MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

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

AGENDA PAGE

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

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

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

MR. HACKBARTH: He is raring to go.

DR. STENSLAND: Out of the gates.

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

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

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

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

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

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

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

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

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

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

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

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

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

Did I hit all of the major things?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Rural hospital margins were -4.9 percent in 2009,

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

Jeff will now discuss our margin projections.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Julian will now take us through some of the

documentation and coding issues that Craig touched on earlier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The first principle is that the transition to MS

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

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

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

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

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

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

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

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

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

law" column.

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

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

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

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

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

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

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

So now let's just to recap the recommendation

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

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

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

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

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

Now I'll open it up for questions.

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

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

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

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

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

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

hospitals?

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

DR. DEAN: That's what I figured.

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

DR. DEAN: $8 billion, okay.

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

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

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

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

DR. STENSLAND: I wouldn't speculate.

DR. DEAN: You just don't know.

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

DR. DEAN: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. STENSLAND: Right.

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

DR. STENSLAND: Right, that's --

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

DR. STENSLAND: That's correct.

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

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

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

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

DR. CHERNEW: Less.

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

DR. CHERNEW: Right.

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

DR. CHERNEW: Right.

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

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

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

MR. HACKBARTH: Right [off microphone].

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

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

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

MR. HACKBARTH: Yes [off microphone].

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

MR. HACKBARTH: Right.

DR. MARK MILLER: That's right.

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

DR. MARK MILLER: In the words --

MS. UCCELLO: And it's not.

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

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

Any damage by that statement?

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

MS. UCCELLO: Okay. Thank you for that.

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

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

MS. UCCELLO: Okay.

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

MR. PETTENGILL: Yes.

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

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

MR. HACKBARTH: In the next rule, right.

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

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

MR. HACKBARTH: Right. Clarifying questions?

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

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

margins still? Do you have that information?

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

MR. GEORGE MILLER: Okay.

DR. STENSLAND: You know, 80, 90.

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

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

MR. GEORGE MILLER: Right.

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

hospitals.

MR. GEORGE MILLER: Right.

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

MR. GEORGE MILLER: Right, right.

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

MR. GEORGE MILLER: Right.

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

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

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

[Laughter.]

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

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

MR. PETTENGILL: That's exactly right.

DR. BERENSON: Okay.

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

DR. STENSLAND: Historically, we did look at ASCs

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

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

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

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

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

MR. KUHN: Okay.

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

MR. PETTENGILL: Yes.

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

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

DR. KANE: Yeah.

MR. PETTENGILL: And if CMS leaves the -2.9

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

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

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

DR. KANE: Yes.

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

are to down to where they should be going forward.

MR. PETTENGILL: Right.

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

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

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

DR. MARK MILLER: Also, just --

DR. BAICKER: [off microphone].

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

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

DR. STENSLAND: Right.

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

happen at that point. Correct?

DR. STENSLAND: Right.

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

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

MR. PETTENGILL: Mm-hmm.

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

MR. HACKBARTH: [off microphone].

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

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

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

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

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

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

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

DR. KANE: Yeah.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. STENSLAND: Correct.

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

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

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

DR. STENSLAND: Yeah.

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

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

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

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

Ron?

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

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

DR. CASTELLANOS: Right.

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

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

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

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

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

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

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

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

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

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

DR. STENSLAND: Certainly when they talk about the

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

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

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

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

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

DR. STENSLAND: The margins?

MR. HACKBARTH: Yes.

DR. STENSLAND: Yes, there.

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

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

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

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

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

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

correct?

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

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

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

MR. ARMSTRONG: The payment itself.

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

MR. ARMSTRONG: There is.

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

MR. ARMSTRONG: Okay, great. Thank you.

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

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

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

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

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

are.

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

MR. HACKBARTH: Yes.

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

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

expert in those things.

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

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

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

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

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

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

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

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

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

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

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

to productivity or not?

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

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

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

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

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

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

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

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

that might be more common across the board.

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

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

MR. HACKBARTH: Yes. Tom?

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

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

the, not the recommendations, but the overall structure.

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

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

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

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

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

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

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

DR. DEAN: [Off microphone.]

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

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

MR. HACKBARTH: Tom --

DR. DEAN: [Off microphone.]

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

MR. HACKBARTH: [Off microphone.]

DR. DEAN: Yes --

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

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

DR. DEAN: Yes.

MR. HACKBARTH: Mary?

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

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

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

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

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

issues. Thanks.

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GEORGE MILLER: Right.

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

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

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

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

[Dr. Stensland nods.]

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

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

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

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

MR. GEORGE MILLER: Okay.

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: And that's --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. PETTENGILL: Say that again?

DR. MARK MILLER: The same set of claims.

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

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

[Laughter.]

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

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

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

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Okay. Thank you.

We'll now have our brief public comment.

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

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

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

CMS states in its analysis that it doesn't

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

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

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

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

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

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

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

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

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

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

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

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

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

AFTERNOON SESSION [1:12 p.m.]

MR. HACKBARTH: Okay, it's time for us to start up. Before I turn it over to our presenters, since I think we've got a lot of new people in the audience this afternoon, different people than we had this morning, let me just make a few comments for their benefit about what we're up to.

Today and tomorrow, the Commission is discussing draft recommendations that I am offering for updates for the respective provider groups that serve Medicare patients. Today and tomorrow are devoted to discussing those drafts. Final votes will occur in January, and the recommendations that we actually vote on in January could obviously be different than the ones we discuss today, based on the conversation that occurs.

Since we last did updates, update recommendations for the Congress, obviously there has been a major legislative change, PPACA, which among other things changes the budget baseline for the Medicare payment systems and writes into law new baselines that differ substantially from what existed before.

All that is very important; however, our task as a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By specialty, we see disparities. Some are due to hours worked, and I will get to that in a minute. Otherwise, actual versus simulated Medicare compensation varies in a way that is consistent with what we know about differences between Medicare and private payer rates. But the bigger disparities are not so much within the specialty and whether it's actual versus simulated Medicare compensation. The biggest disparities lie in how specialties compare to each other, and it appears that the highest compensation is going to those who furnish high-volume growth services.

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

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

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

Cristina will now present our draft update recommendation.

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

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

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

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

Regarding the implications of this recommendation,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. HAYES: That's right.

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

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

MR. HACKBARTH: Right.

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

MR. HACKBARTH: Exactly.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. ARMSTRONG: Yeah.

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

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

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

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

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

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

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

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

MR. ARMSTRONG: Okay.

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

MR. ARMSTRONG: Okay. Good. Thanks.

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

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

MS. BOCCUTI: Maybe you should be more clear about overstating.

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

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

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

MR. ARMSTRONG: Yeah, yeah.

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

MR. ARMSTRONG: Okay. Great. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ron.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. BOCCUTI: No. Oh, it is total. It is total.

Okay, so of the total. Okay. Good. That's what I thought. Both ways, I'm right.

[Laughter.]

DR. STUART: Well, you can do it both ways. That would solve the question.

DR. MARK MILLER: Take one off the transcript.

[Laughter.]

MS. BOCCUTI: We'll talk about that.

MR. HACKBARTH: I think this is a good point, and I stumbled across it a couple times too. We ought to be consistent across the chapters in how we're denominating.

DR. STUART: Right, and also with changes in the fee-for-service percentage of the population being served.

MR. HACKBARTH: Yeah.

DR. STUART: You know these numbers change because of that as well.

The questions are, first, on slide 20, and it's the top bullet point. I guess I'm having trouble looking at the number for hospital outpatient departments, the increase of a tenth of a percent per year, and reconciling that with what we heard this morning about rapid growth in outpatient

services.

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

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

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

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

MR. WINTER: Under current law, ASCs are scheduled

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

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

Nancy.

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

MR. WINTER: Correct.

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

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

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

DR. KANE: [Off microphone.] Yeah.

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

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

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

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

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

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

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

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

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

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

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

and that goes -

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

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

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

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

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

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

and there was a talk back and forth on that.

MR. HACKBARTH: All right.

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

I think the discussion of what productivity was relative –

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

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

DR. KANE: So I guess consistency being not

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

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

So, Herb, lead us on.

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

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

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

MR. KUHN: I saw the chapter.

MS. BOCCUTI: Okay.

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

MS. BOCCUTI: No.

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

MS. BOCCUTI: Right.

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

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

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

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

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

DR. BERENSON: Yeah.

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

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

might cause some behavior change.

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

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

DR. HAYES: [Off microphone.] Yes.

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

DR. HAYES: Paid claims.

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

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

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

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

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

DR. BERENSON: Go for it.

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

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

MR. HACKBARTH: George?

MR. GEORGE MILLER: I want to thank Kate for

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

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

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

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

For example, in dual eligibles, it could be that. Medicare beneficiaries are more likely to go to hospitals as a usual source of care, or to the emergency room. Therefore, when they get outpatient surgery, they go to the hospital instead of the ASC.

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

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

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

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

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

DR. CASTELLANOS: Can I answer that question?

MR. GEORGE MILLER: Sure

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

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

MR. HACKBARTH: It could be issues of location,

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

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

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

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

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

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

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

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

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

MR. HACKBARTH: Mike?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MS. BOCCUTI: 1.3.

DR. HAYES: 1.3.

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

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

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

MR. BUTLER: So it's 2.0 without -

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

MR. BUTLER: Right. Got you.

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

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

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

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

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

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

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

MR. HACKBARTH: Do you -- go ahead.

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

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

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

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

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

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

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

MR. HACKBARTH: Yes, good.

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

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

be higher than they otherwise would be if there was a cut. Does that –

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

MS. BOCCUTI: Right.

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

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

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

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

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

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

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

DR. CHERNEW: [Off microphone]

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

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

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

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

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

recommendation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. STUART: I support the recommendations.

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

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

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

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

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

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

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

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

DR. KANE: I'll go back.

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

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

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

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

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

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

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

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

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

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

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

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

MR. KUHN: I support the recommendations.

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

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

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

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

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

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

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

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

MR. GEORGE MILLER: Right.

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

MR. GEORGE MILLER: Right.

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

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

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

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

MR. HACKBARTH: Cori?

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

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

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

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

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

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

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

DR. MARK MILLER: 0.6.

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

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

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

DR. CHERNEW: Yeah.

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

DR. CHERNEW: Right. I agree with that.

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

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

DR. NAYLOR: Right.

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

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

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

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

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

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

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

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

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

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

And the other comment I would make, some of the data that you referred to in the report but wasn't in the charts in terms of the survey of beneficiaries is about people who have not accessed care. Not just who said, oh, I had no trouble getting an appointment or I had a little trouble getting an appointment, but I didn't go the doctor because I couldn't get an appointment or because I couldn't afford it.

I think that it's really important, even though it looks, apparently from the way you describe it, it looks like it's looked before in prior years. I think it's really important information to keep front and center as we're looking at racial disparities and economic disparities go hand and hand and are only going to grow as people are retiring with relatively less retirement -- or more people are retiring with relatively less retirement income.

Jeff Colgrin and other's study out of U-Penn that looked at low income beneficiaries with high deductible health plans in Massachusetts showed what a huge deal it is, economic barriers to care are for lower income people. And when you talk about the Deficit Reduction Commission or whomever, whichever one them, talking about unified deductibles and things like that, I mean, there are just too many issues that it implicates, I think, to leave it out. So I'd really suggest putting it into the paper. Thanks.

MR. HACKBARTH: Thank you. So based on this conversation, Bob, Mark, and I will talk for sure some more about how to handle ASCs, and then I'll be back in touch with you individually about that.

As my Round 2 comment, I just wanted to raise the issue of how we portray the Commission's view of the SGR situation; namely, the repeated, very short term extensions and their implications for Medicare beneficiaries and physicians. As I recall the chapter, and help me out, I remember there's a passage where that is mentioned, but my recollection is you have to read pretty far into the section to get to that point.

MS. BOCCUTI: It's in the executive summary. We

try to pull it out in the executive summary, but yes, it's down closer to the recommendation.

MR. HACKBARTH: Yeah, so what we're thinking is, if we can think about how to make that message as prominent and clear as possible. Based on our previous discussions of this, I think that we're in unanimous agreement that this one-month extension thing is a real problem and a growing problem for the program. Given that, I'd like that message to come through clearly and strongly. Okay. Thank you very much.

Moving onto the next area, which is outpatient dialysis services, and I was hoping that we would start to close the gap and get closer to being on schedule, but alas, we are falling further and further from the pack. So we've got a new chance to shine here with our next session and we will really be focused and disciplined in our comments. And if we do them when half the Commissioners have gone to the restroom, we will be really -- right.

Okay, Nancy, whenever you are ready.

MS. RAY: Good afternoon. Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2009, there were about 340,000 Medicare

fee-for-service dialysis beneficiaries, and total fee-for-service spending was about $9 billion.

My presentation today is composed of two parts. First, I'm going to briefly describe the new payment method for dialysis services that begins in 2011. Then we will proceed with our payment adequacy analysis. At the end of today's presentation, I will present the Chairman's draft recommendation about updating the payment rates for calendar year 2012.

So MIPPA mandated that CMS modernize the outpatient dialysis payment method. The statute implements a longstanding MedPAC recommendation to broaden the dialysis payment bundle. In 2011, the payment bundle will be expanded from the treatment itself to also include dialysis-related drugs and labs, laboratory services.

Your mailing materials include a table that compares key features of the new payment method with the current payment method. I'm going to summarize some of the key features of the new payment method, but I'm happy to answer any specific questions you might have.

The new payment method increases the number of patient-level adjustors and there are one set of adjustors

for adult and another set for pediatric patients.

The new payment method also includes a low-volume adjustment. This adjustment is expected to help rural facilities.

The new system makes outlier payments and the outlier payments are applicable to the portion of the broader bundle that was previously separately billable, that is, dialysis, drugs, and labs.

There is a four-year transition into the new payment method. As I said, the first year is 2011. The last year is 2014. By November 1 of this year, facilities had the option to opt into the new payment method completely.

Now, there are two budget neutrality factors under the new payment method I want to point out. First, MIPPA requires that estimated total payments for dialysis services be 98 percent of the estimated total amount if the new payment method had not been implemented in 2011.

Second, to ensure budget neutrality during the first year of the phase-in, again, because facilities are choosing whether or not to opt into completely the new method or to transition in over the four years, CMS has

finalized a 3.1 percent transitional budget neutrality adjustment, and this is applied to all payments, both for the facilities completely opting into the new payment method as well as those transitioning in, and I'm going to talk about this a little bit more in a few minutes.

MIPPA includes an annual update for the dialysis sector, and this is new for this sector.

And finally, the ESRD Quality Pay for Performance begins in 2012. This is Medicare's first P4P program and it is consistent with our 2004 recommendation. In 2012, it will use three clinical performance measures, one on dialysis adequacy and two on anemia, and facilities submit these clinical outcomes on their claims. There is a two percent withhold for this P4P program.

So your briefing papers included some potential issues about the new payment method. I want to highlight three in today's presentation.

First, there is limited facility-level information on Dialysis Compare. The Commission has previously stated the importance in monitoring the use of services and quality of care under the new payment method. The new payment method might create incentives for facilities to under-

furnish care, including therapies used to treat renal-related comorbidities. CMS's Dialysis Compare website could be expanded to include, for example, information that is readily available to CMS, including additional ESRD clinical outcomes, rates of ESRD hospitalizations, and NED visits. CMS through the ESRD networks already provides facilities how they fare in terms of these measures compared to other facilities in their region and nationally.

The second issue I want to discuss with you is this 3.1 percent transitional budget neutrality adjustment. Some stakeholders are concerned that this has been set too high. Remember I said that facilities could make a one-time election to opt into the new payment method. Assuming -- CMS assumed that the facilities' decision would be based on what resulted in the greatest revenues, which would not be budget neutral, and that is why CMS is making this transitional budget neutrality adjustment. In CMS's projection, they projected that 43 percent of facilities would opt into the new payment method. However, based on the survey conducted by an industry stakeholder group, it may be that 90 percent of all facilities have opted into the new payment method, suggesting that CMS may have taken out

more than was needed. CMS has yet to formally announce how many facilities have opted into the new payment method.

The last issue I want to talk about concerns the price proxy used in the market basket index for updating the payment rate. The OIG raised concerns about using the PPI as a proxy for the growth in dialysis drug prices. The OIG contends that this will result in updating the payment rate more than it should be, increasing the gap between payment and cost and affecting price accuracy. CMS disagreed with the OIG recommendation for using a different index, stating that the PPI is best as the new payment method moves forward. At issue here is whether the PPI will accurately capture price changes for injectable dialysis drugs that were previously separately paid for under Part B using ASP and drugs that were previously paid for under Part D.

So now I'd like to shift gears and I'd like to move to our payment adequacy analysis. Similar to previous years, there's been a net increase in the number of facilities, and over time, the number of freestanding and for-profit facilities has increased. Of the 5,400 dialysis facilities, about 90 percent are freestanding and about 80 percent are for profit, and about 60 percent are affiliated

with two large national chains.

Here, you can see that both the number of rural and urban facilities continues to grow. Urban facilities have been growing by about 3.7 percent per year since 2005 and rural facilities at about 3.2 percent per year.

We look at several measures to examine access for beneficiaries. One measure we look at is the capacity of facilities by assessing whether the growth in the machines where people are dialyzed tracks dialysis beneficiary growth. For the past five years, dialysis treatment stations have increased by about four percent per year, while all dialysis patients -- and I want to be specific here, that means both Medicare and non-Medicare -- have increased by about four percent per year.

There are few facility closures. Between 2008 and 2009, there was a net increase of more than 250 facilities. The facilities that closed, which were about 60, are smaller and less profitable. Our preliminary findings suggest a greater representation of African-Americans in these closed facilities. We estimate that this affects about one percent of African-American beneficiaries.

That being said, we did look at all facilities,

those that remained in business as well as new facilities, and we see that there is little change in the mix of beneficiaries in terms of their age, sex, and race by type of provider, that is, freestanding versus hospital-based, et cetera.

This year, we looked at whether or not there were any changes in the driving distances in miles for beneficiaries and we looked at it in 2004, 2006, 2008. Longer distances -- researchers have shown that longer distances can affect beneficiaries' adherence with their treatment. And this is also another measure to look at the effect of facility closures. So between 2004 and 2008, we see very little change in the distance that beneficiaries -- between beneficiaries' residence and the dialysis facility overall and across the demographic groups.

We look at changes in the growth of volume of services, and one item we track each year is the growth in the number of dialysis treatments provided to fee-for-service beneficiaries. And as you can see from this chart, these measures closely track between 2004 and 2009. There's about a two percent increase per year change in both of these measures, and that's what you would want to see.

We also look at changes in the volume of dialysis drugs furnished, and recall under the current method, providers receive separate payment for dialysis drugs. First, we look at erythropoietin stimulating agents. ESAs manage patients' anemia, which is a common renal comorbidity. ESAs account for about 70 percent of dialysis drug spending. So between 2005 and 2008, there was a decline in per capita use. This decline was driven by new research that showed cardiovascular risks. However, between 2008 and 2009, per capita use increased by about two percent -- there was about a two percent increase in ESA epo units per treatment.

We also look at changes in the volume of other leading dialysis drugs. Here, we don't look at the per capita use because of the difference in units between drugs, but we look at aggregate volume and we hold price constant, and here, we see a steady increase since 2004 of about six percent per year.

We look at a variety of measures to assess changes in dialysis quality. Quality is moving in the right direction for hemodialysis adequacy. This measures how well the dialysis procedure cleans the patients' blood. A high

proportion of patients are receiving adequate hemodialysis and that's good. Quality is moving in the right direction for anemia management. The proportion of patients with their anemia under control, that is, with their hemoglobin between ten to 12, the range recommended by the FDA, is increasing. And more patients are being dialyzed with an AV fistula, and that's the recommended type of vascular access, the site on the patient's body where blood is removed and returned during hemodialysis.

That being said, improvements are still needed in other parts of care, and this finding is similar to last year's assessment. Patients' nutritional status has shown little improvement over time. This is of concern because in dialysis patients, researchers have linked this measure to higher rates of hospitalization and mortality.

Overall rates of hospitalization are not declining. They have remained steady at about two admissions per year.

Overall and first year adjusted mortality rates have decreased during this time. Nonetheless, mortality is relatively high among dialysis patients, particularly compared to international comparisons, even after adjusting

for case-mix differences.

Finally, the proportion of all dialysis patients registered on the kidney transplant waiting list remains low. Rates of renal transplant between 2007 and 2008 dropped across all demographic groups.

Regarding access to capital, indicators suggest it is adequate. As mentioned earlier, an increasing proportion of facilities are for-profit and freestanding. And there is an increase in the number of facilities, a net increase in the number of facilities. Analysts remain positive about the two largest dialysis providers. Remember I told you that these facilities account for about 60 percent of all facilities. Our assessments suggest that providers, even the smaller chain providers, have access to private capital to fund acquisitions. Investor analysts appear not to be worried about the effect of the new PPS in 2011.

Here is the Medicare margin. This is for both composite rate services and dialysis drugs for 2009. The aggregate margin is 3.1 percent. As in previous years, it is higher for urban facilities than rural facilities and it is higher for facilities affiliated with the two largest chains versus those not affiliated with the two largest

chains.

We project the 2011 margin at 1.3 percent. This includes the MIPPA two percent reduction, the 3.1 transitional budget neutrality adjustment, and the 2.5 percent 2011 payment update. This projection also includes a conservative behavioral offset to account for efficiencies expected under the new payment method. There is an expectation by investor analysts that providers will become more efficient with respect to their use of drugs and labs. There is also research that suggests that improvements in efficiencies in drug use and lab use can be made. Currently, there are differences across types of providers in the use of drugs and labs. And other research has shown efficiencies if some providers adhered more closely to national clinical guidelines.

So we have arrived at the second part of the update process. The Chairman's draft recommendation reads as follows: The Congress should update the composite rate by 1.5 percent for calendar year 2012.

In terms of spending versus current law, this is nearly the same as current law. It's actually a slight drop from current law.

And I want to just explain that in terms of the beneficiary copayment effect, what we mean here is that any increase in the payment rate increases beneficiary copayment, but no more than current law.

That concludes my presentation and I'll try to answer your questions.

MR. HACKBARTH: Thanks, Nancy.

Could you put up Slide 10 for a second. So the second bullet, that the closures disproportionately affected selected beneficiary groups, I think that's the first -- is this the first time that we've had that finding?

MS. RAY: No. Actually, we had that finding several years ago. I'd have to go back and look up --

MR. HACKBARTH: Okay.

MS. RAY: Not in the past two or three years, but going back further than that, we've had this before.

MR. HACKBARTH: Okay. Mitra, Round 1 clarifying questions, Tom, Mary, Peter.

MR. BUTLER: A quick question. We get cost information for this. Is there any lesson learned for our previous discussion about the kind of costs that, you know, on ASCs where we may be looking for cost information? What

led to us to gather cost information in outpatient dialysis where we haven't, for example, in ASCs?

MS. RAY: Oh, well --

MR. BUTLER: Or is the amount that's requested something we can learn from so that we can --

MS. RAY: I mean, HCFA has --

MR. HACKBARTH: From the beginning, almost, of the --

MS. RAY: Yes.

MR. HACKBARTH: -- the ESRD program, to my recollection, they've collected it right from the outset.

MS. RAY: I mean, dialysis facilities -- I hope I'm not misspeaking here -- dialysis facilities, I mean, are an institutional provider, so like hospitals and SNFs, they submit cost report information. So going back through, I'd say at least 1981, 1982 --

MR. HACKBARTH: I can't remember.

MS. RAY: Yes --

MR. HACKBARTH: I've been doing this for a while. I can't remember -- back to 1981, and I can't remember a time that we didn't have cost information on dialysis.

MS. RAY: I mean, that's how the original

composite rate was set back for 80 --

MR. KUHN: And the big distinction, if you remember, from ASCs, there were eight different buckets that basically ASC pricing went into. So to a degree, there wasn't any need to collect that cost information because it was a very crude, antiquated payment system under the old ASC model, and that was another reason why they just didn't collect cost information there.

MR. HACKBARTH: Round 1 clarifying questions, Mike, Cori.

MS. UCCELLO: Just a quick question, and this may be in the paper but I can't remember. This issue of the, I think it was the change that had the better -- was it the better margins? And so is it because of cost, lower cost due to economies of scale or is something else going on?

MS. RAY: There is an economies of scale issue, for sure.

MR. HACKBARTH: A purchasing power advantage for the large chains, yes.

George?

MR. GEORGE MILLER: Thank you for this report. You said that CMS estimates about 50 percent of the dialysis

centers would choose to take a new system, but did I hear you say that actually, or the industry reports about 90 percent?

MS. RAY: CMS estimated 43 percent --

MR. GEORGE MILLER: Forty-three percent, okay.

MS. RAY: -- and industry estimates about 90 percent.

MR. GEORGE MILLER: Okay. So what does that mean? I mean -

MS. RAY: What that -- if that number holds out to be true, with -- well, it means a couple of things. It means, number one, that facilities feel like that they can operate under the new payment method.

MR. GEORGE MILLER: Yes, sooner.

MS. RAY: I mean, that's what it means.

MR. GEORGE MILLER: Right.

MS. RAY: With respect to the transitional budget neutrality factor, it could mean that it has been set too high.

MR. GEORGE MILLER: Okay. So do you have the magnitude of that number? What do we -- if it's set too high, how are we going to address that?

MS. RAY: I have not estimated -- because CMS has not released the number of facilities that have opted into the new payment method, I have not estimated what that number should be. I know that there was an industry report of what they thought it should be, and I think it was a little less than one percent, but that was from the industry.

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: I think the inference we can draw from the number of facilities choosing not to go through the transition but to skip over it --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- is that those facilities or chains -- I assume the chains may be a big part of that.

MS. RAY: The two large chains have opted into the new payment method.

MR. HACKBARTH: Yes. They see opportunities here under the new payment structure to significantly lower their costs.

MR. GEORGE MILLER: Their costs, yes. And a follow-up question. Under the bundling of the new payment system that would include all drugs, what happens if a new

drug comes online down the road and provides tremendous savings? Under the new payment method, how will that new drug be paid for or accounted for?

MS. RAY: That's a good question --

MR. GEORGE MILLER: Thank you.

[Laughter.]

MS. RAY: I want to go back and look at the specific MIPPA provision. The best I can recollect -- I will get back to you on that. I want to just go back and look at the specific MIPPA provision and whether -- I mean, I know it includes the Part B injectables, ESAs -

MR. GEORGE MILLER: Right.

MS. RAY: I just want to see the language, the other language with respect to that.

MR. GEORGE MILLER: Okay. I will save the rest for Round 2.

DR. BERENSON: Yes. Can you go to Slide 14, please. I just want to talk a little bit about the quality areas. It strikes me, not being a particular expert in this area but pretty knowledgeable anyway, that the first nutritional status, phosphorous and calcium management, proportion of patients registered on a kidney transplant

list, are quality metrics that are proximately related to whether a dialysis center really can have some impact on. When you're talking about mortality rates for a patient with diabetes, almost by definition, have four or five or six chronic conditions. It's really hard for me to understand sort of the causal relationship or what the control that a dialysis unit would have. I guess, is anybody thinking along my way or are they prioritizing into the areas? I mean, the reason I like urea clearance and anemia management as wonderful measures and where we should be starting pay-for-performance is that those are directly related to what the center has control over. So let me ask that question.

MS. RAY: Well, I think others do look at the infection-related hospitalizations, again, because that is related to the vascular access, and more use of AV fistulas should reduce infections and therefore reduce hospitalizations --

DR. BERENSON: So specific hospitalizations --

MS. RAY: Right, right --

DR. BERENSON: -- but not just overall hospitalization rates.

MS. RAY: And again, that would translate into the

mortality, as well. And I think, also, cardiovascular-related hospitalization rates. Again, some would view that -- that has been pulled out separately, for example, like in the U.S. Renal Data System books, looking at that over time.

MR. HACKBARTH: And that is something, I think, related. So put up the graph that has the adequacy of analysis, the bar graph. Adequacy of analysis -- adequacy of dialysis. So what was that number again, like 80-some percent?

MS. RAY: For what?

MR. HACKBARTH: For adequate dialysis.

MS. RAY: Oh, that's in the 90s.

MR. HACKBARTH: In the 90s.

MS. RAY: I'm sorry --

MR. HACKBARTH: So is that a function -- and maybe, Bob, you can answer this -- is that a function of the number of treatments per week or the duration of treatments or still other factors?

MS. RAY: I would, again, speaking as a non-clinician, I would probably say both the number of treatments as well as the duration.

MR. HACKBARTH: Under the payment system,

including the new payment system, it's a bundle per treatment --

MS. RAY: Yes.

MR. HACKBARTH: -- and so there's still an incentive from the facility's perspective to do more treatments. So it would be surprising, given that incentive, to see people not getting enough treatments, and I'm sort of curious as to why --

DR. BERENSON: I mean, I think Ron might be able to help here. My understanding is that urea clearance is measuring the success of an individual dialysis and it is not measuring the -- like a hemoglobin A1C is a measure of adequacy of diabetes control over a six-month period, a random blood sugar is just where that patient is at that moment. That urea clearance is really the adequacy of that particular dialysis. That's correct?

DR. CASTELLANOS: [Off microphone.] That's right.

DR. BERENSON: And so we actually don't have a good measure -- I think the literature is beginning to show that more frequent dialysis gets you better outcomes. We don't have an equivalent of a hemoglobin A1C, I believe, so that we can reward those who are doing more frequent

dialyses, but I'm a little out of my league at this point.

MR. HACKBARTH: Okay.

DR. CASTELLANOS: This is something I deal with or have dealt with in the past and it is a function of the duration of the dialysis and the frequency of the dialysis. It's also a function of the type of dialysis. Peritoneal has less adequacies compared to hemodialysis. But it is related to the duration of dialysis and the time and the frequency.

MR. HACKBARTH: Okay. Round 1 clarifying questions. Herb?

MR. KUHN: Just, Nancy, one question following up back on this issue of the migration to those that went into the PPS system in the first year versus those that went through the three-year transition. And I appreciate the explanation to George's question. It obviously says that there's plenty of adequacy here, and perhaps as you indicated, the budget neutrality adjustment might be off as a result of that.

So my question is this. As new PPS systems come online, there's always a look-back to go back and refine them, because obviously you can't project all the marks out

there. And generally, most PPS systems go through a three- or four-year transition and then perhaps a couple of years running them and then it's six years out before the refinements come in place.

But this one, with so many of the providers getting in on the first year, what would be the first year we might have data that we could begin to do the look-backs and start to see -- time the refinements? Obviously, I think that would be a much truncated process since so many jumped in the first year. But would it be three years from now when we would have data that we could look at the adequacy of this? Is it something sooner? Is it something later?

MS. RAY: I think we won't have data until 2012 for the 2011 payment system, and -- yes.

MR. KUHN: Okay. So it'd be 2012?

MS. RAY: Yes.

MR. KUHN: Okay. Thank you.

MR. HACKBARTH: This would hardly be the first time that Medicare changed the payment system and evoked a more dramatic response than was anticipated. That was true with the hospital PPS. The changes in patterns of care were

quicker and stronger than people anticipated. True in home health and some others, as well. So the good news here is changing the payment methods to encourage efficiency, it works, and obviously we have to take care to make sure we properly measure and reward quality, but this stuff works.

DR. KANE: Yes. In the interest of trying to think of measures besides just the clearance for the day of quality, weren't there some kind of before they hit the Medicare level, Medicare eligibility, there's a window of time and how well they're taken care of has an impact on how well their subsequent Medicare period is? I remember this discussion a while back, that there's a period before they go on dialysis, or before they go on Medicare that they're ill and how that gets managed has a big effect on how sick they are when they finally show up for Medicare and whether there's some way to link that to these centers. And I don't know if the centers are the place to look or it's the doctors who are managing them.

DR. CASTELLANOS: [Off microphone.] You have to look at the hospitals.

DR. KANE: The hospitals that are managing them before they go on dialysis? Just remind me, how long does

it -- once a person has end-stage disease, what's the progression between there and when they get on Medicare and start getting treatment?

MS. RAY: A person who is under 65 with end-stage renal -- whose doctor certifies that the patient has end-stage renal disease, there's a three-month waiting period and then Medicare -- as long as that individual meets the Social Security, you know, whatever requirements, there's a three-month waiting period unless the patient chooses to undergo self-dialysis training or if the patient is transplanted.

DR. KANE: I just seem to remember that we had some concern about what was going on before they ended up in the Medicare program and what happened made a big difference in how well their subsequent Medicare experience was.

MR. HACKBARTH: If they're covered by employer-sponsored insurance, then there's a longer period, what, 33 months --

DR. KANE: Thirty-three months. That's what I remember --

MR. HACKBARTH: -- where they're covered. Medicare is secondary --

MS. RAY: Yes.

MR. HACKBARTH: -- and the employer is primary.

MS. RAY: Yes.

DR. KANE: And I guess one question is, are the dialysis centers at all places of accountability for that or is it really much more the doctor-hospital? Is there a way to look at that pre-Medicare period when they are most -- they can be quite vulnerable to the condition that they end up in when they finally go onto Medicare.

MS. RAY: I think some of what you're talking about, the notion that pre-ESRD care, that if a person who's in the Stage IV approaching Stage V of chronic renal failure sees a nephrologist, a specialist, earlier on, that when the person -- if the person eventually ends up to ESRD, that the person won't crash, that there will be a smoother transition and there will be reduced hospital spending. So that's more -- for the under 65 who's not on disability, so not on Medicare, that would be whether they're on other commercial payer or Medicaid and having access -- gaining access earlier on to the appropriate specialty care.

MR. KUHN: And even a little further downstream from there, I know CMS is running some demonstrations now.

I think the high-cost beneficiary demonstration is looking at CKD or chronic kidney disease and ways to forestall or create the prevention of moving into full renal failure. So there is some better work going on there.

DR. KANE: Just in thinking about -- I don't know if you can link it to the quality of the dialysis itself or whether that center's coordination with the other providers is a part of what we want to encourage, but thinking about measures that might also go into this -- again, I'm back on my mode of value and integration and pushing people to look outside their immediate silos to improve the quality -- it might be useful to explore those types of quality measures going forward, and if we ever get to see P4P type things here, that that should be some of it.

DR. BORMAN: Just one question. In the materials and in your presentation, Nancy, you mentioned a falling listing on the transplant list, and as a proponent of someone, that that is something that we should look at. My question, however, would be does that reflect a growing shortage of organ donors relative to the number of people on dialysis, or is it that fewer ESRD participants were simply getting evaluated as a potential transplant recipient,

because we wouldn't want to say that it's a measure of quality that went down if what it's really reflecting is that there's fewer available organ donors.

MS. RAY: Right. That's a good point. And let me be clear that there was -- the percent of people on the wait list -- I mean, I think there was just a -- I mean, it's pretty low, but there was a slight increase. The rate of kidney transplant, there was a decrease in the most recent two-year period. And my recollection is that there was a -- I know between 2006 and 2007, there was a drop in the live donor procedures, and I think that partly may be reflecting the 2007 to 2008 numbers.

DR. BORMAN: And also a drop in deceased donor --

MS. RAY: I need to go back and double-check that.

DR. BORMAN: Okay.

MS. RAY: There was also between 2007 and 2008 a decline in the rate of newly diagnosed ESRD folks due to diabetes, and that -- again, you don't know how that's playing into everything.

DR. BERENSON: I mean, I don't have -- I heard a presentation from a transplant surgeon at Hopkins who feels he's out there suggesting a lack of appropriate referral and

that it is a real problem, partly from financial incentives not to refer was his -- I mean, I'm not saying he is right, but there is at least some published literature suggesting that's a problem.

DR. BORMAN: And that was the reason that I originally brought it up in a discussion a couple of years ago about ESRD. I just want to make sure that if we're going to stake a statement that it's a quality metric, that we just be sure that we're reflecting those kinds of data as opposed to just mere shifts in the number of people on ESRD versus the number of available organs, because there is a chronic organ shortage, as everyone knows.

DR. DEAN: A couple of things. First of all, just a quick thing on the driving distance.

MR. HACKBARTH: Could I remind people to say what they think about the draft recommendation as we go through Round 2.

DR. DEAN: I'm comfortable with the draft recommendation.

On the driving distance, it would be helpful to me to have the range. A lot of things get hidden in an average, and it would be really helpful to know what

percentage of people have to go more than 20 miles or 50 miles or whatever, because I think that's significant. And you're right, there's a lot of data to say it does affect behavior quite significantly.

On the quality issues, as I read through this and also some of the stuff in Tab A about the problems and concerns, it seemed to me that it would really be beneficial to have a much broader-based quality measurement along with some of the things that were listed as hospitalizations, nutrition, I guess, because I think those really are direct things, and there are things that will get missed. I mean, the three that are up there are certainly all reasonable things, but, for instance, hospitalizations due to infections are something that really should be looked at.

And the other concern that I have is that the things that get attention are the things that get measured and the worry is that if you have too narrow a measure -- too narrow an index of quality, those are the things that are going to get attention and there's a real risk that other things may get pushed aside. So I would really urge that we support a broader-based measure of quality, and I think there are a number of things in the chapter that are

actually relatively easy to measure and it would seem to me to be fairly easy to construct a broader-based index, because, I mean, whether it's the albumen levels or numbers of hospitalizations, those are things that are easy to count.

DR. NAYLOR: I support the recommendation.

MR. BUTLER: I support the recommendation and would, for Glenn's benefit, to make sure that he feels like we're making progress, we've now opined on $224 billion of expenditures, which is 77 percent of the total. So we're actually three-quarters of the way done.

[Laughter.]

MR. BUTLER: It just doesn't feel like it.

[Laughter.]

DR. CHERNEW: If that were only our metric.

So I look at the physicians that got one percent update and the hospitals got one percent update and I'm very worried about access in all of those areas, and there's a lot of stuff in here that makes me think I'm not so worried about access. For-profit facilities are entering. There's maybe some efficiencies when we bundle the payment that we haven't figured out if they're exploited. The margins seem

sort of to be reasonable, at least -- now, the challenge is this is almost all Medicare in ways, I think, that some of the other ones aren't, so there's some tricks going in there.

But I guess I look forward to our call when we get to talk broadly about what this is, but I suppose --

[Laughter.]

DR. CHERNEW: I'm not not supportive of this recommendation, if everyone supported this recommendation. I think I could have probably seen a lower recommendation and been supportive of that, too.

MR. HACKBARTH: [Off microphone.] That's important. As a matter of fact, let me just give people who have already gone an opportunity to react, if they wish -- I'm sorry -- give people who have already gone an opportunity to react to what Mike says, if they want to.

MS. BEHROOZI: Yes. Actually, being first or last has its problems, and I felt like I didn't really hear enough about why 1.5, why that was the number. So I wasn't quite ready to say, sure, that's great, but I don't know enough to be against it, either, and so -- yes, I guess I --

MR. HACKBARTH: Does anybody else want --

MS. BEHROOZI: -- why it's different than the others.

DR. NAYLOR: I just understood from the presentation and the report about all of these other changes that are going into place at the same time and assumed that this was -- maybe not a good assumption, but because of the two percent reduction by MIPPA, all of this going into play at the same time, that that was the basis. So I could be persuaded --

MR. HACKBARTH: Peter?

MR. BUTLER: I could be persuaded on one, but at the same time thought that this one did have some careful thought, ended up about where the law is now, and it kind of felt a little bit more sophisticated in terms of how it looked at it than maybe some of our others. So I'd still land on 1.5, but if everybody went with one, I could go with that way.

DR. CHERNEW: [Off microphone.] I'm not pushing -- I just want to be clear. I'm not pushing strongly one way or another --

MR. HACKBARTH: No --

DR. CHERNEW: -- these other areas that --

MR. HACKBARTH: This is exactly the process that we need to do, is not just think about the individuals, but also think across the silos and how they relate to one another. So a good comment, and -

MS. UCCELLO: Yes, I kind of share some of Mike's thoughts on this, and maybe I need to get over this, but when I look at these, I need to know -- understand a little more where these numbers come from, and looking over --

MR. HACKBARTH: Are you talking about the update number?

MS. UCCELLO: The 1.5, yes.

MR. HACKBARTH: Okay.

MS. UCCELLO: And you probably know this, Glenn, but looking at the past recommendations are one, but then the minus two that was in effect -- looking at the projected lower margin, you know, I can see how all of this came about, but, you know, I think there's a range that I could be made comfortable on.

MR. HACKBARTH: That's my sense of all the recommendations. There is not a point -- a right number for all of these. For all the years that I have been doing this, it always seemed to me that there was sort of a range

of reason that you could be within for any given recommendation. This isn't an arithmetic exercise. This is really about judgment and -- go ahead.

MS. UCCELLO: So take that for what it's worth --

MR. HACKBARTH: Okay.

MS. UCCELLO: -- but I think I also want to echo Tom's comment/concerns about some of these quality issues. I'm concerned about some of these, and to the extent that we can figure out more measures, I think that would be a good thing.

MR. GEORGE MILLER: Yes. I want to appreciate and thank Tom for raising the quality issue, because I think between Tom and the statement about why it should be 1.5, I think we should try in the recommendation is to maybe marry those two together, particularly, and Tom mentioned it, in Tab A, there was some angst about the quality in American dialysis centers around America. I'm not saying that's the end-all because the industry came back and pushed back very hard and said all the numbers are wrong, but quite frankly, I remember when the IOM report came out and the hospitals pushed back and said those numbers weren't correct, but from a quality standpoint, when that IOM report came out, the

number, rather you debated the number should be zero. There should be zero deaths in America at hospitals, and therefore, I think we had the opportunity here to raise the quality issue, as Tom talked about.

And in the chapter, we talked about appropriate dialysis being between 93 and 95 percent, and we thought that was good. Why shouldn't it be at 100 percent? And the same thing for hemodialysis and peritoneal dialysis. Why shouldn't that be the quality goal, to be at 100 percent?

So I'd like to make this a pay-for-performance issue around quality, particularly with the margins and the fact that the industry -- if the 90 percent number is correct, they migrated very, very quickly to the additional payment method and this is a good time to put in quality issues, at least in my view.

Because I am also then concerned -- the reason I want the quality issues there is, first, because I'm still concerned about the rate of -- the high percentage of Medicare, the high percentage of dual eligibles, and the high percentage of minorities in this group. I'm concerned about the percentage of, for example, African-Americans who are on the renal transplant list and the percentage who are

waiting for a kidney transplant. They're both low on the transplant list and yet they make up 32 percent of all patients in end-stage renal dialysis. I find that incredible. There may be good reasons. I haven't read them yet. But I think this is a good time to push the quality issue.

So from a policy standpoint, I'd like to see us try to improve the quality standards and then tie them to an improvement, and I, quite frankly, I just don't understand why, as a percentage, African-Americans do not get on the transplant list. I just don't understand that. I think we should set a standard of about a year. It takes time to work them up, but that should be a quality goal, to increase that number, as an example.

MR. HACKBARTH: So Nancy --

MR. GEORGE MILLER: That's a policy issue --

MR. HACKBARTH: -- it may be helpful -- it certainly would be helpful for me if you would just remind us of the link of the new payment system to quality measures. We're going to a new bundle. There is a quality -- a pay-for-performance element in it. Remind us of what the measures are in the pay-for-performance system and how

does that work. What are the goals? In order to do well in pay-for-performance, do you have to -- is it an aspirational goal, or is it beat the average, or how does that aspect of it work?

MS. RAY: Okay --

MR. HACKBARTH: Or hasn't that been decided yet?

MS. RAY: Okay. What's been decided is that -- okay. The P4P begins in 2012. That's been decided, and it is a two percent withhold. That's been decided. And it uses three measures.

MR. HACKBARTH: Right.

MS. RAY: It uses a dialysis -- well, I'm sorry. It uses a dialysis adequacy measure, and then it uses an anemia measure of how many are over 12 -- whose hemoglobin is over 12, which is too high, and then under ten, which is too low.

MR. HACKBARTH: Right. Then what's the third measure?

MS. RAY: I'm sorry, it's -- well, it's one measure on adequacy and two measures on anemia.

MR. HACKBARTH: Oh, okay.

MS. RAY: Okay?

MR. HACKBARTH: Yes.

MS. RAY: All right. All right.

MR. HACKBARTH: So on adequacy, part of the message I hear George sending is we shouldn't be too easily satisfied --

MR. GEORGE MILLER: Right.

MR. HACKBARTH: -- with numbers like 90 percent for adequacy.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: We ought to be really pushing for 100. So on the adequacy measure, how is that going to work? If you're at the national average, are you going to do well and get your P4P money for adequacy, or do you have to really excel?

MS. RAY: So that's the part that's still -- CMS has issued a proposed rule. The comments have been submitted. A final rule has not been issued on that yet.

MR. HACKBARTH: Okay.

MS. RAY: And I can come back with you -- come back to you in January with just a little bit more of the specifics, but it's measured against either the -- for each measure, it's measured against either the national average

or the facility performance for the first year of the program. And each of the three variables is -- you can get up to ten points. But what CMS has proposed is a higher weight for the anemia under ten than the other two measures.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: But nothing addressed the disparities.

MR. HACKBARTH: Not in the current set --

MS. RAY: Not for 2012, but for beyond, that's something we may want to opine on.

DR. BERENSON: First, on the issue that Mike raised, I'm somewhat sympathetic to the point he made. On the other hand, this is a provider who's pretty dependent on Medicare revenues. The margins, the projected margin is 1.3 percent, is that what we've got here, and so there's fewer safety valves here. So I'm sort of conflicted. I see your point, and at the same time it may well be that 1.5 is right because of these other factors.

Let me -- on the quality, I just would make the following point. I initially was surprised that only, I think, 25 percent of the weight in the pay-for-performance was based on the adequacy of dialysis, but it is over 90

percent, whereas the other two measures are down around 60. So I think it sort of makes some sense to emphasize areas where there's more potential gain to be made, so I'm not going to micromanage that decision.

With Tom, I would be for more measures. My point earlier, though, is that I would have them be related to what dialysis units do, not to sort of be sort of a global measurement of hospitalization or of mortality, but specifically those related. Now, if we want dialysis units to be medical homes, which in some ways they -- if they had the right personnel, some nurse practitioners, a couple of internists floating around, they could -- and they see a patient three times a week -- they could well become medical homes, in which case we would want to have a different accountability framework. But right now, that's not how it works.

Most -- virtually all, I would say, dialysis patients -- well, I'll just -- from my own experience, I had a lot of patients in dialysis, but I was the doctor who was managing their diabetes and their hypertension and their congestive heart failure and it would be hard, I think, to attribute to the dialysis center what was going on with all

the other care. If we have ACOs, then the ACO would be responsible to coordinate all of that. So I think we may need a fuller discussion of it. I'm generally in favor of expanding the measurement set, but I know Tom wants to respond.

DR. DEAN: It's sort of like the same situation as holding a hospital responsible for readmissions in that the administrators argue, it's outside of our control. I guess my argument would be that, first of all, some of this is under the dialysis center's control, the infections and those kind of things, maybe not total control, but they do have an influence on it.

And I think -- I mean, it's an excellent point that this would be a great place for the total care of the patient to be monitored and maybe we could push things in that direction. Maybe we could help with coordination. I don't know. But anyway, I would still argue for a broader index.

MR. HACKBARTH: On the first issue of the magnitude of the update and Bob's pointing to the projected 1.3 percent margin, Nancy, my understanding -- when you say that's based on conservative behavioral assumptions,

conservative in this context means that we may have underestimated how quickly dialysis organizations will respond to the new incentives, so we've been pretty cautious in saying how much they'll change their cost structure?

MS. RAY: Yes.

MR. HACKBARTH: And on the other hand, we have the evidence that they seem to be leaping at this opportunity, which may suggest that 1.3 is on the -- could be on the low side at the end of the day. Is that a fair -- Nancy?

MS. RAY: Yes.

MR. HACKBARTH: Okay. Round 2 comments on the recommendation --

MR. KUHN: Yes. Just on the recommendation, I think the range we're talking about of one to 1.5 is a good place for us to be discussing this and I'm fine with that.

One thing, Nancy, on the quality measures, I'm just curious. Has there been any discussion about a set of CAPS measures for dialysis?

MS. RAY: That's still under development, for many years.

MR. HACKBARTH: [Off microphone.] So yes.

MS. RAY: But it's -- yes. It definitely has not

moved as quickly as one might like.

DR. KANE: Well, I'm with Mike. I kind of think, given that they're bundling and they see opportunities to create cost savings here, I think I would be more conservative with my update, relatively more conservative. I'm not sure quite where it falls, but I don't know why they would get a better update than a hospital.

DR. STUART: If I recall, though, that the hospitals are paying back some of the overpayment. So I think we have to put it in that context.

I'm generally comfortable with the recommendation, and if there's further information that comes up before the next meeting, then obviously I'll take that into consideration.

I do have a question, though, about the incidence of the disease itself. If you could look at Slide 11, I mean, that looks really steep, but then partly because there's no zero. But if you look at the rate of increase between 2004 and 2009 in terms of the number of people who are on this benefit -- remember, this is just fee-for-service -- the increase is about ten percent over that five-year period. But it's also worth noting that this is a time

when there was a dramatic reduction in the total number of fee-for-service beneficiaries because of the increase in MA enrollment. And so it would look as though the -- if you take that into consideration, it could be a much higher rate of incidence if individuals that have this disease stay in fee-for-service.

And so my question is, is there any evidence, or do we know the proportion of MA enrollees who are ESRD, because I think we need that information to understand what that rate of increase really is.

MS. RAY: So first of all, to be clear, this is the total population, not just incident cases.

There has --

DR. KANE: [Off microphone.]

MS. RAY: Fee-for-service beneficiaries, total --

DR. KANE: [Off microphone.]

MS. RAY: This is the prevalent population. Okay. All right. And we have seen, according to CMS, an increase in the number of ESRD beneficiaries in MA plans in recent years.

DR. STUART: Equivalent to this?

MS. RAY: Uh -- I have to go back and calculate

the rate of growth. I don't have it for this complete time period. I believe I have it for 2005 to 2008, and I think it -- it's in the paper. It went from something like 22,000 to about 43,000. So that's ESRD patients. That can include both dialysis as well as transplant. CMS doesn't break it out just for dialysis versus transplant. There's other measures that suggest that some of that growth is dialysis, though. And I also -- okay. And that's it.

DR. STUART: I was going to say, I'd like to see a little bit more on this, because I used the term "incidence" and it well could be that it's because if there's more transplantation and the mortality rate is lower, more people are living longer, and so over time, you get that increase. So trying to understand the underlying nature of this disease within this population, I think, would help us to better understand what the implications of payment are.

DR. BAICKER: The general ballpark seems very reasonable to me, but I do -- I am somewhat persuaded by people's thoughts on being a little more conservative, especially in the absence of knowing about selection issues between the plans and what's the differential --

MR. HACKBARTH: Conservative being one -- lower or

higher?

DR. BAICKER: Lower.

MR. HACKBARTH: Lower.

DR. BAICKER: Lower always seems more conservative, doesn't it? Especially not being sure about -

MR. HACKBARTH: [Off microphone.]

DR. BAICKER: That's true.

[Laughter.]

DR. BAICKER: More information on the relative illness and the attractiveness of enrolling diabetic enrolles in Medicare Advantage relative to fee-for-service might be helpful in gauging the magnitude of this update relative to the update for other types of services.

DR. CASTELLANOS: I'm going to take a little different approach as far as quality goes. You know, what we're paying for -- what Medicare is paying for is dialysis. They're not paying for management of that patient. They're only paying for management of that patient while he or she is in dialysis. And that's why you have somewhat limited quality measures, hemoglobin, hematocrit, and the effectiveness of appropriateness in the treatment and the dialysis.

Now, if you want to increase that bundle and you want to put nephrologists in there or put internists in there that are managing the diabetic patient, then I think we have something else to look at. But we are really paying just for the dialysis. We are not paying for -- we are paying for the management of that patient during dialysis.

So I would be a little hesitant before jumping into increasing quality issues. I don't know if -- this bundle just covers dialysis.

MR. GEORGE MILLER: How about infections?

MR. HACKBARTH: Dialysis special needs plans, any special needs plans that are focused on this population. That is sort of what you would want, is here is a challenging population with a lot of health issues and somebody taking the overall responsibility and looking for all the opportunities --

DR. CASTELLANOS: Absolutely, and that's where we should go. I don't want to throw the baby out with the bathwater because there's a lot of good things that we're beginning to see in one of the Medicare programs, and this is the first time we're seeing pay-for-performance as an issue. You don't want to throw that out of the water until

you really want to see how it goes.

And the other thing is this is the first time we have seen appropriateness criteria applied to anemia management with drug management. This is the first time they've used appropriateness, and this is -- we've talked about this before. I think that's where we have to go in Medicare.

MR. GEORGE MILLER: Yes, but Ron, I'm not a physician, but it is the dialysis that causes the anemia, and so shouldn't that be a quality measure and --

DR. CASTELLANOS: It's not the dialysis that causes anemia. It's the chronic renal failure.

MR. GEORGE MILLER: Well, right, but the dialysis is a function of that, and should --

DR. CASTELLANOS: No. The dialysis --

MR. GEORGE MILLER: Should not the physician who is managing that dialysis --

DR. CASTELLANOS: No, dialysis does not cause --

MR. GEORGE MILLER: Well, I shouldn't say cause --

DR. CASTELLANOS: It helps getting rid of the byproducts. What happens is the kidneys don't function --

MR. GEORGE MILLER: Function, right.

DR. CASTELLANOS: -- and that's why you have the anemia. The dialysis doesn't help the anemia at all.

MR. GEORGE MILLER: Okay. So that should not be the place where it should be. What you're saying is that should not be the place where it should be monitored.

DR. CASTELLANOS: No, I didn't say that.

MR. GEORGE MILLER: Okay.

DR. CASTELLANOS: I said, this can be one criteria that you measure during dialysis.

MR. GEORGE MILLER: Okay.

DR. CASTELLANOS: But if you're going to hold somebody responsible for total care, then you really have to go into a special needs program or do something with the total -- these people are train wrecks.

MR. HACKBARTH: Yes. So --

DR. CASTELLANOS: I mean, Bob, you've seen this. These people have -- comorbidities, 20 percent of them die in the first year.

MR. HACKBARTH: So for purposes of this chapter and this report, we can flag the issue of getting the right -- the importance of getting the right quality measures, but deciding exactly how to do that is well beyond the scope of

what we can do for this report. So we can come back to it, but we probably need to move on right now.

DR. CASTELLANOS: Can I make one more point?

MR. HACKBARTH: Sure.

DR. CASTELLANOS: And Peter, I was surprised that Peter hasn't picked this up. Five percent of these patients don't have any insurance at all and they're managed in the hospital and the hospital is getting dinged like anything on these patients, okay. So they're providing the total care, and I don't know if that's recognized on the hospital side, but we see very few hospital-based dialysis centers and the ones that you see in the hospital are the train wrecks or the acutes or people without insurance.

MR. HACKBARTH: Okay. Jennie?

MS. HANSEN: Yes. Sorry I had to step out for a few minutes, so I have just two clarifying questions, back to stage one. What is the average length of time that people are in dialysis? I know people are on a wait list for transplant, but what is the -- is there an average length of time that has been quoted for dialysis users?

MS. RAY: You mean before they get a kidney transplant?

MS. HANSEN: No, just in general, the average length of stay, so to speak.

MS. RAY: Umm -

MS. HANSEN: Ron just said, for example, oftentimes if you're very complicated, your survival rate is very short, a year. But on the average?

MS. RAY: There is survival -- there's one-year and five-year survival data and I will get back to you on that. I just don't have that right here with me.

MS. HANSEN: Sure. That's fine. And then the second clarifying question has to do with the draft recommendation in terms of increased beneficiary cost sharing. Whatever the increase is going to be, there's a correspondence. Is there any information on the fact that cost sharing affects this population more disproportionately, because it's one thing to miss a primary care visit because of the copay, but it's quite different to miss a dialysis treatment because of the copay. Is there any data on that?

MS. RAY: So you're -- so let me make sure I understand your question in terms of does the 20 percent affect patients' adherence to coming in for treatment three

times a week? Is that what you're getting at?

MS. HANSEN: I guess it's actually maybe even a broader question. Is cost of cost sharing an impediment of getting dialysis treatment for this population, because there are -- many people tend to be economically poor, or does Medicaid kick in because it's a dual eligible, in which case it's covered?

MS. RAY: I mean, a higher proportion of dialysis patients are dually eligible for Medicare and Medicaid than across -- than compared to all Medicare beneficiaries. That is the case.

MS. HANSEN: Okay. Could we have a chart next time just to kind of say what the proportionality is?

MS. RAY: Sure.

MS. HANSEN: Thank you. And then otherwise, the 1.5 to one percent, again, I will wait to hear a little bit more, but it seems within the range.

MR. ARMSTRONG: Yes. I would also just agree that that seems like the right range. You know, given how much experience we have with reporting on -- I mean, real information for this population on these services, the relatively sophisticated approach now we're taking to

bundling services, given that these programs, these organizations are highly dependent upon Medicare as a source of revenue, relative to some of the other sections and rates we have set, I could make the argument that I would go more toward 1.5 rather than one percent on this particular rate. But I think anywhere in that range seems fine with me.

DR. BORMAN: I'm generally comfortable with this range, although I was taken by Mike's points, I think are well taken ones. I do think this is a heavily Medicare-dependent area and so I think we do have to consider that.

Just a couple of things. I think that, as Bob has pointed out, the primary manager of the overall individual may vary. It may be someone separate from their nephrologist. In some cases, it is, in fact, a nephrologist who's serving in a dual role, the manager of the dialysis and providing that service, and then the nephrologist who may, in fact, be caring for many things about the patient because their diabetes may, in fact, be the primary thing behind their ESRD and so on and so forth. So I think that's a little bit hard to tease out. I think that if we needed to precisely clarify what's in the service on the physician side, I might suggest going back to the CPT descriptor and

what the professional association described as the services that were provided under that.

I would say that perhaps it would be fair to consider something like missed dialysis treatments as a quality measure because I think the dialysis center is a part of encouraging the individual to come on a regular basis, and perhaps that might be something in my own experience with patients I would say that they do periodically, opt out of treatment for a variety of reasons, and I think that that potentially could have some use as a measure.

I also think that there might be some opportunities relative to monitoring fistula flow rates and how soon intervention happens when abnormal flow rates are detected. So I think as the P4P evolves on this, there will be opportunity for additional dialysis-specific measures.

And then, finally, and it's certainly not necessarily a piece of the update, but since we talked about it in terms of the ASCs, we may want to explore a little bit over time whether there are any disclosure issues here. I understand that a goodly chunk of this market is related to publicly-traded companies, but I think a moderate chunk of

the remaining market may, in fact, have provider investment and whether or not we should in fairness, since we examine that for other areas, whether we should ask that question here, and it may be that it's a non-issue. But I would just throw that out as part of the future work.

MR. HACKBARTH: All right. Thank you, Nancy.

So I just looked down at the schedule and I see a session scheduled to end at 4:15 and we're about 4:15. The problem is that it's the next session that was supposed to end at 4:15. So we are just about an hour behind, so I'm going to exhort all of us to be really efficient and let's see if we can close the gap a little bit here.

Our next topic is hospice, and, Kim, whenever you're ready.

MS. NEUMAN: Good afternoon. We're now going to focus on Medicare hospice services.

Before we look at the data, some background on hospice. The Medicare hospice benefit provides beneficiaries with an alternative to intensive end-of-life care. The benefit includes a broad set of palliative and supportive services for terminally ill beneficiaries who choose to enroll. By enrolling, a patient agree to forgo

curative care for their terminal condition.

More than 1 million Medicare beneficiaries received hospice service in 2009, with total spending of $12 billion. About 42 percent of Medicare decedents in 2009 used hospice, with this use rate increasing substantially over the last decade. This growth in hospice use is a positive indicator of increased awareness of and access to hospice services.

The hospice benefit was implemented in 1983 on the presumption that it would be less costly to Medicare than conventional end-of-life care. Two major constraints were placed on the benefit:

First, to be eligible, a beneficiary must have a life expectancy of six months of less if the disease runs its normal course. Two physicians must initially certify this, and then at specified intervals a hospice physician must recertify this

Congress also placed an aggregate cap on the total payments an individual hospice can receive in a year. If the hospice cap amount [about $22,000 in 2008] multiplied by the number of beneficiaries enrolled by the hospice exceeds total payments to the hospice in that year, the hospice must

repay the excess to Medicare.

In the past few years, the Commission has spent a fair amount of time on hospice. To recap briefly where we've been, our prior analyses showed rapid growth in the number of hospice providers, mostly among for profits; the number of hospice users has increased; average length of stay has increased, driven by longer lengths of stay among patients with the longest stays. We noted concern about the growth in very long stays because it appeared in part to be driven by incentives in the hospice payment system that make very long hospice stays more profitable than shorter stays.

We also identified weaknesses in the accountability of the hospice benefit, including reports of some physicians certifying patients who may not meet the hospice eligibility criteria and questionable relationships between some nursing homes and hospices.

To address this, in March 2009 the Commission made recommendations to: reform the hospice payment system to make it better align with hospices' level of effort in providing care throughout an episode; to increase accountability within the benefit; and to collect more data for administration and oversight of the benefit.

The Patient Protection and Affordable Care Act includes provisions related to hospice, including some areas touched on by the Commission's recommendations. PPACA allows the HHS Secretary to reform the hospice payment system, as the Secretary determines appropriate, no earlier than fiscal year 2014. PPACA also requires that CMS begin collecting data to inform payment system reform by January 2011.

In addition, PPACA includes two hospice accountability measures, which are consistent with Commission recommendations. Effective January 2011, a hospice physician or nurse practitioner will be required to have a face-to-face visit with a hospice patient prior to the third benefit period recertification, which is usually 180 days, and each subsequent recertification. CMS is required to conduct medical review of hospice claims exceeding 180 days for hospices that have many patients with very long stays.

PPACA also includes additional hospice provisions in several areas, such as quality reporting, testing pay for performance, a concurrent care demonstration, and beginning in 2013 adjustments to the market basket updates. I will

discuss some of these provisions later in the presentation and would be happy to address others on question.

So now we'll take a look at the most recently available hospice data. The number of hospices has increased substantially in the last decade, growing 50 percent from 2000 to 2009. This reflects average annual growth of 4.6 percent over the decade and about 2.8 percent growth from 2008 to 2009. The increase in the number hospices has been driven largely by growth in for-profit, free-standing providers. Not shown in the chart, we have seen a modest increase in nonprofit free-standing providers.

Hospice use among Medicare decedents has grown substantially in recent years. The percent of decedents using hospice grew from 23 percent in 2000 to 40 percent in 2008 and 42 percent in 2009. While hospice use rates vary by demographic and beneficiary characteristics, hospice use rates grew substantially from 2000 to 2008 for all groups we examined: age, race, ethnicity, rural, urban, gender, fee-for-service, managed care, and dual eligibles. From 2008 to 2009, use continued to grow among all these groups except Native Americans, whose use in 2009 edged downward one-tenth of a percentage point.

Between 2000 and 2009, Medicare hospice spending quadrupled as the number of hospice users and average length of stay increased. In the most recent two years, between 2008 and 2009, Medicare spending increased 7 percent, the number of hospice users increased 3 percent, and average length of stay among decedents grew from 83 to 86 days.

The increase in average length of stay reflects largely increased lengths of stay for patients with the longest stays. There has been substantial growth in hospice length of stay at the 90th percentile, with an increase from 141 days in 2000 to 237 days in 2009. Growth in length of stay at the 90th percentile slowed somewhat in 2009 compared with the more rapid pace seen earlier in the decade. In contrast, the median length of stay has held steady at 17 days since 2000, and the 25th percentile is five days.

Both the growth in length of stay for very long stays and the persistence of very short stays are a concern. With short stays, there is a concern that beneficiaries may enter hospice too late to receive all the benefits hospice has to offer. With the increase in length of stay among patients with the longest stays, there is concern that financial incentives in the payment system may be driving

some hospices to admit patients before they are eligible for the benefit. In fact, there's a group of hospices -- those that exceed Medicare's aggregate payment cap -- that have very long stays across all diagnoses.

In 2008, the share of hospices exceeding the cap was roughly 10 percent. Between 2007 and 2008, the share of hospices hitting the cap increased slightly, while the total dollars exceeding the cap declined.

Looking at cap hospices, we see that they are almost all for-profit; they have long lengths of stay, even after taking into account patient diagnosis. For example, in 2008, about 47 percent of patients with chronic obstructive pulmonary disease, COPD, had stays exceeding 180 days in above-cap hospices compared to 24 percent in below-cap hospices. Hospices exceeding the cap also have a much higher rate of patients being discharged alive than below-cap hospices. In 2008, 44 percent of the discharges from above-cap hospices were live discharges, compared with 16 percent in below-cap hospices.

The longer lengths of stay and high discharge alive rates for above-cap hospices compared with other hospices may suggest that above-cap hospices are enrolling

beneficiaries before they're ready for the Medicare hospice benefit.

Currently, there are no publicly available quality data covering all hospices. PPACA requires CMS to publish quality measures by 2012, and beginning in 2014, hospices that fail to report quality data will have their payments reduced 2 percentage points. CMS recently completed testing 12 hospice quality measures in seven hospices in New York. The measures tested are generally obtained through abstraction from medical records. Some examples of measures include the percentage of patients with certain symptoms [such as pain, anxiety, or nausea] who received treatment or experienced symptom relief within a specified time period. It remains to be seen whether these or other quality measures will be selected for the public reporting.

Now taking a look at access to capital, hospice is less capital intensive than some other provider types. In terms of access to capital among free-standing hospices, publicly traded hospice chains are reporting strong financial performance and likely have solid access to capital; robust entry of for-profit, free-standing providers and modest growth in nonprofit free-standing providers also

suggests availability of capital. Hospital-based and home health-based providers have access to capital through their parent providers.

Now on to costs. This slide shows the costs per day by provider type. We see that costs per day vary by different provider characteristics. Free-standing hospices have lower costs per day than provider-based hospices. For-profits have lower costs than nonprofits. Above-cap hospices have lower costs than below-cap hospices. Ad rural hospices have lower costs than urban hospices.

Length of stay and indirect costs are two factors that contribute to the cost per day differences across provider types. Hospices with longer lengths of stay have lower costs per day. This is consistent with our work showing patients with longer stays receive fewer visits on average per week than patients with shorter stays. Free-standing hospices have longer lengths of stay than provider-based hospices and, consequently, lower costs per day. But, after taking into account differences in length of stay, free-standing hospices still have lower costs per day. This is because free-standing hospices have lower indirect costs than provider-based hospices, which suggests that the costs

for provider-based hospices may be inflated by the allocation of overhead from the parent provider.

The next slide shows our estimates of aggregate Medicare margins for hospices over time. From 2002 to 2008, the aggregate hospice Medicare margin has fluctuated between 4.5 and 6.5 percent. In 2008, the aggregate margin was 5.1 percent, down from 5.8 percent in 2007.

A couple points about how we estimate margins. Like last year, on the revenue side we exclude Medicare overpayments to cap hospices. On the cost side, consistent with our methodology in the other sectors, we exclude Medicare nonreimbursable costs. This means we exclude bereavement costs and volunteer costs.

The exclusion of bereavement and volunteer costs raises an issue. The statute requires that hospices offer bereavement services to the family members of a deceased Medicare beneficiary, but the statute also specifies that bereavement services are not reimbursable. The statute also requires that hospices use volunteers to provide a certain percentage of services. The costs of bereavement and volunteer services are not insignificant. If they were included in our margin calculations, the margins would be

1.8 percentage points lower. So in developing his draft recommendation for the hospice update, the Chairman has contemplated this issue.

The next slide shows hospice margins overall and by type of provider. Again, the aggregate margin is 5.1 percent. You'll notice this is a 2008 margin, whereas we have 2009 margins for other providers. This one-year lag occurs because we get information on hospice revenues from the Medicare claims data, and the claims data have time lags. For 97 percent of hospices, we do have claims data for the 2009 cost reporting year, and margins for these providers increased from 2008 to 2009 by 1.1 to 1.5 percentage points.

In terms of hospice margins by type of provider, in 2008 free-standing hospices had a margin of 8 percent compared with 2.7 percent for home health-based hospices and -12.2 percent for hospital-based hospices. Part of the reason for these margin differences is the higher indirect costs among provider-based hospices. If home health- and hospital-based hospices had indirect cost structures similar to free-standing hospices, we estimate it would increase their margins by 8 to 11 percentage points. And it would

increase the overall industry-wide Medicare margin by 2 percentage points.

In terms of margins by type of ownership, for-profit hospices had margins of 10 percent compared to 0.2 percent for nonprofit hospices. Focusing on free-standing nonprofits whose costs are not be affected by allocation of overhead from a parent provider, margins are higher -- 3.8 percent. Urban hospices have more favorable margins than rural hospices. And we also see that margins increase with average length of stay.

Looking at providers by average length of stay quintiles, margins increase for each successively higher average length of stay quintile, until the highest quintile where margins dip slightly. The dip in the highest quintile reflects the fact that some hospices in this group exceed the cap and must return overpayments. Above-cap hospices had margins of 19 percent before the return of overpayments and 1 percent after the return of overpayments. Below-cap hospices had margins of 5.5 percent, higher than the 5.1 percent industry-wide Medicare margin.

Finally, hospices with a high share of patients in nursing facilities and assisted living facilities have

higher margins than other hospices. Hospices in the top quartile in terms of percent of patients in nursing and assisted living facilities had a margin of about 13.7 percent compared to -3.3 percent for hospices in the bottom quartile.

The projected 2011 hospice margin is 4.2 percent. To make this projection, we start with the 2008 margin and take into account the following: full market basket updates to the payment rates for 2009 to 2011; cost growth generally in line with projected input price increases; small changes to the wage index values in 2010 and 2011; a reduction in the hospice wage index budget neutrality adjustment in 2010 and 2011, which reduces payments by about 1 percent; additional costs related to the face-to-face recertification visit requirement beginning in 2011.

With regard to 2012, there is one additional policy to note. Hospices payments will be reduced an additional 0.6 percentage points in 2012 due to the continued phase-out of the wage index budget neutrality adjustment.

So, in summary, the supply of providers continues to grow, driven by for-profit hospices; number of hospice

users has increased; length of stay has increased among patients with the longest stays; access to capital appears adequate; the 2008 margin is 5.1 percent; and the projected 2011 margin is 4.2 percent; these margin estimates do not include bereavement and volunteer costs, about 1.8 percentage points.

Taking into account all of these factors, the Chairman has developed the following draft recommendation: "The Congress should update the payment rates for hospice for 2012 by 1.5 percent."

The implications of the recommendation would be a decrease in spending relative to current law. We expect no adverse impact on beneficiaries' access to care or providers' willingness and ability to care for Medicare beneficiaries. As you know, this draft recommendation would affect aggregate payments, not the distribution of payments across providers.

The Commission has made a recommendation to revise the hospice payment system, which would affect the distribution of payments across providers. In March 2009, the Commission recommended that hospice per diem payments be relatively higher at the beginning and end of the hospice

episode and lower in the middle period to better align payments with hospices' level of effort throughout an episode. These reforms would have the effect of changing the distribution of payments across hospices, moving some revenues from hospices that are more profitable to hospices that are less profitable. We plan to re-run this recommendation in the March 2011 report since the Secretary has been given discretion on the structure of a revised payment system.

We also plan to re-run a recommendation in the March report for OIG studies of a number of issues, such as hospices/nursing home financial relationships and differences in patterns of nursing home referrals to hospices; enrollment practices of hospices with unusual utilization patterns, and hospice marketing practices. The OIG has work underway in several of these areas, particularly with regard to hospice and nursing facilities. Since many but not all aspects of the recommendation are under study, we plan to repeat the recommendation.

With that I conclude my presentation and look forward to your discussion and any questions.

MR. HACKBARTH: Thank you, Kim.

So round one clarifying questions, starting on my right-hand side.

MR. ARMSTRONG: You expressed concern about the cost of volunteers. I thought volunteers were free, so I just didn't understand what that would be.

MS. NEUMAN: There is the cost of recruitment of the volunteers and training of volunteers, things of that sort. So the volunteers themselves are free, but the costs associated with getting them and having them do things is not.

MR. ARMSTRONG: Okay. In that area, you implied that this cost had some influence over the final recommendation. Did it have very much influence? It was hard to tell from the comments that you made.

MR. HACKBARTH: Yeah, I would say it did have some influence. So why don't you put the relevant numbers up there.

MR. ARMSTRONG: Slide 17.

MR. HACKBARTH: Yeah.

MS. NEUMAN: This here?

MR. HACKBARTH: Actually, the numbers with the projected margins is the one I was thinking of.

MS. NEUMAN: So the 4.2?

MR. HACKBARTH: Yeah, so 4.2 percent and the combined bereavement and volunteer expenses were 1.8, as I recall, so these are things that they're required to do but by law aren't -- not by law, but are not counted as allowable costs. And so I'm saying since they're required to do them, it seems to me that they are real costs, and we may want to think about what the margin would be taking them into account, and so we would be down from 4.2 to 2.4.

MR. ARMSTRONG: Thank you. That answered my question.

MS. HANSEN: This is great. I just wanted to ask the second aspect of the unpaid-for service, which is the bereavement services. I was trying to recall the description. Have we had a description as to what that profile is of the activity around bereavement, what that service amounts to, the frequency? Or did I recall that it goes for an entire year?

MS. NEUMAN: I believe it's 13 months after the patient is deceased, and it's for the family members of the Medicare beneficiary. And I don't believe that we have data that gives us a sense of how many visits or what kinds of

services that the family members are receiving. But that's something that I can do some more looking at.

DR. CASTELLANOS: Good presentation. The concurrent demonstration project, is there any follow-up on that that you know of at this time?

MS. NEUMAN: My understanding is that that project is still in development. They have not yet released a timeline for implementation. It's supposed to be up to 15 sites where they're going to test what the effect is of allowing folks to elect hospice and continue curative care at the same time. And so it would be a three-year project in up to 15 sites.

DR. CASTELLANOS: Any follow-up on the fraud and abuse that was discussed, that issue?

MS. NEUMAN: As I stated at the beginning of the presentation, the Congress adopted the recommendation that the Commission made for the medical review of the long stay claims. So we'll see as the year goes forward how that goes. I don't have any additional updates for you right now on fraud and abuse.

DR. CASTELLANOS: Hospice excludes some of the Medicare nonreimbursed costs. Does any other provider have

that? In other words, they're excluding some of the nonreimbursable charges, you know, the volunteer costs --

MR. HACKBARTH: Yeah, there are for other providers costs that providers incur that are not counted as allowable costs. The one that always sticks in my mind is TVs and the hospital cost report and things like that. The difference here, I think -- and people can correct me on this -- is that hospitals are not required to provide TVs, and it's not allowed as a cost. Here hospices are required to provide the volunteers and bereavement services, and then we say it's not allowable. And it's that juxtaposition that makes me think, well, maybe we want to take that into account in our recommendation.

DR. CASTELLANOS: Okay. And the last is a rhetorical question. The base rate and the payment rates have really not been recalibrated for almost 37 years. I know we've made some recommendations. Can you give me a good explanation why that hasn't been done?

MS. NEUMAN: That's a difficult question to answer. We can refer back to our discussions last year when you made the recommendation to revise the hospice payments. There was some discussion back and forth about aggregate

payment levels, and a decision was made to recommend something budget neutral at that time. So to the extent -- and that's what the Congress, in fact, put into the law. If the Secretary does change the payment system in 2014 or thereafter, it will be budget neutral. And, you know, there is a question about aggregate payments that we go through every year. That's sort of kind of two separable things.

MR. HACKBARTH: Ron, part of what motivated our originally taking a look at the hospice payment system was that it was a system that was developed a long time ago and never really looked at or refined or improved. And as we began to look at it, we thought, hey, it is ripe after 30 years for some changes.

DR. CASTELLANOS: Thank you.

DR. STUART: I have a couple of questions on Slide 18. First is a math question, and maybe I'm missing something here, but when I add up the number or the percent of hospices that are for-profit and nonprofit, that's 52 percent, if I've got this right, and 35 percent. I end up with 87 percent. Do we have some sort-of-for-profits that are not allocated here?

[Laughter.]

MS. NEUMAN: There's government and other ownership structures that are missing.

DR. STUART: Okay. So they're not included in the not-for-profit.

MS. NEUMAN: Correct.

DR. STUART: Right, okay. And then remind me, in terms of these profit margins, why do we exclude the cap overpayments? I think what that means is that the real profit that a hospice earns after they pay it back is lower than what we have indicated here. Is that correct?

MS. NEUMAN: So if a hospice exceeds the cap, they have to repay the excess back to Medicare. So in our margins, that excess that they have to repay, we don't count that as revenues to them.

DR. STUART: Oh, okay. So it's a question about what exclude means here. So when you say that --

DR. BAICKER: [off microphone] It's net effect.

DR. STUART: -- it excludes the cap overpayments, it means that those are reduced -- those are taken into account in terms of the revenue side.

MS. NEUMAN: They're subtracted from the revenue side.

DR. STUART: They're subtracted.

MS. NEUMAN: Yes.

MR. HACKBARTH: [off microphone] -- cost side.

MS. NEUMAN: It doesn't affect the cost side.

MR. HACKBARTH: Because those aren't allowable --

MS. NEUMAN: If they've exceeded the cap, then the policy is that Medicare has paid too much for the care that they've provided, and so they repay some of that money to the government. It doesn't change the amount of costs they incurred to provide that care.

MR. HACKBARTH: Okay.

MR. KUHN: Kim, just a quick question. If I remember right, those institutions that exceeded the cap are kind of clustered in a set of six or seven states. Is that correct?

MS. NEUMAN: Yes, there's definitely a clustering of states, yes.

MR. KUHN: And how about the growth? Is that also a clustering, or are we seeing that nationwide?

MS. NEUMAN: No, it remains relatively clustered.

MR. KUHN: So if that's the case -- and when we measure access, adequacy and access to care, because of that

clustering in those states, do we feel pretty confident that we are seeing good access in those areas where we're not seeing as high growth as those in those cluster areas?

MS. NEUMAN: There is a chart in your mailing materials that shows the ten states with the highest use of hospice among decedents, so the highest percent of Medicare decedents using hospice. And when we look at the percent of hospices in those states exceeding the cap, we see the whole gamut, from a couple states that have high rates of hospices exceeding the cap to a number of states that have none or very low amounts of hospices exceeding the cap. So we don't think that the cap is what's sort of driving our hospice use rates. It's kind of unrelated.

MR. KUHN: I was just thinking more of the growth of new hospices and just making sure that if we are clustered, if those areas where we're not seeing such high growth, that we do have good access in those areas as well.

MS. NEUMAN: I think that we have seen -- there are a couple states where we have seen some declines in the number of hospices, and we can look at that issue again to sort of check that out. Something that's not in this year's mailing materials but we had last year that sort of speaks

to this issue of number of providers and access is that if you plot the number of providers per beneficiary or per thousand beneficiaries in the hospice use rates, it's a complete scatter. There is no relationship between the number of hospices per beneficiary and how many people enroll, because unlike something that has a fixed, like facility, hospice could be big or little. So the number doesn't necessarily reflect capacity to serve.

So I will definitely take a look and see if there are a few states where we could have concerns about the growth, but overall we haven't seen a relationship between numbers and access.

MR. HACKBARTH: My recollection is that Oregon is a high-use state but a low-growth state, for example.

MS. NEUMAN: Yes.

DR. BERENSON: I have read elsewhere that there have been legal challenges to the way CMS has administered the cap with something about them allocating into a single year's spending that occurs over two years and, therefore, artificially having a cap, and that courts have upheld the challenge. Could you sort of elucidate for us?

MS. NEUMAN: Sure. The crux of the issue is that

the way the statute is written, if a beneficiary switches providers, they need to be able to allocate the beneficiary's time in hospice, days in hospice across those providers. And the way CMS does the calculation is they count the beneficiary in the calculation in the first year they enroll. So CMS is not allocating exactly as the statute says. But if you took the statute to the extreme, it's really impossible to do it exactly as the statute says because you would literally have to wait until every person who was in the hospice passed away before you could know for sure what their total hospice use was over their lifetime and how to allocate appropriately across those years.

So what has happened is a number of hospices have challenged the way CMS is doing it, and a number of courts have found against CMS saying that they're not doing it as the statute has suggested. So in most of those cases, what has happened is it has been remanded back to CMS to do a recalculation, and in some cases, hospices have owed more, not less, and vice versa.

So this is still going on. There's still a fight going on about how this is being done, but it hasn't negated the cap in most cases. It has just -- it's an agency about

the amount, at least as the court has seen it. The court has not said that --

DR. BERENSON: So this doesn't have a prospect then of basically negating the cap such that there would be more money flowing to those high-cost hospices and higher net total margins that we should be considering in the near future? You don't think it's relevant to our discussion?

MS. NEUMAN: It's possible that our estimates of the amount of cap overpayments could be incorrect. We could have too high an estimate. Maybe they don't have to repay all of it. So it is an issue to consider.

If you look at the margins for below-cap hospices, we see about 5.5 percent in 2008. So if you were really worried about this, you could think about as one option focusing on those folks because that would take this issue off the table.

MR. GEORGE MILLER: I'm trying to get my hands around the growth in the for-profit and the length of stay versus not-for-profit. Am I correct in that most of the growth in hospice over the last several years has been in for-profits and that they have the longest length of stay? Which generates more profit for them because they're able to

spread their costs.

MS. NEUMAN: Right, so most of the growth in providers is for-profit, and length of stay is higher in for-profit than nonprofit, even within diagnoses.

MR. GEORGE MILLER: And then the cap overpayments have been mostly in for-profits.

MS. NEUMAN: Right. But, again, for-profit is 50-some percent of providers, and the folks who are hitting the cap is 10 percent, so just as a frame of reference.

MR. GEORGE MILLER: Right, right. Thank you.

MS. UCCELLO: I'm just thinking through some of the issues related to the short stays, because these are just as troubling. But it's not necessarily the facilities' or the hospices' fault that people are coming to them too late. But that said, I'm still interested in what -- and it's probably small just because by definition we're talking about smaller dollars because they're shorter stays. But if we took out these low 20 or 25 percent of stays from our margin calculation, how much would that kind of increase the margin?

MS. NEUMAN: Is what you're saying that if there was a different sort of distribution of length of stay among

people who are in hospice, what would the margins look like today?

MS. UCCELLO: In effect, yeah. If you just take out those low folks, or maybe bump them up. I don't know. But I'm just trying to get a feel for how much that's driving some of the margin versus not. Again, I think it's probably small just because -- in terms of dollars it's a disproportionately smaller share.

MR. HACKBARTH: So if you them out, that would drive up the average margin. But I'm not sure where you go with it.

MS. UCCELLO: Well, I'm just --

MR. HACKBARTH: What's the policy implication? I can understand the math that you're thinking about.

MS. UCCELLO: Yeah, well, and I think I'm just thinking through it because you don't want to penalize the -- but if you had a policy or if there were policies that could help get people in there sooner, then that itself is helping the margins of the hospice. I'm just thinking out loud, but, you know, just -- I'll just stop.

MR. HACKBARTH: Presumably hospices have an incentive to reach out and be available in the community and

get patients early, at an appropriate time when they can help.

MS. UCCELLO: So then it is as much as --

MR. HACKBARTH: It's not that there's not an incentive to do that. But apparently there are other barriers that stand in the way.

MS. NEUMAN: We had a expert panel about a year and a half ago, and we talked about this issue, about the short-stay patients, and sort of what kinds of things could be done to facilitate a more timely entry for those folks who were interested in hospice. And, you know, our expert panelists from the hospice industry cited a lot of issues that, you know, really are outside of the hospice payment system, things like, you know, social and cultural issues, the sort of school of thought in medical practice about trying to cure, you know, sort of very acute care-focused kinds of practices. And, you know, the other thing that people talk about is sort of the fact that you have to give up -- you know, you have to give up curative cure to elect hospice. So the demo that's going to happen will give us some sense of, you know, what the impact of a change like that might be.

MR. BUTLER: I'm trying to come to grips with whether I'm going to support 1.5 or 1.0. It's tipping my hand, but it's based on a little bit of a question here.

Go back to 18 now, and the nonprofit is sitting at -- the free-standing, for example, is 3.8. And I notice in the chapter the bereavement cost, for example, of nonprofits is 2 percent and for-profits is 1.1 percent, which makes me a little worried or concerned, you know, different levels of service. And I'm suspecting -- and this is a question -- that our recommendation to the Secretary to ask the Inspector General to look at the bad behaviors would be more likely to be skewed to the for-profit side than the nonprofit side. And I don't know that, but if that were the case, that would tend to pull that margin down, if they follow through on it. And if all that is true, then I would kind of think, well, the rest probably needs the full 1.5 percent, as I'm looking at this. But unless, you know -- so if the Inspector General really was successful, I have no idea about the potential size of the impact and where it may land in this profile.

MS. NEUMAN: It's really hard to predict. You know, for-profit providers have longer stays than

nonprofits, but we see long stays among both categories. There are providers in both categories that have very long stays that could be, you know, sort of looked at and, you know, it's hard to know what would happen of any kind of looking. But I can't really predict for you. It's pretty hard to predict what will come of that.

DR. MARK MILLER: I don't know why I'm compelled to say this, but the other thing that we are going to re-run is the change in the payment, the underlying payment system, and I need some help to remember here. That does redistribute from high profit to lower profit. It's sort of the other side of your coin, like if they were to do that, that would shift money in the other direction from high profit to low profit, from longer stay to shorter stay, from it turns out for-profit to not-for-profit. I think I said most of that right.

MR. HACKBARTH: Yeah, and if that were to happen, then you might say with that redistribution then you can have a lower update because now the hospices at the low end of the distribution would be paid more and lifted up, and it would be financed out of lower payments at the long end of the distribution. And you could say with that

redistribution, oh, we can live with a smaller increase in the pie, but so long as you have a severe maldistribution, then, you know, that may incline you to say that we need a little bigger number for the people at the low end.

This is something that comes in a lot of different sectors. What do you do when you've got this really broad distribution of margins and you're not confident in how the money's distributed?

DR. NAYLOR: I may tip my hand the other way in this world. I'm wondering -- you know, data has just come out from many sources about the rehospitalization rate, hospitalization rate and rehospitalization rate of people with cognitive impairment, multiple functional deficits, and 48 percent of the people in the Medicare beneficiaries are people over 85 that are receiving hospice. So I'm trying to put together, then, what are the data for the 40.9 percent in the hospice benefit in terms of their cost, Medicare cost in the last six months of life versus the other than 50 -- whatever they are, the remaining, who are not in this service? I mean, because you start at the beginning saying this is something we want to encourage, so I'm wondering can you give us a sense of what are the costs for the people

that are not accessing this service relative -- Medicare costs relative to those?

MS. NEUMAN: So we have not done our own estimate of the costs of people who enroll in hospice at the last six months of life, over the last year of life compared to folks who do not. There is research looking at that, and what I can tell you is that whether hospice saves money or costs more money depends on a number of things.

For the first month or two -- the last month or two months of life, hospice saves money because you reduce high-cost inpatient care in those time periods. The research is less clear on exactly where, but maybe at the third month, fourth month, hospice starts to -- before the third or fourth month before the time of death, hospice starts to cost more money than it saves. So you're saving more money in the last two months of life. As you get out further, you're costing more, and at some point the savings from the last two months will be outweighed by the cost as length of stay gets longer and longer. And it also depends on diagnosis. Certain diagnoses use inpatient services more than others.

So there's not a strict hospice saves money or

doesn't and this is how much. It really depends on a lot of characteristics: how long you're in hospice, you know, what your condition is, the practice patterns in an area, all of that.

DR. NAYLOR: And so the projected recommendations will help address that in terms of the readjustment of payments, more here, more here, and not as much here. I'm really talking about the concern of this rapidly growing population that might be negatively affected in whom we are seeing a great rise in hospital and rehospitalization use. So that's why I'm concerned about the rate. And I guess I would -- 1.5 to 2.

MR. HACKBARTH: We are finishing round one.

MS. BEHROOZI: So the costs associated with volunteers are the training and recruitment and all of that, but you don't pay them for the work that they do, right? But according to your paper, it says that hospices are required to us volunteers to provide services to at least 5 percent of total paid patient care time. So the hospice gets paid for the work that volunteers do? Is that what that means?

MS. NEUMAN: So the hospice gets a per diem

payment regardless of what services are provided on a day, and the hospice is required to use volunteers to provide services or to do functions that amount to in a time perspective equal to 5 percent of the paid time that they expend in providing services.

MS. BEHROOZI: Right, but it's not like the bereavement services that the hospice is not otherwise compensated for, right?

MS. NEUMAN: Right. I mean --

MS. BEHROOZI: It's the services encompassed within the per diem.

MS. NEUMAN: Yes.

MS. BEHROOZI: Are there any limitations on the type of work that volunteers can do?

MS. NEUMAN: They don't count for things like fundraising. It either has to be direct patient care or -- and I'll get back to you on the specifics, but I feel like there is some administrative things that they can do. But like fundraising and things like that, that's a no. That doesn't count.

MS. BEHROOZI: But they can do patient care.

MS. NEUMAN: Like visiting a patient, yeah, yeah.

MS. BEHROOZI: Could you have a nurse volunteer?

MS. NEUMAN: Hospices do have some nurse volunteers, physician volunteers, yes.

MS. BEHROOZI: And it says at least 5 percent of the time. Is there any limit?

MS. NEUMAN: Not that I'm aware of.

MS. BEHROOZI: And does this distinguish between for-profit and not-for-profit agencies?

MS. NEUMAN: As far as the rule or --

MS. BEHROOZI: Yeah.

MS. NEUMAN: No.

MS. BEHROOZI: I just have to say that that seems very weird to me. This is a round two question, but, you know, you're talking about profit-making entities making their income based on people not getting paid. Aren't there laws about that? Oh, I'm a labor lawyer, yeah. I think there are. Maybe we could talk off-line a little bit about whether there are some kind of protections or exemptions or something. That's very strange to me, especially when you see the margins, the extreme margins in some cases, of for-profit agencies using, you know, unpaid labor. It's kind of weird.

MR. HACKBARTH: It is anomalous, and I think part of the reason that we got to this place -- correct me if I'm wrong, Kim -- is I think the volunteer piece has been in since 1983 when this was overwhelmingly a not-for-profit enterprise.

MS. BEHROOZI: Yeah, I get, you know, the admission-driven --

MR. HACKBARTH: And we just haven't changed anything despite the fact that now it has become a largely for-profit enterprise.

MS. BEHROOZI: Yeah, so I would really encourage that we put that at the top of the list for policy modification.

MR. HACKBARTH: Okay, round two, and please be economical in your comments.

DR. BORMAN: I'm generally in a comfort zone with this recommendation. I have one question, Kim. What percentage of this market is Medicare? Could you remind of the ballpark?

MS. NEUMAN: It's like the high 80s.

DR. BORMAN: Okay. I think that there are any number of unknowns here. Particularly, we've spent a lot of

time in the past trying to make some comprehensive comments about this, which the Congress in its wisdom will consider whether to do or not. Making our best educated guesses about the factors, I think we're in a landing zone that is reasonable.

MR. ARMSTRONG: I agree. I would just say, as reflected by several of the comments I, too feel like I have two points of view on this. On the one hand, I'm working very hard in a system that looks at the overall cost of care and health outcomes, and we're investing like crazy in more and more hospice services right now because there's a great return on investment in that. And I think the Medicare program is well served through what we spend on hospice.

On the other hand, in the context of the specific rate decision that we're making right now, these are strong margins relative to margins being made by other sectors in the Medicare program. And I think closer to 1 percent than 1.5 percent is not going to slow the growth of hospice services.

MS. HANSEN: I would just affirm what Scott said.

DR. CASTELLANOS: I second that.

DR. BAICKER: Agreed.

DR. STUART: [off microphone].

DR. KANE: I agree, and I also wonder if we can't have the difference attributed to offset the SGR.

MR. KUHN: I'm fine with that range of discussion.

DR. BERENSON: So everybody's freed up a little time for me to tell --

[Laughter.]

DR. BERENSON: I know it's late in the afternoon, but sometimes an anecdote is so perfect that you got to do it. I will be very fast on this one, I promise.

A couple weeks ago, I was at a social event and met a woman who knew me as a doctor who did health policy. She said, "I have something I just have to tell somebody. Who should I tell about this?" She proceeded to tell me that her mother, 95-year-old mother who had been in a life care community for a number of years, about 15 months before we were talking had been transferred to what she called skilled nursing and I interpreted it as assisted living within that facility. And at that moment, her hospice benefit kicked in, and she said, "It's nice to have these folks coming by, but it's perfectly redundant care." I don't know what they're doing that she's not getting with

her $6,000-a-month payment to the assisted living. And she thought it was a terrible waste, but basically she wasn't out-of-pocket anything and just thought as a good citizen she should tell somebody. I told her I thought she had told somebody who might have something to be able to do about it.

I guess two points I want to make. One, I think we do really want to -- I mean, we've said it before, but I think there is a real issue about nursing home/assisted living being places where there may be inappropriate use of hospice and sort of relationships established that are generating referrals. She was in her 15th month, and she said, "I have no reason to believe my mother's going to die anytime soon. She's got dementia. That's the reason she's in assisted living. But she's not declining in particular. She's just getting her hospice benefit into her 15th month."

And the second thing, tomorrow we're going to be talking about home health co-payments, and I think a similar argument could be made here. I mean, she basically said that, "If I were paying for anything, I probably would have been doing something sooner than this. But, you know, it doesn't affect my mother's payment. I'm just doing this as a Good Samaritan, basically trying to find out who I should

talk to."

So I don't think we're do anything definitive on the home health tomorrow on the co-payment, but I think when we consider rationalizing cost sharing across the program, I'd consider hospice with home health as two places that maybe should have some form of co-payment -- not large co-payment but something that gives everybody -- I won't use the term "skin in the game."

MR. GEORGE MILLER: Yeah, in principle, I agree with what Scott said and everybody around there, until I heard Bob's anecdote. And I guess I got to reflect on the hospital outpatient margins about a negative 10 percent, and we gave them a 1-percent update. The hospice margins are 10, 11 percent for for-profits. They're the reason for the major growth from $2 billion to $12 billion recently. They had the length-of-stay problem. They had the issue that Bob just brought up. I'm not even so sure that I'm going to agree with even the 1 percent, quite frankly, but in principle, I'll agree with Scott.

MS. UCCELLO: Yeah, I agree with Scott, and I'd probably lean more toward 1.

DR. CHERNEW: I think it's important when looking

at these margins to realize that many of the lower ones in some of these groups have the indirect rate in. So other things are being added in there that aren't necessarily the direct costs of the hospice in ways. So that said, this is a particularly labor-intensive procedure, so it's hard to get some of the productivity gains. And I do agree that, when done right, it can have some advantages in terms of the efficiency of care.

All of that said, I guess I am closer to Scott's/last George in where I would come out on the recommendation, recognizing how important and valuable this service is.

MR. BUTLER: That's where I am, too, but I'd just one quick thing. I do feel it's probably the most underutilized of all of the services in Medicare and probably the most misutilized at the same time, and that's kind of the dilemma.

DR. CHERNEW: Right.

MR. BUTLER: Misutilized and underutilized, and how we can really target this so it lands in the right place as a very, very important tool is something that I think we can contribute to, because the staffing so far, I think, on

all of this has been really good, and I think we can make a unique contribution.

DR. NAYLOR: First, I am looking at the not-for-profit margin here, but I obviously could be persuaded by this group. I'm new here, and I think that I'll pay attention closely to what they said. And I'm heartened by the fact that this will be a focal point, palliation and end of life and hospice going forward. So I can land where you are.

DR. DEAN: I guess as far as the update I tend to have the same concerns that George and several others have voiced. This is so difficult because here we have an extremely valuable service that we fail to be able to define. And, you know, the six-month criteria is just totally arbitrary. It got pulled out of mid-air. It's hard to quantify. It's hard to predict. And yet I think we really need to give some serious thought to trying to further clarify the eligibility criteria, although I don't know -- I don't certainly have any better ideas, but, you know, Bob's anecdote is very relevant. I just struggle with it. It's an important -- I mean, the Gawande article I think was a powerful statement about how valuable this is,

but at the same time it's clearly being misused.

MS. BEHROOZI: In the discussion about the ASC recommendation, the level of the recommendation, I was thinking that if we're not going to be using strict failures or empirically derived numbers, we should instead use a principle, and if that principle is 1 percent because of some reason -- because we think 1 percent will help do something to constrain overall costs, or maybe it's Nancy's principle that it's not the most important thing anyway and it seems not unfair -- so it's 1 percent unless -- unless there's some good reason to make it more or there's some good reason to make it less.

So I'd say 1 percent just, you know, to kind of introduce some kind of consistency and something -- a tool for us to use to aggregate ourselves around. But I would say for hospice -- and I'm just thinking about this now, so this is like a very preliminary thing. I think for-profits should pay their workers.

[Laughter.]

MS. BEHROOZI: And that would, you know, compress these margins a little bit and compress the spread between the costs of the for-profits and not-for-profits. And I

don't know, you have to -- obviously not-for-profits should pay their workers, too, but, you know, you can have some different kinds of constraints around the nature of the volunteering in a not-for-profit. But I don't see how you do it in a for-profit, especially when you've got this margin that's clearly being made off the backs of human beings doing the work.

MR. HACKBARTH: Okay, Kim. Well done. Thank you.

As we transition to our last presentation of the day on skilled nursing facilities, I think the point that Mitra just made is well taken, and so one of the things that we will do as we go back through review of the conversation is look at that horizontal, you know, really emphasize the horizontal approach and maybe decision rules of the sort that Mitra suggests. I'm just thinking aloud about this. But when you cut loose from the market basket-based calculation, it does increase the importance and the focus that you put on the horizontal and how we're treating the different sectors equitably. So we will emphasize that as we go through this, and then I'll talk to each of you about it.

Okay, Carol. You are up.

DR. CARTER: I am. Okay. I want to just start with a thumbnail sketch of the industry and remind you that there are about just over 15,000 providers and about 1.6 million beneficiaries. That's about five percent of beneficiaries use SNF services. Program spending in 2010 topped $26 billion. And I wanted to remind you that most SNFs are parts of nursing homes that furnish long-term care, which is a service that Medicare does not cover. Medicare makes up about 12 percent of facility days, but about 23 percent of their revenues. And Medicare pays for this service on a per day basis. That's described in the paper.

We'll be using the same framework that we've been using for the rest of the update discussions. I wanted to point out that there's an appendix in this chapter. PPACA required MedPAC to examine trends in Medicaid utilization, spending, and financial performance for providers where Medicaid is a large share of either revenues or services, and so we've done that for this provider, and that information -- I won't be going into it here, but if you have questions, I can answer them.

Okay. In fiscal 2010, spending for SNF services was over $26 billion. That's the yellow line. Growth in

total spending slowed to about two percent between 2009 and 2010, and this, in part, reflects the beneficiary enrollment in MA plans whose spending is not included, and also a small decline in use. Increases in spending on a fee-for-service basis -- that's the pink line -- were also lower, reflecting a slowdown in the growth in the intensification of the highest payment rehabilitation case-mix days.

Access appears stable for most beneficiaries. We don't have direct measures of access but instead use several indirect measures to gauge it. First, supply has been steady, with a small increase in the providers since 2000. About three-quarters of beneficiaries live in counties with at least five providers, and less than one percent of beneficiaries live in a county without a SNF. There has been a steady growth in the number of bed days available. These increased four percent between 2008 and 2009. Occupancy rates declined slightly, indicating that there was space to admit beneficiaries. There was a small decline in covered days and admissions, reflecting lower hospital use, and Jeff talked about that this morning.

Two indicators of use concern us. First, the number of SNFs treating medically complex patients continues

to decline, even though provider supply is stable.

Second, racial minorities had lower admission rates than whites, but longer stays. Differences in SNF use is consistent with other studies that generally have found that minorities were more likely to use home health care and informal care and less likely to use institutional care. Lower use rates may also reflect differences in hospitalization rates for racial minorities, and that's required for a covered service under Medicare. And finally, the longer stays for racial minorities may also reflect differences in patient comorbidities, which are not reflected in those use rates.

The two trends in service use discussed in the paper underline the importance of previous MedPAC recommendations. First, as I just mentioned, fewer SNFs admit medically complex patients. Revisions to the classification system will make these patients more financially attractive to SNFs. However, payments for non-therapy ancillary services, and those are largely drugs and respiratory therapy, continue to be tied to nursing payments. MedPAC recommended creating a separate payment for NTA services, and his still needs to be done.

A second trend is the continued intensification of therapy services. MedPAC recommended replacing the current therapy component with one that bases therapy payments on patient characteristics. CMS has not acted on this.

Last, the SNF PPS is one of the few prospective payment systems without an outlier policy. This change requires Congressional action. CMS does not have the authority to create an outlier policy.

Turning to quality, we use two measures to assess the quality, risk-adjusted rates of community discharge and potentially avoidable rehospitalizations for five conditions. Here, we see a mixed story for SNF quality. Since 2000, the community discharge rate -- that's the top line -- has increased slightly, indicating improved quality, while the rehospitalization rate is about the same. And between 2007 and 2008, both measures were virtually unchanged.

We looked at differences in quality measures by race and found that the observed differences were not statistically significant once other patient characteristics and comorbidities were considered.

We do see quite a bit of variation in quality

measures across facilities, and here you can see the 10th and the 90th percentile along with the medians. I should point out that the 10th and 90th, these are large samples and they each include over 1,200 facilities. So they're not just small tails. There are a lot of facilities in each of them.

You can see that the community discharge rates vary by more than threefold and the rehospitalization rates vary twofold. And over the next year, we plan to examine policy options to lower the variation across facilities.

Turning to access to capital, because SNFs are parts of larger nursing homes, we assessed the capital for nursing homes. Lending to nursing homes has improved since last year. Despite the condition of many State budgets and the poor economy, this sector is fairly resilient. Even though Medicare is a small share of most homes' revenues, it is seen as a generous payer that homes rely on financially. Medicare continues to be a preferred payer.

Comparing payments and costs, the aggregate Medicare margin was 18.1 percent in 2009. This is for free-standing facilities. This is the ninth year in a row that aggregate margins were above ten percent. There continues

to be variation in the financial performance across location and ownership. Rural facilities had slightly higher margins than their urban counterparts, and for-profit facilities continued to have considerably higher margins than nonprofits, though the difference was smaller this year than in previous years.

Here's a snapshot of the distribution. About half of freestanding SNFs had margins at or above 18.7 percent. One-quarter of SNFs had margins at or below 8.8 percent, while one-quarter had margins over 26 percent. About 14 percent of facilities had negative margins, and this was a smaller share than in 2008. The most rural of SNFs, those in areas with populations under 2,500 and not adjacent to a metro area, had higher-than-average margins.

Not shown in this table, hospital-based facilities continue to have very negative margins, negative 66 percent. We have discussed in previous years the reasons for these large differences in per day costs between hospital-based and freestanding, including their higher staffing levels and the fact that physicians appear to treat SNFs as extensions of their inpatient stays. These factors result in much higher routine and ancillary costs per day.

Our recommendations to revise the PPS would redirect payments from freestanding facilities to hospital-based facilities based on the mix of patients that they treat.

To provide some context for the margins, we compared freestanding SNFs in the top and bottom quartile of Medicare margins. We find the cost differences were much larger than the differences in revenues. Low-margin SNFs had costs per day that were 41 percent higher, in part explained by their lower average daily census and their shorter stays over which to spread their fixed costs. On the revenue side, low-margin SNFs had payments that were seven percent lower than high-margin SNFs, reflecting a smaller share of the more profitable therapy days. Low-margin SNFs also had smaller Medicare shares of days.

We also looked at the performance of relatively efficient SNFs, and like Jeff presented this morning, we looked at -- we used both cost and quality measures to define these. And like the definitions they use in the hospitals, SNFs had to be in the top third for one measure and not in the bottom third for any measure for three years in a row. So they had to have consistent performance both

on quality and cost measures. And nine percent of SNFs, and that was about 800 facilities, met these criteria.

Comparing the efficient SNFs to others, we found that they had costs per day that were nine percent lower after adjusting for differences in case-mix and wages, community discharge rates that were 29 percent higher, and rehospitalization rates that were 16 percent lower, and they had higher margins.

Looking at trends since 2000, although efficient SNFs made up nine percent of the study sample, they made up 11 percent of facilities with low-cost growth and of the facilities with high-revenue growth. It is clear that it is possible to furnish relatively low-cost, high-quality care and do very well financially.

We project the SNF margin for freestanding facilities to be 10.9 percent in 2011. The margin goes down because payments were reduced in 2010 and 2011. In 2010, payments were lowered to more accurately account for the impact of the new case-mix groups that were implemented in 2006. In 2011, CMS reduced the update to account for a past forecasting error.

In addition, SNF costs have been increasing faster

than the market basket. This projection assumed that costs will increase at the actual average cost growth over the past five years. This may be a conservative assumption because cost growth may slow due to broad economic conditions. And we did not factor in any behavioral changes, such as shifts in case-mix that could change payments.

In summary, the factors indicate that payments are adequate, access and quality are stable, capital is available, the Medicare margin was 18.1 percent in 2009, and the projected margin for 2011 is 10.9 percent.

In 2012, the current law calls for payments to be updated by a combination of the market basket increase and the productivity adjustment as required by PPACA. The market basket for SNFs is projected to be 2.6 percent and the productivity adjustment is 1.3 percent. So net payments are slated to increase by 1.3 percent.

The high aggregate margins indicate that Medicare payments are high enough to accommodate a zero update, and here is the Chairman's draft recommendation. It reads, "The Congress should eliminate the update to payment rates for skilled nursing facilities for fiscal year 2012." This

recommendation would lower program spending relative to current law and it is not expected to impact beneficiaries or providers' willingness or ability to care for Medicare beneficiaries.

The update is not the only tool to help improve the accuracy and incentives of the payment system. Past recommendations have sought to improve the payment system and to increase the value of the program's purchases. Related to the payment updates, MedPAC recommended revising the SNF PPS to add a separate NTA component to base therapy components on predicted patient care needs and to add an outlier policy. MedPAC also recommended linking program payments to beneficiary outcomes by establishing a quality incentive payment policy, and PPACA requires the Secretary to develop an implementation for value-based purchasing by October 2011.

If implemented, the Commission's recommendations would narrow the differences in financial performance across facilities and we will be rerunning these recommendations in the chapter. And with that, I look forward to your discussion.

MR. HACKBARTH: Thank you, Carol.

Could I ask you to put up Slide 11, please? I want to pick up with the theme where we just left off, that being the importance of treating similar situations more or less the same as we look across the various provider groups.

Now, when I first saw these numbers, Carol, they surprised me how high they were. You know, for a number of years now, we've had both SNF and home health with quite high margins compared to all of the other provider groups in Medicare. My recollection of the history -- and I may well be wrong, and so please, if I am wrong, correct me. But my recollection is that mostly the SNF margins have been in the 10-, 11-, 12-, 13-percent range, and home health have been usually 4, 5, or 6 percent higher than that, up in the mid- to high teens. And so both have been high, both have been double digits for a long time, home health sort of a notch higher than SNF.

And so when I saw the 18-plus percent -- 18.1 is the median -- or 18 --

DR. CARTER: Yeah, 18.1 for an aggregate.

MR. HACKBARTH: Yeah, in the aggregate. Again, I was surprised. That seemed higher than I remembered. So let me stop there. Are these numbers higher than they have

been --

DR. CARTER: They are higher. Last year we reported for 2008 it was 16.6, and the year before that it was 14.7.

MR. HACKBARTH: Yeah, so they have been sort of creeping higher.

DR. CARTER: They're creeping up, and they do reflect the increasing share of case-mix days in the highest payment groups.

MR. HACKBARTH: Right, right.

DR. CARTER: So something like 90 percent of days are now rehab, and 70 percent of those are in the two highest case-mix groups.

MR. HACKBARTH: Right, right. So here's where I'm going with this. We recommended rebasing of the home health system, which is another way of saying actually cutting the rates. We have not gone to that point in the past with skilled nursing. We've had zero update recommendations for a large number of years now, but have never gone the additional step of saying the rates ought to be rebased and even lowered.

In my mind, part of the difference between the two

have been, A, that -- my recollection of the history was that the home health margins were always somewhat higher, but in addition to that, I've always been concerned about the medically complex skilled nursing patient where we've actually consistently said, you know, there are some potential access problems for the medically complex skilled nursing. And so the way my mind has worked on this is we really needed to fix the case-mix problems that are in SNF before going the additional step of potentially recommending a rebasing. So that has sort of been where my mind has been. But even with that, in my mind, when I saw 18-plus percent is the median margin, I must say I was a little taken aback. We've sort of jumped up there, it sounds like, in two-percentage-points increments the last several years.

So there's not an answer at the end of that, but in keeping with the earlier conversation about, you know, being consistent across sectors, I wanted to offer that for people to chew on.

I think we're starting on Mitra's side, so round one clarifying comments?

MS. BEHROOZI: [off microphone].

MR. HACKBARTH: Okay. Tom? Mary? Peter? Mike?

Cori? I think you're tired.

[Laughter.]

MR. HACKBARTH: George isn't tired.

MR. GEORGE MILLER: No. I am. But you raised a very good point. What would that rebasing look like? Because I think you're right on point.

MR. HACKBARTH: You know, I don't have a rebasing proposal to offer. What we have said in home health is that they ought to go back and look at the average cost -- the product has changed -- and rebase the rates on up-to-date costs as opposed to old patterns of care. How it would be done in SNF I have not even begun to think about.

MR. GEORGE MILLER: But one point that you brought up, if I remember correctly from the presentation, and the medically complex patients have gone down, so that's even, it seems to me, more of a reason. I don't know where those patients are --

MR. HACKBARTH: What do you mean when you say they've come down?

MR. GEORGE MILLER: Fewer medically complex patients. They're treating fewer. Do I have that correct?

DR. CARTER: No. What I said was there were fewer

SNFs treating them, so they're increasingly concentrated at the SNFs that do treat them.

MR. GEORGE MILLER: Okay. All right.

MR. HACKBARTH: So the number of patients isn't shrinking.

MR. GEORGE MILLER: Right.

MR. HACKBARTH: It's just they're more concentrated, which incidentally, to the extent that that's true and you don't have an appropriate payment system for them, and if they're concentrated in a few facilities and you rebase, those people who've been picking up the slack in the system, as it were, and caring for the really difficult patients really get whacked.

DR. CARTER: I would want to just put a couple more pieces of information -- and it's in your chapter. The revisions to the case-mix groups that CMS plans to implement with RUGs-IV really is going to make a big difference for both expanding the number of groups for medically complex cases but also redirects money towards medically complex patients because of the way it moved money from the therapy component to the nursing component.

MR. HACKBARTH: This is probably a question that

is unanswerable, but my impression has been that we've said to CMS, oh, this is a step in the right direction, the changes that they've made, but you've not gone far enough. And so we keep insisting there needs to be a separate non-therapy ancillary payment and, you know, get away from the therapy-based payments.

So if they've gone in the right direction but not far enough, how much of the distance in the right direction have they gone with these changes? How much are they improving the situation for the medically complex?

DR. CARTER: Well, we can't model that because we can't -- there aren't the data to replicate the new classification group, so that has been the problem; otherwise, we would have modeled that. I think they will make a big difference, but I don't know how much.

MR. HACKBARTH: Okay.

DR. BERENSON: I was going to be asking -- I want to pursue this just a little more. When I was at CMS, I visited a SNF that basically only did very complex patients, and I guess my first question is: When you say they tend to be concentrated, are there SNFs that don't have long-term residents that only do skilled nursing for that period of

time?

DR. CARTER: Certainly hospital-based tended --

DR. BERENSON: Hospital-based, yeah, by definition would.

DR. CARTER: I don't know. I haven't looked at that, so I'm not sure.

DR. BERENSON: And do we know if some of those kinds of SNFs are LTCs, also? Can they be both?

DR. CARTER: I don't think they can be both.

DR. BERENSON: Okay. So they can be one or the other.

DR. CARTER: Right.

DR. MARK MILLER: I think on that there may be a couple of exceptions, but generally no.

DR. BERENSON: But the patient population is often similar, right?

DR. MARK MILLER: See, you said this in passing, but I wanted to kind of track on it. You said long-term residents.

DR. BERENSON: I was talking about a long -- nursing home patients, you know.

DR. CARTER: So like a ventilator patient that

might be, right.

DR. BERENSON: I'm talking about ventilator patients, is who I'm talking --

DR. MARK MILLER: And I just want to quickly delineate a couple of things. So long-term-care hospitals, I mean, one of the requirements is -- we'll talk about this tomorrow -- a 25-day length of stay, and so that tends to be people who are in for a long period of time. Then you have the nursing facility which you can -- and I'm sure I'm not doing it justice, but think of it as two ways. There is the residential beneficiaries there and then this group, the skilled nursing facility, which tends to be shorter stay.

DR. CARTER: The average length of stay is about 23 days.

MR. KUHN: One thing, Carol, just to make sure I heard you right. In the current RUGs, 54 RUGs, there's nine that are therapy RUGs, correct? Or rehab --

DR. CARTER: You're thinking about -- there are nine -- the new rehab plus extensive services.

MR. KUHN: Right.

DR. CARTER: There are many more rehab --

MR. KUHN: Right, there's three that are the

rehab, but you said of those RUGs right now that -- what were the percentages that were falling in kind of those upper reaches of those RUGs? Can you just say that one more time?

DR. CARTER: About 92 percent of all days are classified into a rehab RUG, and of those, about 70 percent are in the ultra high and very high.

MR. KUHN: Okay, thanks. And the other quick thing, in the chapter I noticed there was the appendix that talked about that new section of PPACA that asks us to look at Medicaid utilization. Under the statutory reading, this would satisfy the needs for our requirements under the law, this appendix in our annual chapter. Is that our understanding?

DR. MARK MILLER: That is our understanding, and what we're doing is trying -- I'm trying not to laugh as I'm giving --

[Laughter.]

DR. MARK MILLER: We're trying to meet the statutory requirement; you know, we're starting here with skilled nursing facility to try and work up the data as best as we can. There may be some other areas that we'll add as

we go. We are trying to meet it, and, yes, that is our attempt to take the first step in that direction.

DR. KANE: My only question is: If you redistribute this more toward the medically more complex, the aggregate margin would still be 18 percent, or not? I'm just trying to figure out what a redistribution towards --

DR. MARK MILLER: Yeah [off microphone].

DR. KANE: So you would still have an aggregate at 18 percent because the revenue and the costs are still aggregate.

DR. CHERNEW: [off microphone] Unless they change behavior.

DR. KANE: Yes, right. Unless they change behavior in what way? Like --

DR. CHERNEW: [off microphone] more or less profitable.

DR. KANE: Yeah, toward more or less --

DR. CHERNEW: If you make one group relatively more profitable or not and they move around, the costs and the revenues would change.

DR. KANE: Yes, but it's kind of hard to know -- yeah, right.

DR. CHERNEW: Yes, it is.

DR. KANE: Yes, okay. That was my question. That's what's built in right now, and a new case-mix system will just redistribute but -- and assuming not a big behavioral change.

DR. STUART: Yeah, I'm curious in terms of how well we were able to predict margins back in 2007 and 2008. Did we predict that margins would go up even with a zero update?

DR. CARTER: You know, we've never tried to model a behavioral reaction.

DR. STUART: But that's what I'm wondering, because we're projecting that the margins for 2011 are going to drop to 10.9 percent. Now, that's a huge drop from 18.7. But maybe there's this behavioral thing in there, and then next year it will be 19.8 percent.

MR. HACKBARTH: Just a point of clarification. We have been recommending zero updates for a long time, but that's not what skilled nursing facilities have gotten historically.

DR. CARTER: No, they've been getting, you know, market basket minus sometimes --

MR. HACKBARTH: Yeah, so this growth in margins that Carol described going up a couple percentage points is not in a zero update environment.

DR. STUART: The question remains about how well we are able to project what the margin would be given an update, and if there is a strong behavioral response and it's a negative response from the standpoint of access to care, particularly for the kind of person that you would think would need this kind of service, then I think that's something that we should take into consideration.

MS. HANSEN: Well, yes, it's not a question but a quick comment. Just again affirm how we assure this, the access to complex patients. So if the new RUGs system will perhaps provide sufficient incentives for that, that's great. The concentration in certain places, on the one hand I can really understand from an operational standpoint because then you'll have more competently prepared people maybe focused to do that. But as the volume grows, I think as Mary has pointed out, in terms of population, just, you know, assuring that other facilities will be available to do this in a more distributive basis.

MR. HACKBARTH: On to round two [off microphone].

MS. BEHROOZI: Yeah, I like taking a deeper look than just the payment update, as you suggested.

MR. HACKBARTH: So you are saying that you would be open to going below zero?

MS. BEHROOZI: In the result, yes, but doing it in an intelligent way that addresses some of the -- I mean, we've made recommendations. I don't know if they were all adopted whether it would address all of the issues since we have seen margins growing. But, yeah, margins -- I mean, in two years it sounds like margins at the median increased by four points over 14 points, which is a lot in two years.

MR. HACKBARTH: Right, right.

MS. BEHROOZI: That's close to 30 percent, or whatever.

MR. HACKBARTH: I don't want to create expectations or fears in the audience that may not come to pass. I'm surprising Carol and Mark in talking about rebasing, but this is just something that comes to me as -- you know, I've listened to the discussion all day long and the emphasis on, you know, equity, and so an obvious question is, Why are we rebasing home health and not these folks?

DR. KANE: In home health, I recall an exhibit that actually showed the percentage of nursing and therapy and aide visits back whenever it was -- 1998 -- was very different than what is now being visible. But it's hard to tell what's different here in terms of the inputs. There were very different inputs.

MR. HACKBARTH: Yeah, excellent point. That is one of the distinctive characteristics of home health. And as I said earlier, part of my own thinking about this has been that you wouldn't want to do rebasing given our concerns about access to care for medically complex until we felt like the case-mix system had been sufficiently improved.

So, again, you know, let me talk to Mark and Bob and Carol about this, and then I'll talk to each of you after that. Tom, any thoughts to offer?

DR. DEAN: No. I'm comfortable with where we're at [off microphone].

DR. NAYLOR: As am I.

MR. BUTLER: I am okay, too, but I do have an overnight assignment for you because I like your episodes of care so much. I just had a thought, though. This will just

take a second. As we look at all these -- it helps me integrate the day, too. If you take a look at all these silos, particularly all the post-acute, if you had the aggregate dollars at the bottom and you had all of the diseases that we're treating in Medicare, whether it's episodes or the -- and you could look at where all of our dollars are being spent, it would give an interesting profile of the trade-offs between these various post-acute sectors that would kind of give a scorecard that we could kind of say, oh, that's where we're spending the dollars to treat neurological diseases or congestive heart failure or whatever it is. It might be a nice analytical tool, so when we have the trade-offs between rehab versus home health versus hospice, it might help some of our thinking. But you don't have to do it overnight, but in the future.

[Laughter.]

MR. HACKBARTH: Yeah, this is important [off microphone] look at the data in different ways, for example, on a disease basis as opposed to by --

DR. CHERNEW: And, I mean, our push for productivity would involve substituting appropriately across these settings, and that's really hard to encourage in this

silo-based exercise that we march through every winter, and it really emphasizes the lack of integrated policy.

I guess there's just two things I wanted to say before my quick comments on the recommendation. The first one is these are Medicare margins, and there's a huge cross-subsidy. And I know that Glenn has said our job is not to subsidize Medicaid, and I agree with Glenn's point that our job is not to subsidize Medicaid. But I think that we do care about access of the beneficiaries, and so we just have to be cognizant of the connections, whether we want to or not. And given the fiscal situations that the states face, if we do this all based on just Medicare, we might be ideologically pure, which won't really be worth a lot to the beneficiaries who face problems. So I worry a lot about that, just as sort of a sleep-at-night kind of thing.

Secondly, I think we want to move to this sort of long-term care bundling thing, and there's going to be hopefully a lot of demonstrations, not just about looking at it episode-wise, but changing the related incentives. And that will affect how all of this plays out. And so Bob made a point in a previous meeting about fee-for-service in general and how the rates will be set. And so when we make

our recommendations now for a number of these things, we're not just making recommendations in the fee-for-service system going forward, but it has ramifications for how things like bundled -- the level that bundled payments would be at and stuff, and we need to think through that and the ramifications of that.

So the bottom line is I'm comfortable with the recommendation as given. I'm open to the idea of doing something more. But if you're going to do something more, I think it has to be done in this broader context of integration, a cross-subsidy, and the states' Medicaid stuff and all of those things. So it's actually, I think, harder to do -- I might say this again when we get to home care, incidentally, but I think it might be harder to do than it otherwise might have been given all of the complicated moving pieces in this area that's fraught with difficulty.

MS. UCCELLO: I'd agree with that.

DR. BERENSON: Yeah, I'll agree with that.

MR. KUHN: I'm fine [off microphone].

DR. KANE: I'd believe in anything to get up and go home.

[Laughter.]

DR. KANE: But I guess my only thought was -- and I know this is just too complicated, but I am worried a little bit about the high Medicaid places where the Medicare is holding them up. But I'm wondering how hard it would be -- since I see we have total margins, we must have total revenues -- to look at these margins in relationship to the percentage of the total business that's Medicare. And then I don't know if we have Medicaid, but it just would be interesting to see if that's the case, that the high Medicaid places have the highest Medicare margins or not. I don't know if that's truly -- if the high Medicaid places are the places where there's really high Medicare margins, then you'd worry about cutting the Medicare margin. But if the high Medicaid places have relatively low Medicare margins, you're not doing that much more damage to them than they already have done to themselves.

MR. HACKBARTH: In addition to that --

DR. KANE: Does that make sense?

MR. HACKBARTH: I think so. But the other way of looking at this which I have tended to emphasize is that using Medicare rates, high Medicare rates to subsidize low Medicaid rates is problematic because the nursing homes that

need the money most are the ones with high Medicaid shares and low Medicare shares.

DR. KANE: And that's why I want to see if the margins correlate to that at all. I don't know.

DR. STUART: The only thing that I would add to the cross-subsidy issue is that it's really quite different than when we're talking about hospital payment Medicare margins being negative and being offset by private-pay patients. The Medicaid patients are also Medicare, and so trying to figure out what's going to happen to the same patient -- I mean, not during the same stay, obviously, but it's very common for Medicare patients to stay beyond the SNF stay and then become, you know, ultimately Medicaid patients. So I would just add that caution in here in terms of trying to understand what the implications of that are. Otherwise, I support the proposal.

DR. BAICKER: I support it, and I liked Mitra's framing of things as starting with a basic default of something like 1 percent and justifying based on observations like this.

DR. CASTELLANOS: [off microphone] I agree.

MS. HANSEN: I agree, but with a question. It

just struck me, something that Bruce just said. I just wonder how many of the people who end up being Medicaid start off as Medicare. So, in other words, they start off a private-pay or post-acute and then they end up custodially staying for a long time and then ending up Medicaid. And how often does that happen? So just if you know that.

MR. ARMSTRONG: So I agree that in this section we're overpaying for what we're getting, and that to -- the recommendation is to hold payment flat. I think we should consider some kind of rebasing. I don't really fully appreciate the implications of that.

To this whole point about, you know, there are boundaries that get broken between Medicare and other payers and margins and so forth, it happens in all of these different sectors. I think we're here in one sector where I think we're generally believing we're paying more than we should be. But if that's the case, then I wouldn't use the overpayment to subsidize Medicaid programs necessarily. I think we should consider whether we should be subsidizing other parts of the Medicare program as an alternative. And so I don't know what you do with that.

Also, just to Peter's point earlier, you know, at

the end of the morning tomorrow it will be very interesting to have a chance just to talk a little bit about how this along with some of the other sectors really get all kind intermingled in some of our work going forward after January to look at some kind of bundling or other reform ideas that just might make some of these silo decisions a little bit more sensible.

DR. BORMAN: Intellectually, I'm fine with where we are now. I have a little bit of Mike's visceral reaction of concern.

MR. HACKBARTH: Let's see here. 5:50. We made up some ground. So now we'll have our public comment period.

Seeing none, we are -- oh, Marianne.

Is that on?

MS. LOVE: Sorry to be the person who keeps you here late.

I appreciated your comments, Glenn, this morning about trying to work towards harmonizing the updates for settings that are providing the same service. I think from the ASC setting perspective -- I'm sorry, I'm Marianne Love from the ASC Association.

The savings to the Medicare program and the

efficiencies of the ASC setting are baked into the rate differential already. Medicare is paying 44 percent less for a service done in an ASC than in a hospital. So I think moving towards a system that, on an annual basis, is updating things at the same rate is a good step in the right direction.

So we would actually like to see the Commission move towards an affirmative recommendation that is consistent with the hospital outpatient recommendation.

We think the slightly higher recommendation than what you discussed earlier today is warranted. The data that you're looking at for 2009 is the second year of a new payment system in which rates for many common ASC services are being substantially reduced. We know that 2010 is on track to be the lowest growth rate of ASCs probably in the history of the program for the ASC payment setting. And the largest public operators of ASCs are reporting flat or negative same store growth for their centers, Medicare and commercial.

These things, I think, are all important signals that should be considered. One of the things that we're seeing is an increasing number of hospitals buying ASCs,

buying out the physician owners, converting those ASCs to the hospital license. This comes at great expense to the Medicare program and the taxpayers that support it.

So we think an affirmative update recommendation sends a very strong and positive signal to the industry that they'll be on stable ground going forward and continue to provide those savings to the program.

Thank you.

MR. HACKBARTH: Okay, we are adjourned until 8:15 tomorrow morning.

[Whereupon, at 5:53 p.m., the meeting was recessed, to reconvene at 8:15 a.m. on Friday, December 3, 2010.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 3, 2010
8:17 a.m.

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

AGENDA PAGE

P R O C E E D I N G S [8:17 a.m.]

MR. HACKBARTH: Okay. Good morning. So this morning, we continue our discussion of our update recommendations for fiscal year 2012. We have three presentations today.

For those of you in the audience who were not here yesterday, yesterday and today, we are discussing draft recommendations for updates for each of the provider groups serving Medicare beneficiaries. These are draft recommendations that I have prepared and am offering to the Commission for discussion. We will have final votes on recommendations at the January meeting. The final recommendations that we vote on may be the same as the draft or they may be modified as a result of the conversations that we've had yesterday and today.

Since the last time we did update recommendations a year ago, obviously, there's been a major legislative change in PPACA. Among other things, what it did was establish a new budgetary baseline for all of the updates. Obviously, that's very important. However, the task that we've been assigned by the Congress is to provide our best assessment year by year on the level of payment that is

appropriate for the efficient delivery of services in a given provider group, a level of payment that will assure adequate access to high-quality care for Medicare beneficiaries by efficiently managed organizations. So, obviously, the recommendations we make could be different than what is in current law, and if it's higher, that would entail a budgetary cost. If it's lower, it would be a savings.

As always, in talking about the update recommendations, we use a multi-part framework. Where available, one piece of that is information on financial performance, on margins, but that's not the only part of the framework. Other considerations are access for patients and what's happening there, access to capital for the organizations, and the like.

Anything else?

DR. MARK MILLER: [Off microphone.] Updates and distribution under --

MR. HACKBARTH: Oh, yes. Another critical piece is as we conceive of the update process, the update simply establishes the size of the pool of dollars available for a particular provider group. Often, there are important

issues about how that pool of dollars, whatever it might be, are distributed and whether the money is distributed in a way that is fair, equitable, and rewards effective, efficient delivery of care, and so sometimes, not for every provider group, but sometimes in addition to making an update recommendation, we will also make a recommendation about the distribution of those dollars, and in fact, when we proceed with the home health presentation discussion, there are issues about how the existing case-mix system distributes the dollars.

So with that as background, let me turn it over to Evan for the home health presentation.

MR. CHRISTMAN: Good morning. Today, we are going to cover the payment framework as it pertains to home health. We will also review draft recommendations that provide policy options to improve payment accuracy, strengthen patient safeguards, establish beneficiary incentives, and advance program integrity.

I am going to start with the framework. As in previous years, the supply of providers and access to home health continues to increase. Ninety-nine percent of beneficiaries live in an area served by one home health

agency. Sixty percent live in an area served by ten or more. While there are some areas that lack home health agencies, they are relatively few in number. Our measure of access is based on ZIP code-level data which tracks the areas served by a home health agency in the last year. This data may overstate access for some areas because agencies need not serve the entire ZIP code to be counted as serving it. On the other hand, the data may understate access if agencies are willing to serve a given ZIP but did not receive any requests from those areas.

Turning from access to supply, the number of agencies was over 11,300 by the end of 2010, a number that exceeds the peak level of supply reached in the 1990s when Congress significantly changed the benefit to address fraud and problematic payment incentives. The growth in 2010 is consistent with prior years. For example, over 1,000 agencies entered the program in 2009. And while the growth has been significant, for the last few years, it has been concentrated primarily in Texas and Florida.

Next, we look at volume. Use of the benefit has increased significantly in the last seven years. The number of users has increased to 3.3 million in 2009, or over nine

percent of fee-for-service beneficiaries. The number of episodes has risen to 6.6 million in 2009, a growth of more than 50 percent since 2002. The episodes per user has also increased, from 1.6 to two episodes per user in 2009, implying that beneficiaries are staying on service for longer periods.

The 50 percent rise in total episode volume has been accompanied by an increase in episodes serving patients admitted directly to home health from the community. In 2001, home health episodes were split about evenly between patients admitted after a hospital or PAC stay and episodes where the beneficiary was admitted directly from the community. In the years since, episodes for community-admitted patients have increased by over nine percent a year, faster than the rate of growth for all episodes. Because of this fast growth, in 2008, episodes for community-admitted patients were about two-thirds of home health episodes, and post-hospital or PAC episodes represented only about 36 percent of episodes.

At the last meeting, some Commissioners asked whether some of the growth in community-admitted patients was due to beneficiaries using home health after receiving

outpatient surgery. Our review of outpatient surgery claims suggested this was not a major factor, as about 4.5 percent of community-admitted patients in 2001 had outpatient surgery prior to home health and the share for 2008 is slightly lower, at 4.3 percent.

Other shifts in volume which have occurred are related to how CMS changed therapy payments in 2008. In that year, CMS implemented a new system that dropped payment for episodes in the ten to 13 therapy visit range and increased it for episodes above and below this range. If you look at the green bar of the middle graph, you will see that a significant number of episodes were clustered in the ten to 13 therapy visit range in 2007. In 2008, when Medicare reduced its payments for these episodes, they declined. The red bar in each part of this graph shows how agencies reacted after this change in 2009. Visits increased for the two groups with higher payment and decreased for the group with lower payment.

The timing and nature of the change in episode volume suggests that the use of therapy visits as a payment factor may permit payment incentives to trump patient characteristics in setting therapy plans of care. Later, we

will discuss a predictive approach that uses patient characteristics to set therapy payment that would be less prone to manipulation.

This next table shows risk-adjusted quality measures for home health. For the first five measures, all measures of a beneficiary's functioning, the steadily rising line indicates there has been consistent increase in the number of beneficiaries who improved. The bottom blue and green lines show adverse events, such as hospital admissions or the use of urgent care. A decline would indicate improvement for these measures. However, the rate of adverse events has not changed significantly.

Last year, the Commission expressed concern that the current measures were too broad and did not necessarily measure outcomes related to the need for skilled care. We have launched a project to develop clinically-focused measures and expect to report them when they are complete.

Next, we look at capital. It is worth noting that home health agencies, even publicly-traded ones, are less capital intensive than other health care providers. Also, few are publicly traded. Financial analysts have concluded that for those publicly-traded ones, they have adequate

access to capital, though because of the payment reductions in the PPACA and several Federal investigations into industry billing practices, the terms are not as favorable as prior years. For agencies not part of publicly-traded companies, the continuing entry of new agencies reflects that smaller entities are able to get the capital they need to expand. As I mentioned earlier, over 1,000 new agencies entered Medicare in 2009, and so far, over 500 have entered in 2010.

Next, we turn our attention to margins for 2009. You can see that overall margins for freestanding providers in 2009 are 17.7 percent. However, there is variation in the margins. For example, the agency at the 25th percentile had a margin of 2.2 percent while the agency at the 75th percentile had a margin of over 26 percent. Margins for providers that serve mostly urban patients were 17.9 percent, while they were 16.6 percent for agencies that serve mostly rural patients. For-profit margins equal 18.7 percent. Nonprofit margins were 14.4 percent.

These numbers highlight two concerns that the Commission has had for many years, that home health margins have been excessive and that the wide variance in margins

may reflect inaccuracies in the case-mix.

I would note that we only report margins for freestanding providers in this presentation. Hospital-based providers, whose margins were included in those reported during the review of hospital payments, averaged a margin of negative-5.4 percent in 2009.

Since 2001, home health margins for freestanding providers have averaged 17.5 percent. The high margins are the result of at least two factors. The first factor is that home health agency cost growth has been lower than the payment update in most years. Because actual inflation has been lower than market basket inflation, payment increases have exceeded the growth in providers' costs.

The second factor is that the number of visits in an episode has always been lower than what Medicare assumed when it initially set home health rates. Medicare assumed the average episode would include 32 visits, while under PPS the average has been about 22 visits. As a result, Medicare rates assumed more costs in the average episode than providers actually incur.

We estimate margins of 14.5 percent in 2011. This is the result of several payment and cost changes. Agencies

received a two percent update in 2010, offset by a 2.75 percent reduction for coding. In 2011, the PPACA reduced the payment update to 1.2 percent and included a base rate reduction of 2.5 percent. The PPACA also includes a three percent rural add-on. And in addition, CMS reduced payments by 3.89 percent in 2011 for changes in coding.

We expect case-mix to increase by another two percent in 2010 and 2011 and assumed cost growth of one percent in 2010 and a higher rate of 1.7 percent in 2011.

Here is a summary of our indicators. Beneficiaries have good access to care in most areas. The number of agencies continues to increase, reaching over 11,000 agencies in 2010. The number of episodes and rate of use continues to rise. Quality shows improvement on most measures. Access to capital is adequate. Margins for 2011 are projected to equal 14.5 percent. And margins, again, for 2009 were 17.7 percent. These findings are very similar to prior years.

Next, we will turn to recommendations. Before I do that, let me remind Commissioners of changes in the PPACA that have some relation to our draft payment adequacy recommendation for 2012. Recall that in last year's March

report, we recommended that home health payments be rebased to equal costs in 2011. The PPACA implements a phased rebasing which begins in 2014 and is phased in over four years. The reductions would be limited to no more than 3.5 percent a year, and this reduction would be offset each year by the payment update. Given the positive indicators for the industry, the delay seems unnecessary. In addition, including the market basket update as an offset makes these reductions similar and in some cases smaller than those that industry has weathered in the past, so it would likely result in agencies maintaining high margins.

Here is a draft recommendation for 2012. It calls for an acceleration of the rebasing already in law and the elimination of the market basket update. It reads, "The Congress should direct the Secretary to begin a two-year rebasing of home health rates in 2012 and eliminate the market basket update for 2012." This would be a decrease relative to current law, and in terms of beneficiary and provider implications, we expect that some providers may choose to withdraw from the program but that remaining supply should be adequate to provide adequate access to care.

In addition to concerns about high margins, there has also been concern about the distribution of payments and whether the payment system provides appropriate incentives. First, as shown earlier, the inclusion of the therapy visits as a factor in setting payments allows agencies to follow financial incentives when determining the number of therapy visits provided. In addition, a review of the payment system indicates that it overpays for high case-mix episodes, which are predominately therapy, and underpaid for low case-mix episodes. For example, in a review of data from 2007, high-margin agencies had a case-mix that was seven percent higher than low-margin agencies.

An analysis by the Urban Institute found that the current system is highly dependent on the use of therapy as a predictor for its accuracy. With therapy as a predictor, the system could explain 55 percent of costs. Without it, the explanatory value dropped to 7.6 percent. Perhaps most importantly, the case-mix explains one-tenth of one percent of the variation in non-therapy costs, meaning the system is weakest in explaining the services that are most commonly provided. And notably, the case-mix properly identified only 15 percent of high-cost non-therapy episodes.

All of these factors suggest the case-mix system needs to change. If the current system remains in place, agencies will have an incentive to avoid non-therapy cases, base the amount of therapy provided on payment incentives and not patient characteristics, and also to avoid high-cost non-therapy cases.

Urban developed a revised system that did not use therapy visits as a factor in setting payments and relied solely on patient characteristics. The revised system they developed explained about 15 percent of costs, or about double the explanatory power of the current system when its therapy thresholds are removed. Please note that the prediction estimates for the revised system have been updated and the numbers on the slide here are slightly different from those in the paper we sent you.

The improvement was better at the service level. For non-therapy services, the explanatory value of the revised model was 15 percent compared to eight percent for the current case-mix without its therapy thresholds. For therapy services, the revised model had an explanatory value that was more than double the current system without therapy thresholds. The revised system was also more accurate in

identifying high-cost non-therapy cases, identifying about 28 percent of them, or nearly double the current system. This analysis suggests that an alternate case-mix which drops the therapy thresholds would have better accuracy and better incentives than the current system.

This leads to a draft recommendation. It would urge the Secretary to develop a revised case-mix system similar to the one I just described. It reads, "The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and non-therapy services and no longer use the number of therapy visits as a payment factor." This would be a budget neutral change. It would increase access to care for therapy patients. Payments will be redistributed to providers that focus on non-therapy services from those that are more focused on therapy services.

Now, we have a preliminary model of the impact, and generally, payments would increase for providers that deliver more non-therapy and decrease for those that deliver more therapy. Payments would increase for dual-eligibles, severely ill patients who receive high amounts of nursing and aide services, and at the provider level, it would

increase payment for patient-based nonprofit, rural, and small providers.

We also plan to reprint the third recommendation from last year's report that sets up a framework for Medicaid safeguards. This recommendation addresses concerns that providers may stint on care when the rebasing is implemented. It reads, "The Congress should direct the Secretary to expeditiously modify the home health payment system to protect beneficiaries from stinting or lower quality of care in response to rebasing. The approaches should include risk corridors and blended payment that mix prospective payment with elements of cost-based reimbursement." And this would be budget neutral and it should maintain beneficiary access to care and provider willingness to serve beneficiaries.

Another issue is ensuring appropriate use of the home health benefit. Today, physicians and home health agencies are principally responsible for following Medicare's enrollment and coverage standards, but several studies have raised questions about how effectively they serve this role. Many reports suggest that physician oversight can be weak and the locus of control with agencies

which have a financial interest in eligibility -- excuse me, and the locus of control remains with agencies which have a financial interest in eligibility and plan of care decisions.

Concerns about overutilization are further exacerbated by the lack of cost sharing in home health. Studies have generally found that beneficiaries consume more health care services when they have limited or no cost sharing and that these additional services do not always contribute to better health. The rapid rise in home health volume suggests that at least some of this growth may be increasing Medicare's costs without improving beneficiaries' health.

Adding a copay requirement would permit patient choice to serve as an offset to the incentives in the home health PPS which reward additional volume. However, the copay needs to set appropriate incentives. It should not drive beneficiaries to other high-cost settings and it should minimize negative impact for high-need and low-income patients.

One approach is to establish a fixed per episode copay that applies to episodes for community-admitted

patients. As pointed out earlier, these are the majority of episodes and one of the fastest growing category of episodes. A copay could be charged at the per visit or per episode level, but given the incentive that providers have to deliver more episodes, a per episode copay seems most appropriate.

To protect low-income beneficiaries, dual eligibles could be exempt from the copay. The copay could also exclude episodes with few visits. With this design, about 32 percent of episodes in 2008 would have been subject to the copay.

The amount of the copay depends on the minimum value you would want a beneficiary to place on an episode and how strongly you want them to consider alternatives. An amount equal to ten percent, or $300 per episode, might be an example of an initial value that is appropriate. For a typical episode, this amount would average out to about $17 per visit, roughly in the middle range of the cost sharing a beneficiary would pay for an evaluation and management office visit covered under Part B.

To ensure that the incentives of this copay are not diminished by secondary insurance, Medicare could

require that beneficiaries pay this out of pocket similar to the true out-of-pocket feature in the Part D benefit. Excluding home health cost sharing would avert an increase in secondary insurance premiums that would result if it was permitted to cover these costs.

With these parameters, here is a draft recommendation which would establish a copay as I just described. "The Congress should establish a per episode copay for home health episodes that are not preceded by hospitalization or post-acute care use. To protect access for low-income beneficiaries, dual eligible Medicare and Medicaid beneficiaries should be excluded from the requirement. The copay should be exempt from first-dollar coverage." And this would decrease spending. Some beneficiaries would have to seek outpatient or ambulatory care as a substitute, and providers would experience some decline in demand.

And finally, we turn to program integrity. This slide lists the 25 counties with the highest frequency of home health use in 2008. If you compare the share of users and the episode per user for each county to the national average listed below and to the left in yellow, you will see

that these counties are well above average in home health utilization. Note that the share of beneficiaries using home health is two to four times the national average, while the average number of episodes per user is also significantly greater than the national average. Five of these counties have more episodes than fee-for-service beneficiaries.

Differences of this magnitude raise concern that fraud may be an issue in some areas, particularly because some of these areas, such as Miami, have already seen significant program integrity activities. We cannot make definitive judgments about the role of fraud in high-use areas from this data, but differences of this magnitude suggest a need for closer inspection, and if fraud is revealed to be a factor, swift action.

Medicare has new authorities to fight fraud in the PPACA and home health may be an appropriate place to use these new authorities. Specifically, in areas where the Secretary concludes there is widespread risk of fraud, she can implement local moratoria on the enrollment of new providers and suspend payments for services in areas that appear to have widespread fraud.

This brings me to a draft recommendation. "The Secretary, with the Office of the Inspector General, should conduct medical review activities in counties that have aberrant home health utilization. The Secretary should implement the new authorities to suspend payment and the enrollment of new providers if they indicate significant fraud." And this could potentially decrease spending, and appropriately targeted reviews should not significantly affect beneficiary access to care or provider willingness to serve them.

This completes my presentation and I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Evan. Well done.

Today is a new day for the timekeeper and I'm under pressure today because people have plane reservations and train reservations, so we're going to adhere closely to the schedule.

Before we launch into our round one clarifying comments, I want to raise a couple issues that I'd like people to think about and ask clarifying questions about during round one and make comments on in round two.

Evan has laid out a package of recommendations, five in total, plus re-running last year's recommendation with regard to looking at modifying the payment system using risk corridors or blended payment. So there are a lot of moving parts here.

One of the issues that I'd like you to react to is the sequencing of these different recommendations. So, for example, obviously one of the recommendations is to rebase the rates, but we're also talking about changing the case-mix system in order to redistribute the dollars. We're also talking about potentially moving away from fully prospective payment to one that is blended payment or at least includes risk corridors. The sequencing of those things could matter, and I want you to think about that and react to that when we get to the round two comments.

DR. CHERNEW: Do you mean the sequencing in the chapter --

MR. HACKBARTH: No. Operationally -- the policy. The policy. Does the order in which we do these policy changes matter? So food for thought there.

DR. DEAN: Evan, as you know, I've been concerned about this area for some time. You said that the case-mix

changes would be beneficial, you thought, to smaller providers, if I heard that right. Do you have any idea of the magnitude? Because I think in my area that's the major concern. We've got a whole lot of very small providers, many of which are marginal or non-existent at this point. And there's obviously a huge variation across the country in terms of Medicare expenditures per beneficiary.

Without getting into a lot of detail, is it anticipated that this change would even out some of that?

MR. CHRISTMAN: I guess I'll start with the small providers comment, and the boost they get, it's real but it's not big. It's about 2 percent. And that's principally -- you know, there's nothing in the model that specifically is geared to an agency size. It's just that they're doing a little bit more of the non-therapy, and the payments for those episode types go up. And so that's why they come out ahead.

In terms of the spending, I think it would have some effect nationwide, but I don't know that there would be a huge shift in what you see from the per capitas today. But we haven't really looked at that.

DR. DEAN: The other issue, of course, in rural

areas is travel time, and that can probably double the cost of the visits. Is any of that involved in this new adjustment?

MR. CHRISTMAN: This does not. This looks simply at patient severity. You know, travel time is something that is a very difficult issue for us to look at because, frankly, we hear that concern from providers in all settings.

DR. DEAN: Yeah, well, I understand that.

DR. MARK MILLER: Can I ask a couple things? There was a rural effect as well, right?

MR. CHRISTMAN: Yes, the rural does go up. If I try and do the number off the top of my head, I won't say it right.

DR. MARK MILLER: And also hospital-based?

MR. CHRISTMAN: Right.

DR. MARK MILLER: And the reason I bring that up is because, Tom, you've raised both of those issues before in your comments.

Then on the travel point, is there a change in law that addresses that?

MR. CHRISTMAN: No. Well, it's one of the issues

that CMS is charged with studying --

DR. MARK MILLER: That was it.

MR. CHRISTMAN: -- as a part of their look at potential refinements.

DR. MARK MILLER: All right.

MR. CHRISTMAN: But I guess, you know, on this front we've had people from very urban areas come and tell us the same thing, that because of congestion or what-not that their areas are difficult to get around and they have higher travel costs. And so it's something that may deserve some attention, but whether we'll be able to find relative differences I think is an interesting question.

DR. NAYLOR: Thank you for this great paper. On the case-mix refinement, proposed refinement, to what extent is comorbidity being captured? It wasn't captured in earlier OASIS, the extent to which having multiple complex conditions affect outcomes. And cognitive impairment, to what extent is that -- you lay out here some of the areas, but I was wanting to make sure that those factors were...

MR. CHRISTMAN: We haven't done anything explicitly going down the comorbidities alley too far, and that's because we were sort of starting from scratch and

rebuilding a whole system. I think we could think about that. You know, when CMS did its refinements in 2008, they added some comorbidities. And I think the difficulty is that overall we find that diagnosis isn't as limited in how correlated it is with home health use. So you can add some of those comorbidities. How much additional explanatory value you really get is -- go ahead. I'm sorry.

DR. NAYLOR: I was just going to say across our work, which has now spanned a long time, the sheer presence of multiple comorbidities, reinforced by Gerry Anderson and others, really impacts the care needs and complexity. And that's been absent in case-mix for home health, and I think if we're moving forward, it would be great -- cognitive impairment adds greatly to the complexity of the care needs in the face of these, and I think it would be great to consider.

MR. CHRISTMAN: I'm sorry. I can't recall off the top of my head, but there are some cognitive things in the model.

DR. NAYLOR: Okay. The second thing, which goes to the threshold for co-pay and dual eligibles would be exempt, but how did you arrive at that threshold?

MR. CHRISTMAN: Of $300?

DR. NAYLOR: Yeah.

MR. CHRISTMAN: We started off thinking, you know, normally co-payments in Part B, for example, coinsurance runs 20 percent, and that would result in a co-pay of $600. And we just felt that that was probably a bit of a big jump to go from zero to $600, and so, you know, 10 percent, $300, became I think what we were just offering as, you know, a discussion target. It just comes out arithmetically also. That's kind of in the range of what a beneficiary would pay for some types of outpatient physician visits. And that's offered just as a comparitor, not as something that's instructive. You know, it really comes down to the two points that I mentioned, which is sort of what's the minimum value that you'd want a beneficiary to place on these services and how much do you want them to think about alternatives. I think from at least my perspective, I don't have more guidance to offer than that.

DR. NAYLOR: Thank you.

MR. BUTLER: On page 23, the one that gets your attention, I'd like to understand not just the fraud and abuse piece but the variation question just in general and

how significant it is. These numbers suggest about at least twice as much number of episodes per users and two to four times as many -- so maybe six times the national average in utilization, if you'd kind of do the simple math. But these are small number accounting.

So at the two ends of the spectrum, do you have any sense, like, you know, 10 percent of the counties use 50 percent of the home health, or any other -- a number of counties have almost none? So, you know, what's the variation whether or not it's due to fraud and abuse?

MR. CHRISTMAN: Okay. So in terms of the percents in counties like you talked about them, I haven't racked it up that way, so I don't know. The variation that we've seen in home health among counties is greater than any of the individual payment systems we've looked at. So there's more variation in home health than hospice, than physician services, and other things. And as I recall, the variation between sort of the price-adjusted and health status-adjusted variation is about twofold between the CBSA at the 75th percentile and the CBSA at the 25th percentile, so in the interquartile range there. And it goes to sort of threefold if you look at the 10th and the 90th.

In Hildalgo County, there's McAllen, Texas, and that variation is about, I believe, six or seven times the national average -- again, at the per beneficiary level in health and price adjusted.

DR. MARK MILLER: We can also come back with, you know -- what you asked is doable. We can come back with a more specific statement about this many counties account for this much of the spending, that type of thing.

MR. BUTLER: My interest is not just, you know, the obvious targets, but what is the variation and ultimately how is it complemented by SNFs or the presence of other services? Just to get a sense of what's going on in the communities.

DR. MARK MILLER: We can speak to some of that. There was a presentation, I want to say either in September or October -- I can't remember right at the moment -- and we continued to do some work. When you look at variation across the country, a lot of the variation does seem to be driven by differences in post-acute care. And, two, there is some assumption, but, yeah, doesn't one of these things substitute for the other? Not so much. You're high, you're high.

MS. UCCELLO: I'm thinking about the co-pay and the incentives to drive people into other services, especially if supplementary coverage fills in the cost sharing for these other services.

MR. HACKBARTH: Could I suggest we come back to that in round two? I think that's a really important issue.

MS. UCCELLO: Okay.

MR. HACKBARTH: Unless there's just --

MS. UCCELLO: My question was just how substitutable are these. Is that two?

MR. HACKBARTH: Yeah. You know, I don't think that there's a simple answer to that, and it's going to take some discussion. So let's come back to it.

MR. GEORGE MILLER: Yes, I want to address that issue but will do it in round two.

Slide 5 and Slide 12, I've got the same question for both of those slides. That is, the increase in admitted patients from the community increased by more than 10 percent annually. Do you have that broken down for for-profit and not-for-profit for that increase? And on Slide 12, the same question, number of home health agencies continue to grow. Do you have the growth for for-profits

and not-for-profits?

MR. CHRISTMAN: The growth in agencies has been predominantly for-profits, so I'm going to say 80 to 90 percent has been for-profit. But, you know, with that said, I would just remind you that the financial performance differences between the for-profits and the nonprofits is a very small sector.

MR. GEORGE MILLER: I saw that. Very well taken. But still the predominance of the growth and the explosion, and in McAllen, Texas, is for-profit. Okay.

DR. BERENSON: Could you go back to 23 again where Peter was? I want to just pick up that substitutability question. I'm interested in the interaction between the home health in Medicare and home and community-based services in Medicaid. Well, first, just a simple question. What's the percentage who are duals, do you know?

MR. CHRISTMAN: It's between 35 -- episodes, between 35 and 40 percent.

DR. BERENSON: 35 and 40. In general, are home and community-based services provided by Medicaid through sort of waivers and home health complementary services? Or is there a substitutability component? I mean, do they work

together or do they work as substitutes, I guess is my question.

MR. CHRISTMAN: My understanding of this is not very strong, but it's sort of similar to the SNF world. I think whenever they can move folks into the Medicare benefit, they do, you know, if they qualify. But whether they function in a complementary manner the way you're describing, I'm couldn't -- I'm not sure I can --

DR. BERENSON: I mean, because it's striking. I mean, there's other hypotheses, but when you're looking at Texas and Mississippi and Louisiana and states like that, I mean, I just raise the question of whether they're not really providing an alternative in Medicaid, and so at least there's some attempt to use Medicare as the source of care. I mean, also personally having visited some parts of Texas and seen that there were six home health agencies in a town of 2,000 people, I don't think that's the whole issue. But I'm wondering whether it is playing a part, and I think we'd want to look into that.

MR. CHRISTMAN: There are a number of areas on that chart that are areas that have seen lots and lots of growth in agencies. And so, you know, you have a concern

that's part of the story. But there are a few that are as you're laying out. You know, I believe it's either Louisiana or Mississippi, for example, that has certificate of need and just hasn't seen a lot of growth in agencies, but we still see a lot of growth in volume and growth in high use.

MR. KUHN: Evan, one issue didn't come up, and I just want to check and see. The issue of the outlier, the kind of charging that we saw a couple years ago that CMS tamped down, has that issue been pretty much dealt with? Or is there going to be needed an additional policy work in that area?

MR. CHRISTMAN: They made a number of changes that I think we kind of have to see how they work. The two changes they made were -- just briefly, there were agencies that were manipulating their billing to charge for outlier episodes and get high payments for services that either weren't covered or were much cheaper than what Medicare assumed they cost. So they were able to make money on outliers, and CMS took two actions. One is they shrank the size of the outlier pool; it puts fewer dollars at risk. They went from a 5-percent pool to a 2.5-percent pool. And

they implemented an agency cap such that for no individual agency no more than 10 percent of their Medicare payments could be outlier payments. So if they exceed that cap in outlier payments, they have to give it back.

So, you know, I think that will have a significant effect. There are agencies that had very high rates of outliers. My understanding, you know, one home health executive told me -- an association executive told me that their phone was ringing off the hook because some agencies felt that their business plans had been exploded, and they were trying to figure out how to function in this new world.

So that change went into effect, if I'm counting my years right, in the 2010 payment year. So I think we're kind of waiting to see what happens there, and right now we're kind of just focused on fixing the core case-mix.

DR. STUART: My question regards the interpretation of the data on Slide 7. We've seen this before, and the question I have is that the interpretation of the rise in the proportion of the population that meet these criteria and the expression both here and in the chapter is that this represents an increase in quality of care. But my understanding is that these are unadjusted

rate. Is that correct?

MR. CHRISTMAN: They're adjusted.

DR. STUART: They are adjusted.

MR. CHRISTMAN: They are adjusted.

DR. STUART: For?

MR. CHRISTMAN: Differences in, changes in comorbidities, functional characteristics, demographics.

DR. STUART: They are adjusted okay. All right. Thank you.

MR. HACKBARTH: On that same issue, in previous discussions the question that has come up about these measures is are they truly objective measures. Do you want to address that, Evan?

MR. CHRISTMAN: Sure. If I'm following you, there's probably two sets of concerns. One has been that these aren't based on claims data. These is the self-reported information from the industry.

And a second concern has been sort of this divergence between the adverse event rates and the functional rates. The functional rates show improvement. The adverse event rates kind of stay steady.

You know, a third concern has been that these are

sort of broad measures of quality, so, for example, they show improvement in walking even for people who may not have shown up at home health with a walking dysfunction.

So we have some work underway that addresses some of these things where we can. We're looking at clinically focused measures that look at improvement in walking for patients that just received a hip and knee replacement, and we are looking at claims-based hospitalization rates so that, you know, we can use that data and see how it compares to the self-reported data.

I think that sort of describes the past concerns and sort of what we're doing to come up with alternative measures.

DR. BAICKER: Just a brief follow-up on that. I would think the risk adjusters are unlikely to be perfect, and so this is also consistent with the story where as you just start getting more people enrolled, you're marching down the distribution, so it's a selection story even with the adjustment. You're getting healthy people in and they can walk real well.

My other question may be in the category of round one and a half, but it does have a factual nub, which is,

I'm really interested in the interaction of Recommendations 2 and 4, which both seems like great ideas, to foreshadow round two. But what I'm not clear on is how we would expect them to interact if they were deployed together. For example, are the services where you want people -- when people are paying more, you expect some services to get cut back. Are those the services that are being overcompensated now? So how would you expect introducing this co-payment to affect your ability to go back and do the better payment system? That's a question in the long run about the elasticities of different kinds of consumption, but in the short run, the models are all based on the behavior from the previous pricing regime. You introduce a co-payment, all sorts of things shake out differently. How do you build that into the model of what the right risk adjuster should be?

MR. CHRISTMAN: Sure. I haven't thought too much about this question, but I guess what I would say is, you know, the case-mix adjustment, the purpose of that is to pay more accurately for services, and it will increase payment for the non-therapy and decrease payment for the therapy. And that has definitely been one driver of volume, people

favoring those therapy cases. But whether that would affect the number of patients coming from the community, I don't think it would and here's why. I think that it comes down to the fact that about 10 percent of beneficiaries go to the hospital at all during the year, and so from the agency perspective, the pool of potential patients that they've sort of been expanding it to in the community-admitted is just so large. Whether they're going to offer them therapy or non-therapy services, you know, I think that the factors driving in that direction aren't going to be changed by the change in the case-mix. What they may offer or favor may change, but, you know, we've had this situation where hospital discharges have been flat or declining and agency census has been increasing. And so, in some sense, there's got to be -- I think the hypothesis is that there's at least some supply-induced demand in there, and what they offer may change, but the fact that the community-admitted patients is just such a larger potential market that many agencies will continue to look there.

DR. CASTELLANOS: First of all, good presentation. In your discussion, you mentioned that physician oversight was weak. I know in the material that you sent you

discussed that wide window of 90 days ahead of time and 30 days afterwards, and there was no discussion at all concerning recertification. I know we had briefly talked about this before. Has there been any more discussion as far as maybe tightening that up from the physician or physician-extended side, similar to perhaps what we've tried to accomplish with hospice?

MR. CHRISTMAN: Part of the struggle is that there's already, I think, some measures that are somewhat similar to what we've done in hospice in place and home health, not the exact same, and there's a couple of different questions in there. One is the window, and under the PPACA a beneficiary is supposed to have a prior encounter with a physician or a nurse practitioner before a physician can certify for home health. And out of concerns of maintaining access to care, CMS settled on a window that permits that prior encounter to occur up to 90 days before or 30 days after the physician certifies home health.

MR. HACKBARTH: Evan, is there a recertification required for each new episode?

MR. CHRISTMAN: Yes, there is. There's a recertification. The physician has to basically sign a

legally binding attestation that has False Claims Act and all that good stuff attached to it. And so the wrinkle is that the face-to-face encounter requirement right now only applies to initial certifications of home health. So when they're being recertified, the physician still has to fill out a legal attestation and all that good stuff.

MR. HACKBARTH: But no face-to-face for the --

MR. CHRISTMAN: No face-to-face.

DR. CASTELLANOS: Is there any more discussion as to our tightening that up, specifically recertification, face-to-face and cutting down on the window?

MR. CHRISTMAN: It's certainly something that we could consider. I don't remember exactly what we thought it has established for a window in hospice. And I think my opinion is that a more timely evaluation would be valuable, and just in the interest of balance -- I mean, they did it out of concern of access to care, so there are folks on the other side --

MR. HACKBARTH: As I recall, in a comment letter we suggested a narrower window, recognizing that it would require a legislative change, but a narrower window may be a good thing.

The other time we discussed this, though, Ron -- and you'll remember -- we had a draft recommendation to increase physician involvement in this. And I can't remember all the specifics of it, but ultimately we dropped it because we couldn't quite figure out how to make it work. I'm not going to be able to remember all the issues, but I remember well Tom saying that he was uncomfortable with the ability of physicians to monitor the use of the benefit, that they don't have the knowledge.

So it's definitely an area of interest, and we can go back to it. We need to bring forward that past discussion and see if we can use it as the foundation.

DR. CASTELLANOS: Thank you.

MS. HANSEN: Evan, you said something actually in response to one of the questions just asked. Did I hear you say that 10 percent of the Medicare beneficiaries have a hospital episode in any given year? Or did I mishear?

MR. CHRISTMAN: I hope I said that, yes, and I hope it's right. But that's the number --

[Laughter.]

MR. CHRISTMAN: I mean, if you know something different, please tell me. But I believe that's the number.

I make it a point of having this conversation with the hospital folks, and I believe that's what we landed on last time we had the conversation.

MS. HANSEN: I actually would like to follow up on that just so that we get a sense so that if there are about, say, just on the average, for the Medicare beneficiaries who are 65 and older, it's under 40 million, so that would be -- potentially 10 percent of that population would go. So if we could just verify that number, that would be good.

MR. CHRISTMAN: Sure.

MS. HANSEN: And then, secondly, back to Slide 23, this is just more of -- it just ticked my curiosity of the previous work on, say, the more efficient areas of services in communities that are -- use of Medicare services is on the opposite side, so it would be -- and I saw the earlier chart about the fact that some of the quality indicators of rehospitalizations or other things don't change. But is there a little bit more descriptive sense of the more -- kind of almost the -- whether it's the 10 percent that was brought up earlier, but just the more efficient Medicare use counties with good outcomes on the part of beneficiaries.

MR. CHRISTMAN: I think we could definitely pull

up areas that meet some sort of national average and what they look at. I think the difficulty is that, you know, even this data is a county-level average, and it's going to consist of providers who are really doing the right things and providers who are practicing in the wild, to use the term that's been used before. So really saying that, you know, this county looks good and this may represent some sort of optimum of home health I think would be difficult to conclude.

DR. MARK MILLER: The only thing I will add to this is you remember the conversation yesterday, we're also trying to get some data from Managed Care Plan to see what their patterns are like. But each of these always have compromises. Whether you're able to link that to quality outcomes is more difficult. I'm just trying to run this fact to ground. It's about 10 million admissions, but it's closer to 20 percent, I think, of beneficiaries. And I think that was...

MR. HACKBARTH: Clarifying questions?

DR. BORMAN: Evan, could you put up Slide 14? And, Glenn, this is really a clarification for you, and if you want to defer it to the next round, I understand.

This is a compound sentence here, so it's really two things. It's begin the two-year home rebasing and eliminate the market basket. In terms of us thinking to the next part of your question for sequencing, could you share the strength of the linkage? The "and" there, is this something that "if" and "and" together needs to stay together or is this something that we need to consider separately?

MR. HACKBARTH: I think the reason -- and, Evan, jump in if I'm off the mark here. But I think the reason for structuring it this way is that PPACA actually says go forward with rebasing, but then also give updates, which has the effect of undoing some of the rebasing. So, you know, if your goal is to bring the rates closer into line with the underlying costs, to go down and then up doesn't seem to make a lot of sense. And so this just makes it clear that we think that there ought to be rebasing and don't turn around and offset part of that through a market basket increase.

DR. BORMAN: Thank you.

MR. HACKBARTH: Round 2 now. We've got 45 minutes left in this session and, unfortunately, we've also got a

lot of different recommendations, so we're going to have to be really disciplined in how we go through this. Let me just also raise one other issue that I'd like people to react to. I raise the question of the sequencing of the recommendations that would influence the rates and the distribution of the dollars.

Another issue that I'd like you to react to relates to the recommendation on the co-pay. We have planned for the spring another discussion on restructuring of the Medicare benefit package, and the reason I wanted to offer this here, the home health co-pay is, this is one of the few services where there's zero co-pay today.

So one train of thought would be, well, a major overhaul of all of the structure is down the road and may take a long time. A more focused recommendation in one of the areas where we have zero may move more quickly. But again, that's an issue I'd like you to react to. Mitra?

MS. BEHROOZI: So on the sequencing question, which I hadn't thought about it at all until you raised it so this is off the top of my head, I mean, what I have thought about since the prior presentation that Evan did about this is that one of the big concerns is not the level

of -- is in addition to the level of the margins is the wide variability.

So I love the redistributive effect of the case-mix index adjuster, and I think that that's the priority just because that is so much more dramatically worse than in other payment systems, and because we don't want to do harm where there are providers who are trying to do the right thing and provide the non-therapy services. So that would not only protect them, but reward them in a way that they haven't been rewarded and take some of the money away that's not being spent appropriately at the high end.

I think consistent with that, then risk -- the whole risk corridor recommendation moves in the same direction of sort of bringing the ends closer to the middle. And then that middle being too high, you know, is what, I guess, would be addressed by rebasing. So while I understand that in current law, the way it's set out, it would take a long time to get there. I don't know that it's so important to necessarily move that up so fast and hard, and that's not really going to solve, I think, the worst problems because, you know, payments have been cut before and volume continues to grow and payments continue to grow.

I mean, rates have been cut before.

So I think that's, to me, the third in the line of three. Certainly, the final recommendation on doing more to combat fraud I totally support and would go farther probably.

On co-payments, I certainly like -- I think that what we need to do, and as you said, Glenn, this is an opportunity to do it in a targeted way, but we need to be consistent with what we want to do on the broader scene, which is to encourage the use of high value services and discourage the use of low value services.

So I appreciate that you wouldn't be proposing using -- applying a co-payment to post-acute services after a hospital or a post-acute stay. But then when it comes to the co-payment on the second or from the community episodes, I have some issues with imposing the co-pay as proposed here.

First, I think that having it be a flat co-payment doesn't relate it to the value of the services to the beneficiary. I mean, we're starting with the payment system structure to address provider incentives. Right? So we're talking about a 60-day bundle and we're talking about

adjusting the case-mix index within that bundle. But to the beneficiary, the 60 days is not relevant to how many services or what type of services they might be receiving within that bundle.

So for everybody to pay $300, or whatever that is, for that same period of time within which they might get 30 aide visits or 50 nurse visits is not very targeted in terms of the value to them, unless I'm misunderstanding it. I do note, though, that you said that we could also exempt episodes with very low numbers of visits, and I think that's a good approach.

But I think it would be helpful to, I don't know, allow the Secretary or somebody to develop a more targeted or more nuanced kind of approach that addresses it from the beneficiary value standpoint. I think there's also a potential that it doesn't relate to value to the program because if you treat all community admissions the same way, then you might be missing some opportunities to incent the utilization of home care that would avoid a hospitalization or something like that. I know you looked at the post-outpatient surgery category, but again, it might be useful to be more nuanced in the approach.

I also think -- and I said this the last time -- that a number like $300 is too high. It's too high for low-income people who are not dual eligibles, and I say this all the time, I know. Sorry. I'm a broken record. Dual eligible is not coextensive with low income. It's really not.

Again, if it's the same number for all people who are not dual eligibles, then you're going to have a lot of people at the lower end of the income scale making a decision based on the $300 that has nothing to do with, really, the value of the services to them. It will just be about the $300. Again, I think there's evidence that shows us a lot smaller number can be used to drive behavior while mitigating the potential effect of being too high a barrier that will make people avoid needed care.

I think, again, we need to look at it from the beneficiary perspective rather than the program perspective, starting with the 20 percent because that's what the program does in other areas. And here's the cost to the program of the benefit just is not looking at it from the beneficiary perspective. If you want to look at driving behavior, I don't think you need to start with, well, 20 percent of the

cost of the benefit to the program. You look at what would drive beneficiary behavior in a constructive way, again.

But on the point of exempting duals, this is more of a question and relates to what Bob raised about the state interplay. If you exempt duals, wouldn't that mean that you're exempting the state from covering the co-payment and then encourage a little bit more about what Bob brought up about possible shifting of what might otherwise be a state program?

And then the substitutability, that kind of also relates to what Cori was raising about would this not only possibly drive people to more expensive post-acute care, but even to hospice, I guess, right, where we see evidence that that's sort of growing into a long-term home care benefit. So I think taking those considerations into account is important.

DR. DEAN: Where to start? Just in response to the question about recertification, I guess it is true that we get forms stuck in front of us to sign about which we know very little as to what's actually happening. That isn't necessarily an argument against the concept.

I guess, Evan, I'm still not really clear as to

what the criteria for recertification is. Does it require that progress be demonstrated? I mean, for instance, when we're using, for instance, physical therapy and their swing bed program, that is the main criteria, that they have to demonstrate progress, and if they do, they can continue. If they hit a plateau, then not. What are the criteria for continuation?

MR. CHRISTMAN: As I understand it, really it's the two keys are the same as in initial certification, broadly. Is the patient still home-bound? And they still have a need for skilled care so they still need the physical therapy. Do they still need the nursing service.

DR. DEAN: Is need defined?

MR. CHRISTMAN: You're wading into waters I just don't know as well.

DR. DEAN: And that may be an issue in and of itself, if the criteria for continuing are very imprecise, it certainly --

MR. HACKBARTH: So right now, we don't have a recertification draft recommendation on the table for consideration, and there are issues that we would need to think through. Ron has asked that we consider that in the

future and we will, but right now, that is not one of the draft recommendations.

DR. DEAN: I understand, and I guess I would just say, I would agree with Ron. I think it deserves some exploration.

MR. HACKBARTH: What about the existing draft recommendations? What are your thoughts?

DR. DEAN: Well, I certainly agree with the direction of them. As far as prioritizing or sequencing, I'm not quite sure. Certainly the fraud issue probably ought to be number one, I would think, and then if the case-mix adjustments and rebasing is -- if there's an expectation that that will result in a more reasonable distribution of the resources, I'm certainly supportive. I guess I'm not sure I understand them well enough to really comment on that.

Looking at the data, the wide variation in resources expended per beneficiary is disturbing. The data, I think, that we saw that you folks sent me a while back there's a tenfold difference between expenditures per beneficiary across states, from the lowest users to the highest users. There just isn't anywhere near that much

variation in terms of clinical justification or clinical need.

So we clearly have a problem. Obviously, it's a complex one to know how to get a handle on it, but obviously I think these are a start.

So I guess, you know, how or what the strategy of the sequence should be, I think those are right moves. I guess I still am concerned about the low volume providers that I'm not sure are going to do well in any of these things.

The example in the written material of the fact that there's an area where Medicare payments were judged to be adequate, but there wasn't enough Medicare patients to support an agency, and so the agency went out of business, and how we respond to that I'm not quite sure except the bottom line is you have beneficiaries that don't have a service.

So I think it still is a worry even though it isn't -- Medicare may be approaching it in a reasonable way, and yet, still -- and that's certainly the case in the areas where I'm at. You have, admittedly, not large numbers, but you certainly have beneficiaries that just don't have access

to this service. So obviously I'm concerned. I don't know exactly what the response is.

MR. HACKBARTH: In a way, this relates to the rural report.

DR. DEAN: Yeah -- [off microphone.]

MR. HACKBARTH: Right. The question you and I have discussed via email is when there are situations like this, take the example of home health, Medicare is paying well. There just aren't enough Medicare patients to make the home health agency viable. Is the best way to solve that problem through still higher Medicare rates, or should the Federal Government provide support through some other channel to assure adequate access to essential health care services? So that's a question, I think, is better discussed not in the home health update, but in the broader, what should our policy be towards rural issues.

DR. DEAN: And I accept that. I think it is -- I mean, it's an outlier issue and how we respond to it. And like I've said, it's not huge numbers of people. I acknowledge that. And yet, at the same time, there are folks that could benefit. I mean, in our setting, there are other services that fill part of these gaps. That didn't

answer any of your questions probably.

MR. HACKBARTH: Sort of like I've got the drift. Mary?

DR. NAYLOR: So my recommendations in terms of sequencing would be that we would proceed immediately with efforts around the case-mix. I think that there are really important questions about whether or not the right set of people are getting to home care from hospital to post-acute. We still have no change in the needle on readmission rates in 30 days from hospitals, et cetera, and that they're getting to the right and most efficient services.

There are some issues around that. So I think that this case-mix work is going to help, really help in helping us to get that path much clearer, right people to the most effective and efficient sets of services which -- so I really think that's important.

I think this movement around the quality measures, which is not an explicit part of the recommendation, but part of the report, is also equally important, that we get the right set of measures to help us to understand that we've done that.

I was also immediately moved on number five, on

their review of the Office of Inspector General. Putting back lower and not immediately the recommendations related to rebasing, and then obviously protecting beneficiaries from possible stinting from rebasing, it seems to me, would -- they go together, but I would not put them immediately.

I would recommend that we recommend testing the impact of co-pay. I do agree with earlier comments that low income and dual eligibles are not the same, so we would really want to make sure that we were not in any way hurting low-income beneficiaries who absolutely need access to these services and who will absolutely look at that $300 as just a barrier that they can't overcome.

And finally, since it was raised on the certification, I would say this is also an opportunity for us to look at consistencies across the policies in hospice, advance practice nurses, certify, recertify. Here, I would think that we would also want to look at the capacity of advance practice nurses to participate as active players in that process.

MR. HACKBARTH: So let me just clarify on thing, Peter, before you go. So, Evan, briefly describe the timing of rebasing as it exists in current law and PPACA.

MR. CHRISTMAN: Sure. It would start in 2014 and starting in that year, the Secretary could begin to dial down payments by 3.5 percent in that year and each of the three following years. And then in each year, that 3.5 percent would be offset by the market basket update that year, which will be around 1 or 2 percent.

MR. HACKBARTH: And so the length of the rebasing process is stretched out by the fact that they're going down and then increasing by the market basket. So to get to the ultimate goal takes more years. Is that right? So you start in 2014 and you have a rather protracted process to get to the destination.

So one of the things that I feel pretty strongly about is that we need to rebase and we need to do it and at a pace significantly faster than that. I offered let's do it starting in 2012. We don't need to resolve it today, but even if we were to change the sequencing and say, oh, we've got to do the case-mix thing before we rebase, I would like to still be clear that oh, we're not talking about start in 2014 and do it over the next ten years or something.

DR. NAYLOR: I totally agree with that.

MR. HACKBARTH: Okay.

DR. MARK MILLER: Can I get just one other clarification? It starts in '14 or it can start in '14?

MR. CHRISTMAN: I believe it's required to start in '14.

DR. MARK MILLER: Okay.

MR. BUTLER: So just to clarify, I guess, if we had the right system case-mix today, coupled with a good co-pay and you could extract all of the targeted dollars through that means as opposed to rebasing, that would be my preference. So in other words, let's pretend we have the case-mix system done today and we were ready to go with co-pays, I would try to get to the spending target through those two means and not rebasing at all, if there was a way to do it. In other words, redistribute the dollars at a lower amount using the case-mix, and also have a co-pay. We just practically can't do that.

DR. MARK MILLER: Can I just ask, and just for clarification, the case-mix, as discussed, is a budget neutral transaction. So what I'm ask --

MR. BUTLER: See, I would marry it with the budget goal.

DR. MARK MILLER: So I'm going to restate. This

is exactly what I'm trying to draw out. You're almost saying something -- I'm asking. You're saying the case-mix would have the effect of leveling out payments. We were seeing that as a budget neutral transaction. Are you suggesting you would say no, you take the payments out of this side? Is that conceptually what you're saying?

MR. BUTLER: I think so, yes.

MR. HACKBARTH: So a non-budget neutral case-mix?

MR. BUTLER: Case-mix. In other words, I'm trying to get the rebasing done in combination. Throw it into the case-mix equation so it's not a budget neutral. I don't think we could do that given that we don't have the case-mix done in a timely fashion. But you said if it had been.

MR. HACKBARTH: Yeah.

MR. BUTLER: So I don't have an answer to how to do that. But in the end -- my point is, and everybody else's is, you're trying to affect individual behaviors in how the services are delivered at the local level, and rebasing is a blunt instrument that just takes money out of the system and it doesn't do anything about underlying delivery of services and behaviors of the individuals using them, I don't think.

MR. HACKBARTH: At the patient level or the --

MR. BUTLER: Yeah, or even in the -- let me --

MR. HACKBARTH: Well, rebasing. I'm sorry. Go ahead, Peter.

MR. BUTLER: It takes profits out of the system.

MR. HACKBARTH: Yes.

MR. BUTLER: I understand that. It doesn't necessarily change incentives for the home health to do things anything differently.

MR. HACKBARTH: Well --

MR. BUTLER: Except cheaper.

MR. HACKBARTH: For hospitals. We talk about pressure on the rates being an important force in improving efficiency. And so, I think the level of the rates matters a lot. If you have a base rate that is well above the cost of delivering the service, I think that's a problem.

MR. BUTLER: It doesn't do anything about the therapy services though, the way the system is skewed.

MR. HACKBARTH: And I agree and that's why I haven't said, oh, rebasing is the only thing we need to do in home health. Unfortunately, we've got a lot of things that we need to do in home health. That's why we've got so

many recommendations. So rebasing isn't a panacea, but I don't see if we did everything else but rebasing, that would solve the problem either. I think we need to do it all.

MR. BUTLER: Right. It's tricky. The other thing I would say, Mitra brings up an interesting point on the -- I think you're almost suggesting means testing at a co-pay level, which is, I think you're almost suggesting, at least you said $300 is too much. You didn't go as far as saying maybe it's $100 for this group and $400 for this group. But it's an interesting question because we have limited means testing at the premium level now at Part B and it does have implications.

How would you begin to think about it? Because you might have some kind of means testing, but in a consistent way across the various services, I don't know, but it's something that we should think about when we think about the $300.

MR. HACKBARTH: Yeah. And again, it goes back to the question of whether to think about the home health co-pay in isolation or as part of a broader redesign of the benefit structure. Mike?

DR. CHERNEW: So first let me say I find these an

absolutely wonderful set of recommendations and I'm rarely that positive as an economist. So first --

MR. HACKBARTH: I'm worried. What comes next?

DR. CHERNEW: My goal is three minutes so I'm going to talk quickly. First let me point out that if someone is unfortunate to get stricken with cancer, they have a huge set of co-pay requirements. Is someone, unfortunately, has a heart attack, they'll pay hospital co-pay requirements that dwarf any of the things we're talking about here. That said -- so I'm very supportive of the co-pay. I think $300 is too high for the reason Mitra said. I think you can much of the bang for a substantially lower number, so we'll have to discuss what the number is.

But the idea of not having a co-pay, I think, is incredibly inequitable to people that have -- we basically tax poor and rich people who have things that there's no behavioral thing that they can do to get around it. There's no evidence of fraud. There's none of these other beneficial things that this co-pay might do. So I think relatively speaking, the co-pay one is very important.

I want to say that it's very important that we do this in a way that doesn't make the admin part really

burdensome. So while I think it will be nice if we could have physicians certify people, I hardly think that's costless.

So I think some of these other tools, before I went through all these administrative things where I have people having to do this and you have to fill out that paperwork and you're going to have to do this thing with this oversight, I think a lot can be done if you try and get some of the payment and incentives right before you layer on a bunch of administrative things.

So that's why I really like the attitude behind many of these proposals, which I think go in the spirit of setting payment incentives right. So I think, for example, the case-mix stuff is extremely important. I'm worried about saying to order that first. I think we need to start on it immediately, but I think we can do things.

I would have put first, honestly, the fraud. The fraud stuff undermines support for the program. We will not have this program, we will not have rates that make this program viable if we can't control the spending. Everybody wants to control the spending that's fraudulent, let alone not valuable. Let's ignore the not valuable but not

fraudulent stuff because otherwise we're not going to be able to preserve the care that is so important for everybody else to get -- that we all agree on. So I think the fraud has to be done immediately in practice as we work on the case-mix stuff.

I think the co-pay stuff should go in as soon as we could do it. I would like to make it part of a broader benefit design thing, but I wouldn't want to hold it up to wait for that. I think the rebasing part is important. The one that I would put last, if I was doing all of these ones, is the blended payment recommendation three, and the reason is, I find it sort of goes everywhere with we're going to do some of this, some of that, with these corridors.

So unless I learn more and think more about just the implementation speed with which one can do all of those various things, it strikes me as taking Peter's basic view of we do the case-mix stuff and the co-pay stuff, the rebasing is important. I'm very supportive of the recommendation three on the blended payment amounts and corridors and all of that stuff, but I think we might not need it quite as badly as we got some of the other things done. So I might make that one last, if you asked us to

prioritize these, which you did.

MR. HACKBARTH: It occurs to me now that maybe the new Commissioners, this recommendation about corridors and blended payment may just be way too abstract, and so let me just really briefly recount the history here.

This was an issue that over time Bill Scanlon persuaded me was an important problem. And Bill's argument, which I ultimately found compelling, was that to have a prospective payment system you need a well-defined product, and home health is not a well-defined product. It's quite amorphous and malleable depending on how people want to use it.

And so, he thought it was ill-suited to a fully prospective payment. That's one of the reasons that you have (a) very high profit levels, and (b) a really wide range of profitability. And so, Bill said, in recognition of how ill-defined this product is, we should move away from fully prospective payment and use a system like blended payment or risk corridors that would, as Mitra pointed out, narrow the distribution. Take some money away from the very high profit agencies and maybe put a floor under some of the low profit and just really tighten up the distribution of

financial performance.

The language here is carried over from our last discussion of this. We stopped short of saying, we know exactly which to use, risk corridors versus blended payment. We thought it required more study. So that's where this comes from. Cori?

MS. UCCELLO: I am generally supportive of all of these recommendations. I agree with a lot of what Mike said. In terms of the sequencing, you know, I'm not sure I really have much to add on that. I think the case-mix -- I think rebasing before the case-mix could just exacerbate the problems of some of the inequities there.

In terms of the co-pay, in general I am very supportive of co-pay mechanisms. Clarification, I mean, we've been talking about this $300 number, but we don't have a number in the recommendation. Are we explicitly kind of leaving that or implicitly leaving that to the Secretary? Or do we really want to come up with a number? Just with respect to that, too, I agree that $300 gut-wise just seems high, especially if I think about this, you know, no-first-hour coverage and the substitutability and other kinds of things. But if that were $100 instead, I think you would

still get -- I mean, it still serves as a signal to people, and then I would be less concerned about some of these other issues.

MR. CHRISTMAN: Could I just say -- and this is just a point of clarification. You know, the co-pay amount, it is just sort of a stalking horse we put out there. But the point I guess I would just make is that as you go below $300, on a per visit amount home health is going to be cheaper than going to the doctor when it's more expensive for Medicare. So --

MS. UCCELLO: So you get substitution the other way.

MR. CHRISTMAN: Yeah, and again, there's a lot of factors you're going to weigh when you do the co-pay, and the optics of $300 is a lot. And so I don't want to dissuade anybody, but I just want to --

MS. UCCELLO: But it's also $300 -- that's also, you know, 17 if you're at the average, and even -- you know, what if you're at five, which is higher than visits, which is -- you know, where do you set that? So I just -- you know, signal-wise, just trying to get that right place.

MR. GEORGE MILLER: Yes, I agree with Mike that we

should address the fraud issue first, and in general, I'm comfortable with most of these recommendations. The one I have a little bit of trouble with that everybody's discussing is the co-pay. Had you come and said we need to redefine benefits because this particular product line, home care, needs to have a co-pay, I would be fine with that separately.

My problem is that we're trying this in an industry where apparently there's a lot of fraud, and one solution -- and these are my words -- seems to be there's fraud here and so how to solve the problem is we should have a co-pay and have people help pay for services and benefits they may not necessarily need. You take that aside, then I don't have a problem with the co-pay, but I agree that it should be probably, like Peter, means-tested to have that co-pay.

One thing that could be -- since we're talking about redistributing some of these services and reallocating, maybe instead of talking about a co-pay but maybe a beneficiary sharing I helping to reduce some of the costs in some way. I don't know the answer to that. I don't have a solution. And maybe co-pay is a better

solution, but if we try to achieve some savings in this market, maybe having the beneficiary share in some of that savings may be a way to think about it.

So, in general, I support the recommendations. I think fraud should go first. I could be persuaded about the co-pay, but it depends on what order and the sequencing.

DR. BERENSON: I support a co-pay, although this discussion suggests the need for quickly having that spring conversation because while I think $300 may be too much -- and yesterday it was noted again that the SNF after 20 days is $141 a day, that can add up to lots of barriers to access. The hospital first stay is over a thousand hours, something like that. So it's hard to have this discussion without having the bigger discussion, but I think it's reasonable to do it and to make the recommendation.

As I said yesterday, I think I would use the same argument to have a co-pay in hospice as well. I didn't quite follow Mitra's logic as to why you want to not pay on the per episode basis. You know, some patients go into the hospital for two days or three days and have the same first-day co-pay as somebody in the ICU for three months. Maybe that's not the right way. I'm not sure what marginal

decision you want the beneficiary to make based on the latter days, but this is not the time to have that conversation, I think. I think we do need to have a good, robust discussion of this in the spring.

On sequencing, I'm not sure I see much need for sequencing. The rebasing, as I understand it, it's in law to begin in 2014, and we're suggesting we move it up. So I think that if we're going to do it, it has to go right away, and Congress will either do it or they won't do it. The co-pay is another thing that Congress has to do, and we want to recommend that.

If it's the Secretary who has to do the case-mix work and then sort of the more complicated risk corridors, that kind of thing, that latter is going to take awhile. I mean, that's not going to be anything they're going to do right away. If, in fact, the rebasing, Congress does pass that, moves it up, then I think CMS takes that into account with any transition they do in the case-mix. I mean, I just think that we want to push all of this stuff out quickly, and I don't see any sort of logic that you have to wait for one to be done before you can propose the next one. I just think you just -- I don't think we have that kind of control

over the different actors and to how they're going to do all of this stuff.

So I would be for making these recommendations without a recommendation on sequencing.

MR. KUHN: As I think about the sequencing issue, I really want to -- where I'm thinking about it is a little bit where Mary was. What are the items that are going to accelerate and help us get to -- or create a better platform for hospitals and other health care organizations to deal with readmissions, ultimately get to ACOs, et cetera? What if any of these things could help accelerate towards that integration and create that platform? Particularly when you look at the data on page 7 and you look at the final two things, any hospital admission and any urgent care, we're not making any progress in those areas. And any of these recommendations that can help accelerate us in that direction to move forward would be where I would think on the sequencing. And of all the things that we have before us, I think the case-mix probably does the best or probably would be the one that would help us create that better platform and improve the system that would make it easier to implement the readmission issues, those kinds of things that

are out there.

So I would think we would go there as we go forward, although I think Bob makes some pretty persuasive arguments that it's just kind of all in.

On the issue of the co-pays, to help me kind of think this one through -- and I do think $300 is very high. But what would help me to think this one through a little bit is to look at little bit more at the underlying bad debt policies that we see with other providers out there. We've talked about hospitals, but hospitals, there is a bad debt provision in current Medicare law which I think covers up to 70 percent of the bad debt after due diligence in trying to collect. But there's no bad debt opportunities for Medicare to recover for other provider types out there, and it would be interesting to see for physician offices these other kind of settings out there, what's the absorption rate of the providers on the bad debt side of this and to see what's out there.

One could argue that with the kind of margins we're seeing here with home health, there's plenty of room to absorb some bad debt here, and it shouldn't create an access issue. But I'd like to kind of understand a little

bit what goes on in the other provider areas. Are we seeing bad debt go up because of the economy going down? Would that create a barrier? So that would help me kind of think that one through a little bit more.

DR. KANE: Well, I think since a 17-percent margin kind of gives you -- it attracts a lot of people that you don't necessarily want to have in the business since it has no capital requirements. I mean, they might need a little bit of IT, a little bit of a management control system, a little bit of worker training, and then it's like gravy. So I think my first priority would be to get rid of the 17-percent profit margin because it's just attracting in a lot of people who are not necessarily there for the right reasons. And I'm not talking for-profit or not-for-profit. I just think that's just way too much. So, therefore, the rebasing -- by the way, as I recall, there was something like double the number of visits in the old system, in the old episodes, upon which the current rates are based, as there are now -- change in skill mix but also like double the number of visits.

So let's just get down to the right amount, and I think that will solve some of the problems and who's in this

business and who's doing the stuff they shouldn't be doing.

MR. HACKBARTH: I really agree with that point. You know, it's an invitation to fraud to have huge profits. But on the declining visits, I think it was from the low 30s to low 20s.

DR. MARK MILLER: Correct.

MR. CHRISTMAN: Right. It was 32 to 22.

DR. KANE: 32 to 22, and then a change in mix that goes with higher skill.

MR. CHRISTMAN: Right.

DR. KANE: But, still, that's a big chunk of -- you know, what are we doing paying for that? I do think the case-mix is a no-brainer. Why not? You know, it obviously does the right things and rewards the right kind of behavior. And I do think that the fraud deterrent -- I mean, is there any way we can, you know, pay home health people -- Medicare beneficiaries who get approached with inappropriate marketing, I mean, I just think there's all kinds of reasons we should try to get rid of the bad actors in this business.

And on modifying the system with corridors and all that, I know I must have voted for that recommendation, but

I guess I'd rather see that energy spent towards, you know, what Herb was just talking about. What kind of outcome measures should we be focusing on and trying to encourage and build into the payment system rather than, you know, making sure that everybody -- from a financial way that they all get -- I'd rather say let's do it more from the outcome measure, that people don't get stinted because they had better outcomes because they're using the hospital, they're not being admitted to the hospital or urgent care.

On the co-pays, I'm very conflicts on this. I think picking one group that has to pay and another group that doesn't gets a little dicey because we've been trying to push substitute of inpatient care with outpatient care, and, you know, there's ambulatory surgery. So, you know, are they going to have to pay the co-pay, but if you had your surgery inpatient, you know, you don't.

There's also all the chronic disease management programs we're trying to see get going where home care is a central part of some of them, home monitoring systems, intervention. So I'm kind of not sure we know where to put the co-pay to encourage value as opposed to discouraging inappropriate utilization. So I kind of think that's

something we should recommend that we should maybe study, but I'm not sure we're ready to make that kind of a broad-based recommendation. I'm all for co-pays, but I think we should try to think about how to structure it to encourage more appropriate utilization, but when we don't know what that is, it's a little awkward to just say, well, because you came in from the hospital but you didn't. You know, I'm not comfortable with that. I think that's the one I'm the most uncomfortable with.

DR. STUART: I strongly support Recommendations 1, 2, and 5, and I think that order is fine. I don't support number 3. I understand Bill Scanlon's arguments on this, but the arguments are based on frustration, I think, rather than based upon any empirical evidence that this thing would actually work. And I'm really impressed with the analysis that Urban did regarding the case-mix, and so I would say, you know, before we say anything about bring cost reimbursement back, "Ahhh," I just don't want to do that. I would put my nickels on the case-mix. So I would get rid of number 3.

I'm also not at all sanguine about number 4 on co-pay, and part of that -- there are two basic reasons why.

I'm not opposed to cost sharing, but if you think about it, co-pays are generally applied to relatively low-cost -- not always but relatively low-cost services that are provided in some kind of a sequence. And so the question is, well, do I want to continue to use this brand-name drug or am I going to use a generic drug, or do I continue to go to the physician or maybe I visit some other type of practitioner. So it has to do with what the margin is, and the margin here, as I understand it, is a $6,000, approximately, cost of an episode. So the question that would be relevant to the beneficiaries is, Well, do I have the whole episode or do I have none of it? And I'm just uncomfortable about that, and I think that Nancy has raised that.

I don't know of any evidence base that would be relevant to understanding what a co-pay, whatever the level is, would actually have in terms of numbers of episodes. And, in fact, is that something that we really want beneficiaries to do? Or does it get back -- and I don't want to raise this as a large issue, but it comes back in. Is it really the definition of the episode that we're concerned about? Maybe the episodes shouldn't be as long as they are. Maybe they should be shorter. Maybe there should

be fewer resources within the episode. The co-pay wouldn't affect that at all. And so I'm not opposed to cost sharing, but I don't think co-pay is necessarily the right way to go about this.

The second piece, I think I heard you say, Evan, that -- maybe it was just in those counties, but that home health is heavily used by duals. Was it 35 --

MR. CHRISTMAN: That was a nationwide number. That was not just in those counties.

DR. STUART: Okay. Well, whatever the number is, it's high. And if we're not going to apply any type of cost sharing for dual eligibles, then logically we have to come up with some other mechanism to deal with the potential overuse or misallocation of resources for that very large proportion of the population. And so if you follow the logic that you have to come up with some other tool to address the issue for 35 percent of the users of this benefit, then the question is, Well, that tool, if it's going to be effective for the dual eligibles, might that be better than a co-pay or other form of cost sharing for the non-duals? And that's something that comes up again and again here, and I think we just kind of shovel it under the

rug and assume that, well, you can't charge duals anything and so we have to have some other kind of tool, but we don't spend a whole lot of time on what those tools are.

So I think that item 4 is -- that we're not ready for prime time on making a recommendation for a specific kind of change in policy. I really do think that we need to think this thing through more carefully. In the perfect world, I agree with Mike, this is something that you'd like to do in terms of looking at the broader structure for the program as a whole. I'm not opposed to going in for something else if we had a strong consensus that we knew what the something else is, and I just don't hear that consensus.

And then, finally, I'd like to come back to this. Evan, the reason I raised the question about improving quality -- because I think quality of care really is at the heart of this -- is that there's nothing on the slide -- and I checked and I didn't see anything in the text -- about what the case-mix -- in fact, whether it was case-mix-adjusted at all or what that case-mix adjustment looked like. So what I'd like to see is I'd like to see this chart reproduced for values that are not case-mix-adjusted.

Kate followed up and raised the issue that I had, which is a selection issue. If we think about the population growing who are getting this benefit and it starts from a very frail population becomes less frail, we have the selection issue, you'd expect that all of these indicators would be higher, and so if we were to compare the adjusted and non-adjusted and see that we have very different trends for the adjusted, then I'd be more sanguine about saying, yeah, well, there really is improvement in quality. But I'm not convinced on the face of it yet that we know enough to say that there really is an improvement in quality of care.

MR. HACKBARTH: Let me just pick up on Bruce's comments about the co-pay. As I hear this conversation, there are different potential rationales for looking at a co-pay. One, and the reason that this is being discussed at all, is that there are indications of potentially significant overuse of the benefit, and having some amount of co-pay might address that -- maybe not without collateral problems, but that's the potential rationale.

As a number of people have pointed out, then you start thinking about substitution questions and whether, you

know, we want people to go to the most efficient, and if you put in the co-pay are we going to steer people away from a potentially low-cost service into a higher-cost service, as Mary was indicating. And, you know, that's a really complicated question, and I'm not sure that any benefit design can perfectly address the issues of substitution. Those are really clinical judgments that, you know, you need to make working with real live patients on the ground. No benefit structure is going to be tweaked to the point where you can get people making exactly the right decisions. You can maybe get better, but it's going to be elusive.

The third rationale for looking at a co-pay for this is it's one of the only services that doesn't have a co-pay. We've got finite resources in Medicare, and as Bob was pointing out, there's not a whole lot of rhyme or reason to the way we distribute the burden among Medicare beneficiaries, impose very heavy co-pays on hospitalized patients that may have very little control over their ability to use the services. And just as a matter of equity, if we've got a finite amount of resources, we ought to think about restructuring the benefits so that the burden is shared more equitably at a high level, and in the

process, you know, introduce protections for low-income beneficiaries and the like.

So, you know, we sort of bounce around among potentially competing rationales for restructuring. The more I listen to the conversation, the more I think that maybe we need to talk about this as part of, you know, a bigger discussion about the benefit package as opposed to in isolation, even though I think we've got a serious problem with overuse.

I'll just stop there.

DR. STUART: I just want to make clear: I am not opposed to cost sharing.

MR. HACKBARTH: Yes.

DR. STUART: So my concern is more on the technical grounds of whether this is going to have the effect in terms of patient behavior that you want it to have.

MR. HACKBARTH: Right.

DR. BAICKER: Yes, separating this out into the patient side things and the provider side things, the co-payment is the odd man out. And being the only one on the patient side -- and in some ways you could unbundle that

into the same set of issues we're talking about on the provider side. There's the level of co-payment. There is the tilt in who should be paying more, who should be paying less, which services, et cetera. And I'm strongly in favor of co-payments. It seems both inefficient and inequitable to have zero co-payment on this highly malleable service when there are co-payments on things that are less discretionary. And for all those reasons, I'd very much be in favor of it, but I do think we probably need to unbundle it into those different components the same way we're doing on the provider side.

On the provider side things, I join everyone in being firmly anti-fraud, so let's certainly do that first.

[Laughter.]

DR. BAICKER: That's right. I'm going to take a bold stand here. Fraud is bad. And then thinking about --

DR. STUART: A tough decision.

DR. BAICKER: Yes. -- rebasing versus the changing in case-mix, I was a little unclear on the distinction that Peter was making in that I think of rebasing plus change in case-mix as non-budget neutral change in case-mix. You know, we're saying, okay, we're

going to tilt things and we're going to let the overall level be dialed up or, in this case, down. And I'm favor of both, and I don't know whether there's any advantage of doing one first versus the other if the case-mix isn't quite ready and the rebasing is. But I think of those together as changing the mix of payments to people and changing the total amount of money in the system at the same time. And treating them as separate recommendations just seems like decomposing that a little bit based on the availability of the measures, and that seems fine to me.

As for the risk corridor one, it is a little abstract for me to think about the particulars right not. It seems to warrant further discussion.

DR. CASTELLANOS: Quickly, I'm in favor of all of them. I strongly recommend the fraud and rebasing. Rebasing is already in law for 2014.

Like Mike and like a lot of us, I like the concept of co-pay. I'm a provider and I realize the value of co-pay in the provider community. I think it needs a lot of work.

Like Bob, I think we should push on all five of them at this time.

MS. HANSEN: Yes, I think the combination of the

rebasing, the case-mix, and the fraud are kind of a coordinated campaign that can be done, and I think as everybody is saying, the obvious one is the fraud one, especially since we can work with the -- or really refer this to the OIG, which actually gives a real important signal, you know, to the broader community.

The co-pay discussion I think merits the kind of discussion that other people have focused on. I am definitely also supportive of some sense of co-pay.

And then it sounds to me that Recommendation 3, which is the repeat or the Scanlon aspect, does really take a lot of intellectual rigor and complexity of doing it. So it's still worthy of doing it, but it just will require perhaps some other people in the broader field to perhaps focus on this kind of work that can inform us over time. But bottom line, I think it's still very merit worthy but very complex and requires a great of rigor to that.

MR. ARMSTRONG: Glenn, I just briefly would affirm I support the direction for all five of the recommendations.

With respect to the sequencing question, I, too, am like Bob. I'd do all five of them tomorrow if we could. I recognize there are some issues that have been raised, in

particular on the co-pays, but I'm not uncomfortable with a $300 co-pay, but I recognize it's complicated issue. And I really appreciated the way that you asked us to be cognizant of the fact there are several different, sometimes overlapping goals for implementing co-pays, and I think clarity around that is good. But I just think the risk is low enough that we shouldn't be too cautious about that in a world where there are such -- where we're paying so much more than what we're getting for through this program.

Then finally, to the point that was made by a couple of people earlier about the supervision and the recertification, I really believe that is worth some follow-up discussion at some point, partly because -- actually, probably mainly because I do see investments in home health and the value of home health and the return to the Medicare program at least to -- well, to a fairly large degree as an investment in advancing the health of the patients as part of a care system. And to the degree clinicians are accountable for the patient's care, at least at some point through that process or at various points through that process, it increases the likelihood that their care in home health is connected to a broader care plan for their health

in the broader sense.

So I know that's really not our topic for today, but I think both Tom and Ron said that this would be a worthy conversation for the future, and I would agree with that.

DR. BORMAN: I'm generally supportive of the package, and I share Bob and Scott's thoughts about moving forward expeditiously. I do think that some -- more than one of them raise issues -- or fall into the camp of the more complicated vertical and horizontal and generational and all inequities that we've talked about at points in the past. I do think that I'm comfortable with carrying forward number 3 because, as we carry forward many of our recommendations that don't get implemented, I think there's still a great deal of thought behind that. Nothing that we do here particularly changes the somewhat vague nature of what can be wonderful services under this umbrella, but it's a very broad basket of services and not uniformly applied. None of that changes that, and number 3 does speak to trying to deal with that in the context of improving this.

So I think rebasing is going to happen. I think the margins here suggest that it can happen sooner rather

than later without distinct harm to most, if not all, beneficiaries. So that I think those things go together, and if you have the rebasing -- I think the case-mix needs to happen additionally, so no reason not to proceed forward with that now. Number 3 is a carry forward. I think we do need to endorse a co-pay. Frankly, it sounds almost to me like it's a little bit -- what we've suggested is a little bit more like a deductible because it isn't indexed to the number of services and whatever. You know, but not being an insurance glossary person, I may be out of my depth there. But I think that we have endorsed the issues -- understand the issues with first-dollar coverage. Our own work that we've contracted out certainly supports some of those issues. And I think we can make a recommendation with being able to say that the specifics may require more work, that we ourselves may want to commit that we will examine this in this time frame; we may want to advocate some outsource or whatever for that. But I think not to go on record as part of this package that there should be a co-pay would be a mistake, or whatever we want to call it. So, in general, I'm supportive.

MR. HACKBARTH: We're at 10:12 right now, so we're

12 minutes behind. We've got to leave time for two more presentations, so thank you, Evan.

Now we need to move on to inpatient rehab facilities.

Christine, are you going first? Okay. Whenever you're ready.

MS. AGUIAR: During this presentation, we will discuss the adequacy of Medicare payments to inpatient rehabilitation facilities, also referred to as IRFs. IRFs provide intensive rehabilitation services, such as physical and occupational therapy, to patients after an injury, illness, or surgery. IRFs may be specialized units within an acute care hospital or freestanding hospitals. About 80 percent of IRFs are hospital-based and 20 percent are freestanding.

Medicare fee-for-service is the principal payer for IRF services, accounting for about 60 percent of total cases in 2009 and $6 billion in spending. Since 2002, IRFs have been paid on a per discharge basis, where rates vary based on patients' conditions, wages, and certain facility characteristics.

To qualify as an IRF, facilities must meet certain

criteria. IRF patients must require at least two types of therapy, one of which must be physical or occupational therapy. The patients must also generally need to tolerate three hours of therapy per day for at least five days per week. The facilities must meet the Medicare Conditions of Participation for acute care hospitals and satisfy additional criteria, such as having a medical director of rehabilitation on a full-time basis, having a pre-admission screening process for patients, and using a coordinated interdisciplinary team approach led by a rehabilitation physician.

In addition to the above criteria, IRFs must also meet the compliance threshold, also known as the 60 percent rule. The compliance threshold is important to understand because of the impact that it had on many of the measures of payment adequacy, so I will spend a few minutes to go over it.

The compliance threshold is a requirement that stipulates that no fewer than 60 percent of all IRF patients have at least one of 13 conditions. The purpose of the compliance threshold is to distinguish IRFs from acute care hospitals, and the 13 conditions are diagnoses that

typically require intensive in-hospital rehabilitation. Enforcement of the compliance threshold was renewed in 2004.

Also in 2004, CMS limited the types of major joint replacement patients that counted toward the threshold. Major joint replacements, such as hip and knee replacements, were commonly treated in IRFs before 2004. The combination of most of those patients not counting towards the threshold and renewed enforcement of the threshold resulted in a substantial decline in volume after 2004. As volume declined, occupancy rates and the number of rehabilitation beds fell, as well. Case-mix increased as the IRF patient population shifted to more severe patients that counted towards the threshold. Growth in cost per case also increased, as fixed costs were spread across fewer patients.

The compliance threshold was originally set at 75 percent. However, it was permanently capped at 60 percent in 2007. Since then, the industry has begun to stabilize in its response to the compliance threshold, as we will see in the following slides.

Just as a quick reminder, we use the same framework for payment adequacy as we use in other sectors.

I will now begin discussing our measures of access

to care. On this chart, you see the supply of IRFs from 2002 to 2009. Supply peaked in 2005 and decreased after that. In 2009, changes in supply varied by category of provider, with the overall picture suggesting that the supply of IRFs is stabilizing. The categories with the highest growth are freestanding and rural IRFs. Growth in rural IRFs occurred among hospital-based IRFs. There is at least one IRF located in every State, although IRFs are not evenly distributed among States. However, because other Medicare providers, such as skilled nursing facilities and home health agencies, also provide rehabilitation services, it is unlikely that many areas exist where IRFs are the only therapy provider available to beneficiaries.

Occupancy rates are one measure of provider capacity. Occupancy rates have been falling since 2002 and fell at a higher rate in 2004 when enforcement of the compliance threshold was renewed. In 2009, occupancy rates remain relatively stable, increasing slightly for both freestanding and hospital-based IRFs, although occupancy was higher for freestanding IRFs. The occupancy rate across all IRFs was 62.8 percent in 2009, which indicates that capacity is adequate to handle current demand and IRFs can likely

accommodate future increases.

The number of rehabilitation beds is another measure of capacity. The number of IRF beds declined by an average of 1.1 percent each year between 2004 and 2008, as IRFs adjusted to a decrease in cases due to renewed enforcement of the compliance threshold. In 2009, the total number of IRF beds decreased slightly, by 0.3 percent, the result of a decrease in hospital-based IRF beds and an increase in freestanding IRF beds.

This chart presents fee-for-service spending on IRFs, the number of fee-for-service cases, and fee-for-service payment per case from 2002 through 2009. As you can see, the number of IRF cases declined after 2004 when enforcement of the compliance threshold was renewed. However, volume began to stabilize in 2008 after the compliance threshold was capped at 60 percent. In 2009, volume remained relatively stable, with the number of cases increasing by 1.5 percent. The increase in the number of cases from 2008 to 2009 was due to an increase in both the number of unique beneficiaries receiving IRF care and an increase in the number of beneficiaries with more than one IRF stay in a year. The average fee-for-service payment per

case declined by half-a-percent between 2008 and 2009 because payments in 2009 were held at 2007 levels.

We also analyzed IRF patient mix, which has changed since 2004 as IRFs adjusted to meet the compliance threshold. As expected, the share of cases with conditions that count towards the compliance threshold has increased. For example, the share of stroke patients, shown on the graph in orange, increased by 3.9 percentage points between 2004 and 2010. Also, as expected, the share of major joint replacement cases, shown here in red, have fallen since 2004 when CMS limited the types of these cases that count towards the compliance threshold. Case-mix also increased as the patient mix increased, and between 2008 and 2009, case-mix grew by 2.3 percent.

We also analyzed changes in acute care hospital discharge destinations from 2004 to 2010 for hip and knee replacement patients to assess whether the compliance threshold impacted these beneficiaries' access to care. As you can see, acute care discharges to IRFs for hip and knee replacements declined by 15 percentage points between 2004 and 2009. However, discharges to skilled nursing facilities and home health agencies increased over the same period by

four and ten percentage points, respectively. Beneficiaries with hip and knee replacements that were previously treated in IRFs were able to receive rehabilitation services in other settings.

Now we will move on to two more payment adequacy measures, quality of care and access to capital. We measure quality by the difference between functional status from admission and discharge. Between 2004 and 2010, the gain in functional status increased 3.3 points for all fee-for-service patients. However, over the same time period, the functional status at admission declined because IRFs admitted more severely impaired cases that met the compliance thresholds. Currently, we cannot conclude whether the gain in functional status between admission and discharge is due to an improvement in quality or due to the declining functional status at admission.

Also, with respect to IRF quality measurement, the Patient Protection and Affordable Care Act requires IRFs to begin submitting quality measures in fiscal year 2014. We recently held a meeting with rehabilitation clinicians, researchers, and IRF medical directors to discuss the types of measures that IRFs should be required to report. I will

present the results of that meeting during the January presentation.

Access to capital is another measure of payment adequacy. Hospital-based units have access to capital through their parent institution, and as we heard during the inpatient hospital presentation yesterday, hospitals' access to capital appears adequate. Therefore, it is likely the hospital-based IRF units have adequate access to capital.

To measure access to capital for freestanding facilities, we review access to the credit markets for two major national chains. These chains continue to experience positive revenue growth and are able to access the capital markets.

We will now move on to measures of Medicare payments and providers' costs. This graph displays growth in payments and costs per case since 2002. Payments per case have grown faster than cost per case since the implementation of the PPS in 2002. In 2004, the gap between the growth of payments and costs began to close when volume declined due to renewed enforcement of the compliance threshold and the limitation on the major joint replacement patients that counted towards the threshold. With the lower

volume of fee-for-service patients, fixed costs were spread over a smaller number of cases and growth in cost per case accelerated.

Adjusting IRF costs per case for differences in wages, case-mix, and outlier payments permits a standardized comparison of costs across different types of IRFs. This table displays the characteristics of IRFs in the low- and high-cost quartiles of adjusted cost per case. This data permits us to begin constructing the profile of efficient IRF providers. While we cannot identify efficient providers without risk-adjusted quality measures, we can begin to see patterns in efficiencies with costs.

Larger bed size and higher occupancy rates are characteristics of IRFs in the low-cost quartile. The median bed size decreased from 37 beds in the low-cost quartile to 18 beds in the high-cost quartile. Occupancy rates also decrease across quartiles, with the average occupancy rate for IRFs in the low-cost quartile approaching 70 percent, while IRFs in the high-cost quartile are, on average, at half occupancy. Given that freestanding IRFs are more likely to be larger facilities and to have higher occupancy rates, it is not surprising that these facilities

are more likely to be in the low-cost quartile.

Case-mix does not vary by much across quartiles, suggesting that it is not case-mix but rather bed size and occupancy rates that are more indicative of lower cost per case.

This chart shows the Medicare margins for IRFs. IRF margins declined between 2008 and 2009, but remained a healthy 8.4 percent across the industry. The margin decline in 2009 is expected because 2009 payment rates were frozen at 2007 levels.

Margins vary across providers. Urban IRFs have higher margins than rural IRFs. However, the 18.4 percent rural adjustment factor contributes to the close margins for urban and rural providers.

Freestanding IRFs have substantially higher margins than hospital-based IRFs, and the difference between freestanding and hospital-based IRF margins grew larger in 2009. While freestanding IRF margins increased in 2009 to 20 percent, despite not having a payment update for that year, hospital-based IRF margins declined to point-five percent. The difference in margins between freestanding and hospital-based IRFs is likely due to the ability to manage

costs, which we will see on the next slide, and due to economies of scale. Hospital-based units, in general, have fewer beds than freestanding facilities and have lower occupancy rates.

To illustrate the difference in freestanding and hospital-based IRFs' abilities to manage costs, this graph shows the growth in cost per case for hospital-based IRFs, represented in the red bars, and freestanding IRFs, represented in the yellow bars. Growth in average cost per case for freestanding and hospital-based IRFs peaked in 2005, as the industry managed a decline in volume due to renewed enforcement of the compliance threshold. However, after 2005, freestanding IRFs were able to lower the growth in cost per case while cost per case continued to grow at higher rates for hospital-based IRFs.

As we have seen, aggregate Medicare margins for IRFs in 2009 were 8.4 percent. To project the aggregate Medicare margin for 2011, we modeled the following policy changes for 2010 and 2011. Market basket minus 2.5 percent, as specified in PPACA, for 2010 and 2011, and an adjustment to the outlier threshold in 2011 that CMS estimated will slightly reduce IRF payments. We estimate that Medicare

margins for 2011 will be 8.1 percent.

In summary, our indicators of payment adequacy for IRFs are generally positive. Supply and capacity are stable and adequate to meet demand. With the compliance threshold permanently set at 60 percent, the decline in volume since 2004 tapered off, and volume remains stable in 2009. We have seen an increase in functional gain, which suggests improved quality. However, we cannot conclude definitively without risk adjustment. Access to credit appears adequate for hospital-based and freestanding IRFs. Finally, we project the 2011 aggregate Medicare margins to be 8.1 percent, down slightly from the 8.4 percent margins in 2009. To the extent that IRFs restrain their cost growth, the projected 2011 margin could be higher than we have estimated.

The Chairman's draft recommendation for your view is: "The Congress should eliminate the update to the payment rates for inpatient rehabilitation facilities for fiscal year 2012." On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the payments in 2012. We estimate that this recommendation will decrease Federal

program spending relative to current law. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries. This recommendation may increase the financial pressure on some providers, but overall, a minimal effect on providers' willingness and ability to care for the Medicare beneficiaries is expected.

This concludes the presentation and I welcome any questions.

MR. HACKBARTH: Thank you, Christine. Well done.

We have 35 minutes for discussion, and so I think we're starting with Karen this time. Clarifying questions. Scott?

MR. ARMSTRONG: In some of the other sections, we've seen margins for hospital-based programs lower in part because of the higher overhead expenses, the burden that they're carrying. Is that part of what explains the differential margins for the hospital-based IRFs?

MS. AGUIAR: Sure. I'll take a crack at it, and then Craig, who's more familiar with the margins, could elaborate. I believe, especially with the hospital-based margins, we see a relationships with bed size which indicates that there is an economy of scale. And so of the

providers that have the bed size in the one-to-ten range, about 99 percent of them are hospital-based. The majority of hospital-based have between -- have less than 60 beds, whereas the higher percent -- about half of freestanding facilities have 60 or more beds. So there is that relationship in the margins there with economies of scale.

MR. LISK: Yes . You have to think the economies of scale is really the major factor here rather than the overhead is. You have to think as one of the requirements is having a full-time director of rehabilitation. So you divide that over ten beds, your cost is going to be a lot higher per bed for that expense versus a place with 60 beds, which may have more than just one person related to that.

But the other thing is when you look at the occupancy rate, too, is there are differences, the lower occupancy rate in the hospital-based versus the freestanding, too.

DR. CASTELLANOS: I'm not sure if this is appropriate at this time, but first of all, I support this. I think there's a real value. One of the criteria to get into the rehabilitation for the patient is he or she must be able to undergo three hours a day, right. Why is that just

for five days a week and not on weekends?

MS. AGUIAR: I'm not sure that it's not on weekends. I believe it's three hours a day for five days per week, and when you have -- do you want to elaborate on this?

MR. LISK: It was clarified more recently that it's for five days a week, and in fact, sometimes people need rest for their therapy, so they need some break. But it is -- I think that's something that has been, like, clarified recently. We can get back to you more specifically on that, but --

MS. AGUIAR: Yes --

DR. CASTELLANOS: I'd really like you to get back to me.

MS. AGUIAR: Yes, we will get back, and what it is is that therapy has to begin, I believe, within 36 hours, depending -- even if that person started on a weekend. So when they were admitted to the IRF is when that sort of clock starts, and then it has to begin, I believe, within 36 hours from them and then has to be at least, you know, three hours a day for five days. But we'll get back to you --

DR. CASTELLANOS: Thank you.

MR. LISK: The other thing, I think, is it's not 35 hours a week, and I think there was some indication from the industry that it wants to go to it being 35 hours a week, or maybe I did my math wrong, but -- but anyway --

DR. CASTELLANOS: Get back to me.

MR. HACKBARTH: Jennie, did I skip over you? Okay. Kate, clarifying question, Bruce, Nancy.

DR. KANE: Yes. It would be -- I know we had something in the paper about the MA plan use of IRFs. It would also be interested to look at the non-Medicare margins for this sector, just to get a sense of how far differently Medicare is to others, because this is an -- unlike home health, it actually has capital requirements, and so when you look at a profit margin, it's not the same kind of profit margin as when you're looking at home health and it would be better -- it would be kind of good to see how far off or close we are as we start to say, let's get those profits down. Now, I don't think they had a big problem when it was up around 14 percent, or even maybe eight percent. I don't know. But not having any sense of what the overall profitability is or the capital requirements means we're just picking a number for the profit side. So

do we have any sense of their non-Medicare profitability?

MR. LISK: If I look at the total margin for the freestanding facilities, because it's more difficult to separate that out on the hospital-based, the total margin on the freestanding is a little bit lower than what it is for what Medicare is paying --

DR. KANE: So we're overpaying relative to what the private sector and Medicaid might be paying.

MR. LISK: That --

DR. KANE: Or Medicare is paying.

MR. LISK: -- might be the implication on the freestanding. I don't know what it comes out to on the hospital-based side.

DR. KANE: Okay. My only other question is, do we have a sense -- in 2009, I notice the freestandings actually lowered their cost per case. Do we have a sense of how they did that?

MS. AGUIAR: I have asked one of the representatives who sort of was doing exceptionally well with their margins, but I do think I should probably go back and ask more providers to get sort of a broader -- I would rather go back and ask them again before I report back to

you on that.

DR. KANE: If there are any quality measures, it would be kind of nice to see how that goes along with what happens with the cost changes.

MS. AGUIAR: Yes.

DR. BERENSON: Yes. I have a data question and the easiest way to deal with it is to read two sentences from the paper. It wasn't in your presentation here. "In the first three years of renewed enforcement of the compliance threshold, 2004 to 2006, the aggregate percent of Medicare cases meeting the threshold increased rapidly from 45 to 60.1 percent. However, when Congress capped the threshold permanently at 60 percent in 2007, the compliance rate began to level off and it has remained between 61 and 63 percent."

I find it remarkable that the threshold level is the same as the average. I would have thought that a bunch would have rates at 70 or 75. Is this, one, correct, and two, are IRFs able to titrate their admissions so that they're all coming in at 60 percent?

MS. AGUIAR: We do get this data from eRehabData, and unfortunately, they don't have a complete sample of all

of the IRFs. Specifically, they're missing the largest freestanding IRF provider, which accounts for 20 percent of total revenues and 50 percent of all freestanding and for-profit revenues. So there is somewhat of a limitation. That aside, this data -- it has been consistent. We've been seeing this consistent trend previously, so we don't have any reason to think that that's not true.

What it indicates, sort of what it suggests is that they were reaching -- they were going towards having to comply for a 75 percent threshold, because originally when CMS -- in 2004, when they renewed enforcement of the compliance threshold, it was set at 75 percent and there was a four- or five-year, I believe, phase-in period to that. Then in 2007, it was capped permanently at 60 percent. So it seemed like they were reaching to meet that 75 percent threshold, and then once it was stuck at 60 percent, their compliance rate has been hovering around there.

DR. BERENSON: It wasn't clear. What happens to an IRF that doesn't meet the compliance rate?

MS. AGUIAR: I believe that they are not allowed -- they don't receive payment, I believe --

MR. LISK: They become no longer an IRF and they

become a PPS hospital --

MS. AGUIAR: Yes.

MR. LISK: -- and so they would be paid under PPS, which --

DR. BERENSON: The incentive is to make 60 percent, but not more than 60 percent.

MS. AGUIAR: Right. Exactly.

DR. CHERNEW: Can you just remind me what the copay is on an IRF stay?

MS. AGUIAR: It's the hospital inpatient copay. I believe it's $1,200, and it's only for patients that are admitted from the community, the community admits.

MR. HACKBARTH: So somebody is transferred after an acute inpatient stay, it's zero.

MS. AGUIAR: Right. Exactly. But they do have, after a certain number of days, they have a copay.

MR. LISK: Yes, if they exceed the Medicare limits on stays, then there is those --

DR. CHERNEW: Right.

MS. AGUIAR: Right.

DR. CHERNEW: But if you had a hip or a knee replacement and you were deciding between an IRF or home

care, the IRF copay is $1,200, or you might not be in the community, so I'm not sure exactly how this would work, but just conceptually. The home care, which you showed on one of your slides the substitutability --

MS. AGUIAR: Right.

DR. CHERNEW: -- it now would be zero. Home care would be free and the IRF would be $1,200.

MS. AGUIAR: Right --

MR. HACKBARTH: [Off microphone.] -- patient surgery.

MS. AGUIAR: Exactly.

DR. CHERNEW: [Off microphone.]

MR. HACKBARTH: So if they had a knee replacement or a hip replacement, that would be -- I think it's still inpatient --

MS. AGUIAR: Exactly.

MR. HACKBARTH: -- and so when they were transferred to the IRF, the copay would be zero.

MS. AGUIAR: Right. They wouldn't have the copay --

MR. HACKBARTH: And if they went home, it would be zero.

DR. MARK MILLER: And what's happening here is there's a $1,000 copayment on hospital -- or deductible on hospitalization, right?

MS. AGUIAR: Yes.

DR. MARK MILLER: That's what we're talking about here. And this is considered a continuation of the hospitalization, is that the point?

MS. AGUIAR: Yes. Exactly.

MR. BUTLER: All right. I have several slides to walk through to see if I can understand --

DR. MARK MILLER: [Off microphone.] I'm sorry. Just to stay on his point for one second, in the circumstances where somebody comes from the community, however --

MS. AGUIAR: Yes, that's correct.

DR. MARK MILLER: -- it's as if they pay a $1,000 deductible on a hospitalization, except they would be going to the IRF. And so in that instance, your point --

DR. CHERNEW: I don't mean to go across presentations, recognizing that would be too silo-breaking, but --

[Laughter.]

DR. CHERNEW: -- we were talking about a copay in the other one --

DR. MARK MILLER: I know.

DR. CHERNEW: -- and this is a substitute service, as you can see from Slide, whichever one -- Slide 10 shows you there's some substitutability between home health, up ten, IRF, down 15 percent. And so it strikes me as a potential thing that someone might be interested in, the copay symmetry. That was the only reason why I wanted to know.

MR. HACKBARTH: Absolutely. Do we know -- do you know off the top of your head what the percentage of admissions to IRFs come after an acute in-hospital stay as opposed to from the community?

MS. AGUIAR: I could get you the exact number. I believe it's less than three percent that come from the community to the IRFs.

MR. HACKBARTH: Right. So typically, it's going to be zero.

DR. STUART: But I believe the law on episode of illness would allow up to a 30-day or 29-day gap between the discharge from a hospital and an admission to an IRF would

be a continuous stay. So it might not -- so it depends on how you've looked at the relationship between discharge and admission. I mean, there could be a gap and it still would not generate the deductible.

MR. HACKBARTH: Okay. Peter, you're up.

MR. BUTLER: So I've understood in the past the differences in the hospital-based SNFs and home health and why the numbers don't add up here, and I understand the baseline on this and the different -- the economies of scale question. I clearly understand why there could be a difference. What I don't understand is the trend. One of your slides, and you're going back to 2004, so there's been relatively stable occupancy for both the freestanding as well as the hospital-based, modest declines in both. But the headlines is stable occupancy rate. So it's not like one has declined and the other hasn't.

So now go to Slide 16 and you say the main reason for the decline of 12 percent down to point-five percent in the hospital-based profitability, which has not occurred on the other side, is the growth in cost, and this slide clearly demonstrates that. It shows, though, in those earlier years that apparently the hospital-based folks could

manage the costs as well as the freestanding and suddenly they lost their -- they couldn't do it anymore, even though their occupancy didn't decline. It just -- it doesn't kind of make sense to me that this is just a, suddenly, something happened there.

So I come back to, do we have a change in the mix of patients, which is always Glenn's argument. If you can say that, then you can justify a difference in a rate increase or a rate amount.

So now go back to Slide 9, and I realize we're sitting here with one month before we're going to vote on something, so I don't know that we can get answers to this trend, but it is pretty striking that one would go up so much more than the others. I kind of wonder if this profile would look different in the hospital-based versus the freestanding, so that the mapping -- not that stroke, and these are measures of case-mix, but it would tell something about the underlying trend that would help explain the -- because I don't think management of the costs is significantly different in the two enterprises. I think we do have a mix thing going on. I don't know that we can quantify it, but I wanted to highlight that and see if

there's some way to kind of, just as the earlier question was how did they reduce their costs, I'm skeptical something else is going on.

MR. HACKBARTH: Interesting question, so Christine, have you looked at this? Have you done this graph for hospital-based versus freestanding?

MS. AGUIAR: No, I haven't, and I have to look to see if we are able to with this data source.

MR. HACKBARTH: Okay.

MS. AGUIAR: I have to look into it, and if we can, then I'll definitely produce that for you.

MR. HACKBARTH: Okay. So then turn to the graph on page 16. Do you have any hypotheses in response to Peter's question about why the marked difference in the trend on hospital-based versus freestanding?

MS. AGUIAR: So, I mean, I'm speculating at this point. What it seems to me is that both hospital-based and freestanding were both under some of the same pressures and responding to the 60 percent rule -- I'm sorry, to the compliance threshold, which was reinforced in 2004, and so which is why I think you saw a volume decline and a decline in occupancy rates and beds across for both.

And then it seems to me what this sort of implies is that the freestanding, which do tend to be larger and to have higher occupancy rates in general than the hospital-based facilities, were more able to control their cost growth, were more able to respond to the compliance threshold and therefore were just more effective at doing so.

The question of whether or not the patient mix and the case-mix is different, we haven't looked at that. So I'm going to check back to see if we can check into that. I think the one thing to keep in mind here is that the freestanding is dominated by one chain in particular who has 50 percent of freestanding revenues, and that chain, their margins are even higher. They're about 25 percent margins. So they are doing exceptionally well. They're doing better even sort of than you would expect if there was no payment cut in 2008 and 2009. So the freestanding numbers are also brought up by that company specifically.

MR. HACKBARTH: Yes.

MS. AGUIAR: And I think, you know, when we stratified the results of cost per discharge by the low cost -- when we standardized them, looked at low cost and high

cost, you sort of saw some of the same story. It's, like, higher occupancy rates, higher number of beds, of course, more likely to be freestanding is what sort of pushes you in the efficiency with managing your costs category.

MR. HACKBARTH: Yes. So let me ask this. I think that the decline in admissions was similar between the hospital-based and freestanding -- I'm a lawyer, I'm not a mathematician. Because of the smaller size of the hospital-based, any given decline in occupancy would have more of an effect on their year-to-year change in costs than it would for a larger institution, is that right?

MS. AGUIAR: Right, I think.

MR. BUTLER: The Slide 4 shows that the declines in occupancy was very modest and similar. I mean, it's not -- I wouldn't think it would explain all of that.

MR. HACKBARTH: Okay.

DR. MARK MILLER: The other thing here is we've -- and I don't know at least half of what I'm going to suggest, but there's also we've been tracking hospital cost growth and during that period it was a lot more rapid than the market basket. That's some of the discussions we've had in the hospital world about their cost relative to their input

cost. And I don't know what the cost growth has been on the IRF side. mean, we've been sort of making this argument that the hospital cost growth is not under the same kind of pressure because of the payment on the private sector side, and so I'm trying to figure out whether freestanding IRF cost growth is slower than the cost growth we've seen in the hospital sector.

MR. HACKBARTH: So you --

MR. LISK: Actually, can I add a piece of information that may be somewhat helpful? We can try to see whether we can go back and do what Christine is talking about in the analysis, but again, it's one large chain. So they're freestanding, so this will be a differential. But they did indicate they weren't as impacted as much by the 60 percent rule or the 75 percent rule because they did not do as much on the hip and knee replacements, for instance. And I think hospitals had a lot -- many hospitals had a lot more of those and had to adjust for those. So there could have been a bigger shift and change in the case-mix there, but that's what we need to go back and check. But that is one possibility, what we're seeing there. It's one reason for the differential.

MR. HACKBARTH: So you understand the gist of the issue that Peter is raising.

MS. AGUIAR: Yes.

MR. HACKBARTH: Let's see if we can bring some analysis to bear.

Mary, any clarifying? Tom? Mitra?

Okay. Round 2 comments. Karen?

DR. BORMAN: I generally support the recommendation.

MR. ARMSTRONG: I also support the recommendation.

MS. HANSEN: I support.

DR. CASTELLANOS: I'd support.

DR. BAICKER: I support it, as well.

DR. STUART: I support it.

MR. GEORGE MILLER: Aye.

DR. CHERNEW: Aye.

MR. BUTLER: Subject to understanding if there's a case-mix change or not, I would like to understand that.

DR. NAYLOR: [Off microphone.] Aye.

DR. DEAN: Yes, I would support the recommendation. It just strikes me, to compare this discussion and these data with the ones we saw previously,

it seems to me that in this situation and this service, we, correctly or incorrectly, we've been able to define the benefit in a more precise way and it looks like utilization is under reasonable control. I think there's maybe a lesson there for our previous discussion.

MS. BEHROOZI: Starting with the one "unless," the margins are high enough, so I support the recommendation.

MR. HACKBARTH: All right. Thank you very much.

[Pause.]

MR. HACKBARTH: So we are now to our final presentation on long-term care hospital services. And, Dana, you can start whenever ready.

MS. KELLEY: Good morning. So turning to our long-term care hospital update, you are well familiar with the update framework by this point, so I'll just start with a little bit of background on LTCHs to refresh your memory.

Patients with clinically complex problems who need hospital care for relatively extended periods are sometimes treated in LTCHs. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay greater than 25 days for its Medicare patients.

Due to these long stays and the level of care provided, care in LTCHs is expensive, averaging $37,500 per case in 2009. Medicare pays LTCHs under a per-discharge PPS and the LTCH PPS uses the same MS DRGs as are used in the acute care hospital PPS, but with weights that are specific to LTCHs.

For some patients, payments are adjusted to be more in line with those for similar patients in acute care hospitals, and I'll talk a little bit more about that in a minute.

Following implementation of the PPS in fiscal year 2003, Medicare spending for LTCH services grew rapidly, climbing an average of 29 percent per year between 2003 and 2005. This growth prompted concerns about the demand for LTCH care, patient selection, and the possible unbundling of services from the acute care PPS.

As a result, CMS implemented regulations such as the 25 percent rule, which reduces payments for hospitals within hospitals if they admit a certain share of their patients from their host hospitals. Between 2005 and 2008, growth in spending slowed to less than 1 percent per year.

After Congress rolled back or delayed

implementation of some of CMS's regulations in the Medicare, Medicaid, and CHIP Extension Act of 2007, spending for LTCH services began to climb again, as you can see here, rising 6.4 percent between '08 and '09, to reach $4.9 billion.

I'm going to quickly review changes to LTCH payment policies that were wrought by MMSI and subsequent amendments as well as by the Affordable Care Act, because so many of them affect factors we consider in our update framework.

First, as I mentioned, Congress delayed the phase-in of the 25 percent rule, as well as reductions in payment for LTCH cases with the very shortest lengths of stay. Second, in exchange for this regulatory relief, the industry faces a moratorium on new LTCHs and new LTCH beds through December 2012.

Third, Congress mandated that CMS report on the use of facility and patient criteria for LTCHs. You'll remember that this is something the Commission recommended back in 2004. The report from CMS was due July 2009, but as of today is still pending.

The fourth bullet here refers to PPACA as mandated reductions and updates to the LTCH payment rates. PPACA

required CMS to reduce the update by a quarter point for the second half of fiscal year 2010 and by a half point for fiscal year 2011. And then finally, PPACA mandates that CMS implement a pay-for-reporting program for LTCHs by October 2013.

You'll recall that LTCHs don't submit any quality data to CMS. In October, staff convened a panel to provide input on the development of quality measures, and I'm going to go ahead and present our update findings, and then report on the findings from the panel.

So turning now to our update framework, our first consideration is access to care. We have no direct indicators of benes access to LTCH services, so we focus on changes in capacity and use. But it's important to keep in mind that, as a previous service we've discussed this morning, the product is not well-defined.

There are not established criteria for admission to an LTCH so it's not clear whether the patients treated there require that level of care. And remember that many Medicare beneficiaries live in areas without LTCHs and so, presumably, are receiving similar services in other facilities.

So to gauge access to services we'll first look at available capacity, and you can see here the number of LTCHs in the U.S. From the early '90s, which isn't shown in this slide, but up until 2005, the number of LTCHs quadrupled. Growth in the number of LTCHs leveled off between 2005 and 2008, that period when CMS implemented the payment regulations that limited the growth in the spending.

As we've seen, spending began to climb again between '08 and '09, and the number of LTCHs did as well, rising 6.6 percent. This was surprising to some observers because the moratorium Congress imposed -- because of the moratorium that Congress imposed beginning in July 2007. But exceptions to the moratorium were made for LTCHs that were already in the construction pipeline and that exception allowed this influx in facilities that we've seen. Preliminary analysis suggests that far fewer LTCHs opened in 2010.

The rate of growth in the number of LTCH beds picked up between '08 and '09 as well, and nationwide, in 2009, there were about 27,000 certified LTCH beds. This shows growth in the number of cases per 10,000 fee-for-service beneficiaries and we can see a slight increase over

the past few years after a period of rapid growth. So taken together, these trends suggest to us that access to care has been maintained during the period.

Turning now to quality, as I said, LTCHs don't submit quality data to CMS so we rely on trends and in-facility mortality, mortality within 30 days of discharge, and readmission to acute care to assess gross changes in the quality of care in LTCHs. In 2009, these rates were stable or declining for most of the top 20 diagnoses.

Access to capital, as you know, allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access capital, it might, in part, reflect problems with the adequacy of Medicare payments since Medicare provides about two-thirds of LTCH revenues, typically.

In 2010, the three largest LTCH chains, which together own slightly more than half of all LTCHs, continued with construction of new LTCHs that were already in the pipeline, and thus exempt from the moratorium on new facilities. In addition, these chains acquired other LTCHs and other PAC providers.

According to the chains' filings with the SEC, all

three have access to revolving credit facilities that they've tapped to finance these acquisitions. LTCH companies are increasingly diversified, both horizontally and vertically, which may improve their ability to control costs and better position the companies for payment policy changes.

Nevertheless, policy makers' increased scrutiny of LTCH spending and quality has heightened investor anxiety about the industry, and some analysts consider it to be one of the most risky of the health care provider settings. Smaller chains and non-chain facilities have more difficulty accessing capital, but also are more likely to be limited by the moratorium.

How have LTCHs per case payments compared to per case costs? In the first years of the PPS, LTCHs appeared to be very responsive to changes in their payments, adjusting their costs per case when payments per case changed. Payment per case increased rapidly after the PPS was implemented, climbing an average of 16.6 percent per year between '03 and '05.

Much of this growth was due to improvements in the documentation and coding of patients following the

implementation of the new classification system. During this early period, cost per case also increased rapidly, albeit at a somewhat slower pace.

Between ‘05 and ‘08, growth in cost per case outpaced that for payments as regulatory changes slowed growth in payment per case to an average of 1.5 percent per year. After Congress delayed the implementation of some of CMS’s stringent payment policies, growth in payments per case began to pick up again, and between ‘08 and ‘09, per case payments climbed 6.4 percent. Cost per case rose less than 2 percent.

Consistent with this pattern of payment and cost growth, margins for LTCHs rose rapidly after the implementation of the PPS, rising from a bit under zero under TEFRA to a peak of 12 percent in 2005. At that point, margins began to fall as growth in payments leveled off. However, in 2009, LTCH margins began to increase again, reaching 5.7 percent.

This next slide shows 2005 and 2009 Medicare margins for different LTCH groups as well as the share each presents -- each represents of total providers and total cases. You’ll remember that ‘05 was the peak in LTCH

margins.

As you can see, there's a wide spread in margins, similar to what you've seen in other settings with a quarter of LTCHs having margins of minus 6.4 percent or less, and another quarter having margins that are 14.1 percent or more in 2009.

Margins for for-profit LTCHs are quite a bit higher than those for non-for-profits. We haven't broken out margins by urban and rural area here because there are so few rural LTCHs, about 21 or so. Margins for rural LTCHs are negative, which because of their small size, may reflect, in part, a lack of economies of scale.

We looked more closely at high and low-margin LTCHs to get a better idea of what's driving the margins. Because LTCHs often operate in the red when they first open, in this part of the analysis we included only LTCHs that filed cost reports in 2008 and 2009.

This slide compares LTCHs in the top quartile of margins with those in the bottom quartile. We found that lower standardized costs, rather than higher payments, drove the differences in financial performance between LTCHs with the highest and lowest margins.

High-margin LTCHs also care for more patients with mean total discharges of 533 compared with 410 for low-margin LTCHs. High-margin LTCHs have far fewer high cost outlier cases and lower outlier payments. In addition, they have a lower share of short stay cases, and you'll recall the facility's margins may be negatively affected by both these types of patients. Finally, high-margin LTCHs are much more likely to be for-profit.

So for purposes of projecting 2011 margins, we modeled a number of policy changes. First we included updates in 2010 and 2011. For both years, the update was the market basket less adjustments for documentation and coding improvements and the PPACA-mandated reduction for the applicable year. This resulted in a small but positive update in 2010 and an update for 2011 of minus .49 percent.

We also made an adjustment for changes to outliers in both years which we estimate will increase aggregate payments. Altogether, these effects will result in somewhat greater growth in provider costs than in aggregate payments. Assuming provider's costs go up at the projected market basket levels, we've projected a margin of 4.8 percent in 2011. You'll note that that's a positive margin in spite of

the negative update that facilities receive that year.

So to sum up our update analysis, the number of facilities and beds are up in 2009. We're seeing stability in the use of services. We've little information about quality in LTCHs, but mortality and readmission rates appear to be stable. LTCHs appear to have access to the capital they need, although the moratorium should now begin to limit opportunities for expansion.

Our projected margin for 2011 is 4.8 percent, and our projected decline in the aggregate margin is consistent with expected effects of Congressionally-mandated reductions and updates to payments.

We make our recommendation to the Secretary because there's no legislated update to the LTCH PPS. Our draft recommendation reads that the Secretary should eliminate the update to payment rates for long-term care hospitals for rate year 2012.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. So eliminating the update for 2012 will produce savings relative to a market basket. We do not anticipate any adverse impact on beneficiaries or on providers' willingness

and ability to care for patients.

Before I turn it over to you, let me fill you in on the findings from our recent panel discussion on quality measurement in LTCHs. As I mentioned, PPACA requires CMS to implement a pay-for-reporting program by October 2013. To help us provide input to CMS on measures that can yield meaningful information about LTCH quality, and hopefully influence the provision of care, staff convened a panel of clinicians, LTCH administrators and medical directors, quality measurement analysts, and researchers with knowledge of best practices in caring for post-ICU patients in LTCHs and other settings.

Our panel suggested that CMS begin with a starter set of measures building on those that LTCHs are already using for internal quality measurement purposes. One of the challenges for CMS will be to determine national specifications for the measures, consistent definitions of numerators and denominators, patient inclusion and exclusion criteria.

Panelists discussed several outcome measures. These three were considered to be the most basic. Panelists noted that many readmissions to acute care hospitals are

planned so that any measure of readmission should focus on unplanned readmissions. However, they cautioned that there are facility characteristics that can affect the rate of unplanned readmissions such as the presence of an ICU in the LTCH. So that will be something that CMS will need to keep in mind.

We asked the panel what patient safety issues were prevalent in LTCHs and what measures could be used to track trends in this area and encourage best practices. These measures that I've outlined here are discussed in detail in the paper and I can take any questions you have during our Q&A.

I do want to note that the general consensus among our panelists is that most, if not all, LTCHs are already collecting these types of measures internally.

Panelists also discussed some process measures that can help to improve quality of life for LTCHs patients. These include a meaningful use of the Electronic Health Record, advanced care planning and end of life discussions, measures that monitor polypharmacy and its affects, and the use of a ventilator weaning protocol.

Finally, panelists discussed the issue of risk

adjustment of quality measures in LTCHs. There was agreement that risk adjustment was generally not appropriate for patient safety measures as long as present on admission indicator was used. The consensus was that the development of a pressure ulcer was a bad outcome, no matter how complex the patient.

Panelists agreed that risk adjustment was necessary for outcomes measures, but the consensus was that risk varies less in LTCHs than in other settings, and many in the group argued that the issue of risk adjustment should not be an impediment to moving forward. There was also general agreement that until a common assessment tool is available, CMS's starter set of measures should be ones that can be collected from administrative data.

The findings from our panel meeting are summarized in the paper and will be shared with CMS staff. You may want to discuss whether MedPAC should make a formal recommendation on the development of a pay-for-reporting program for LTCHs. Such a recommendation might include encouragement to move to pay-for-performance as soon as possible.

A recommendation could also outline some guiding

principles for choosing the starter set of measures, such as that the number of measures should be relatively small, claims-based, and focused on outcomes and patient safety. A MedPAC recommendation could also suggest future directions for quality measurement in the LTCH setting, such as the use of an assessment tool and the types of measures that might be included in an expanded measure set.

So now I'll turn back to the draft update recommendation and turn the discussion over to you, and I look forward to your questions.

MR. HACKBARTH: Thank you, Dana, well done. So let's see. Which side are we starting on this time for Round 1 clarifying questions? Mitra, that would be you.

MS. BEHROOZI: Just being from a state where we don't have LTCHs, is it unique to New York? There are places that don't have LTCHs, right?

MS. KELLEY: Yes. New York is, I think, one of the few places that actually does this.

MS. BEHROOZI: And do you know anything about the characteristics of the places where it's not du jure but it's defacto that there aren't LTCHs? This might be too big a question for the first round.

MS. KELLEY: Much of the growth, for example, has been in the south, in Texas, Louisiana are standard places. And in places where there is not such a strict certificate of need.

MS. BEHROOZI: So where you don't find LTCHs where it's not forbidden, where it's not prohibited?

MS. KELLEY: What's been very interesting about the growth in LTCHs and the lack of growth in other places is that in recent years, we've seen most of the growth in areas that already have LTCHs. So there appears to be a concentration on duplicating services in particular areas rather than kind of dispersing them.

Rural areas typically do not have LTCHs and from a policy perspective, one would suspect that that's because the population simply doesn't support that many critical care patients in the area. Other than that, I don't have --

MS. BEHROOZI: Do you have a sense of where the services are provided? I mean, can you --

MS. KELLEY: When they're not in an LTCH?

MS. BEHROOZI: Yeah.

MS. KELLEY: Sure. Generally, patients are -- not all, but many patients stay in the acute care hospital for

longer and then they generally go to other types of post-acute care providers, particularly SNFs after the longer hospital stay.

MR. HACKBARTH: Mitra's questions make me think it might be useful for the new Commissioners to just spend another minute on sort of the context for this particular discussion. One feature of it Mitra has put her finger on which is the distribution patterns of LTCHs is interesting at least. They are concentrated in, as Dana just pointed out, rather than spreading. A lot of the new development is in areas where there are already LTCHs. So there are large swaths of the country dealing with, presumably, very similar sort of patients but doing it in other types of settings.

Related to that, of course, is that LTCHs are a relatively expensive setting. And so, four years ago, was it, Dana, the Commission recommended that in order to make sure that this very expensive resource was used for the patients who could best benefit from the level of care and cost of care, there ought to be facility and patient criteria on who's eligible for a Medicare payment.

Congress asked CMS to do a report on that, which is, as Dana said, is still pending. Could you put up Slide

10 for a second, Dana? Another interesting facet of the history here, and Nancy has often remarked on this. So here we have the advent of a prospective payment system. Usually the idea for doing prospective payment is it's going to help make the system more efficient and lower cost.

Well, we did prospective payment and cost growth and revenue growth took off. It became an attractive business opportunity for some people and we had rapid growth in the number of LTCHs, but again with this peculiar pattern of only in some parts of the country, which is, in part, a function of regulatory restrictions, but not entirely, and then sort of piling on in select markets, all of which led us to be concerned, again, about whether we have a sensible payment system, whether the criteria of who's going in are proper, and also concern about the payment levels.

Some of these issues have been dealt with by CMS and the Congress through ways that, at least to me, are cruder than I would like. The restrictions on the referral patterns that CMS instituted by regulation, four or five years ago, to me is a cruder approach than facility and patient criteria.

And then most recently, Congress has come in with

an absolute moratorium, which is sort of the ultimate crude tool. But there's some really unique dynamics at work in this field. I just wanted to highlight some of that history for the new Commissioners.

Okay. Continuing with Round 1 clarifying questions, Tom?

DR. DEAN: Yeah, just to follow up on Mitra's question, I suspect it's beyond any information you have, but this is a sort of unique model of care and it would seem -- are you aware of any comparative studies?

I mean, we know these patients get taken care of in places where these facilities don't exist, obviously, and through other means. It would seem that there would be a real value in trying to track patients that have roughly equivalent problems through different routes of care and see if we can come to some indication about both cost and outcome.

MS. KELLEY: The Commission took a look at that back -- we reported on it in 2004. We used 2001 data. So it's dated. But we looked at areas without -- what we tried to do was look at patients who looked similar to LTCH patients, but who did not use LTCHs, and to see how their

episode costs compared to LTCH patients.

The problem in our analysis and that has affected subsequent research also, is that we don't have any outcome data or quality measures. So we have no way to decide whether maybe it does cost more in an LTCH, but they may be getting much better care or much more appropriate care having better outcomes.

What we found and what other researchers have found as well is that the episode costs for LTCH patients are generally higher, and in some cases much higher, than if patients don't use LTCHs. But that cost difference really narrows if you focus on the most complex patients with the highest severity levels and, I think, declines to sort of statistical insignificance. That's also especially true for ventilator-dependent patients who are cared for in LTCHs.

DR. DEAN: Do you know what proportion of the patients admitted to LTCHs meet those criteria, the most complex?

MS. KELLEY: I can dance around that one a little bit. About 12 percent of patients have been -- in aggregate, have been on a ventilator for more than 96 hours. That percentage differs across different facilities. One of

the national associations did a study recently looking at -- trying to look at the cost of LTCH care, and they found that LTCH care was a savings for about, I want to say, 40 percent of patients. Those again were the sickest patients.

So there do seem to be, shall we say, a substantial number of patients that probably are not of the highest acuity.

MR. HACKBARTH: Round 1 clarifying questions. George?

MR. GEORGE MILLER: The staff has done an excellent job of providing demographic information in most of the other presentations to date, but I didn't see --

MS. KELLEY: I'm sorry about that. I can speak to that.

MR. GEORGE MILLER: Okay.

MS. KELLEY: And also, we'll make sure that that's included in the chapter as well.

MR. GEORGE MILLER: Yes.

MS. KELLEY: The use of the services is pretty much in line with demographics, with the general demographics of the program. Slightly more minority use, but not -- I wouldn't say an alarming difference. What is

very interesting is that other researchers who have looked at the use of LTCH care following discharge from an ICU with ventilator dependency, they have found a fairly significant difference in LTCH use among African-American patients, and the research that I've seen has not been able to tease out whether that's a referral issue, whether that's a family preference.

The mortality rate for patients who are ventilator-dependent, when they leave the acute care hospital, is very, very high. And so, there are patients who go to hospice and there are differences in patient election of those services across demographic groups. I will definitely refer to this in the paper.

MR. GEORGE MILLER: And a follow up to that, 70 percent of this is paid by Medicare. Do you know what the breakdown of the rest of the 30 percent would be?

MS. KELLEY: Off the top of my head, I'm going to get it wrong, so I will also include that.

MR. GEORGE MILLER: Okay. Do you know if Medicaid is a large --

MS. KELLEY: Medicaid is not large there.

MR. GEORGE MILLER: So this is not a dual eligible

issue as well, or would it be?

MS. KELLEY: I'm not sure.

MR. GEORGE MILLER: Okay. Thank you.

DR. BERENSON: I missed any discussion on what the cost-sharing obligations of beneficiaries.

MS. KELLEY: Well, this is the hospital service. You know, generally, an acute hospital service. So it's the same premium and cost-sharing as in the acute care hospital and as with as Cristina was talking about, with IRFs, if the patient comes directly from the hospital they've already met that obligation.

DR. BERENSON: With Bruce's notion of the 30-day episode.

MS. KELLEY: Yes.

DR. BERENSON: So, theoretically, but these are very sick patients, or many are. Okay.

MS. KELLEY: These are. I would say in most cases home health care is probably not the substitute if that's the question.

DR. BERENSON: Yeah, and so that's where I was going next. In the work you did five or six years ago, whenever it was, the alternatives where you don't have LTCH

presumably would be either a continued long stay in an acute care hospital or in some cases the SNF --

MS. KELLEY: Yes.

DR. BERENSON: -- the complex SNF patients.

MS. KELLEY: Yeah. Some areas do have very high complexity SNFs where patients are cared for.

DR. BERENSON: And there, we would then have a very significant incompatibility of cost-sharing obligations between the patient, the beneficiary who's in a SNF and after day 20 is facing a daily significant out-of-pocket, whereas here they're not.

MS. KELLEY: True.

DR. BERENSON: Okay.

MR. KUHN: Two quick questions: One on page 18, when you were talking about the suggested outcome measures, and I was particularly interested in the one in the in-facility mortality. I remember looking at some data several years ago where it appears that mortality rates for short-stay patients was much higher than for longer-stay. One of the policy assumptions people were drawing from that is that these individuals perhaps maybe should have been more directed to hospice rather than admission to a LTCH.

When you had this conversation with the community, is there a discussion of differentiating on the inpatient mortality in terms of short stay, long stay?

MS. KELLEY: One of the things we heard loudly and clearly from our panelists was that often patients end up in the LTCH because physicians in the acute care hospital want to shift a patient elsewhere, and either the family or the physician wants to avoid difficult decisions. There was a consensus that patients come to the LTCH sometimes who should not come. Their survival, expectations for survival are quite low, and it's probably not the most appropriate place for them to be cared for. On the other hand, sometimes there aren't easy decisions about where else they should go.

MR. KUHN: Thank you. And in that regard, obviously, a facility or patient criteria would probably help in some of the decision-making as we go in that direction. So I know CMS has a report pending, but I also understand the industry has put together some pretty thoughtful recommendations of some criteria. Have we all reviewed their recommendations, and do we have a pretty favorable view of those, or what's the --

MS. KELLEY: I think the criteria that the industry has developed, or has recommended, is similar to the types of criteria that the Commission recommended back in 2004 -- setting up parameters for staffing qualifications, and also sort of some patient criteria that can help sort of narrow the patient population a little bit. RTI did the work for CMS on criteria, and they had very similar recommendations as well.

DR. MARK MILLER: This may be dated, but at the time that the two associations developed their criteria there was some difference between the two of them.

MS. KELLEY: Yes.

DR. MARK MILLER: Is that still true?

MS. KELLEY: The industry, I think, has been working together, increasingly working together on coming to consensus on these issues, but I think that there is sort of a general waiting to see what CMS is going to say.

DR. MARK MILLER: Yeah, and I just tease this out because I think perhaps behind your question is if the industry has criteria and we've suggested criteria, and I think there is some static between the two --

MS. KELLEY: There was --

DR. MARK MILLER: -- associations for a while, which may be working its way out. And then there's this issue of where the circumstance stands with CMS.

And I just want to make this conceptual point just to make sure. When we talk about the criteria here, we're talking about the criteria for this level of care --

MS. KELLEY: Right.

DR. MARK MILLER: -- as opposed to this is what it takes to get into an LTCH. I mean, as Bob is pointing out, a person like this can be treated in other settings. So when we spoke to the criteria, what we meant was a level of care that's needed as opposed to you have to go to an LTCH when you meet these criteria.

MR. HACKBARTH: I would think that the moratorium is a reason for the associations to sort of get together and say --

MS. KELLEY: Well, there's -- I would say that there are disagreements in the industry about the pros and cons of the moratorium.

MR. HACKBARTH: So my recollection, Dana is that, and this is going to be a gross oversimplification, but there's sort of a group of LTCHs that have been around for a

long time --

MS. KELLEY: Yes, that's right.

MR. HACKBARTH: -- that are largely or exclusively not for profit.

MS. KELLEY: That's correct.

MR. HACKBARTH: And then there are the newer ones.

MS. KELLEY: Yes.

MR. HACKBARTH: Are the associations divided along those lines?

MS. KELLEY: Not perfectly, but yeah.

MR. HACKBARTH: Okay. Nancy.

DR. KANE: Yeah, a couple questions. One is something just to link up something I've been working on. Are the staff required to get vaccinated for the flu season?

MS. KELLEY: The staff have to meet all the qualifications that acute care hospitals have to meet. So if the answer there is yes --

DR. KANE: That they don't have to.

MS. KELLEY: -- then they don't here either.

DR. KANE: Because I was reading that CDC was pointing out that they really should, but in long-term care facilities there's a much lower staff influenza vaccination

rate, and I just wondered if that would be one of the criteria we'd want to put in there since these people seem a pretty vulnerable to --

MS. KELLEY: These people are very vulnerable, yes.

DR. KANE: Then on slide 13, on the differences between the high margin and low margin I'm wondering two things. One is do we know if there are any quality differences even in mortality and discharge?

MS. KELLEY: Not really significant ones.

DR. KANE: So they look the same.

And do we know for the high-margin ones whether there' are any physician ownership issues around who goes, whether there's physician ownership of the high-margin ones that's any different than the low-margin ones?

MS. KELLEY: I don't know the answer to that.

DR. KANE: Because I think we're starting to collect that data. I thought we were. I'm not sure if that's actually happening. I'm wondering if it might be useful to get a sense of whether there is some selection going on in that referral that has to do with physician ownership issues.

MS. KELLEY: Okay.

MR. HACKBARTH: Clarifying questions? Kate.

DR. BAICKER: Just a quick one, I was very excited about all the different outcome measures you were talking about. To what extent are those measurable in other populations, so that we could get a better answer to the comparability of treatment in different settings? Do we have the data we would need to compare different settings?

MS. KELLEY: CMS has been working on a demonstration of the post-acute care tool that they tested in a variety of post-acute care settings including LTCHs, and the report on that demonstration is due in June or -- June? July?

June. So we're very much looking forward to the results of that, and CMS's goal has been to try to develop a tool that can be used across the post-acute care settings.

What we won't have is a similar kind of tool in the acute care hospital, and of course that's a place of overlap here too. But you know it certainly moves us in the right direction, and it would provide a lot of information about the care that's provided inside LTCHs, much more than we currently have.

MR. HACKBARTH: Round one questions?

[No response.]

MR. HACKBARTH: Round two comments, reactions to the recommendations? Mitra.

MS. BEHROOZI: I would support the recommendation, and certainly the concerns about quality are well placed. But just the concerns about having a payment system that seems to incent, I don't know whether it's building facilities or selection of patients or whatever, that we just seem to be paying too much for.

You said it, Dana. I'll just repeat it. The industry's own study showed that there was an efficiency gain or whatever, a savings, in a minority of the cases that we're paying them too much for is of real concern. So with that, I support the recommendation.

DR. DEAN: Yeah, I'd support the recommendation. I would also support Mitra's comments. It seems to me that sitting here with a kind of unique model of care for which we have a moratorium on is not a very satisfactory arrangement. I mean if this is a good way to do things, we should take off the moratorium; if it's not a good way to do things, then we should get much more aggressive in the other

direction.

So the quality issues I think are crucial, and the comparative, some sort of comparative information about how this approach relates to the other alternatives and whether or not the patients that are entering these facilities really are the ones that stand to benefit from this type of care are questions we don't really have answers to, it doesn't sound like right now. And I think we really need answers if we're going to come up with a logical approach.

MS. KELLEY: I think I have just one response to that. I think this was suggested in one of the earlier presentations today. I think in home health. I think we've got a lot of good actors here and then perhaps other providers who are not performing the way we would like. So I think the challenge is to try and direct the care in the way that we want as opposed to in a way that sort of is a financial performance issue.

DR. DEAN: Sorting out the good guys from the bad guys has always been a challenge.

DR. NAYLOR: I also support the recommendation and strongly endorse Tom's recommendation about comparative effectiveness work. I don't know that we do that, but

studies that would help us to uncover how similar populations are being served, how well and what are the costs associated with it. It's a great opportunity, and I think we need to encourage it.

MR. HACKBARTH: One of the reasons that this demonstration project and developing common information tools across the different post-acute settings is so important, that's the raw material with which you can begin to look at oh, these patients require this resource and other patients can be cared equally well for in another setting. So we're making progress towards that.

Peter.

MR. BUTLER: I support the recommendation and would like a short editorial as I reflect over our decisions over the last day and a half. We have again supported the migration of post-acute care to free-standing for-profit entities in a fairly rapid way and pretty much locked in, in many cases, double-digit profit levels.

This is nothing against for-profits. I think they manage costs well. They often add discipline to the market. So that's not the point. But we have kind of -- that's what we've in effect done, embraced that.

My second point, so what are the implications? It runs maybe, or maybe not, counter to the bundling that we need to get on with. At least it is posing either greater barriers or greater facilitations, and I think we need to worry about that.

Secondly, we really never talk about the willingness of the for-profits in the post-acute world to accept the charity care. We are just focusing on the Medicare access. So I'm a little concerned for those post-acute care providers that are in the non-Medicare business, the potential implications.

Finally, I think that we do need to think about again for-profits aren't bad, but who really do we want to be the assemblers of the bundles. We know the MA plan should do it. I think we need -- I'm not sure hospital-centric bundling is any better, and I'm not sure that multispecialty physician group bundling is necessarily better. We need patient-centric bundling, and I don't know how we have that discussion so that you really kind of -- otherwise, everybody is trying to be the bundler, and we're kind of letting it happen in ways potentially that I think we could be a more proactive voice in thinking about how

this happens.

MR. HACKBARTH: Peter, when you say your first point, when you say that the recommendations we've discussed encourage the growth of a for-profit, free-standing, post-acute industry, I take it what you mean by that is because the hospital-based services in the post-acute area typically have much lower or negative margins and we're not making any payment adjustment for that, which is causing them to exit, these hospitals to exit these businesses in favor of it being taken up by free-standing, for-profit providers. Am I understanding you correctly?

MR. BUTLER: A little bit of that, but I'm not trying to protect underperformance in the hospital-based services. I'm really not.

I just think that the other way of looking at it is the profit margins that we are supporting are encouraging the for-profits to enter and do more of it, maybe even more than is necessary. So set aside any biases against the hospital-based because actually in many of these areas we aren't that great at doing it. It's not our primary focus.

MR. HACKBARTH: Generally speaking, the conclusion that you draw from that is we need to be aggressive in

holding down the rates and squeezing out the very high profit margins that are attracting.

MR. BUTLER: [Off microphone.] Yes.

DR. CHERNEW: I support the recommendation, and I very much support what Peter said although I want to point out one thing. The problem is if you think there's heterogeneity, which we often think there is, you can't squeeze out the profit margins of the for-profits without destroying the profit margins of the ones that you might. I'm not arguing this because of the quality measure issue, but you can't get rid of the ones that you think are for-profit and the ones that you have that implication for without hurting the other ones even more because we don't have that lever.

And the problem that I think we have is a review of some personal bias. I am skeptical that we -- and we, I mean that sort of very broadly -- are nimble enough to both observe everything we would want to observe in terms of the heterogeneity and then develop the regulations in a way to get it done much more precisely. So in the end I support Peter's view of having a much more holistic, bundled view.

We talked about like 10 different types of payment

mechanisms. Roughly, five or six of them are all long-term care type, post-acute type services with some level of substitutability.

We have very siloed discussions, very inconsistent incentives in terms of co-pays, as Bob pointed out about what happens, very different incentives about profit margins, very different incentives about a whole series of things, very little ability to have quality measures. We often treat the quality measures completely different, so the same person in a nursing home might have a different quality set of metrics than that person in a long-term care facility.

So my view is although I completely agree with Mary that we need much more clinical research I don't view that as fundamentally informing payment strategy as much as actually clinical providers, to help them decide what to do. And we need to make sure that we have the payment system that enables the providers that want to do well and succeed, with that information, to be able to succeed instead of one that just pushes care down.

And we need to come up with quality measures that are patient-centric across the whole type of patient as

opposed to site of care, place-centric. I guess site and place are redundant, but anyway centric.

I think my general spirit of the recommendations would be to move as quickly as we can. I like this recommendation.

But separately, sort of our other June report type thing, to try and get through these silos instead of spending all of our time trying to look within the silos about huge amounts of heterogeneity, and then we realize yeah, but those people could be here, and then we have to do another one, and then we have to do another one.

Then we want to put something in, but someone points out there is some sort of cleavage in the payment system. So you get this if you've been discharged from this after three days, but not after four days.

So you see all these ones with green and red bars, and you see people, like I think it was Evans. They split out. They were all lumped in the middle. Now they're all lumped to the sides.

And we have an exception for the 25 percent rule, but if it's even, if it's a county that begins with a vowel, we give them an exception. And you know all --

MR. HACKBARTH: Payment reform is important, I take it.

[Laughter.]

DR. CHERNEW: Right. So I guess my point is I think we should just go forward with this and devote a lot of these other more detailed energies towards getting us to where we want to go as opposed to the interim steps in this bad system.

MR. HACKBARTH: Yeah. Cori.

MS. UCCELLO: I agree with the recommendation, and I agree that we do need to think about this stuff more holistically and substitution and make sure all that makes sense, but that's not for today.

MR. GEORGE MILLER: I agree with the recommendation. I agree with Peter except for I'd like to substitute the word "bad actors" -- I think Nancy used that term -- versus "for-profit," which is probably surprising coming from me.

And I also agree with Michael that we should probably try to find a way to find quality measures that go across silos and sectors, so that we can evaluate collectively should a patient be in an LTCH versus an acute

care hospital setting and be able to differentiate that.

Like it or not, there is still a cost issue. Is the quality better, but do we pay $1,000 more for it in a different setting? So those are some of the issues we should discuss.

And certainly quality has got to be the lever first, I think, and certainly cost, but we do it inversely. We talk about the quality, but we look at the revenue data, and then we make the decision. So somehow we got to link those two stronger together in my view.

DR. BERENSON: I support the recommendation and at this moment have nothing to add to what has been a very good conversation.

MR. KUHN: I'm generally supportive of the recommendation although I would be a lot more enthusiastic if we could add to the recommendation a restatement of I guess the four-year ago proposal of some classification criteria that's out there.

You know, by the time this report is published in March of next year we'll be two years out from when a report is due from CMS. The industry has already coalesced around a set of criteria, and if you look at this industry, the

only -- as it was reported here, the only criteria for LTCHs is that it's an acute care hospital with an average length of stay of 25 days or more. You know.

I think they're entitled to a little bit more or else they're going to be caught in this quagmire that we're caught in here -- is that it's hard to make decisions when you really don't have these things nailed down a little tighter. And I think if we could rethink that and put something, a little stronger statement there, I think that would be very helpful.

MR. HACKBARTH: Well, what we could do is rerun that recommendation in a text box and include a passage in the text, reiterating how important we think this is and urging to get on with it.

Nancy.

DR. KANE: Yeah, I support the recommendation. I think we don't know enough to not accept that the profit margins seem and the supplies seem -- they're there, and we don't know if we want more or less of it at this point.

I just wanted to follow up on something Bob mentioned about the cost-sharing difference between a SNF and a LTCH. That's kind of worrisome to me, and I'm

wondering how many people actually go out to the SNF 20 days, whatever it is, and then switch to the LTCH to avoid. I wonder how much of this is being driven by the cost-sharing aspects of demand rather than the medical needs as well, and it would be interesting to sort of get a sense.

I don't know if any of these people get admitted from SNFs, but if they are it would be interesting to see what that episode looks like and whether it's right at the day they start cost-sharing that they get transferred into the LTCH.

MS. KELLEY: It's something close to 20, 18 to 20 percent --

DR. KANE: That's a lot.

MS. KELLEY: -- that get admitted, well, not necessarily directly from a SNF. They get admitted -- they are not admitted directly from the acute care hospital. Most of these patients were somewhere. I mean most of these patients weren't at home.

DR. KANE: If you're on a ventilator, you weren't at home. So it would be nice get a better sense.

And maybe one recommendation we could add to all this is something about the co-pay differential and how that

incentive to go to an LTCH when the co-pay starts picking up in a SNF might be waived if indeed that's what's happening. I don't know.

MR. HACKBARTH: You know, I agree with the general point about looking at the co-pay structure around issues of substitution of services. That's really important.

But we also need to remember that the way this system works now the vast majority of patients have supplemental coverage. That means these issues are irrelevant. They're not facing cost-sharing at the point of service. So the issues are less sharp than they seem in the abstract.

Bruce.

DR. STUART: I support the recommendation.

DR. BAICKER: I support the recommendation. I support Mike's little rant. And I'm wildly --

[Laughter.]

DR. CHERNEW: [Off microphone.] [Inaudible].

DR. BAICKER: And I'm very enthusiastic about increased data availability and better metrics that would let us look across silos better.

DR. CASTELLANOS: I likewise support the

recommendation. I think the discussion has been very, very positive, and I look forward to trying to solve this post-acute care setting dilemma.

MS. HANSEN: I support the recommendation, and I think I picked up also this whole issue of general cost-sharing as a larger topic. I know definitely that right now there's a great deal of coverage by supplemental policies, but that is going to be changing as a result of PPACA.

So I just wonder if when we talk about benefit design in the future and we were talking about cost-sharing, especially with the home health benefit, whether or not there's work underway or whether there is some work that we could think about that speaks to the whole Medicare sets of programs that we do and is existing cost structure of what the co-pay would be, with the asterisk, knowing that right now these supplemental programs do cover it. But if we're starting to move to the principal of cost-sharing, could we have something that's a little bit more unified, describing this, and having it come described by virtue of the current siloed programs?

But I think it was Mike who was starting to say, you know, it's really regardless of let's just say that

there's an example of a septicemia or some of the diagnoses that are listed here in these areas. What would normally, possibly happen from a more client basis -- occur -- because if you were in a rural place where you don't have this versus a place that could use other services than a facility-based service? How does that show up in the cost-sharing and trajectory that they would go through?

So it's turning it around, but anticipating what we need to think about the whole concept of appropriate cost-sharing in the benefit design for the future.

MR. HACKBARTH: On Jennie's first point, PPACA, my recollection -- somebody correct me if I've got this wrong -- is that by 2015 the insurance commissioners are supposed to submit recommendations on including cost-sharing in the 2 most popular models of supplemental coverage, which currently have basically no cost-sharing at the point of service. Is that right?

Scott.

MR. ARMSTRONG: I, too, support the direction that the recommendations are taking us in.

I also just want to say I really appreciate how Peter and Mike framed the broader set of issues that I look

forward to us talking about.

I was just looking and recognized if you put skilled nursing, the inpatient rehab and long-term acute care hospitals, what we spend on those, it's starting to get to get to $40 billion. At this inflation rate, it will catch up with what we spend on provider payments pretty soon. So it just seems to me that the way to get it under control and to feel that we're getting a better return is to look at how it all holds together in some different way from the way in which this siloed approach requires us to look at it.

DR. BORMAN: I support the recommendation. I would just throw out the thought that as we identify some areas about, that potentially could be enlightened by comparative effectiveness reviews or sponsorship of work, perhaps we should be having a running list that we might share as PCORI takes shape and moves forward because some of the things that were kind of in an abstract on the starter set for them to look at may or may not be at the point of the sword so much as some of the things that we might help identify in our conversations.

MR. HACKBARTH: Okay, I just want to offer a

thought on this issue of for-profit, not-for-profit. You know we've got 17 commissioners. I imagine we probably have 17 different points of view on that issue.

My own I think may be similar to Peter's. I don't personally have an objection in principle to for-profit institutions. I don't think for-profit are inherently worse than not-for-profit.

I do believe though that they respond differently to the payment systems, and we see that in a variety of different ways. One way, which Nancy flagged, is if you have really substantial overpayments that's going to attract a lot of for-profit activity, aggressive entry into places where there are high profit levels.

Another way we see evidence of in the hospital payment system, if you remember the low pressure, medium pressure, high pressure analysis that we discussed yesterday. For-profits, even when they were under low pressure, tended to have lower costs whereas not-for-profits, if they have high revenues, are inclined to say: Oh, I have a mission. You know. It's to delivery health care to my community. I've got more money. I'm going to invest more in that mission.

A for-profit is going to look at oh, I need to make a return to my shareholders, and I'm not going to maybe incur some additional costs that a not-for-profit might. So they, for sure, respond differently to the incentives and typically will respond aggressively.

I think the job of the Commission and what we need to do on Medicare is make sure that our payment systems are fair and don't allow undue opportunities for people to make inappropriate profit, and we need to maintain pressure across all of the payment systems.

Then I join Mike's --

DR. CHERNEW: [Off microphone.] Rant.

MR. HACKBARTH: -- rant.

[Laughter.]

MR. HACKBARTH: You know, about the urgency and the importance of moving on and getting to new payment models and getting out of the fee-for-service silos that we're in. So that's my final word for this meeting.

Thank you, Dana.

We'll now have our public comment period.

MR. KALMAN: Good morning. I'm Ed Kalman. I'm general counsel to the National Association of Long-Term

Care Hospitals. I'd like to help clarify the Medicaid question that was raised.

As you see, the growth in long-term care hospitals in the states of Texas and Louisiana, those states have a limit on Medicaid days. They only allow 30 Medicaid days. So these patients with very long stays have used these days up. If you look at the data, a lot of these patients are dually eligible. I come from Massachusetts. We have -- and New York where New York Health and Hospitals in the long-term care hospital business, we have lots of Medicaid patients because they cross over. So that's helpful to that question.

We are also the association that did the study on cost-effectiveness, and we did it because we wanted to show over a hospital episode of care whether there are patients where the Medicare program saves money. And we wanted to come up with a predictive model so that those patients could be identified before they came to a long-term care hospital with administrative data that's available to both the hospitals and later to CMS so they can do a payment adjustment.

So we are recommending a payment model that

rewards long-term hospitals for admitting cases that save money, and it's quite substantial. We found -- we've got a linked file; we followed the cases -- that long-term care hospitals in 2010, using 2010 payment policies, saved the government $282 million. You take that and what CBO would do with that over five and ten years, it's not short money.

Also, we've identified these are high CMI cases, as you know, that are at very high risk of readmission if they stay in acute hospitals because of the incentives of IPPS which also generates more costs.

So I hope that's helpful.

MR. HACKBARTH: Okay. We are adjourned. Thank you.

[Whereupon, at 11:53 a.m., the meeting was adjourned.]