practices, good measures are available, we could make so
17 much progress, as opposed to thinking that if we have a
18 measure for every specialty that's going to be the fix to
19 the SGR.
20 It's just strategically, I don't believe, well
21 thought out.
22 DR. MILSTEIN: Clearly, whether you are on the buy

1 or sell side of health care greatly effects whether one sees
2 the measurement cup as half full or half empty. Obviously,
3 I'm on the buy side and so I see it as half full.
4 I would make a couple of comments here as we think
5 about whether or not our update recommendations ought to
6 routinely include a recommendation with respect to
7 allocation between P4P and base. First, I think it was
8 Senator Bennett in Joint Economic Committee hearings last
9 spring, who said that he had recounted, in thinking about
10 this issue in relation to both physicians and other health
11 care provider performance, that he had spent a fair number
12 of years of his life trying to defend the food industry
13 against food labeling using many of the perspectives that
14 are valid perspective that have been shared about are the
15 measures good enough and how much would it cost to do this.
16 His comment was, in retrospect, he was way off
17 base and that had it begun earlier in an even more imperfect
18 fashion, the good things that subsequently happened would
19 have happened sooner. It's simply one perspective from
20 someone who was on both sides of the equation, first being
21 on the side of the group being evaluated when they felt
22 measures were not really ready. and then later from more of

1 a public interest.

2 Secondly, I think we have to again link back to

3 our comment in last year's report on sustainability that one

4 of the only ways one can imagine getting a reasonable

5 progress on performance lift on the efficiency domain that

6 Bob's earlier comment related to, as well as quality, is to

7 think about better synchronization between Medicare and

8 private purchasers. I think the last time I looked there

9 were over 100 private payer physician P4P programs listed in

10 that compilation that RWJ, I think, has paid Leapfrog to do.

11 But we are not as far along as any of us would

12 like to be, but the situation is not as impossible as some

13 might portray it.

14 MR. HACKBARTH: Thank you, Cristina.

15 Our concluding session is on dialysis.

16 MS. RAY: Good morning.

17 There are more than 320,000 dialysis patients in

18 the United States. Most of these patients are covered by

19 Medicare. Thus, how Medicare pays for outpatient dialysis

20 services is quite relevant to their care.

21 My presentation on outpatient dialysis is composed

22 of two parts. First, I will provide you with information to

1 help support your assessment of the adequacy of Medicare's
2 payments for dialysis services.
3 Second, I will present a draft recommendation for
4 you to consider about updating the composite rate, that's
5 the payment rate for each dialysis treatment, for calendar
6 year 2008.
7 Here are the six payment adequacy factors that we
8 will be considering. These are the same factors that you've
9 seen for all of the other provider groups.
10 Moving to beneficiaries' access to care, it
11 appears to be generally good for most beneficiaries. There
12 was a net increase of about 79 facilities between 2004 and
13 2005. The number of dialysis stations is keeping pace with
14 the growth of the patient population.
15 There seems to be little change in the mix of
16 patients providers treat. For example, the demographic and
17 clinical characteristics of patients treated by freestanding
18 facilities did not change between 2004 and 2005.
19 With respect to facilities that closed, some of
20 what we found is intuitive. Facilities that closed are more
21 likely to be smaller and less profitable than those that
22 remained in business. We also see that African-Americans

1 and dual eligibles are overrepresented in facilities that
2 closed.
3 In conclusion, we will keep monitoring patient
4 characteristics for different provider groups but again,
5 based on all of the evidence, access appears to be generally
6 good.
7 Dialysis patients received care in about 4,500
8 dialysis facilities. Most providers are freestanding and
9 for-profit and, in particular, 60 percent of all facilities
10 are affiliated with two national publicly traded chains, and
11 I'll refer to these two chains as the large dialysis
12 organizations.
13 This slide shows that the large dialysis
14 organizations operate in most states. The red dots are the
15 LDOs and the yellow dots are all other facilities that
16 include hospital-based, freestanding associated with a
17 smaller chain, and then freestanding not associated with any
18 chain.
19 Moving on to volume of services, we have looked at
20 a number of pieces of information about the changes here.
21 First, we see that the growth in the number of dialysis
22 treatments has kept pace with the growth in the patient

1 population. However, spending patterns have changed.
2 Expenditures for composite rate services increased while
3 payments for drugs decreased between 2004 and 2005. Why did
4 this happen? Because of changes in the MMA.
5 Very briefly, the MMA changes increased the
6 payment for the composite rate, that's the payment for each
7 dialysis treatment, by about 8.7 percent through an add-on
8 payment, while it decreased the drug payment rate for
9 separately billable drugs. CMS paid dialysis providers the
10 Average Acquisition Payment in 2005, which lowered the drug
11 payment rate. CMS did update this add-on payment in 2006
12 and 2007 to account for the increase in drug expenditures as
13 mandated by the MMA.
14 This figure shows the change in spending patterns.
15 What you see here is the trade-off in payments for drugs and
16 composite rate services. The MMA moved some of the drugs'
17 profits to the composite rate through the add-on payment.
18 Overall, spending grew more slowly between 2004
19 2005, by about 4 percent. Previous year growth averaged
20 about 10 percent per year. Between 1996 and 2004, drug
21 payments grew 15 percent per year. Between 2004 and 2005
22 payments fell by 10 percent, drug payments fell by 10

1 percent.

2 So how did the volume of drugs change between 2004

3 and 2005? And how are patients' outcomes affected? First,

4 we looked at the aggregate volume of drugs and we held price

5 constant in 2004 and 2005. And here we see modest increases

6 in the aggregate use of erythropoietin, which accounts for

7 about 70 percent of dialysis drug spending, as well as all

8 other drugs.

9 We also for erythropoietin, because it is the

10 dominant drug here, we looked at the dose per treatment

11 between 2004 and 2005. And here we found that it stayed

12 about the same in 2004 and 2005.

13 In GAO's report that was just released this week,

14 they also show that it remained stable between 2004 and

15 2005, and they looked at the first six months of 2006 and

16 show a slight increase between 2005 and 2006.

17 We also looked at the quality of care using the

18 claims data. Providers are required to report patients'

19 adequacy of dialysis and their anemia status on the dialysis

20 and epo claims. Our analysis of the claims data suggest

21 that the proportion of patients receiving adequate dialysis

22 and with their anemia under control remained stable between

1 2004 and 2005.

2 Two stories to keep in mind when considering the

3 growth in dialysis drugs. First, clinical guidelines

4 recommended their use. At the same time, Medicare's payment

5 policy promoted their use. Medicare pays according to the

6 number of units given. And drugs are profitable, even after

7 the MMA's changes, which you will see later on.

8 Moving on to dialysis quality, it is improving for

9 some measures. The proportion of patients receiving

10 adequate dialysis and patients with their anemia under

11 control has improved. At the same time, there has been

12 concern about the rising erythropoietin dose per treatment.

13 It has increased between 1991 and 2004. And that

14 information is in your briefing paper.

15 Again this raises the concern about whether paying

16 for drugs on a per unit basis promotes efficient behavior

17 from providers. One policy option the Commission can think

18 about evaluating in the future is bundling drugs as an

19 interim step until CMS bundles both composite rate services

20 and dialysis drugs, labs, and other commonly provided

21 services. A dialysis drug bundle might be one step towards

22 addressing the potential incentive for overuse.

1 We also looked at the nutritional status of
2 patients and that measure shows little change over time.
3 One strategy that Medicare might consider is collecting
4 information about patients' nutritional status on
5 hemodialysis claims. This type of information could be used
6 in Medicare's quality improvement efforts. We don't collect
7 this information for all patients like we do patients'
8 anemia status and adequacy of dialysis.
9 CMS and researchers have shown how valuable this
10 information has been, the anemia status and dialysis
11 adequacy, to monitor care, to pay for care and to try to
12 improve care.
13 Moving on to access to capital, indicators suggest
14 it is adequate. There is an increase in the number of
15 facilities, providers have access to private capital to fund
16 acquisitions. The four largest chains merged into two
17 chains. That was financed in large part through private
18 capital. And that occurred in 2005 and 2006. Analysts are
19 positive about the large dialysis organizations and their
20 stock prices have generally increased over the last two
21 years.
22 So let's move to our analysis of Medicare's

1 payments and providers' costs. We looked at providers'
2 Medicare allowable costs for the most recent year that data
3 is available. For this analysis, I used 2004 and 2005.
4 Costs per treatment grew about 2.8 percent annually between
5 2000 and 2005. And you see that there is some variation
6 here. This annual cost growth approximates the 2.9 percent
7 annual growth in input prices estimated by CMS's market
8 basket for dialysis services.

9 Let's move to our audit correction. Our margin
10 analysis is based on the costs being Medicare allowable.
11 That is why we have considered and continue to consider how
12 CMS's audit efforts affect the level of costs. The BBA
13 mandated that CMS audit facilities' cost reports every three
14 years. The 2001 cost reports provide a sufficient sample of
15 audited cost reports to analyze. We find it reported costs
16 are about 5 percent than audited costs. Therefore, we
17 determine the Medicare margin by applying this audit
18 correction to the costs of composite rate services for
19 facilities whose cost reports have not yet been settled by
20 CMS.

21 Here is the Medicare margin for both composite
22 rate services and dialysis drugs. It has increased since

1 2003, which we predicted to be to 4 percent in 2007. I'd
2 like to remind you of a couple of points to consider as you
3 look at these margins. First, on average, drugs were still
4 profitable under the Average Acquisition Payment, that is
5 Medicare's payment policy for drugs in 2005.
6 Two, part of the drug profit moved to the
7 composite rate in 2005 through the add-on payment. So even
8 though aggregate drug spending fell, aggregate composite
9 rates spending increased.
10 Providers also received an update to the composite
11 rate in 2005 and 2006, and an update to the add-on payment
12 in 2006, and they will also receive one in 2007.
13 Finally, the drug costs per treatment decreased
14 between 2004 and 2005.
15 You can see here that the Medicare margin varies
16 by provider type. It was larger for the large dialysis
17 organizations than for everybody else. This difference
18 stems from differences in drug's profitability between these
19 provider types.
20 The second part of our update process is to
21 consider cost changes in the payment year we are making a
22 recommendation for, that is 2008. CMS's ESRD market basket

1 projects providers' costs will increase by 2.7 percent in
2 2008. As is the case with other provider groups, we
3 consider the Commission's policy goal to create incentives
4 for efficiency. So I would like to start your discussion
5 with last year's recommendation, that is to update the
6 composite rate by the ESRD market basket less half of
7 productivity growth. Again that productivity growth goal is
8 1.3 percent.
9 There is no provision law for a composite rate
10 update, so this would increase spending. And beneficiary
11 and provider implications is that no effect, we expect on
12 their ability to furnish care.
13 Before I turn it over to your discussion,
14 commissioners could consider raising some concerns about the
15 payment method for composite rate services. We already
16 raised the first two items in our June 2005 report when we
17 recommended that the Congress combine the composite rate and
18 the add-on payment and eliminate differences in paying for
19 composite rate services between hospital-based and
20 freestanding dialysis facilities.
21 Also, commissioners this year could raise concerns
22 about the MMA requirement that CMS update the add-on payment

1 based on the growth in drug expenditures. Updating based on
2 such an approach is not consistent with the Commission's
3 approach for developing payment policy.
4 I look forward to your questions.
5 MR. HACKBARTH: Nancy, could we just go back to
6 the slide with the margins on it? I just want to connect
7 that to the draft recommendation. As we've discussed, the
8 draft recommendations are simply a carryover of what we
9 recommended last year.
10 When we made this recommendation last year, we
11 talked about making it consistent with the hospital
12 recommendation, which was the same. We thought that that
13 made sense because last year when we were projecting the
14 dialysis margins, we were looking at either zero or slightly
15 negative projected margins, whereas now these numbers are
16 quite different.
17 I think it might be useful for you, Nancy, just to
18 explain why these numbers are different than what we were
19 looking at last year at this time.
20 MS. DePARLE: You're saying last year, but 2006
21 isn't up there.
22 MR. HACKBARTH: I'm talking about last year when

1 we were making our recommendation for 2007.

2 MS. DePARLE: But shouldn't we have a number?

3 DR. MILLER: What we were doing last year -- and

4 let me sure this is right. What Glenn is referring to is

5 last year we were projecting 2006.

6 MS. RAY: Right. Last year we were projecting --

7 this year, like the hospitals, we are working from 2005 cost

8 reports. We don't have -- neither do hospitals -- have 2006

9 cost reports.

10 But last year dialysis was projecting 2003 to 2006

11 because we did not have a sufficient sample of 2004.

12 This year you've seen now 2004, which shows the

13 increase from 2003, as well as the 2005.

14 DR. MILLER: I think there was another piece of

15 why we were thinking zero at that time. In addition to

16 working with 2003 data because we not gotten the 2004 at

17 that point, we were making more conservative assumptions

18 about what was going to happen with drugs. And two things

19 changed dramatically. Do you want to pick up the storyline

20 there?

21 MS. RAY: I think we were very conservative in

22 estimating drug's profitability last year, moving from 2003

1 to 2006, whereas what we have seen here is at least for the
2 large dialysis organizations separately billable drugs are
3 quite profitable in 2005.
4 DR. MILLER: And the add-on.
5 MS. RAY: And then in addition to that, the add-on
6 payment represents the excess profits that used to be paid
7 for drugs before the MMA took into effect. So now providers
8 are receiving this add-on payment. In addition to that, the
9 add-on payment was updated in 2006. So our projection
10 reflects that, as well as the update to the composite rate
11 in 2005 and 2006.
12 DR. MILLER: Which at the time we did the estimate
13 last year, we didn't know what they were going to update the
14 add-on by. And this I'm a little hazy on, that's basically
15 an administrative decision.
16 MS. RAY: Right. We knew what the add-on was
17 going to be. It was the update to the composite rate.
18 Because that's not in law. So that's just a slight
19 clarification.
20 DR. CROSSON: Just one question about the
21 difference between the allowable costs and the audited
22 costs. Is that a surprise? And is there any specific

1 finding that causes that? Or is it just sort of an
2 observation across multiple types of entities and multiple
3 types of costs?
4 MS. RAY: Actually, the difference in costs -- and
5 I can get back to you with more specific information. But
6 there tends to be a bigger gap between the general
7 administrative cost category versus the other categories of
8 labor, costs and the other direct costs.
9 This difference between audited costs and reported
10 costs we have, as you see, looked at it for 2001. Looking
11 back though, we previously analyzed 1996 cost reports and
12 also found a difference there between audited and reported
13 costs. And our predecessor commission, ProPAC, used earlier
14 cost report claims from I believe either the late '80s or
15 the early '90s and also found a difference between audited
16 and reported.
17 So there is some history in looking at the
18 difference. And again my analysis indicates that there
19 tends to be a bigger difference in the administrative and
20 general cost category.
21 MR. HACKBARTH: Nancy, for the benefit of the new
22 commissioners, you may want to just say a few more words and

1 explain why we have the audit adjustment here and not in
2 other provider groups.
3 MS. RAY: The BBA requires that CMS audit dialysis
4 provider cost reports once every three years. I'm not aware
5 that there is a similar statutory requirement for other
6 provider groups. I think what we said last year is if we
7 had this information for other provider groups we would
8 consider it as well in our updated analysis.
9 MS. BURKE: Nancy, at the bottom of slide three
10 you note that dual eligibles and African-Americans are
11 overrepresented in the facilities that closed, in particular
12 with respect to African-Americans, they tend to be higher
13 risk population in terms of the presence in the dialysis
14 population.
15 In the text of the report, you had noted that your
16 prior analysis had shown that patients treated by closed
17 facilities in 2001 were being treated in newly opened
18 facilities in 2002, that there were similar populations, the
19 presumption being even though they were in the area of
20 closed facilities that they were being taken up.
21 This issue is one that continues to concern me,
22 and I wonder, there is no discussion in the text about

1 whether this is, in fact, a growing problem or, in fact,
2 presents a particular set of circumstance. And that is
3 whether or not this population, that are particularly
4 vulnerable, likely to be low income, certainly predominately
5 African-American, if in fact there continues to be this
6 trend of the closing of facilities that service and
7 therefore in those areas, whether they in fact will get
8 adequate care.

9 They also tend to have higher rates of
10 noncompliance and dietary issues and a whole variety of
11 things.

12 DR. HOLTZ-EAKIN: Sheila, can I interrupt. do we
13 know if this is driven by Katrina in any way? I'm worried
14 about the 2005 drop.

15 MS. RAY: I did look at that. Actually, I looked
16 at the states that facilities closed. And it does not
17 appear to be driven by Katrina, no.

18 MS. BURKE: So my question is are we able to
19 determine or are we going to looking at going forth whether
20 or not this particularly vulnerable population is going to
21 be put at additional risk because there is this
22 disproportionate closure of facilities in these areas?

1 Again, we looked back in 2001, but circumstances are
2 radically different than they were in 2001. I don't think
3 we can assume that because they were served in places that
4 were closed that they're necessarily going to be picked up
5 by the additional beds in some of these other areas.
6 MS. RAY: Right. I think this is important area.
7 We will continue to monitor this. We will look at it again
8 next year.
9 I do want to note that the proportion of patients
10 treated in facilities that remained open in both years, 2004
11 and 2005, treated about 40 percent -- 40 percent of their
12 patients were African-American, which is the same share in
13 the general dialysis population.
14 But again, this is a point which we will note in
15 the text that we will continue to monitor this.
16 I also want to make the point, when we looked at
17 the share of African-Americans treated by provider type, by
18 the large dialysis organizations, by the freestanding
19 facilities, that did remain constant between 2004 and 2005.
20 And I think that's also another way to just keep monitoring
21 this same point.
22 MS. BURKE: It is. Query whether or not -- and

1 that was going to be my other question -- whether there was
2 a predominant population treated by hospital-based
3 facilities. It appears that that's not the case, that
4 they're fairly widely distributed, as are the other
5 populations.

6 But again, I don't want to presume that if, in
7 fact, you see a predominance of closures in a particular
8 geographic area, that they are naturally going to get just
9 picked up. Although you see distributional effects are
10 similar, I think we need to keep a close eye on it.

11 MS. BEHROOZI: I might have misread something and
12 I'm trying to find it now.

13 Had you said something in the paper about, in
14 terms of the proportionate share of African-Americans and
15 low-income patients, that they were more likely to be seen -
16 - maybe a steady level over the years, but more likely to be
17 seen in the freestanding facilities rather than the chains?

18 MS. RAY: There are more likely to be treated by
19 freestanding than hospital-based. That we do see.

20 DR. CASTELLANOS: To this point, the illegal
21 immigrant and the high, high risk patients are seen in the
22 hospital setting rather than the freestanding setting. If

1 you look at that, you'll see -- I happen to be involved in
2 dialysis. But we have a preponderance of illegal immigrants
3 where we live and we have high preponderance of high-risk
4 patients. And these patients are kept in the hospital
5 setting versus the freestanding setting.
6 A separate concept, and I would like perhaps Dr.
7 Milstein and Jay to comment on this. Dialysis is the only
8 part of Medicare right now under pay-for-performance. Not
9 the nephrology, but the dialysis. And we have two large
10 organized chains today. We have a lot of freestandings, but
11 predominantly two large chains that control the dialysis
12 market.
13 In my conversation with other nephrologists, one
14 of their concerns is that the dialysis units seem to focus
15 in on the quality issues that they get paid for rather than
16 some of the other indicators. And I think you very
17 carefully stated that today. You mentioned that the quality
18 issues of hemoglobin, which they look at very adequately,
19 and the adequacy of dialysis, which they look at carefully.
20 But you also mentioned maybe nutrition they don't.
21 This is the nephrologists telling me, and I think
22 this may be a little small snapshot of what pay-for-

1 performance will be in the Medicare group. I'm mentioning
2 this because this is what the nephrologists tell me. And
3 I'd like any comments from you concerning this, and perhaps
4 as a snapshot for us to look at pay-for-performance.
5 MR. HACKBARTH: When you answer that, Nancy, could
6 you just clarify for me whether there's payment connected to
7 these measures at this point or whether they're just
8 measuring?
9 MS. RAY: For providers paid under the fee-for-
10 service program, payment is not linked to performance yet.
11 The anemia information and the adequacy of dialysis
12 information is collected on dialysis claims and epo claims
13 but there is no P4P yet under the fee-for-service system.
14 There is a dialysis demonstration going on and for
15 those providers participating my understanding is there is
16 pay-for-performance there but not in the fee-for-service.
17 DR. CASTELLANOS: That's the group I'm looking at,
18 the ones in that demonstration project.
19 DR. MILSTEIN: There is evidence on the question
20 you've raised, which is the question of whether or not
21 within broad clinical performance category performance rises
22 across all facets of performance, not just those that are

1 being measured and rewarded. The best published research on
2 this is from the VA, which has had pay-for-performance
3 programs going for a while. And they've actually published
4 a paper in which they address this issue directly.
5 The bottom line is that which gets measured and
6 paid rises the most. That which is in clinical areas
7 related to that which is being measured and paid rises
8 significantly less. And then domains that are not being
9 measured at all rise the least or rise not at all.
10 There is a slight halo effect, as it were, within
11 a clinical area associated with P4P, but it's not as robust
12 as one might hope.
13 DR. CROSSON: I would just reiterate a little bit
14 about what Nick said later on, which is that some thought
15 needs to be given to prioritization, even within a laudable
16 area called pay-for-performance. Because, as Arnie just
17 said, you will get activity in things that you pay for, more
18 than activity in things that you don't pay for.
19 DR. REISCHAUER: But at the same time, we don't
20 have the counterfactual, which is what if you don't pay-for-
21 performance at all? What happens to these various measures?
22 Some increase in some places might be better than no

1 increase anywhere.

2 DR. MILSTEIN: I don't want to get too far into

3 this but there actually is a difference piece of research

4 that Judy Hibbard has published, which sheds some light on

5 the rate at which performance is getting better and getting

6 worse in the United States, absent any pay-for-performance.

7 The answer is it's going nowhere and we know what the

8 baseline levels are which are not anything anyone would like

9 to defend.

10 MR. HACKBARTH: Any other comments?

11 Thank you, Nancy.

12 We'll now have a brief public comment period. As

13 usual, I ask you to keep your comments no more than a couple

14 of minutes. And please begin by identifying yourself.

15 MR. CHIANCHIANO: Good morning. I'm Dolph

16 Chianchiano from the National Kidney Foundation and I'd like

17 to relate the first and third presentations.

18 There's been a lot of interest in the last month

19 or so about anemia therapy for dialysis patients but anemia

20 doesn't begin with the onset of dialysis in chronic kidney

21 disease. It starts in stage three of chronic kidney

22 disease.

1 There is evidence that dialysis patients have an
2 easier time in having their anemia managed if they have
3 received anemia therapy before the initiation of dialysis.
4 So my question to the Commission is whether you
5 might be interested in exploring the impact of the changes
6 in payment from the Medicare Modernization Act on the access
7 to anemia therapy before dialysis in the physicians'
8 offices?
9 Thank you.
10 MR. DeJESUS: Good morning. My name is Pavel
11 DeJesus and I'm with the Office of the Governor of Puerto
12 Rico here in Washington, D.C.
13 And I just want to come and register our concern
14 regarding the move to decrease the wage index floor. Our
15 dialysis providers in Puerto Rico are very concerned that
16 this is going to have a disproportionate effect on their
17 ability to render care.
18 This is particularly the case given the
19 difficulties that they have, our patients have in getting
20 access to care in Puerto Rico, and an apparent above average
21 need for care in Puerto Rico in this area.
22 So we would ask you to revisit the issue of a

1 suspension, and we would make you aware that we've provided
2 materials to staff members on this issue and that we are
3 available to work with you or answer additional questions.
4 Thank you.
5 MS. TROOP: Good morning. My name is Becky Troop
6 and I am an oncology nurse at a local hospital here. My
7 role is a patient educator and advocate for a local cancer
8 program.
9 I want to thank MedPAC for discussing the bundling
10 issue and applaud you for your positive proactive
11 recommendations to the CMS to address how bundling distorts
12 ASP.
13 I came here with prepared concerns about it but I
14 know that you have voted to address the issue, and for that
15 I am very grateful. So all I wanted to say, on behalf of
16 myself and my patients, is thank you.
17 MS. PECK: Barbara Peck with the American College
18 of Surgeons.
19 On the issue of access, I just wanted to point out
20 that we are really seeing a lot of access issues in the most
21 vulnerable areas. Most, like Dr. Borman said, in acute
22 services. I think the IOM studies that came out earlier

1 this year really point to that, that there is access
2 problems, and that the Medicare payment policies that you
3 set affect this because physicians are being driven back
4 into their offices because their reimbursements are being
5 cut and their office is really the only place where they can
6 generate revenue. So they're not taking call because they
7 can't take the risk of either not being paid for treating
8 patients or being paid less. And the office is the place
9 they have to go.
10 So I think the IOM study is a place you could look
11 for more statistics on that.
12 And then second, it sort of seems like the
13 Commission views the physician world as primary care and
14 everyone else. Really that group of everyone else is really
15 variant. And I think the issue of workforce is a good
16 example of that, where there's a lot of residency programs
17 in the everyone else that have very similar numbers to
18 primary care but they're not filling their residency
19 programs. Actually the number of physicians in their field
20 is dropping. And they're very similar to primary care and
21 it can't really be viewed as just one big group of people.
22 I think we would just urge the Commission to look

1 at things with a broader scope and not just two groups.

2 MS. McILRATH: Sharon McIlrath with the AMA. Just

3 two really quick questions.

4 One is I don't think you should necessarily be

5 surprised that things in Medicare and the private sector do

6 not look so very different. 75 percent of the private

7 carriers in the last survey that we did also use the

8 Medicare conversion factor and just tie to that. So to some

9 extent what is happening in Medicare is being replicated

10 everywhere else, as well.

11 The other comment is if you're going to really get

12 into productivity more and, in effect I think it sounds as

13 though the way you're going is perhaps a double productivity

14 adjustment for certain physicians or certain procedures,

15 then I think you need to be sure that the one that is

16 applied to the MEI is adequate.

17 There was a conference that CMS where they looked

18 at the possibility of a physician-specific productivity

19 adjustment. Also at that conference was a group that has

20 done one on just a health sector productivity factor. So

21 you might want to look at that.

22 One other point is that this is being applied to

1 what a physician office looked like in 1973, and there are a
2 lot of differences in the staff makeup and that sort of
3 thing in an office today than in 1973.
4 MR. HACKBARTH: Thank you. We're adjourned.
5 [Whereupon, at 11:13 a.m., the meeting was
6 adjourned.]
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